NATIONAL QUALITY FORUM

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MEASURE APPLICATIONS PARTNERSHIP
MEDICAID TASK FORCE
IN-PERSON MEETING

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THURSDAY, JUNE 5, 2014

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The Task Force met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 9:00 a.m., Harold Pincus, Chair, presiding.

PRESENT:
HAROLD PINCUS, MD, Columbia University, Chair
GEORGE ANDREWS, MD, MBA, CPE, FACP, Humana, Inc.
MARSHALL CHIN, MD, MPH, FACP, SME: Disparities
FOSTER GESTEN, MD, FACP, National Association of Medicaid Directors *
NANCY HANRAHAN, PhD, RN, FAAN, SME: Care Coordination
MARC LEIB, MD, JD, SME: State Medicaid
CYNTHIA PELLEGRINI, March of Dimes
JENNIFER SAYLES, MD, MPH, L.A. Care Health Plan
ALVIA SIDDIQI, MD, FAAFP, American Academy of Family Physicians
ANN MARIE SULLIVAN, MD, SME: Mental Health

NQF STAFF:
HELEN BURSTIN
MEGAN DUEVEL ANDERSON
LAURA IBRAGIMOVA
KAREN JOHNSON
ALLISON LUDWIG

ALEXANDRA OGUNGBEMI

ALSO PRESENT:

FARZANA ALAMGIR *
SEPHEEN BYRON
STEPHEN CHA
ANDREW CHALSMA *
JUNQING LIU
ERIN GIOVANNETTI *
ALAN HOFFMAN
MARSHA LILLIE-BLANTON
KAREN LLANOS
DORIS LOTZ
EDDY MEYERS *
D.E.B. POTTER
CHERYL ROBERTS *
MARGO ROSENBACH *
MARSHA SMITH *
CAROL STANLEY *

* present by teleconference

A G E N D A

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

9:05 a.m.

CHAIR PINCUS: So, why don't we get started. I want to welcome everybody here to the Medicaid Task Force for the National Quality Forum and the Measurement Applications Partnership.

We have a fair amount of work to do over these two days, and I'm looking forward to working with all of you. I thought we'd start off by having some introductions, and just go around the room, and people can introduce themselves.

I'm Harold Pincus. I had a fair amount of experience working with NQF in a number of ways. I'm on the Measurement Applications Partnership Coordinating Committee, and have also worked on the endorsement process on several committees, as well. My day job is at Columbia University where I'm Vice Chair of Psychiatry and Director

of our Translational Research Institute at Columbia. And also I'm Director of Quality and Outcomes Research at New York Presbyterian Hospital.

MS. DUEVEL ANDERSON: Hi, I'm Megan Duevel Anderson. I'm the Project Manager for the Medicaid Task Force, and welcome all. Thank you so much for being here.

MS. LUDWIG: Good morning, everybody. I'm Allison Ludwig. I'm staff here at NQF.

DR. BURSTIN: Good morning, everybody. Helen Burstin, Chief Scientific Officer at NQF; new title as of a week ago. It's still strange to say, but welcome, everyone.

MEMBER HANRAHAN: Congratulations.

DR. BURSTIN: Thank you.

MEMBER HANRAHAN: Nancy Hanrahan. I'm a nurse. I am on the faculty at the University of Pennsylvania, and I mostly do research in the field of Behavioral Health and

Substance Use.

MEMBER PELLIGRINI: Good morning. I'm Cindy Pelligrini. I'm Senior Vice President for Public Policy and Government Affairs at the March of Dimes. My office is just two blocks away, so March of Dimes sends me to anything involving NQF, so I represent us on the National Priorities Partnership. I'm on the MAP Clinician Work Group, and I think the Patient-Centered Work Group, and this one, and the Maternity Action Team.

MS. LOTZ: I'm Doris Lotz. I'm the New Hampshire Chief Medical Officer, and I'm here to present the New Hampshire measure application experience to you later this morning.

MEMBER LEIB: I'm Marc Leib. I'm the Chief Medical Officer of the Arizona Medicaid Program, commonly known as AHCCCS.

MR. CHA: Hi, I'm Steve Cha. I'm the Chief Medical Officer for CMCS and just here in

support of our Quality Team. I apologize I can't stay the whole day, but I wanted to listen as much as I could. Thanks.

MS. JOHNSON: Good morning. I'm Karen Johnson. I'm a Senior Director here at NQF, and I'm here just to help with any of the technical questions that you might have.

MS. SULLIVAN: Hi, I'm Ann Sullivan. I'm the Acting Commissioner, the Office of Mental Health in the State of New York.

MEMBER ANDREWS: Good morning. I'm George Andrews and I'm Humana's Corporate Chief of Quality.

MEMBER CHIN: Marshall Chin. I'm a General Internist and a Disparities Health Researcher University of Chicago. This is my third current NQF Group. I'm on the MAP Coordinating Committee, I'm on the Risk Adjustment and Socioeconomic Status Committee, and this one.

MEMBER SAYLES: Good morning. I'm

Jennifer Sayles. This is my first MAP meeting. I previously was the Medical Director of Quality at LA Care Health Plan and recently started in a role as Associate Chief Medical Officer for the LA County Department of Health Services.

MEMBER SIDDIQI: Hi, I'm Alvia Siddiqi. I'm the Medical Director for Illinois HealthConnect, which is the Primary Care Case Management, PCCM program. We should talk later. And I am a family physician so I'm representing the American Academy of Family Physicians today.

MS. LLANOS: Hi, everyone. I'm Karen Llanos. I'm at the Center for Medicaid Services at CMS, and lead the work related to the Medicaid Core Set, as well as the Adult grant program which is testing the collection of the measures. And then we also have some folks here representing the Quality team, Dr. Marsha Lillie-Blanton, our Chief Quality Officer, and

Elizabeth Hill.

MS. LASH: Good morning. I'm Sarah Lash, Senior Director here at NQF.

CHAIR PINCUS: Do we have some people on the phone, as well?

MS. STANLEY: Carol Stanley, Quality Improvement with Virginia Medicaid.

CHAIR PINCUS: Anyone else?

MS. ROSENBACH: Margo Rosenbach for Mathematica Policy Research.

CHAIR PINCUS: Anyone else? Thank you.

So, I don't know how many of you have had direct experience with the issues around the program that we're actually going to be reviewing measures around, the Medicaid Voluntary State Reporting Program, but I was actually involved with the initial go-round for selecting the measures. And a number of other people --- I don't know if people here were there. Helen, were you there, the original sort

of measure selection process for this?

DR. BURSTIN: Yes.

CHAIR PINCUS: And it was really sort of an interesting experience where I don't know, I guess about 50 people were in the room and we reviewed different measures in subgroups and then sort of narrowed them down, and then voted in a larger group with a series of, you know, little remote control buttons, which actually immediately --- then it gave me feedback about the relative votes for each of the ones. And it was --- actually, a lot got done in an amazingly fast amount of time. And it actually some sense given how compressed the time was.

And what's nice about this meeting is now we're going to get some information about it, so what happened? What was the result of all that? At least preliminarily we're getting a picture of which states participated, which states didn't, what was the experience of

states that participated. And we're going to be looking at this in several different ways. So, at least from my point of view I find it to be a fascinating process, and I'm looking forward to really doing what we can to help out CMS in terms of making this program more effective and meaningful, and really sort of continuously improving it over time. So, let's go through the slides initially.

So, here's the full list of members that include members of specific organizations that are designated. And, by the way, not everybody could come. Some people like Foster Gesten just emailed us last night that he was ill and was unable to come. And then there are certain people here as the representatives of specific subject matter issues, Care Coordination, Disparities, Medicaid ACOs, mental health and state Medicaid programs that are key to the Medicaid population, and are obviously relevant. And then, of course, we

have people from CMS which runs the Medicaid Program along with the states.

So, our charge, and let me --- I'm actually going to read this because I think this is key as we think about it, is to advise the MAP Coordinating Committee on --- so, we will make recommendations to the committee above us, so to speak, that then makes recommendations to CMS. So, we're advising the MAP Coordinating Committee on recommendations to CMS for strengthening and revising measures and the identification of high-priority measure gaps in the Initial Core set of Health Care Quality Measures for Adults Enrolled in Medicaid, the Medicaid Adult Core Set.

So, those are the two key components that we have as our charge. One is to recommend around the existing measures, make recommendations about how we can improve the existing measures. And the second one is to identify high-priority measure gaps, so those

are the sort of main areas that we're going to be coming to some conclusions on.

And as noted from before, the Task Force consists of some people who are currently on the Measurement Applications Coordinating Committee, like myself and Marshall, and other people who have been involved in MAP or NQF activities in one way or another that have some particular relevant expertise for the Adult Medicaid population.

And the other important thing here is that our report, the report of the MAP is due to CMS in August, so it's a fairly tight time frame.

So, some of the things that have come up at other meetings that have happened, and speaking specifically about the webinar that we had, and I guess it was just a webinar meeting. Right? Oh, the webinar and teleconference. So, it's to think about how we can think about this on an annual basis in terms

of adding measures to fill gaps so that we may want to come up with recommendations around that.

What measures no longer make sense either because the measures have been changed, sort of the core measure from which those measures were derived has been changed for various reasons, or because of the evolution of various other programs, it makes sense to either retire measures or to make some significant changes with those measures.

We want to hear from states individually, and we have that on the agenda to hear from states, including states that participated, as well as states that didn't participate, how we understand some of the issues of the diversity of states and populations within states, and the way in which Medicaid is implemented in different states in terms of how they put together different benefit packages and other kinds of

arrangements through managed care.

And then to think about the reality of the fact that, you know, there really is no set standard for how everything is done, not just within the Medicaid Program, but really for the entire health care system. So, how do we sort of navigate within this sort of trade-off between trying to get everything to be the same and comparable versus the reality that everything is different?

So, what we want to do today is really get a deep understanding of what's going on as states have tried to apply these Adult Core Set Measures. What's been their experience, and what they can do, what they can't do, the degree to which they're able to get things that are aligned in a similar way, and what some of the differences are, what are ways in which we might be able to overcome some of those differences and think of ways of sort of dealing with that. Getting the states direct

experience, both quantitatively and qualitatively about how they have tried to grapple with these problems and issues. And then from that, to come up with some sensible recommendations about what to do with a current measure set, adding, making changes, removing measures to the set. And then to think about is there a way we can advise CMS about how to improve the program over time.

So, basically, we are meeting today, June 5th and 6th. We have to go through all the material, all the sort of testimony, so to speak, and come to some conclusions at the end of tomorrow. The staff will put together a report that we'll have an opportunity to review. And that then goes to the MAP Coordinating Committee, which is meeting July 18th, and we'll be presenting the results of our report. There'll be discussion there, and they'll be coming to some conclusions, putting their stamp on the final report. Then that has

to go out to the public to review that, and to get feedback. And then we need to respond to those comments that come back from the public to see if there's any changes that need to be made. And then the final report goes to CMS on August 30th.

And then, presumably, the process begins again in terms of implementing, see what the responses of the states, getting information back on sort of the continual improvement process.

So, Karen, do you want to talk a little bit about sort of what the experience has been from your perspective?

MS. LLANOS: Sure, absolutely. And I will say just to kind of finish the time line, according to the legislation we have to issue annual updates by January 1st of each year, and then they'll take place the following year, as well.

So, I think first, thank you,

Harold, NQF, and MAP Members. I think we are so looking forward to hearing from the State panelists, as well as the MAP Members on their experiences and expertise, and ways that we can continue to evolve the Core Set.

In April when we all met via webinar, I think we wanted to make sure that folks knew how this MAP would be different than some of the others MAPS you might be serving on. And I think there's probably about two to three key differences; the first one is this is a voluntary reporting program, so there's no incentives or payment tied to measure collection, as it is in some of the other CMS programs. Completely voluntary at the state level. We've seen a great amount of state uptake this year, but that's because we had an Adult Grant Program that's also a two-year program that's ending, so just to kind of capture what you'll see in this first year of reporting, which is my second point, is we just closed

first year reporting, so this is a brand new reporting program in many respects.

We spent last year tightening the technical specifications. We just released this year's, and we've learned a lot from the technical assistance questions, from the feedback from our grantees, and then from non-grantee states on how we could make the specifications clearer, how some modifications or changes needed to be made in order to make this a state reporting program, which is my third point.

This is --- the reporting unit is the State Medicaid Agency, which is again different probably than some of the other reporting programs. So, that means that a lot of what the capabilities and the resources are are really tied to what the State Medicaid Agency has the capability of doing.

And in some cases that means the data source has to be claims-only, in some cases

they have capacity to collect electronically derived measures, sometimes they don't. And that's a lot of the variation that Harold mentioned we're dealing with, I think, in an effort to create a standardized national set. It also means there's a lot of challenges in that, and it's really almost on a state-by-state capacity basis in some cases, and that's certainly what we're learning. But I think the great piece of it is we're just beginning, and we've got great state partners that are here to talk to us about how this first year went, good and bad, I'm sure, and how we can continue to evolve the program.

So, I think the last piece that I'll mention is because it is a very new reporting program, I think we'll want to think about how we can focus on incremental changes since states just kind of spent the past year or so building capacity to collect the current set. So, I would just leave you with, I think we're

open to hearing how we can continue to make this a strong set that can be used by states to understand a broad picture of what their Medicaid Program is providing to adults on Medicaid, and I think we just look forward to hearing more feedback.

CHAIR PINCUS: Thank you, Karen. I think what's important here is that this is really the first time this has ever been attempted. It's a totally new program. And in some ways we're all learning as we're going through this, so it's kind of, you know --- it's an interesting experience to try to do that. And I think it's not like if we find some problems, that anybody would feel criticized or anything like that because, you know, there's no real sort of ownership of it. It's really kind of an experiment, and I think whatever insights we can gain both from hearing from the states, and hearing about the experiences that CMS has had in going through this, and our own experiences,

that I think we should have a free flow of discussion and ideas, and try to generate some really good thinking about this.

So, there's been a tremendous amount of work. You know, NQF has a terrific staff, and they've been sort of plowing through all of the information and material, so Megan and Karen are going to present now some information about how the --- what information has currently been gleaned so far, and give some context to the information in terms of the overall Medicaid Program.

MS. LASH: Actually, I'll just add a few housekeeping announcements before we dive into the content. At least we have one new person in the room that hasn't been through the NQF wringer meeting procedures before, so I wanted to add my thanks to everyone for being here, and to our state panelists, especially, for sharing their perspectives, and to our Project Sponsors at CMS for bringing this

opportunity to MAP.

I wanted to note that we've made a large reservation at DC Coast this evening for dinner at 6 p.m., if anyone would like to join us, rather than ordering room service. And you'll see, you know, a few empty seats in the room today. Those are really for a larger meeting previously this week, and this small group should be able to engage in very active discussion. And please speak up as much as you like.

When you do so, it's very important that your microphone is on so your voice can be broadcast over the web, and over the phone for people joining us remotely, but also for the record. And our court reporter will wave at you and insist that you turn your mic on, if not. So, the way you monitor that is the red light indicates that you are transmitting. If it's flashing green that means that too many other people have their microphone on, and you won't

be broadcasting until someone turns it off.

If you would like to sort of get in the queue to make a comment or ask a question, the way our committees typically indicate that is to turn your tent card on its side. And anyone on the web could use the chat feature to communicate directly with our staff on the side of the room.

And, finally, if anyone needs materials for today's meeting, those are available electronically on our project website through SharePoint, and we also have flash drives if that's an easier mode for gaining those.

I think that takes care of it. Are there any questions of a logistical nature before we get started? Okay.

CHAIR PINCUS: And just one more thing, the point about the microphone. I've already been told that I have to move the microphone closer, so probably need to do that

when you speak.

MS. DUEVEL ANDERSON: Okay. Well, everyone, thank you so much. We are actually going to get started on understanding the Initial Year of Reporting the Medicaid Adult Core Set. There's going to be a lot of information provided.

We have four big components to this section of the agenda, and we're going to talk about the population overview, we're going to talk about the properties of the Adult Core Set and Measures themselves. And then we're also going to look at the MAP prior recommendations and talk about how MAP has previously provided input to CMS. And then we're going to hear from Karen about the implementation of the Medicaid Adult Core Set.

This information is intended to inform your decision making about the measures, and also available or priority gaps and high-level strategic issues, so if you have any

questions feel free to raise your tent cards, but there's going to be quite a few slides and some information during this portion of the meeting.

So, the population overview, we've seen some of this information in prior convenings, but we really wanted to respond to the Task Force interest and requests. This is our best effort to understand the diversity of the Medicaid population and the quality of care across Medicaid throughout the states. The intent of the background information is really to inform your decision making about the best use of the measures at the state level reporting and identification of gaps.

So, though this information is from 2009, we know that about half of all Medicaid enrollees are adults, and half of those adults are elderly and disabled adults, but the other half are non-elderly and non-disabled adults. So, this is actually -- in 2009 was pushing 32

million people that are adults on Medicaid.

We have some spending information. Total expenditures for Medicaid were about $414 billion in 2011. About two-thirds of that was from inpatient care and payments to MCOs, so acute care made up about 60 percent of that $413 million. This is going to be helpful when considering whether or not the measures that are in the Core Set are really meeting the needs of the -- addressing the care that's provided to Medicaid-eligible adults. There is a significant amount of home health and nursing care facility -- nursing facility care, as well.

So, we wanted to look at the impact of Medicaid on access to care, outcomes, and quality of care. We know that Medicaid adults are both poorer and sicker than the average low-income adults with private insurance. On this slide, you want to focus on -- the screen had some issues, but I'll just talk through it.

So, there's a middle blue section of the slide of each of the bar graph clusters, and they show that among other adults with less than 39 percent of the federal poverty level for an income level there are more Medicaid enrollees. Those enrollees have higher levels of fair or poor health that's self-reported, higher level of fair or poor mental health, more -- about half of them have more than one chronic condition, and more than half have any limitation to their activities of daily living. Now, this again is compared to -- the darker bars are the private insurance, and the lighter bars are the uninsured.

So, kind of a little bit more about the health status to expand on this. There is more than half of the non-elderly adult population is overweight, diabetic, hypertensive, has high cholesterol, or a combination of these conditions, so multiple chronic conditions.

The overall morbidity is actually about 50 percent greater than the privately insured population, so there's significant effects on their health as a result of these chronic conditions. There's also a large number of women for Medicaid adults in their reproductive years, so two of three women and about half of the births in the United States are covered by Medicaid which we'll see some measures on maternal and prenatal care in the Core Set.

There's also additional family planning services that are covered. Approximately another two-thirds of family planning services are covered by Medicaid.

So, the Task Force asked about diversity across the Medicaid adult population, and diversity in the states. We know that the racial and ethnic minority populations were disproportionately represented among Medicaid enrollees across

geographic regions. There's actually similar levels of enrollment in Medicaid, about 21 percent of the population in different regions of the United States is uniformly enrolled. An additional nearly five million adults have enrolled in Medicaid as of March 2014 compared to the same time of last year, so Medicaid expansion decisions have really affected the enrollment, and the enrollment expansion decisions and eligibility levels vary significantly by state. We'll see in future slides that federal poverty limits can vary from zero to 215 percent for adults in Medicaid.

There is significant disparities in the portion of the population that are new to Medicaid as a result -- in this same amount of time from last year. Some states have seen an increase of 12 percent or 13 percent, and other states have seen an increase of only 3 percent.

We looked at some rurality, and

about half of states with rural populations have chosen to expand while half of the states with a majority of rural populations did not.

This is a pretty familiar slide for most of us, and we can see the states that have implemented an expansion in 2014, there are 28 states, including the District of Columbia, those are in the dark blue. Light blue states are called open debate states. That means the governor has made strong indications or process has gone through legislature but they haven't actually implemented the expansion yet. And there are 19 states that are not moving forward with Medicaid expansion at this time.

A similar graph shows the eligibility income limits. Seventeen states have a federal poverty level of less than 54 percent for adults in Medicaid, five states have between 50 and 100 percent, another 26 have been 111 and 138 percent federal poverty limit for Medicaid enrollment. There are three states

that have higher levels, as well.

So, there is a couple of different groups that we think about when we think about Medicaid. We have children, pregnant women, parents and childless adults. There is a variation across the regions of the country for each of these individuals relative to the federal poverty limit, so those on the right-hand side, childless adults, the states that are in the southern part of the United States have actually a very low limit of the income levels for childless adults, but other states, or other regions across the country have quite similar income limits, about 138 percent.

Parents have similar income limits for a majority of the states, but in the southern region of the United States we actually see only about 52 percent of the federal poverty limit for an income eligibility level. Pregnant women is pretty uniform across

the different regions of the country, and children is also pretty uniform, and at higher levels of the federal poverty limit.

That was a lot of information. Does anybody have any questions?

CHAIR PINCUS: Just what is the average poverty level?

MS. DUEVEL ANDERSON: I don't know.

CHAIR PINCUS: Because I think it's helpful to sort of give that kind of context here.

(Off microphone comment.)

CHAIR PINCUS: Yes, numbers, yes. What's --

(Off microphone comment.)

CHAIR PINCUS: No, income.

(Off microphone comment.)

CHAIR PINCUS: Yes, state-dependent but sort of on average.

(Off microphone comment.)

COURT REPORTER: Could you please

use your microphone?

MS. LILLIE-BLANTON: So, let's say it's about $12,000 for a family of one, when you go up it's about $14,000 for a family of two, maybe about $15-16,000 for a family of three. And those aren't exact because I don't -- but it's about that.

CHAIR PINCUS: I think it just gives -- it's helpful in getting a sense of context.

MEMBER HANRAHAN: Is there any sense of why the South is so different?

(Laughter.)

MEMBER HANRAHAN: I mean, it's so dramatically different.

CHAIR PINCUS: That's a long story.

MEMBER HANRAHAN: Okay, so it's too long to tell, but -- and it's basically how they interpret the -- or how they establish their regulations around income. Right? Okay. You don't have to say -- say no more.

MS. DUEVEL ANDERSON: So, I think

this is kind of exactly the question that we were getting over the web meeting and teleconference, and it's important to think about kind of the diversity of the programs from what we heard from the Task Force in the web meeting. And there's -- that would be reflective of what are the measures that are needed, what are the quality of care issues that you would like to address?

We do have measure gaps and strategic issues, kind of White papers over there, so if this is an ongoing question that we need to further understand, that would be a welcome thing to do, issues we can further discuss here.

MR. CHA: I would just add that, you know, I think this describes some Medicaid income eligibility limits, and I think you had a slide earlier which gets at this, but for the purposes of this Committee I think it's

critically important to understand the prior history of Medicaid with categorical eligibility, and that in many states adult, particularly childless adults, the median income was zero for many states. So, I mention that because with -- the previous report is 4.8, we just released new numbers this morning, we're over 6 million new Medicaid enrollees. As we think about that new population coming in, it is changing the face of the kinds of quality metrics we need to track, and the kinds of conditions that we should be sensitive to within the Medicaid Program because of that primarily adult male population, particularly around behavioral health, substance abuse, for instance, among others. So, I think it is partly about the income limit, but it's really -- a big piece of the story as we move into this new world is about the removal of that categorical eligibility for expansion states.

MEMBER HANRAHAN: I think also that

in considering measures, health measures is what we're doing. What I read from this data and this information is that poverty is an overwhelming confounder to everything we examine around measures. And I know enough about the research world enough to know that we're still trying to pull apart the meaning of that, so just to say what's the elephant in the room. It's really -- poverty is a terrible level of people's health.

MS. LLANOS: So, I think there's one other piece that will provide some additional context in a broader sense. So, there's a Child Core Set that we released three and a half years ago, as well, that State Medicaid and CHIP agencies have been collecting over the past three years. So, I just want to make sure folks know the whole context, so it's not -- we're not just measuring adults for the purposes of this conversation. Yes, but we've also had this other reporting program that states have also

been working on. That would include the children, some of the pregnant women measures, and we can discuss that a little bit more, but there are some overlap in terms of the types of quality health care issues.

CHAIR PINCUS: So, I'll call on myself for a couple of comments. I think that's a really important point, Karen, because -- and we may want to hear back in one of the other segments of our meeting about the degree of overlap of experience in implementing the child measures, as compared to the adult measures, because I think that's -- you know, for the child measures, I think -- which relates to some of the information that Megan has just presented. Because it seems to me that two things become very apparent from this. One is sort of, you know, as Nancy said, the overwhelming importance of poverty and how that reflects on the sort of social determinants of health that are so important to think about,

that are sort of outside the health care system in a lot of ways as we sort of begin to address that.

The other thing is that the Medicaid expansion is making the states more different increasingly so, so that there's even greater diversity and variation among states in terms of the populations that are being included.

MEMBER HANRAHAN: Just to ask you a question about that. I don't understand how that is impacting this phenomena of poverty, and then ultimately how we look at measures of health. Are we seeing more people, impoverished people, or recognized impoverished people in our databases now that we can examine or, you know, what is the meaning of that, in your opinion, in the work we're doing? To you, to what you just said, Harold.

CHAIR PINCUS: I think that -- I guess the two points are that -- your point about poverty being -- you know, obviously,

that's the intent of Medicaid to really focus on making sure that there's a way of providing health services or paying for health services for the most vulnerable populations. And one way of capturing the definition of vulnerability is by poverty, is by certain sort of categorical elements, how it's designed. So, that's sort of implicit or explicit, actually within the Medicaid program as a whole, that that's its focus, so that's going to be there. But it also points to the fact that given that fact, there's a role for health care, but there's also a role beyond health care because a lot of the variation that we're going to see, and a lot of the strategies for improving health are going to be outside the health care system. That's true for every population in a lot of ways, but it's exaggerated for people that are most vulnerable.

MS. DUEVEL ANDERSON: Okay. So, we're going to have a real quick snapshot --

(Off microphone comment.)

MS. DUEVEL ANDERSON: Oh, of course.

MEMBER CHIN: I just have a basic question, but given this is a voluntary program and evolution, both now as well as thinking about the future what is the use of these measures along the spectrum of quality improvement and accountability in different types of audiences in all of today's discussion?

MS. LLANOS: So, the ultimate purpose of the Core Set is two-fold. So, it's -- one, will be some of the first time that CMS is having access to data from a State Medicaid agency across -- to a degree on a parsimonious set of health care quality measures, so it'll help us understand how the Medicaid Program is performing at some point.

Ultimately, what we want to see is the states want to collect these measures, see the value of the measures for their own

purposes, and to use that data to drive local innovation and quality improvement. So, we've got a technical assistance and analytic support program that will work with states to understand how they collect and report the measures. But, ultimately, we know we don't want this to be a program for reporting's sake. Right? It's voluntary so that will kind of be difficult to do. We want states to take ownership, and understanding, and seeing the value of how these measures can help them understand how to be more effective purchasers, and how to really use it to understand what areas need to be improved continually.

MS. LASH: Could I voice a question that I think we've heard indications of earlier, and that is the intention or the ability of the measures to generate comparisons across states. I think many people have jumped to that as a potential use for these measures, but in some of our conversations leading up to

this meeting we've discussed, as you said, the real audience for the measurement information being the state itself, to look inward. And, as you said, drive purchasing decisions and other design issues, so do you just want to confirm or elaborate on that at all?

MS. LLANOS: Sure. So, certainly in this first year of reporting we're not -- we're taking it really slow in terms of what do the data mean, so we're not publishing data publicly. We want to make sure we understand, one, at CMS what the data mean. Two, to make sure that we're actually not creating a disincentive for a state to collect the measures. I think we want to make sure that states see these measures for the value. I think, ultimately, at some point they can be used to do state-to-state comparison. I think a state will always -- I'm looking at Dr. Lotz because I don't want to speak for a state, but I -- in our interactions with our grantees, they kind of want to know how

they're performing compared to others. I don't think we want to be that specific just yet, but certainly we've been hearing that. I think we want to operate cautiously in that area until we really know that we've got confidence in the data that's reporting for that.

MS. LOTZ: So, that's from the formal CMS perspective, and I can't tell you how much I appreciate that. But because the states are very varied, they deal in very different political environments, and Medicaid is a political organization as much as it is anything else, so you have to respect that. But prior to CMS taking on this more formal approach to measures, developing the tech specs, and requiring, or not requiring but at least enabling states to report on similar measures, through the Medicaid Medical Director's Network we have already gotten together on a few occasions to look at a situation, try to measure it similarly, and then go that next step to say

okay, now who's got the best measure, and how did you get there?

When you look at the medical literature there are many quality improvement initiatives, but not all of them deal with -- or not many of them deal with the complexities inside the Medicaid Program, so it's certainly the vulnerability of our populations, but as well the highly charged environments that we work in, and the kind of opportunities that present, and how you navigate through those opportunities toward success. So, we are already doing that. It's, obviously, as Karen said, not a CMS mandate, and we appreciate that because there's no right way that's emerged, there's no best practice. But that being said, we're a chummy group. You know, for the most part the Medicaid Medical Directors across the country know each other. We get together periodically, and there's a lot of informal comparisons or discussions going on that's

enabled by saying let's all measure this the same way and let's see who's really got a beat on how they might go about -- how they went about getting to better performance, and how can we share that?

MR. CHA: Just one more frame to respond to that question. I think that, you know, at CMS we have -- I guess we're looking at the Core Sets from two main perspectives. One is, I think as discussed, how we get all of our states to uniformly report, and how we can develop some capacity, initial, preliminary toward state comparison, how we support individual states in some of their QI efforts in that frame. But I did also want to just frame up the other way that these fold into our discussions, which is that we are heavily engaged in large-scale reforms with some of these states, and large and federal investments in some of these delivery reforms for states with shared savings, large restructures of

investments to try and think about how we promote and transform delivery systems within a state at a time. And I think in that frame it has to be much more state-specific given the level of investment and deep dive into that state.

But I will tell you, the conversation starts here with each of the states. How can we start with this Core Set, and how can we leverage off this Core Set. Because of the work that you all have done and contributed, it is -- and the states have not pushed back. I think the concern in those Leapfrog states is really about capacity, data systems, all those types of issues. Some of these are amount of care states, some of these are not, so all of those types of issues. But I just wanted to frame up that there is sort of the effort to use these for all states, and then how we use these for those Leapfrog states. And it is critically important and central to both

those conversations.

CHAIR PINCUS: So, Steve, what you're saying is -- Stephen. Do you prefer Steve or Stephen?

MR. CHA: Either one. Steve's fine.

CHAIR PINCUS: So, I mean, I think what you're expressing is really the challenge that both we, and especially the Medicaid Program faces. It's sort of --- with these measures it's kind of like trying to hit a moving target while riding a runaway train kind of thing, where there's significant changes going on. And that's on top of the large variability across states in both populations and programs.

MR. CHA: Yes, I guess I would defer to Karen and Marsha and their thoughts, but it strikes me that it is hard to anticipate all the variations between states in that second bucket. That I think the primary charge for the Committee should be focused around that first

bucket of uniformly measuring, but having in the backdrop an understanding that this is --- has impact way beyond some of the QI efforts that we're describing, well into some of the formations of these Leapfrog efforts, as well.

CHAIR PINCUS: I think, and we'll probably come to discuss more of this later on. This is not --- the issue of sort of the variation in terms of programs and populations, and sort of --- and the issues that come into this for measurements is not limited to just the Medicaid Program. It cuts across the private sector, as well. And there's been some information that's been gleaned from some of the private sector work that can be informative to this, as well.

MS. DUEVEL ANDERSON: Okay. So, this is a great discussion. So, this is just, again, a snapshot of the current Core Set. I'm actually going to talk about the CMS goals and the structure of the program pretty briefly next.

There are 26 measures in the Core Set. We're going to talk about the different characteristics of them and their properties. The Medicaid Adult Core Set addresses the different --- the six different properties of the National Quality Strategy. The priorities that have been identified to be addressed by the most measures are healthy living and well being, and also patient safety. So, the National Quality Strategy and the CMS Quality Strategy priorities are listed here. So, what we'd like the Task Force to think about is whether or not this is the right balance of the priorities to be addressed, and whether or not there are priorities that are not sufficiently addressed among these different strategies.

There are some other characteristics that we consider, and we'll review the measure selection criteria in a moment, but the majority of the measures in the Core Set are NQF-endorsed. There are a majority

of process measures, and there are some outcome measures. Yes, Cindy?

MEMBER PELLIGRINI: Sorry, just a quick question. Do we have a document that would show us which of the measures are categorized in which of those buckets, whether it's care coordination or wellness promotion? Because there are some that I think we could probably argue about what they are.

MS. DUEVEL ANDERSON: Yes, there's been a lot of work to partner with CMS to address the --- to address tagging measures to which properties. There is a draft criterion to do that, so we can look at the measures. By that I think there was a spreadsheet that was made available during the web meeting that had listed the properties in the priorities that were addressed, but we didn't re-post that. We can make it available again.

MEMBER PELLIGRINI: If we're going to be talking about whether that's the right

balance, that would help.

MS. DUEVEL ANDERSON: Sure. Okay. So, in addition to having a majority of process measures, there are also some outcome measures in the Core Set. There are some measures that are identified as disparity-sensitive and four measures that are risk-adjusted.

The majority of the measures have both one or both administrative claims or electronic data. There's also measures that have e-measures available, and some measures that require survey data collection.

Alignment has been stressed in the web meeting, and previous conversations with this Task Force, so 15 of the 26 measures are in use in one or more federal programs. Three are aligned with the Medicaid Children's Core Set. And this looks funny because the slide number is next to the actual number, but 12 measures are in the Health Insurance Quality Rating System, and additional --- the new beta

set has recently received --- or was recently released, so those 12 measures align with the 26. Yes?

MEMBER SIDDIQI: Quick question. What's the e-measure reporting ability for states?

MS. DUEVEL ANDERSON: So, there's both electronic or the hybrid measures have C-- some hybrid measures in the Core Set, some measures that have been identified through NQF endorsement as having e-specification, and that's what that number reflects, is they're NQF-endorsed.

(Off microphone comment.)

DR. BURSTIN: Well, I'm certainly happy to take the question about what an e-measure is, but I also think that part of that question which I can't answer, which is more for Medicaid, is how do states actually report e-measures, I think is part of the second part of that question.

The first part of it is really just looking at --- and Steve's already giggling, so that's not good. But the idea would be to see if there are some measures that can be developed either completely out of electronic health records and potentially rolled up. Or even more so, we're recently is more hybrid measures where there's a group of --- a set of information that comes from claims, and then certain clinical data are pulled in to enhance the measure and make it more clinically relevant off of the EHR.

MS. LLANOS: I can start. I think the --- when we first identified both the Children and Adult Core Sets, the biggest piece of feedback that we got from states was the data source was most important and critical to uptake on any kind of measure. And I will say I think based on our experiences with both Core Sets, the e-measures, measures that don't have a paper specification that are just e-measure

only, and we've only got a couple of those in the set, those probably have the least number of states reporting. I think that's just a data capacity issue that is across the country, so it really varies from state to state. Sometimes it varies from health plan to health plan, or provider to provider.

DR. BURSTIN: One more thought. I perhaps said a population level, the other way to frame an e-measure I think would also be to think about whether there are other population level state electronic data sets from which information could be pulled, which is sort of a very different model than we've talked about in terms of the provider level e-measures of pulling it out of EHR. I mean, could you pull data directly from State Registries, for example, to get to the immunization measures for the state? And perhaps that's already been considered significantly, but it might be an interesting discussion with the State Medicaid

Directors in the room.

MR. CHA: And I think some of that is happening. Where we're seeing the e-measures being reported to some degree. And I should also add as much as plan to plan, sometimes vendor to vendor for the HIE in terms of interaction between the state and the vendor they've selected. But we do have states that have moved forward with Health Information Exchanges, fairly robust in some states. And in those states we're seeing a little bit more integration of these data sources, but it is still a challenge, and I think it's still something we're trying to unpack. Again, if you don't know the answer in Medicaid, the questions probably vary state to state.

MEMBER ANDREWS: Just to clarify for everybody. So, adult BMI, there is a code. It's a hybrid. You have to look at the record, or you can use a code and report it. So, would that be an e-measure?

MS. LLANOS: The one that we've got in our Core Set is, I believe you can either just do it from claims, or you can do a medical chart review hybrid. So, if it's the one that you've got here, it's the NCQA measure where --- so, it's the NCQA measure. So, I think it also happens to be a measure in our Meaningful Use Program, so a state actually has a couple of different options in collecting this one.

MS. DUEVEL ANDERSON: And when we go through the measure by measure review, we'll actually note whether or not states reported, or had the ability to report the hybrid measures, so we can talk more on the measure level.

CHAIR PINCUS: And one of the issues we may want to discuss during the measure by measure review is what are the implications of having a hybrid measure where there's options to report either a claims-based or a chart review measure?

MS. DUEVEL ANDERSON: Okay. So, in addition to the National Quality Strategy, we also tried to look at some of the conditions that were covered in the current Medicaid Adult Core Set. And each measure was kind of looked at quickly, and we do have quite a few measures on preventative care and screening, some measures on behavioral health and substance abuse, and cardiovascular and diabetes. There are measures of care coordination and experience, but there are also measures of maternal and prenatal health, two measures of respiratory care including COPD and asthma, and one measure to address AIDS and HIV care.

So, having considered this information, I'm going to go through the measure selection criteria pretty deliberately. These seven criteria have been used across all of MAP, and we might want to consider if any of these would like to be emphasized for the purposes of the Task Force

decision making, and we'll open it up to discussion after I go through each of them.

So, the first criteria is that NQF-endorsed measures are required for programs that measure sets, unless no relevant endorsed measures are available. And the second criteria is that the program measures that adequately addresses each of the National Quality Strategy three aims. The program set is responsive to specific program goals and requirements. We're going to go over those CMS goals very specifically in a minute. And the measure set includes an appropriate mix of measure types, so we talked about the fact that the program is majority made of process measures. The measure set enables measurement of person and family-centered care and services. The measure set includes considerations for health care disparities and cultural competency, and we'll probably continue to discuss that, but we've already had

some discussion on that this morning. And the measure set promotes parsimony and alignment. Does anybody have any questions on the MAP measure selection criteria?

And the criteria are really intended to look at the set as a whole, but there are also often pretty --- really good for evaluating a single measure, so when we think about a single measure, how does it contribute to the measure set, and how does it meet the measure selection criteria?

So, in the fall of last year, MAP was able to convene the Dual-Eligible Beneficiary Work Group to do an expedited review of the current Adult Core Set, and provide just-in-time input to CMS for their annual feedback.

That report was distributed among the other materials, and is readily available if anyone would like a copy. They completely a reassessment of the Core Set, and found that

they really appreciated the investment made to identify the Core Set Measures, and the need for states and CMS taking experience with their use throughout this first year of reporting.

So, there was found to be sufficient attention to the different aims and priorities of the National Quality Strategy and the CMS Quality Strategy. The set was found to be adequate to address the stated goals of the program with a satisfactory portion of outcome measures, and strong alignment with the program set and other federal programs.

They also determined that large changes to the set would be premature given the need to gain more experience, and that changes could have unintended consequences given the states' significant efforts to build up their capacity and their infrastructure, and have a negative impact on the CMS goal for increasing participation and driving quality improvement.

There are three overarching types

of measure-specific recommendations. The measures should be used in their endorsed form, when possible, to maintain their scientific validity and reliability. Paired and composite measures should be used as designed to maintain their integrity and prevent data collection challenges. And measures that have lost endorsements should be reevaluated for their use in the Core Set.

And there's two phases of this. In a case where a measure has lost endorsement but the steward intends to resubmit the updated version should be used in the Core Set. But when the steward has no intention of providing an update, the measure should no longer be used, and a suitable replacement should be identified. This is because of the concerns about validity and reliability, and maintaining the measure over time.

Some avenues for strengthening the Core Set were identified. That over the long

term additional key areas needed to be addressed, mental health screening, and potentially a composite measure for it. Access to services, particularly reproductive health services for individuals with disabilities, and wrap-around services to Medicaid social determinants of health. We've already heard about the impact of other services and other socioeconomic status issues that affect health. And the individual goals of care should be addressed, including functional status and quality of life.

We have some significant feedback that we're going to be reviewing from the implementation of the Adult Core Set. Our colleague, Karen Johnson, is going to present at the end of this section, but the Medicaid Adult Core Set was a requirement of the Affordable Care Act to identify a parsimonious set of measures that is reflective of the diverse health care needs of adults in

Medicaid.

The Core Set was additionally identified through a multi-stakeholder process, much similar to MAP and how we convene. A voluntary reporting began in federal fiscal year of 2013 with the Technical Assistance Program. We've heard about that TA Program, and we're so glad that Mathematica has joined us on the phone. The two-year grant program began in December 2012 to support Medicaid agencies in collecting and reporting the measures. And 26 states have participated in that grant program, and are required to complete at least 15 measures in 2014. In the future, CMS has plans to make some of the information reported by states publicly available, and they've talked about avenues to do that through reports to the Secretary.

CMS has three very specific goals for the Core Set. It's a new reporting program, and CMS is working really hard with the states

to understand the Core Measures and refine the reporting guidance, so we'll hear a lot about adaptations.

The three specific goals are really to increase the number of states reporting the Core Set Measures, increase the number of measures reported by each state, and increase the states using the Core Set to drive quality improvement. So, we really want to keep these three goals in mind, and you'll probably hear me say them a couple of times throughout the two days, but when we're making decisions, really, these are the goals we want to keep in mind.

CHAIR PINCUS: And just to re-emphasize that, because I think that, you know, one thing that we've learned from this measurement process is that when you put these measures out there, that's what people focus on. People focus their resources on that so, you know, if we have measures in there that are of lesser importance, less valid, and don't have

measures that focus on key needs of important components of the population, we may be focusing resources or indirectly causing resources to be focused in the wrong place. So, we should be thinking about that very seriously.

MS. DUEVEL ANDERSON: In addition to the 26 states that were part of the grantee program, we have four non-grantee states that participated in data collection and reporting in 2014, so a total of 30 states. There is a list of them on the screen, but they also have the number of measures that were reported. We have some superstars that reported 24 measures, and some other states that were able to report 15, 16, 17 measures as part of the grant program. And there is an additional four states that were non-grantees that participated in reporting varying levels of the measures, so Virginia is going to share a presentation later this morning, and they were able to report eight

measures as a non-grantee state. But we also have -- Louisiana will be over the phone and in the room we're so happy to have someone from New Hampshire representing us, so thank you, Dr. Lotz.

This is a kind of a small graph, a tight graph of the number of states that reported each measure. We're going to look at this a little bit more closely as we go throughout the two days, but you'll see states, there's --- some of the measures had high levels of reporting, some of the measures on diabetes, cervical cancer screening, postpartum care had more than 25 measures, or 25 states that reported those measures, while other measures really did not have strong levels of reporting, and there were some measures that had moderate levels of reporting.

At the very top you'll see HIV viral load suppression. This is a measure that was newly added to the Core Set, so there wasn't any

reporting for federal fiscal year 2014.

CHAIR PINCUS: One question. When we say that a state reported a measure, does that mean they reported it for the entire Medicaid population, or for a portion of the Medicaid population?

MS. DUEVEL ANDERSON: Yes. So, actually, Karen is going to touch on that briefly. And there was individual measure sheets that actually clarified for each measure states sometimes reported different populations, whether or not it was the Medicaid adult population or if it was Medicaid with duals population. It varies by measure and by state.

MEMBER ANDREWS: I have a question.

MS. DUEVEL ANDERSON: Of course.

MEMBER ANDREWS: Is there an ideal or optimal number of measures that a state would be expected to report on?

MS. LLANOS: No. So, the reason you

see 15 most commonly is because those are part of a grant program where the minimum requirement of reporting was 15.

MS. DUEVEL ANDERSON: I think the CMS goal of increasing the number of measures reported and the number of states reporting measures, we did see seven measures reported by Illinois, and eight measures reported by Virginia. We know that states are otherwise collecting and using other measurement information, but this is just what they happened to report for a variety of reasons. And I think that is welcome information. Okay, are there any other questions? Okay, Karen.

MS. JOHNSON: Thank you. So, I just wanted to go through very quickly some summary feedback on implementation that was provided to us. Oh, thank you. I've never actually used this thing.

CHAIR PINCUS: A little closer to the microphone.

MS. JOHNSON: Okay. So, first of all, in going through the measures, this says all measures are modified. That's not really true, most of the measures are modified from the specs that were submitted or endorsed by NQF because they are rolled up or aggregated to the program level. So, most of the measures in the Core Set were specified for health plans, some for facilities, I think one or two maybe at the clinician level. So, in terms of, you know, have these measures been changed? The answer there is yes, almost all of them have been changed from the actual specifications in the measures simply because of the roll up.

The guidance given to states allows for calculation of a weighted average if they are using aggregated data. So, generally, one thinks about calculating these scores or measures just by taking patient level data and then aggregating to whatever level of analysis they are interested in, but states may not

actually have that patient level data. They may be given aggregated data, for example, from MCOs that are operating in their state. So, the idea of using a weighted average is just to take those aggregated data that they are given and combine them in some way to get some kind of --- one number, one state right. So, that is what is allowed.

I think it is --- you should just keep in mind that the reliability and validity of the measure scores are unknown to some extent because the testing that was done on measures that are endorsed by NQF, the testing is done at the level of analysis where they're specified. So, generally, one could usually imagine that reliability might increase because you're increasing your sample size, but that's just something to keep in mind.

CHAIR PINCUS: We know --- do they describe how they weighted the measures? Is that available?

MS. JOHNSON: I have not seen that level of detail. I don't know if the other ---

MS. LLANOS: We get that information through CARTS from the states.

CHAIR PINCUS: Okay, so you would know whether or not they use similar processes and methods for doing that.

MS. LLANOS: Yes, it would be on a measure by measure basis, and it would be up to the state whether or not we encourage them to tell us if they weighted --- used a weighted average, describe the weighting.

MEMBER HANRAHAN: It says here that guidance allows calculation of weighted average based on eligible populations. I would think that the weights would then be population-weighted based on their eligibility. Is that not correct?

MS. LLANOS: So, I think the weighted averages when you're doing a state rate, I'm looking at the other Karen, because I think

that's what this bullet represents. So, the guidance that we provide to states is if they're doing a statewide rate, to --- we've issued Technical Assistance Guidance before on how to develop a weighted rate. And I think it's per eligible population because it depends on what the particular measure is, and who you've got in there. So, I'm not exactly sure I've answered your question.

(Off microphone comment.)

MS. JOHNSON: Yes, I think what --- the idea there behind it is if you're, for example, weighting up over five MCOs, you just --- you know, you give more weight to the MCO that covers the bigger population in your state. I think that's what it's trying to do.

CHAIR PINCUS: What about population characteristics, you know, age, or comorbidity, or which eligibility category they fell into?

MS. LLANOS: That sounds like more of

a state-specific one. If the state would choose that, that's not the guidance that we've given them to do.

MEMBER HANRAHAN: So, it seems to me that this is a major issue. Right? Because we're really questioning the reliability and validity of the data that we're about to review. And nothing is perfectly reliable and valid, I know that, but can you kind of give us a sense of how you counsel these states, and how they would put these numbers together to get the best possible ---

MS. JOHNSON: Well, I think, number one, how you weight isn't necessarily --- the reliability and validity of the measure doesn't necessarily depend on how things are weighted to fit it together. It's a kind of a different question.

At NQF, we think about reliability and validity in a couple of different ways. And a lot of times the testing that is done for

reliability and validity is done at what we call the data element level, so it's going in and saying, you know, is this data element that's used in the calculation, is it consistently get-at-able for lack of a nice jargon there, and does it really reflect what you're trying to show? And a lot of measures that come through, that's kind of testing that is done. And that --- it doesn't really matter what your level of analysis is if that's the kind of testing that is done.

Reliability and validity in the measure score looks at differences --- it actually does look at the scores that are computed, and in that case for reliability what you're interested in is really can you tell the difference between the units that you're comparing. So, to some extent, as long as you're not thinking right now about comparing across states, reliability may not be as concerning right now. Again, reliability at the score

level you probably still may already have reliability at the data element level. And validity is similar, but I think you could probably say that if you had validity of the measure score at a lower level of analysis, I think that would probably roll up to a higher level there.

DR. BURSTIN: And just to add to what Karen said, I thought she described that great, was the idea that as you roll --- we have less concerns about reliability rolling up than we do rolling down. As you get to smaller units of analysis, is I think when you get more threats to those kind of properties. Rolling up, in general, particularly for measures that have data element reliability or validity testing are fine, usually.

CHAIR PINCUS: I think an important point of what Karen made, I think, is that a lot of the issues around how we think about reliability really are dependent upon how the

measures are to be used, so that if we're --- if there's an intention to compare across states is one issue, versus if the goal is to have states utilize this over time to improve their performance. It's a different issue.

MS. JOHNSON: Yes.

MEMBER ANDREWS: I have a question, comment on this. If the purpose here is to be reporting at the state level on the Medicaid population performance on a particular measure, and I pick hemoglobin A1c as an example, and I have in the state X number of diabetics, and those X number of diabetics in that population is supported by two or three Managed Care Organizations, it doesn't make a difference how many there are supporting them because the end result is I'm going to be reporting at the state level. So, what matters is down to the patient level how many of my eligibles that I have, who are diabetics, are getting the control that I need to see? So, I

don't see why these should be weighted, because let's say one managed care organization has more or less, that is a different piece of information that the state would want to have to work closer with that organization or entity to get a better result. But at the end of the day, I as the state will be reporting across the platform on all of my individual eligibles on the kind of performance I was able to get.

MS. JOHNSON: So, let me give you my understanding, and then we'll see if Karen agrees with me. Let's pretend that you have two Managed Care Organizations, and one rate for their patients is 98 percent, and the other rate for the other MCO is 5 percent. What do you do --- how do you get a state rate from that? And I think the idea there is, you know, they're very different and somehow you need to combine those to make one rate. How do you do that? And they're just saying well, give a little bit more weight to the bigger group, the bigger MCO. So,

I think that's how the calculation would work.

MS. LLANOS: Right. And I would just add to that, I think --- so, I think the conversations focusing on what the state is reporting to CMS, but the state is also doing lots of other things with that information. It's not probably using that state rate for C-- I don't know. I look to you guys and to the two state folks, but I would say a state is likely using health plan level information to manage their state. They are probably rolling it down to the practice site in some cases, so they're probably doing a lot more with it than what we're seeing in terms of getting to the patient level, insuring that at a local level, care is being provided.

MS. JOHNSON: Okay. Oh, I'm sorry.

MS. LOTZ: Well, one of the reasons that the states were invited to talk about our experience and where we think there could be areas of improvement, and to somewhat get ahead

of the presentation, this idea of how to aggregate these disparate data sources into a statewide rate is something that I'll simply say at least New Hampshire, we would very much appreciate a standard approach so that we can have the comparability across states, and so we're not all kind of reinventing the wheel as we go. So, strong request to just pick a method, export it to the states and let us all use it, because the variation is not the optimum strategy to aggregating these various data points.

MS. JOHNSON: Okay. Going on, in some of the materials that we looked at the term "adaptation" came through, and I don't know if you'll be seeing those detailed reports, but the adaptations that generally were talked about were what we would call instructions for reporting. So, most often those were saying you should report this rates out for particular age groups, for example 18 to 64, and 65 to 74. This

kind of instruction about reporting is not something that NQF would consider a material change to the measure, and those are not the kind of things that you would be concerned about in terms of changing specifications. Because, again, we do not consider that a change in specification, it's just an instruction for reporting.

CHAIR PINCUS: Just a point of clarification. So, when --- if a state reports a separate rate for the 18 to 64 and from 65 to 74, does that mean they do that instead of reporting a combined overall rate, or in addition to?

MS. JOHNSON: My understanding is that they would have a state rate for 18 to 64, and a state rate for 65 to 74. But, Karen, you might know better than me.

MS. LLANOS: So, it depends on the state, and so we ask them to do that --- if the --- as long as it aligned with whatever the

specification for the measure was, so if it was not to 74, we weren't asking them to provide an age range above what the specification said. In some cases, we did get a state that gave us broader, like a total of three rates sometimes, but that wasn't the case all the time. So, they weren't --- I think unless the measure asks for a total rate, I think we asked them for by the age segments.

MS. JOHNSON: And I think, generally, if a measure doesn't have instructions on how to stratify, the specification would just say compute this for 18 to 74 year olds. So, this is just extra guidance to split them out into these groupings that are meaningful for the Medicaid population.

Some of the modifications that were suggested by CMS in terms of the guidance would constitute what, again, at NQF we would call a material change to the measure. And really, the

one that was the most obvious was allowing a different method of risk-adjustment, or actually allowing not having risk-adjustment to measures that are supposed to be risk-adjusted. So, it turns out that that really only affects the one measure, the all-cause readmission measure. And the guidance for FY13 I believe was that states could either come up with their own risk-adjustment methodology or just not use one at all. I'm not sure if they changed that for the 2014. They may have changed that to just don't do any risk-adjustment at all.

Again, risk-adjustment is used to level the playing field because there's different --- it's a different case mix, you know, in a hospital, or even at a state level. So, again, if you're not intending to compare across states, risk-adjustment is not that big of a deal, unless you think --- and this came up already. It may be a big deal if you're

expecting large changes in your population across time. So, that is the one that ---

CHAIR PINCUS: Is happening for many states.

MS. JOHNSON: Exactly. So, that one is a little tricky. And to be honest, I think the concern with that particular measure is that there was not a Medicaid adjustor, a risk-adjustment for the Medicaid population. I am not sure if the developer is working on that to try to come up with a risk-adjustment methodology. It's the NCQA health claim measure.

DR. BURSTIN: They are actively working on a Medicaid risk-adjustment model is what we had heard when it came through endorsement, which is a while now, so my guess is it may be done.

MS. JOHNSON: So, this may become a moot point at some point soon.

MEMBER SAYLES: Can I make one other

comment on that, just --- I think just in thinking about this, the goal of --- if you take the 30-day all-cause readmission measure, that the goal is not to compare, but to look inward at the state level. I think the risk-adjustment, I mean, I can say from personal experience has become a huge issue because what do you really want to be doing within the state? Well, do you want to be at --- you know, in a managed care state you want to be looking at your health plans and how they're performing. And at the health plan level you want to be looking at your medical groups and how they're performing. And you need to be able to kind of set benchmarks and compare across. And when you have both big transitions and shifts in patient population combined with disproportionately what groups or plans take on those populations, it makes it --- I mean, you really can't --- there's not much meaningful quality improvement work, necessarily. I mean,

you can try and do things but your measurement is going to be very inconsistent and off, so I think, you know, I think there are implications beyond just the state comparison that are pretty significant in those kinds of measures that probably should be considered.

MS. SULLIVAN: Yes, and I was wondering if some states did do some risk-adjustment, if we could understand what they did, because I think there's always questions, especially with this population as to what you mean by risk-adjustment? How much --- and what their experience was with it. And whether or not they felt it helped with the kinds of things you're talking about or not, because where you put your risk --- what you risk-adjust is very critical. So, if some places have done it, it might be interesting to know what the outcome was, and how helpful they thought it was.

MS. JOHNSON: NQF did not see that

level of detail. I don't know if that was included in the CARTS data or not.

MS. LLANOS: There are four states that did their own risk-adjustment. We had asked them not to do any kind of risk-adjustment because a Medicaid-specific risk-adjustor didn't exist. And then there were four --- I mean, I think we could probably pepper in some of that in the measure by measure review, but we've not had a chance to dig deep into it since reporting closed recently.

MS. JOHNSON: Okay. Some of the other modifications that were done to implement the measures in general would not be considered a material change, and would not be something that you would necessarily, I think, have to worry too much about.

One is using a more restricted age range. So, for example, the measure may be specified for all adults 18 and older, and the guidance may be to only report up through age

75, or something like that, just as an example. In some cases there was some guidance where they gave just a little bit more detail about how to compete the measure that may not have been in the actual specification in the measure. So, one example of that was you need to compute age, you know, for one of your measures. And the guidance may be, okay, compute the age as of the end of the year, or those are the kind of things that would not really be a material change to the measure. It's really just an analytic decision on how to compute something.

Finally, there's changing the denominator from enrollees to member months. And I put a star on that one because I went back and forth in my mind about whether that would be a material change or not. And definitely member months is kind of how Medicaid and health plans, too, think a lot of times about their panels. And I think a lot of, you know, whether

that would be a huge change or not may actually depend on even more in-the-grass details about how enrollees were counted originally. You know, if someone is on Medicaid for one out of 12 months, does that count as an enrollee? I don't know if it did in the original measures. And sometimes if you're counting member-months, I know back in the day when I used to do this kind of work, a lot of times you would say well, if there was a gap of one month or 30 days, or something like that we kind of assumed that that was just something a little bit off with our data, and we wouldn't assume that those people were not enrolled. So, that kind of ---those things kind of depend, but I think in general you probably don't have to worry too much about the change from enrollees to member-months.

CHAIR PINCUS: Just a question. So, that is potentially an answerable question.

MS. JOHNSON: Yes, at the individual

level.

CHAIR PINCUS: And I don't know, Helen, whether one can go back to the measure stewards about, you know, sort of asking them about, you know, is there a way to test how much of a difference it makes whether they do it one way or the other?

MEMBER SAYLES: So, I mean, aren't the measure --- I mean, all those measure specifications have very specific criteria around this. Right? So, it's like the HEDIS is --- I guess maybe I'm confused, but the HEDIS is 11 of 12 months with a gap of no more than 45 days for those measures. So, yes, you could report it for a member who's --- an enrollee who met that criteria, or the member-months. That's just a math calculation of that, but either way that's the same, so is that what you're saying?

MS. JOHNSON: Yes.

MEMBER SAYLES: Okay.

MS. JOHNSON: Yes. And what I didn't have access to was all the HEDIS, you know, all the really deep details of how the HEDIS measures and such are specified, so I couldn't look and see. But you're right, if that's how the measures are specified to that level of granularity, then it probably wouldn't matter anyway. Obviously, you couldn't take a state level measure computed that way and compare it to another one where it's looking at enrollees as the denominator but that's understood in all of these measures.

MS. ROSENBACH: This is Margo.

CHAIR PINCUS: Oh, yes?

MS. ROSENBACH: Hi, this is Margo from Mathematica. I just wanted to clarify that the measures that use member-months for the denominator are the PQI measures, and they do not have continuous eligibility requirements. So, they're originally specified for population-based kind of denominator, and so to

create a Medicaid population-based denominator, that's why we specified as member-months rather than enrollees. So, to the extent that there were to be a continuous eligibility requirement, that could take the place of a member-months criterion, but currently there is no continuous eligibility criterion for the PQI measures.

MS. LLANOS: This is Karen. Thanks, Margo, I was just going to say that. And I think the other piece to note is I believe we did that on --- after speaking to the measure steward.

MS. ROSENBACH: That's correct.

CHAIR PINCUS: I guess one of the questions is that as we go through this and issues come up for particular measures, the question will be one, does this pertain only to the Medicaid population, or to broader populations? And what is our ability to go back to the measure stewards about finding ways to sort of fix problems that might have been

identified through this process? I don't know, Helen, if you want to comment on that?

DR. BURSTIN: I mean, that's part of why we do our annual updates and our maintenance process. Again, if there's any evidence that there needs to be a change, and particularly material changes, we can work with the developers to do that. I think what we're really finding is as we're changing levels of analysis of measures, which is now happening very frequently, this is becoming a bigger and bigger issue. For example, NCQA now is trying to take some provider level measures and make them health plan measures, and it's really complex based on the way they've been structured. Do you need, for example, two visits to the provider if you're rolling up to a health plan? Things like that, so NCQA has been really thinking about that quite hard, so I think this is an area where more work needs to be done.

MS. JOHNSON: There were a few modifications to the specifications that were done I think just to help with --- to help states implement. For the most part, I think these maintain the intent of the specs, not surprisingly, but could affect comparability across states. And, again, if that's not a concern then, you know, it's not a concern. A couple of examples would be identifying those transferred to another institution. And there may be different ways of doing it, and I don't remember the details of this particular one. It could just be that the specs were originally set up maybe using a certain type of claims data, and you have to translate that to whatever kind of data you have in your house if you're a state.

Another one is using vital records instead of medical records to obtain gestational age. So, the guidance was clear that that should only be done if you could verify that the information that's on the vital

records is actually accurate, so that's kind of the underlying assumption there. So, again, probably not a problem, but if you do get to the point where you're comparing across states, you may want to look, in particular, more closely at these kinds of guidance.

So, again, we were told about some of the implementation lessons learned, if you will. The reporting was done for federal fiscal year 2013. I always have to put that down in calendar dates to remind myself what that means, so October 2012 to September 2013. Most of them have been adapted, again that's using some of the terminology that you may or may not have looked at. And, again, the most common adaptation is stratification for particular age groups.

I think as Karen mentioned, either if not this morning then in some of your earlier meetings, CMS did have a contract to provide technical assistance, so some of the

information on the feedback just comes from the technical assistance requests, so things that were --- the states asked for help on might be things that were a little concerning or a little harder for the states.

So, in general, most of the measures only had very few requests for technical assistance, so one could either assume that the specifications were fairly straightforward to implement without too many problems, or I guess the other conclusion that you come to is some states weren't even considering particular measures so they didn't need to ask a question, one of those things.

There were --- the measures that had the most requests for the most part were the ones where the denominator changed from enrollees to member-months. And I think the thing there was that that guidance to change to member-months, my understanding is that happened a little bit late in the reporting

period, so it wasn't, I think, so much that people were confused about how to do it, as just the specs changed midway, so there was clarification about that. And Karen is nodding, so I think I have that right.

And then, finally, I believe this is my last slide. The reporting population did vary across states, and we were not, in the materials that we looked at, we weren't given specifics, but in some cases states reported what was listed as Medicaid only, others were Medicaid and CHIP, others were Medicaid with the duals, others Medicaid, CHIP, and duals. And then sometimes even something other, for example, the managed care population. So, I think your question about what is actually being reported across states is a very pertinent question.

CHAIR PINCUS: Are there additional questions that we want to pose to Karen? Okay, Alvia?

MEMBER SIDDIQI: So, were states actually asked to specifically report on their entire population or the Medicaid, CHIP, and dual-eligibles, was that all clearly defined, including the member-month denominator questions? Just curious if there was guidance given to the state, or is it that they reported these differences because that guidance was not given?

MS. LLANOS: The guidance varies by what the particular measure's eligible population is. I would assume that if they did Medicaid and CHIP, it's probably for some of our Maternity Core Measures. That's probably where it would make the most sense. Not all states reported on duals. I think that was probably the hardest population to add to their rates. And I would say I think the other piece to note is it's the very first time we asked these types of questions in our reporting system. Normally, it was just one very broad bucket, and this was

our attempt at segmenting what the Medicaid Adult Population could be, so this has been a learning experience. And I think the definition of it, or the interpretation of those particular --- it's a drop-down menu, was subject to some of that.

CHAIR PINCUS: Other questions?

MEMBER ANDREWS: Yes, in the comment that you made about transfer to another institution. How --- I mean, do the states have guidance as to how to treat a transfer? Because, again, a Managed Care Organization would not consider it, as an example, as a readmission, but if you are not a Managed Care Organization and you're a facility, you will say it's an admission to my facility today. I don't know where you're coming from, or from another institution.

From the state's perspective, how is that looked, or is there guidance as to how to look at that? Is it a second admission, is

it a readmission? What is it?

MS. JOHNSON: I believe that particular comment had more to do with how the measure is constructed. So, for example, you know, the readmission measure, you want to attribute the readmission to the right facility. And there are rules depending on how a particular measure is specified, and I don't remember exactly which ones are which. So, I think the guidance there was just --- it's written --- it could be pretty specific. It might say use, and I don't remember the name of the variable, but it might say use a particular variable that you're used to in the Medicaid system, but if you're an MCO system you're not going to have that name of that variable with those same values. Right? 01 means sent home, 02 means sent to a nursing home, et cetera, et cetera. So, they just try to make sure that whatever your variable is that you use a very similar one.

Now, the question about how it works if the state only received the aggregated data is a different question. I don't know how they would do that.

MS. LILLIE-BLANTON: I just wanted to follow-up quickly on the question about populations in states. There is some variation between Medicaid and CHIP reporting because we have separate CHIP programs in some states. I think there are about 17 states that still have separate CHIP programs. And in that case, it could become more difficult for a Medicaid agency to access the data for CHIP. But we still don't view that as a major problem because by and large, CHIP is a program that serves children under age 18, but there are some states which have included adults, particularly pregnant women and mothers in their CHIP programs, but there was a point in time when Congress stopped states from doing that and made it a program exclusively for children. So,

while that is a variation, we don't view it as a major variation that presents a problem in terms of us capturing the population of adults in a state.

MS. LLANOS: Margo wants to clarify something, if that's okay.

CHAIR PINCUS: You said?

MS. LLANOS: Margo, did you want to clarify something on Slide 39?

MS. ROSENBACH: Sure. So, I think the first thing to clarify is about the use of vital records to obtain gestational age. That actually is part of the measure steward's specifications. The measure steward provides a very detailed list of ways to obtain gestational age, and vital records is now part of that. And it's part of our enhancements to the resource manual for the coming year. We do provide a lot more detail on the calculation of the data elements in the various maternity measures, including gestational age. So, that

is definitely acceptable.

And then I'm not exactly sure what the first bullet is referring to in terms of identification of those transferred to another institution. We do have a measure related to timely transition of --- timely transmission of transition record as part of our care transition measure, and there is a very explicit definition of how to identify that, and also a worksheet that helps states and plans to abstract the information required for that measure.

I think the only other clarification I would provide is on Slide 40 where it's mentioned that information is based on FFY2013 reporting. And, actually, what we used is the measurement period specified by the individual measure stewards. So, for example, in the HEDIS measures, it would be based on calendar year for the most part, although some of the measures do have a look-back period. And

then in other measures we're again aligned with what's in the measure steward's specifications, so while the --- I think the reporting cycle is called FFY2013 reporting, the actual period of measurement does align with what's in the measure steward's specifications.

CHAIR PINCUS: So, some of this stuff will come up when we go do the measure by measure kind of process, but there are two things that come out very clearly. Number one is, you know, we're going to be thinking as we go through the measure by measure process, to think about what kind of recommendations we can give about sort of further standardizing these measures to CMS. And number two is, there also will be feedback that we can give to both the measure stewards, and also to the NQF endorsement process in terms of the reexamination of the measures with regard to additional specifications or issues with regard to the measure itself.

DR. BURSTIN: I also don't want to lose Doris' earlier point about the need for a standard approach to aggregation as being important ---

CHAIR PINCUS: Right, and I think that's key. So ---

MS. ROSENBACH: This is Margo again, if I could just comment on that. We actually do have a Technical Assistance Brief that covers that in fairly great detail both for administrative measures, as well as those using a hybrid method. So, we do actually have something that does standardize the approach, and I think what we need to do is make sure that it gets disseminated more broadly, particularly for those doing the adult quality measures.

CHAIR PINCUS: So, we're running a little bit late, but I think it is a good time to take a five-minute break if it's okay, Doris, with ---

(Off microphone comment.)

CHAIR PINCUS: Okay, good. So, let's take a five-minute break and get together at five of the hour.

(Whereupon, the above-entitled matter went off the record at 10:49 a.m., and resumed at 11:00 a.m.)

MS. DUEVEL ANDERSON: So, we are going to have New Hampshire go through their slides fairly quickly, and then we're going to transition to Virginia to respect their time and finish their presentation before 12 noon. And then we'll have time for questions for later in the afternoon. We'll have a lot of time for Work Group Task Force discussion and questions to the state panelists that are still able to be with us. So, New Hampshire is going to go through their slides, and then Virginia. Does that work for you, to start about 11:30 and end by noon?

MS. STANLEY: Yes, we just need to

end by noon.

MS. DUEVEL ANDERSON: Thank you so much for the flexibility.

MS. STANLEY: Okay.

MS. DUEVEL ANDERSON: Great.

CHAIR PINCUS: Doris, do you want to get started?

MS. LOTZ: All right. I'm Doris Lotz. I'm the New Hampshire Medicaid Chief Medical Officer, and again we're here to speak to New Hampshire's experience on their measure application during the AMQ process. And I'd like to just pause really briefly because I don't know who's on the phone from my team, so if you could just quickly go around the room and we'll make sure we've got audio, and you can talk back to us, as well, so that I know who's on the phone. So, who's in the room in New Hampshire, please?

MR. CHALSMA: Hi, Doris. It's Andrew Chalsma.

MS. ALAMGIR: And Farzana here.

MS. LOTZ: Okay.

MR. CHALSMA: And that's it.

MS. LOTZ: And that is great. So, what I'm going to do, Andrew and Farzana, is go through these slides fairly quickly, which I think I can do, and then leave a little time for Q&A for you folks, because I know that, Andrew, we only have you for --- until you have to bump up against your next meeting.

So, moving along here then the way I've organized this presentation is to look first at measure generation, kind of the nuts and bolts of creating the measure, looking at what that measure means as we try to influence quality, and then talking about measurement for the future.

These are the 16 measures that New Hampshire reported on, and I'm sorry, I'm really flying here. We looked at it from the point of view of what was feasible, where we

could capture some synergies, and where we wanted to build some capacity.

Ideally, we want to be data-driven in our choices, but this is fairly new for us. And as I mentioned earlier in the conversation, we deal with a lot of political, and logistic, and other realities so we may find some opportunity that says this really ought to be a number one priority, but if you can't align it appropriately in the context, you're not going to be able to move it forward successfully.

So, on the feasible we've --- the Committee here on site has already talked about the ease of using administrative data versus some of the other --- challenges using other data sets. I won't linger on that.

Where we had synergy -- we were rolling out Managed Care in New Hampshire, so we committed to doing CAHPS for our Managed Care population, and it was easy then to do it at a

statewide level and contribute that as one of our 16 measures.

Where we wanted to build capacity, not surprisingly, we wanted to link data sets because we understand that we're sitting on rich data, sometimes in our own shop, and sometimes in the shop right next door, so we wanted to look at follow-up after mental health hospitalization with a keen eye toward looking at our inpatient mental health facility, New Hampshire Hospital, which is the designated psych facility for the state. It seems a little bit odd to us that you would look at Medicaid population, in particular, and keep a hospital like that out of the measurement, and then perhaps subsequently out of whatever quality improvement followed.

We wanted to look at delivery because we were curious about linking our data to the vital statistics data. And for a hybrid measure, which was brand new for us, we looked

at postpartum care.

So, I think it's interesting to the Committee given their deliberation over the next day to look at the measures that we didn't choose, and fortunately we're under a little time crunch and I can be brief, having said primarily to my folks in New Hampshire that many of these issues have already been touched on. So, we didn't do what was expensive, where we thought there was a lack of clarity around the measure definition, and there are some unique New Hampshire concerns.

So, what is too expensive? Chart abstraction. I'm curious about an earlier conversation, Andrew and Farzana, about e-measures. I have to plead complete ignorance on what e-measures are. Perhaps you guys are familiar with that. But we did a little quick back of the envelope calculation when we were preparing for this talk and we figured that

every hybrid measure costs us about $40-50,000. And since it's a fixed sample size, that's the same whether you're a little state or a big state. There are six of them currently in the measure set. That gets to you about $300,000. Then you have to do CAHPS for kids, CAHPS for adults, CAHPS for the CHIP population which we still have to do separately, and you're looking at about a half a million dollars just to generate the measure, and that's on top of a smaller state budget, so that hits us really hard. So, we're very willing, and very enthusiastic and excited about measurement and informing quality improvement through that data-driven analysis, but we're not, you know, able to do everything that we'd like to do because of the financial costs.

We already talked about the all-cause readmission and the lack of risk-adjustment -- that would be in the room here, sorry, Andrew and Farzana. Chlamydial

screening, just another example of a challenging measure to work with. The denominator is built off of birth control, prescribed birth control methods, so that leaves everyone who is using barrier methods out of the denominator. That's not right.

The adherence to antipsych for individuals. We did do the overall Medicaid adherence which is really not one measure, but at least seven given the different drugs that it looks at. And this one we thought well, our populations aren't very large. We have some small population size challenges to deal with in New Hampshire. And, again, it was complex weaving together drugs from the medical claims and the pharmacy claims, and so on.

A few unique New Hampshire circumstances. We don't pay for readmissions in 30 days, so our readmission rate would look really, really good. It would be zero, but not because it really is zero, but because of the

physical policy that we have in the state.

At the time when we were applying for the grant, that was October of '12, we hadn't decided yet whether we were expanding or not. We didn't have a substance use disorder benefit, so it didn't seem reasonable to do that measure. And Karen has already spoken about, you know, different circumstances in different states, and allowing states to choose their measures I think is great because we're always going to have these quirky circumstances. And I already mentioned small populations.

So, these next couple of slides really get to where were we successful, and where we think there might be something for the Committee to ponder as they go forward. In the claim-base measures, you know, we had done some claim-based measures already so that wasn't brand new to us, but we did really enjoy the ability to explore weaving together different data types. So, a little distinct from the

commercial sector, we --- they generate all their own data. They generate all their own hybrid measures, or they may use a subcontractor, but they have their own claims measure.

In Medicaid we're really weaving together multiple data sets that have been generated from multiple different sources, and that is somewhat unique to our population. So, we enjoyed as part of this grant the ability to create a data aggregation system that will also be our platform for transparent web reporting that's going to look at various data sources. It's going to be able to look across the data sets and create some statewide aggregate data. It's going to allow sub-patient population analysis, and it's going to allow user-generated custom reporting, so coming soon to a computer near you in July we should be able to look at some of the web-based platforms that we built to say if I, for

instance, wanted to just look at the aging population I'd be able to sort by age, sort by some of the waiver services, and be able to build a report that looks just at that population. Looking at foster care, et cetera.

Let's see. So, that was really fun. What I've listed here as notable is something I would leave the Committee to ponder. So, Medicaid programs have to be able to handle these multiple diverse data sets, and how do we build in the capacity? In the room here we've talked several times about well, if there was comparability between states --- there will be comparability between states. And I applaud CMS, and not, you know, getting ahead of where the science might be, but I'm concerned that some of the nature of the comments in the room here is that well, since it's not happening it may not be a priority. Maybe we don't have to deal with it. I would really discourage that line of thinking. It's going to happen across

states informally as I already referred to as soon as that data gets published, and I hope that it will be because, you know, good, bad, or indifferent there's nothing like transparency to move quality improvement along.

I would hope that the data would be published, and people will then be comparing. So, to have the means to be able to compare across states, you know, as it relates to the risk-adjustment we've talked about, as it relates to waiting to get to statewide reports, statewide measures, this is huge. And I'm glad that Harold already said that it would be something you would consider when you consider each individual measure. Please deliberate on how we can standardize the technical specifications, and how we can look at really creating meaningful metrics that can be --- that we want to be compared across the states.

With regard to CAHPS, our learning moment here was being able to over-sample for sub-populations, but what we found here that I'd like to leave the Committee with is that there's very little variation across the sub-populations. So, to go right to the notable, with very little variation do we have to do sub-populations? I mentioned the expense already. We have to worry in a small state about sample fatigue. We have blended our SCHIP program into our Medicaid program, but we are still understanding that we're obligated to report on the SCHIP population, so that means two CAHPS surveys that are essentially hitting the same patient population. And now CMS is contemplating a national CAHPS. If we could really feel good about the validity, the integrity of aggregating different sources and blending that into a broader rate, whether it's going to be a statewide rate or a national rate, this would reduce expense. It would improve

efficiency. And I'll just, again, leave you with that.

So, regarding linking the data sets. We had two interesting opportunities here. We did look at our vital records for the early elective delivery, and we improved the ease of linking the data sets. We found that this really still is very situational, so we didn't aggregate them into some common database, but working with the state epidemiologist who is a fabulous resource for us, he created the algorithm that looked at the right data elements and the administrative data set, and the data elements in the vital stats, and once we worked through that looking toward the birth records, this is an algorithm that could be exported routinely as Medicaid patients enroll or dis-enroll as we look at some of the changes in the Medicaid program, as we look at different data that we want to extract for that.

We're about to put together a statewide registry, vaccine registry, rather, and I'm hoping that some of the good work that came out of this algorithm could help us look at that vaccine registry and continue to think about how to link data sets.

The other data set that we looked at was, as I already mentioned, our Institute of Mental Disease New Hampshire Hospital. And what we were able to do here was to put some --- flag some notice in the MMIS system that told us when these folks were getting admitted. Many of you may know that there's no Medicaid claiming when they go into an IMD. It's kind of like they disappear from the Medicaid program because we don't pay that, and programs tend to follow the money, so we just lose sight of them when they go into an IMD, and then they suddenly reappear in Medicaid. So, to have a meaningful metric, to have a metric be meaningful like follow-up after mental health admission, you need your

inpatient mental health facilities. You need to be able to aggregate that. That's another example, and we've talked about a few others this morning. We'll talk about a few throughout the rest of the day, I'm sure, where a HEDIS measure, while well intentioned is not really well designed for a Medicaid population. But it doesn't too much to modify it, we just have to make sure that everyone is doing it the same way, that it retains, you know, the validity and the reliability that want it to. And I'll go back to this because I really want to beat this drum, that we have state comparability.

The other thing that was mentioned by a member of our team, and I think it was you, Andrew, so feel free to jump in here if I give you a moment, is that would there be any ability in building the MMIS architecture to allow for easier database linkage. Interesting thought, not exactly the purview of this particular Committee, but there are several folks from CMS

here, so I would ask them to continue to think about that.

The hybrid measures, going right away to what was --- this was brand new for us so we had no experience. Big aha moment was how many records were missing, how many records were incomplete, but we had to keep them in our denominator which artificially lowers our rate. For our postpartum care we had a rate of about 65 percent, and I somehow don't think that's really true. When we look at our CAHPS report, when we look at our independent reporting it looks like we have very good access for our folks that are pregnant, and I don't know why that would drop off postpartum, so that was a concern.

And I already mentioned some of the problems with the hybrid measures. Most notably, they're laudable, they're good measures and we'll continue to work with our HIE to see what we can do as far as extracting

medical data from a Health Information Exchange. That's many years in the offing, but meanwhile we need to be very mindful of what it costs to produce that kind of a measure.

So, with that in mind, the Agency for Healthcare Research and Quality published, or I should say that there were two researchers that published in Health Affairs in January '14, a look at the quality indicators from AHRQ. And they did some modeling about what had the most impact. They looked at 13 measures and long story short, six of those measures provide us 93 percent of the impact, interesting, you know. So, I started to think about this idea of a Quality ROI. You know, do we need to measure everything, do we need to report everything?

I'm a huge fan of data so it kind of argues against myself to say wow, should we report less? But at some point we do have to consider, you know, what resources are needed to generate some of these measures.

Shifting gears from generating the measures to actually measuring quality. Some of our thinking that went into this was, once again, what kind of state leadership was required. This was a fabulous grant that dedicated money to building state infrastructure to do quality reporting. That was an incredible gift from CMS to the states, but it still took an amazing amount of time to get the position numbers, to put them out for hiring, to do some training, so I'll --- one of the positions that I have that was supported by the grant were about a year and a half into the grant and he'll start in June. So, even when you have dedicated federal funds, actually marshaling the resources to do this kind of work is a very, very long and tortuous process. So, we had to look at, you know, what could we do with the existing resources we had? We had to look at operational logistics, not the least of which was time. Most Managed Care Organizations

when they're looking at quality improvement projects are looking at three to five-year time cycles. We had two years. And with one of our measures we actually had to abandon one of our quality improvement projects and substitute another a year into the grant.

And the last consideration was did we have a clever idea to test? Ideally, again, we'd be data-driven, but we had some clever ideas so let me tell you about them. That sounds a little bit self-congratulatory, and I don't mean that, but that's what we're here for to some extent.

All right. Early elective deliveries. We're a small state so how do we take advantage of that? We linked the claims to the vital statistics, as I said already, and we got this really alarming number that 25 percent of our deliveries were early elective deliveries, and we went oh, my gosh, that's really bad.

To speak to one of the Medicaid Medical Director exercises that I referred to earlier, the Medicaid Medical Directors had gotten together informally, had put their data together and they came up with a rate of about nine and a half percent. I thought oh, man, are we an outlier? But what do we do about that? Well, the first thing you do about that is make sure your data is good. So, with that in mind, we had 325 early elective deliveries, 92 of them would fall out as not having met any appropriate criteria, 328 in the denominator, 92 in the numerator saying that they were inappropriate early elective deliveries. We said we can do 92 chart reviews, we're small, so we did. And we actually requested and got 91 charts which is excellent. And when we recalculated it based on a chart review, a comprehensive chart review our rate dropped down to 4.6. I can live with that. There's still opportunities to improve. We're going to look at heart stop policies which

have tremendous variation across the state, and we're going to try to bring that number really lower. But it brings forward a change that's already been made in the measure, which is super, that there will be chart review with this.

But it also --- the other sort of clever idea we wanted to test in addition to looking at every single chart and really seeing if the measure measured what it was supposed to be measuring, and the short answer is no. But the other clever idea we had was well, we're a unique population. What might be the psychosocial drivers, if any, that are not part of the JCAHO-NQF allowances, so to speak? And what we found out of the 17 charts, those small numbers again, the 17 that contributed to that 4.6 rate was that there was a heavy burden of mental illness and substance use for which the pregnancy just seemed to be complicated, the management of those two issues, and the

decision was made to elect early. So, notable.

Is there a need to think about that measure, perhaps amend it for a Medicaid population looking at some of these psychosocial drivers that, you know, are not necessarily clinical but looking at a more comprehensive holistic approach may have provided a compelling reason to think about an early delivery. Maybe not, but something for, again, the Committee to consider going forward.

Our redo quality improvement measure that we launched in November or December just last year was to look at the antidepressant medication management with the clever part of the idea being that even though we have a lot of managed care in our state, we, the state, retains ownership of the pharmacy and the administration of pharmacy services.

Pharmacy data comes to us a lot quicker than medical claims data, which can have a three or six-month run-out. And if you

have a measure that says how well are you adherent 12 weeks down the road, you can't be waiting for a three or a six-month time run-out to do anything about it. So, we did some test analysis and found that about 20 percent of the new prescriptions for antidepressants were actually being used for new onset depression. They're also for those of you who are clinical in the room know that they're used for an awful lot of other things, but we thought hey, 20 percent is not bad, you know, we have a 80 percent false positive rate. How can we work with that?

So, what we decided to do was to drop a letter to our patients predicated first on that look at the pharmacy data, but then reach out through the prescriber to say you're the one who really knows whether you're prescribing this. We wanted to minimize that 80 percent false negative rate, or false positive rate I should say, and let them drop the letter, and

not to interfere too much with the prescriber-patient relationship, as well. So, we asked --- we drafted the letter, we let them be the signator, we stamped an envelope addressed to the patient, basically said please review this if it's for new onset depression and you're okay with this, drop the letter in the mail, and then fax us back some thoughts on the program. And I'm happy to report there were really no negative comments back. So, we did that in advance of the 12-month look, and we did it again in advance of the 12-week look, pardon me, and the six-month look, and we don't have data yet to show how that's working, but we'll see if there some capacity to really take more timely data and export that into a quality improvement project.

So, where are the priorities and gaps? This is the slide that I think the Committee was probably anticipating from the state presenters, so I'm giving it to you. But

from here, I want to go a little far afield, and I'm only a couple of slides away from my end where I get a little wonky on you.

So, certainly, we could use some measures in long-term care services and supports, home and community-based care. You know this already. I'd like to put a finer point on the earlier slide that said oh, look, we have like six outcome measures. Not really. We could use a lot more outcome measures, and I'll say why in just a little bit.

Those states that are expanding their Medicare -- I'm sorry, their Medicaid populations have also frequently expanded their substance use treatment programs and benefits, so we could use some outcome measures there. Among the states, we're becoming increasingly concerned about neonatal addiction syndrome, so it would be great because like state-to-state comparability, to have some measures that look at that so that we

can see who's really got a good bead on how to get a handle on this, and how we can share and steal across states like we would like to do.

We also --- and when I was looking at your slide deck from your April presentation from your webinar, there was a nod toward looking at access measures. I would continue to think in that line. Emergency department is an access issue for Medicaid states. It may not be the right place to access, but it is where they do get access, so we should be looking at these access measures in a more formal and disciplined way. And, once again, allow that state-to-state comparability so we can learn from each other.

Unmet challenges, I've talked about a few of them, so please scan the slide and we'll skip it. Here are some of the solutions that I've mentioned already, you know, potentially building something into the MMIS architecture, continuing to improve the detail.

I'm happy that the 2014 Tech Spec that was put out just in May has more detail. I'm cautiously optimistic that it's comprehensive, but I'm practical to say it probably could use even more, and you may be surprised to hear that states, at least New Hampshire, would welcome being very prescriptive in this department.

The costs I've mentioned already. They're not insignificant, but they would be improved if we do include, you know, more standardization, if we think maybe a little bit about where there are overlapping efforts both from a cost and efficiency point of view, as well as from a sampling fatigue. And, you know, where we continue to try to build kind of quality infrastructure as we're doing with the majority of our grant money to really have it be a quality system, and not, for example, be overly reliant on administrative claims, which are really a claims payment system.

Whoa, what happened to my slides? That's one way of cutting me off. Well, moving beyond that, but this is where I got weird on you guys, so you're missing that.

So, where I wanted to go a little further afield from where the directive from Megan and the staff at NQF were asking the states to go is to look --- we're all about quality improvement, and yet we don't have any measures or any sort of standard approach to how we measure how our programs are being administered. How do we define a Medicaid program success? What are our goals? I mean, obviously, to be good stewards of public funds, to improve health outcomes for our patients. I can rattle that off, and in various variation that exists in 56 states and territories, I'm sure. But how do we measure that, and how do we know when we're succeeding?

We're very much focused with our measure set at health care services, and I think

we should look beyond that. I think we could also look beyond that to measure --- to understand more about what part of measurement can inform removing the barrier? Our measures for the most part don't speak to any kind of treatment or intervention that would target improvement. It would be great if we could come up with a measure set that informed how we go about improving that outcome.

Another takeaway on this slide, I think this is my last one. Is that we may want to have less measures that talk about infrastructure, that talk about process. There are a lot of process measures there. And in somewhat an analogous and complementary way to the way states are looking at payment reform and thinking about ACOs, and saying --- or even some of the value-based financial policy that's coming down. Here's your chunk of money and you just manage within it. And is it necessary for us to be so prescriptive in the infrastructure

and the process measures to say this is the way you do it?

Because I have a tendency to be relatively blunt, and I'm feeling the crunch of time, why do we care? As long as we can define what the outcomes are, are we not giving them --- do we not want them to have the latitude to explore what works for the population that they're looking at? So, what I'm saying a bit more formally is that we should stop being so reliant on structure and process measures. They're easy to measure. It's what we've historically measured, but we may be doing ourselves a disservice as we think about where we're going with fiscal policy to continue to say that this is how we will measure the quality of the product. It really doesn't matter, we just need to get to the outcomes and let them understand their local nuances, or their political constraints, or their resource constraints, and just have them manage those

outcomes and be done with it. That would also help with respect to, you know, efficiency and resource allocation.

And then the last sort of wonky point that I wanted to leave you with is this idea of Medicaid sort of transcending being more than a payer. I think that our lack of clear articulation of goals and how we go about achieving those goals beyond a mission statement. I'm talking about a disciplined approach to measuring ourselves with the kind of quality tenets that we bring to these quality improvement projects. We should look at our own internal management, and we should be able to say how Medicaid fits into a broader construct.

Population health is becoming a wonderful buzzword, and what do we really know what it means? But that being said, we can't change that political paradigm, but can we articulately in our self-interest, and more importantly in the self-interest of the

population that we are the public stewards of, can we say how Medicaid fits into that construct?

I think we can if we sit down and think about it long enough, but we should --- there's nothing unique from one state to the next how that fits in. And we ought to be able to not just speak to that, but through our measurement science, through our data and analytics, through our quality improvement shop, we ought to be able to demonstrate how we are integrated into a greater picture. What's the value-added that the Medicaid program is bringing to a broader improvement of health care across the U.S.? It's a little bit, you know, pie in the sky, but I think it's important because in the last several months I participated in a few conversations that basically summed by saying well, Medicaid is just a payer, so just pay the bills and move on. Thank you very much. And that is so

fundamentally wrong. And yet, I look at the tools that I have that demonstrate where we provide value and they're not as robust as they ought to be.

To sum, you know, as the MAP Task Force deliberates over the next day and a half, I think I would ask you to choose your measures carefully because they do cost money, but don't be afraid of measuring things that are important. Comparability is huge. We want the comparability. We want the details so that we can be efficient with our resources. We want the public reporting so that we can share where there are successes. We want to be able to look at ourselves and demonstrate that we provide value not just to our population, but to the much bigger mission of improving the efficiency and effectiveness of health care across the country. And we could use some help because that is still very theoretical right now, and there is no reason why each state should invent that

on their own. And with that, I've probably taken more time than I promised to, but I did want to end with those very thoughtful, at least my thoughtful comments and ask the Committee to give me feedback on whether there's merit in it, or whether I should just kind of stick to measuring and doing smaller quality improvement projects. I suspect not, but I'd like to hear some detail around individual thinking there.

So, technical questions in particular for my team while they're still with us, and then I'm certainly available to answer other questions because I'll be here throughout the day. I can't see the name, I'm sorry. Alvia. I'm sorry, I ---

MEMBER SIDDIQI: Alvia.

MS. LOTZ: Thank you, pardon me.

MEMBER SIDDIQI: That was an excellent presentation, so thank you so much. That was just very informative. I had a question

about how the EED rate, that Early Elective Delivery rate was so different from when you did the chart review from the claims data. So, was it that people were not billing it correctly, that you think the rates were so much higher from 4 percent to 25 percent, or what happened there?

MS. LOTZ: Andrew, do you want to speak to that, please?

MR. CHALSMA: Yes, I think a lot of it was that there is no incentive, the particular codes are not --- get on the claims because it relates to billing, and to use them as a clinical marker doesn't work sometimes. I think that was the majority of it that, you know, that indications just simply didn't make it on the scalings. And when you pay by --- using a DRG system, you know, most of that just isn't going to matter.

CHAIR PINCUS: Are there any other technical questions for Doris' group, because

Doris is going to be here and I know that there's some time issues for Virginia to present. Any other technical issues?

MEMBER ANDREWS: Just a quick question on the all-cause readmission, was that non-elective?

MS. LOTZ: I'm not sure I understand, all-cause readmission. We didn't report out on that measure.

MEMBER ANDREWS: Well, readmissions can be defined as elective or non-elective readmissions.

MS. LOTZ: When we looked at it before, Andrew, how did we approach that? I know Andrea did some work on that.

MR. CHALSMA: I'm not really sure. I mean, I think it would be all --- it wasn't distinguished based on elective or not.

DR. BURSTIN: Most of the readmission measures exclude planned readmissions.

MR. CHALSMA: Yes.

CHAIR PINCUS: So, why don't we move on to Virginia, because I know that they have some time pressure.

MS. LOTZ: Inasmuch as the New Hampshire team wants to stay on and listen or even answer questions later on, you can be here all day long, you're welcome to stay. So, with that I'll conclude the formal New Hampshire report, but we can probably bring them on for technical questions if there are others later on.

MR. CHA: Before they drop off, I have lots of thoughts and great presentation, but I will just save the technical question for now, which is you mentioned the idea of database linkages with MMIS, and I'm wondering --- you said there might be someone on the phone to speak to that, so I'm wondering if someone could speak --- say just a couple of more sentences on that.

MS. LOTZ: Andrew, that would be you again. That idea came from you.

MR. CHALSMA: Well, we were saying the MMIS, the state claims processing system, so in the long run if you want to have a measurement relying on federal records data, which I think would be really valuable because you've got better records --- the majority of that really is clinical information, or is derived from clinical information. So, you know, that would be an example of something that in the long run you could use as a rich source of data for quality improvement if you are actively linking your electronic federal records to your electronic MMIS, or enrollment system or something, so that you can look at the whole picture. Especially with the births, you know, since that at least for New Hampshire is a huge part of our business, the babies and the moms, so there's a lot in that data. And, you know, so it's fully integrated, you know, and

on line and readily available to query. It would be a lot easier to then develop projects around that.

CHAIR PINCUS: Thank you. So, let's move on to Virginia. And, Cheryl, I think that --- are you --- you have a team together to present?

MS. ROBERTS: Yes. Good. Because we're following, first of all, thank you for inviting us. And I'm sorry that we couldn't come, as you probably can figure from the newspaper, we have both a budget crisis and an expansion crisis. So, I actually had to leave a meeting from the Governor's staff to come run and do this. So, I've been part of this, so we wanted to make sure that we participate because it's important. What I'm going to do is I'm going to talk very quickly. For those who hear my drawl and my speed, I always tell people that I'm a New Yorker and I've been transported here

as a transfer, so I'm going to be moving quickly. And I guess whoever is doing my slides, I'm going to say go. Basically, what I'm going to do is in the next two to three minutes I'm going to talk about a little bit of basics about our program and what it is. It's important because quality is a very big part of our program. It's not a separate dataset but actually integrated into the program. The decisions are made because of the quality outcomes and the measures, so I'm going to do the opening and then Carol Stanley, who is our right hand and guru, she's going to talk to you about actual measurements. Can you go next? Next.

Our program is called Medallion 3.0. It's a joke about how we got there, but basically the reason I say it's 3.0 is because we redid the whole entire program last year from top to bottom, from our contract to how we do our measurements, to doing electronic

reporting, and so as we go through, we wanted to reflect that, so that's where the 3.0. I make jokes now so the next one is going to be 4G, and I'm hearing now some other one is right behind it, almost like the iPhone 5. Please go to the next one.

Our program has about 700,000 enrollees that are in Managed Care here. I guess one of the largest states. This is a reflection, and this plays a role who we're covering in Managed Care right now. We're covering pregnant women like everyone else, and children, including foster care children. We're one of six states that is doing foster care children in Managed Care. Have parents, we have the aged, blind, and disabled, and that's a difference in most states. We've had that from the inception of the program. We also have something that most states don't have. We cover the acute care for the home-based and community waiver population. What's not here in the 700,000 and

we need to talk about a little bit is we're also doing the dual population. We're part of the dual demo, and actually we went live in May, and in July of this year we'll be moving 14,000 people into the dual program. Can you go next one?

We're statewide, as this shows you. In terms of demographics in terms of our states, we have big urban areas, suburban areas, rural areas, almost frontier areas. As a result of that, even as we talk about the states, not everything is the same. Even as we look at our measures, we see disparities in different places and we've had to make adjustments accordingly. Next.

This just gives you a sense of the health plans. The reason I'm bringing that up is that four of our health plans are health systems. That gives us a leg up on quality, to be honest. It's because they control not only the health plan, but they're also connected to

the hospitals and the physicians in terms of the network and so their quality measures as well as their quality is because this is a corporate issue. That's a big issue for us. That means that when they look at the measures they're looking at across lines of business. Same thing with our Anthem, and our Kaiser, and CoventryCares.

One of the things we're trying to do, and New Hampshire says they are too, is that we look at our measures, and we're talking about that, not just lined up just for Medicaid alone. We have some them are Medicaid, but most of them looking at the whole business as a whole. That's part of what our Secretary is looking at, and we have that kind of initiative, so then when you get your biggest bang if your measures are lined up in your commercial and your state employee benefits, also in your Medicaid, the Exchange, your duals. Any kind of way that you

can make those all line up, that's where you get your bang for your buck because you're looking at moving the whole population. Our physicians are not doing data based on the payee source, so what you really want to do is move the whole measure and the whole metrics up. And I think that's what New Hampshire was saying and, therefore, that's where you get your bang for your buck. That's why you see in South Carolina when they're looking at a pregnancy program, they're looking at it from top to bottom and then, therefore, they could see the whole population move to the right versus the actual, if you're just doing Medicaid alone. So, even as we pick our plans and our partnerships, we're very conscious of the fact of the breadth and depth that they have not only just in quality, because we require that all our plans have NCQA. That's a requirement, we don't move from it, we've had that since 1996. All plans have to have that, but it's also important because we

know that they affect not only the physicians but actually the actual populations we're trying to reach.

And that's our model. We don't take Managed Care. Most people look at it politically and Managed Care is for financing. We don't look at it that way. We're one of those people we believe that it's not about the financing of it. We're looking at Managed Care as actually improving the health care and the value for people. It's part of our purchase optioning. And I'm going to run through these slides because you could read them later. Next.

I call it this way, we have Managed Care gives us our ROI, the biggest one is the control of the physician community, the type of things that they can leverage. We see such innovation programs. We see it in our measures but it starts with the program. It starts both with the contract, it start with pay for performances, and it starts with actually the

actual program. Huge differences in our maternity program based on the plan, but it started with the programs and then looking at it at the end of the measures. Next.

One of the things we're proud of is that that was part of our new contract. Each plan has to do two innovation models and a lot of them did payment for performance measures, some things are medical home. We're looking at this as part of our integration. What we're trying to do is, again, recognize that some of this innovation that we're seeing that you look at, at the end, we're actually seeing is actually coming from the actual provider community. We want that reflected. We want the plans to have those kinds of partnerships. You know, we see the outcomes but we also see the investment in the plans with the providers. Next.

And then last but not least, very proud of this. Bob Hurley, Dr. Bob Hurley who

was a big Managed Care proponent in the '80s, he once said to us if it's not measurable it doesn't exist, so as a result of it we went straight with NCQA, we have HEDIS measures. Because we had adults in the beginning, we had measures accordingly. Carol is going to explain that. Big on quality collaboratives with the plans. We have a collaborative meeting, it's like our annual meeting is on June, and I just wrote it down, June 24th, and if the Quality Forum wants to come down because you're not that far away, you're welcome to come. Carol can send you a formal invitation. They do best practices there, we give awards, we have panels. We do spend a lot of time on our quality performance aligning with populations, whether or not we have measures, obviously, for pregnancy and children which is normal, adult measures. But even now, working in foster care, we're doing psychotropic measures because, again, we want to make sure that we're all aligned. We do

annual reports. And the big one is, believe it or not, and I tell this to everyone, measures help you when you are going for the Governor and for the legislators and budgets. It's where you can prove that it makes a difference, the investments that you're making are making a difference, and it hits them where they understand it. Where people like to hear about cost savings, they also want to hear that the population is getting better, and that's really where you're talking about your value purchasing. And I'm going to turn it over to Carol to talk about the measures.

MS. STANLEY: Okay. Thanks, Cheryl. You can go to the next slide, please. And the next one.

Okay. So, as Cheryl mentioned, we --- because we require all of our health plans to be NCQA-accredited we are able to tap into the value of that through all of the HEDIS measures that they report to NCQA. And what we

do, we actually in partnership with the Managed Care plans, we select a priority set of HEDIS measures which are then integrated into our Managed Care Quality Strategy. And by focusing on a subset of the full book of HEDIS measures, we're able to really focus on improvement efforts instead of trying to be all things to all people, which would really dilute the quality improvement initiatives going on. So, next slide.

So, what you're looking at is rather detailed, but basically these adult quality measures are those that are in our Managed Care contract with the health plans, and in our Managed Care Quality Strategy, and these are the adult measures that we've been tracking at least since 2010 with all of the health plans and monitoring their performance. And you can see in this matrix we've included a column that shows you whether it's one of the CMS core measures. So, actually, we selected all of

these adults measures, these are all HEDIS measures, prior to the release of the Core Measure Set that CMS is using. So we were really pleased to see measures that came out from CMS, how many of them are we already tracking and consider high priority for improvement. Next.

We are currently implementing a pay for performance incentive awards for Managed Care plans, and we've included in that set, we have three HEDIS measures. And two of those measures are also CMS Adult Core Measures, and those are the blood pressure control measure and timeliness of prenatal care. So, we're entering sort of the next generation of our quality improvement initiative where actually, you know, financially reward those health plans that perform exceptionally well and to our expectations based on these two measures in addition to some other ones. Next slide.

As I mentioned, our Managed Care

Quality Strategy includes a number of the Adult Core Measures that you all are meeting about. Our current version of the quality strategy is active from calendar year 2011 to 2015, so we currently have begun our brainstorming sessions for the next iteration of our Managed Care Quality Strategy to identify the subset of quality measures that we consider to be top priority for improvement over a five-year period.

Now, one of the things we're doing is working with the Managed Care Plans first to establish some logical criteria for selecting the set of quality measures. So, internally, we're conducting some demographics of our state, we're looking at some medical trends to really pare down the list of quality measures that we and the Managed Care Plans consider high priority, high impact, good return on investment to improve the health of our populations.

One of the things we will certainly build into criteria is looking at those measures that are on the CMS Core Measure Set for adults in addition to the CHIPRA measures. But as New Hampshire stated, we see really great value and tapping into those National Core Measure Sets for benchmarking purposes, comparisons, so we know that those measures have been vetted extensively and are based on clinical guidelines, and have been validated. So, we really find a lot of use in considering those measures when we select our measure set for the next five years. We're looking at needing to make a decision on that measure set by March of 2015 so that we can include those in the Managed Care contracts by July 1. Next slide.

Some of the recommendations based on just, you know, our one-year experience in reporting these measures to CMS is, as New Hampshire stated, we'd like to see transparency

with reporting even if only one state reports on a particular measure. I think it's exceptionally valuable for everyone to have access to that information. It helps us advocate for selecting certain measures, it enables benchmarking, and really sees the current landscape as far as which states are working on which measures, and what the performance is on those.

And I know this has been discussed, but also recognizing the need for efficiencies with regards to Adult Quality Measures for Medicaid, Medicare, exchanges, and the expansions. And as Cheryl even mentioned, alignment with the commercial lines of business. We really see a lot of value when it comes to population health. The more we can be engaged in some common measures that affect all of the adult populations we're focused on, the better the impact is going to be.

You know, young adults here on

Medicaid today are eventually going to be on Medicare, and it's going to be beneficial to Medicare if those Medicaid populations can be as healthy as they can. And even, you know, we hear how improving the health of the children population is going to benefit the adult populations once they become adults, so it comes full circle in where we can focus on improving the populations regardless of who the payer or purchasers are.

Some other recommendations is to really identify some regulatory and innovative efforts to combine improvement efforts for adult populations, and that goes in line with what I just said.

One of the things that we ran into when --- next slide, please, sorry. One of the issues we ran into when we were entering the scores into CARTS for these adult measures was that we were entering our HEDIS 2013 scores, and some of the technical specifications were not

up to date as far as things like age categories that the HEDIS measures were using. And one specific example I can give you is breast cancer screening. The HEDIS technical specifications for 2013 had specific age categories that were different from what was in the CARTS system, and that I perceive as sort of a barrier because it doesn't accurately reflect the current technical specifications that are being used by the measure steward. And I think it's really important that before CARTS is turned on for people to start entering that, there's assurance that the technical specs and the fields are reflective of the measure steward, that that can be a deterrent, I think, to entering that.

And another thing that I've heard today that I would hope that you stick to the measure steward technical specifications as much as possible because every state is very different. And by trying to adapt the technical

specifications for certain state preferences would really, I think, take away from the ability to use these scores and measures as benchmarks. And these are measures that have been highly vetted through the process, and are valid as they are, and diluting those or changing certain things for a particular state when we're all very different I think would not --- I think it would sort of be a deterrent to actually reporting them because it's not going to be consistent and used for the purpose it's been set up for. So, I just want to encourage you to really consider not deviating from the measure stewards have set forth as the technical specifications for the measures used.

And the final slide, I think a couple of more things. I don't know if it's been considered having a measure for sickle cell which, you know, we see as a high-cost, high-severity issue in our state. And, also,

I've seen some iterations of it but each year having an annual crosswalk published of those measures that are used by the federal agencies ranging from CMS to AHRQ, and Medicare/Medicaid to really see the crosswalk between those regulatory agencies that have published these quality measures, and even looking at the Meaningful Use Measures because that's important, as well as the synergy when looking at the various quality measures.

So, I think that kind of captures our current state of affairs here in Virginia. And I think we're ready for questions.

CHAIR PINCUS: Thank you very much. So, questions from the Task Force? Cindy.

MEMBER PELLIGRINI: Thank you. And thank you for a very helpful presentation. Back just a couple of slides there was the statement, "Identify regulatory and innovative efforts to combine improvement efforts for adult populations in order to create synergies for

population health." And I think you mentioned --- you referenced back to your example about child health, improving child health then resulting in improvements for adult health. But I'm still not sure I've quite wrapped my head around what you mean here. Can you give any other examples of what you had in mind?

MS. STANLEY: Sure. I think an example of an adult measure would be flu vaccine, because that cuts across all payers, all purchasers, and it's a Medicare-focused, it's a Medicaid dual eligible focus, and I think by just taking things up to the next generation of quality initiatives, trying to identify a way to really align those efforts because providers are getting, you know, similar but different messages regarding flu shot initiatives, so I think that would just be one example. Mammography use is another one. It's an Adult Core Measure for Medicaid, but it's also been an initiative for Medicare quality

for quite some time now. And somehow linking those two would be beneficial.

CHAIR PINCUS: I had a couple of questions. So, one, and Doris, I think this applies to New Hampshire, as well. So, I was trying to get clear and see if there was a difference between, Doris, what you said about the need to make modifications in HEDIS measures, to apply them to the Medicaid population versus what was just communicated to us by Virginia saying don't make modifications in HEDIS measures, that to use these. Is there a difference there, or am I missing something? So, could Virginia maybe respond to that first, just you said that there should not be any differences in terms of adaptation of HEDIS measures for Medicaid?

MS. STANLEY: Yes, what I was conveying was we are already using HEDIS measures, so there's a good set of benchmarks for us to tap into that NCQA publishes for more

than 100 Managed Care Plans. And the same holds true for these Adult Core Measures, is if there are variations to what NCQA has published as the technical specifications, it's not going to enable the benchmarking that currently occurs with publication by NCQA.

With that said, NCQA does from time to time change technical specifications for certain measures, and I think, you know, that would need to be addressed by the CMS CARTS system is to reflect those changes that are made by the measure steward.

MS. LOTZ: Well, this is Doris from New Hampshire. So, let me just engage you in a little bit of a dialogue here. It depends a little bit I think on who you want to compare to. If you want to compare to the commercial population, then quite so. You know, if the measures are changed, then you break that link, so to speak. But what we were experiencing in New Hampshire is we wanted to make sure that the

measure was accurately measuring the Medicaid population. And the comparator that we would want to make would be to other Medicaid organizations.

If you're talking about Medicaid Managed Care, then I wouldn't want them to use the commercial HEDIS measures. Let's say, for example, we do have, you know, a Medicaid risk-adjustment for the all-cause readmission rate. Then I would want my Medicaid Managed Care companies to use that Medicaid risk-adjustment standard approach. So, my thinking from New Hampshire, my team's thinking from New Hampshire, is that we would like greater specificity to reflect the measures -- to ensure that the measure is reflecting what it's trying to measure within a Medicaid population. And that we understand that we would not be as able to reliably compare to the commercial population, but if it was explicitly stated in the measure specs, then all of the 56 states and

territories would be doing it the same way, and it would markedly enhance both the validity of what we're getting out of the Medicaid population and our comparability to other states. So, that's where I was saying no, I want the measures, the HEDIS measures amended to reflect the Medicaid population. But, you know, Virginia, you may disagree with that, so please push back if you think that you're of a different opinion.

MS. STANLEY: Well, we do use the Medicaid measures specification for HEDIS. We don't compare ourselves to the commercial Managed Care Plan performance. We're comparing ourselves to the other Medicaid Managed Care Plans that are using the Medicaid HEDIS technical specification measures.

MS. ROBERTS: But we do see that it improves if we're in line with what the commercial, I'll move to commercial, is focused on the bigger topics. For example, if they're

all focused on hypertension that you see that all of our measures improve if anyone is lined up to the exact priority.

CHAIR PINCUS: But I take it that there's not really a disagreement?

MS. ROBERTS: No, we're in agreement.

CHAIR PINCUS: Okay. Other questions? I guess another question that I had was, and again this could apply to both states, is to give us a little bit more insight in terms of the choices you made about which measures you chose not to report on. But, specifically, asking Virginia a bit more about sort of the thinking that you went through in terms of making determination about what not to report on.

MS. STANLEY: Right. We take a really methodical approach to the quality measures that we focus, so we only reported on those measures that we require the health plans to

report on directly to us so that we have consistency over three to five years of agreeing on the subset of measures that we collect and subsequently become in the public domain. So, we wouldn't report on a measure that doesn't appear on a list that we consider high priority over, you know, a three to five-year period when it's reasonable to see improvement. That's not to say that this next iteration of our Quality Strategy that we wouldn't select any non-HEDIS measures, but to be consistent and to manage expectations of our health plans, and to manage expectations of our members and other key stakeholders, we find it very valuable to agree on a set of Quality Measures and only report on those.

CHAIR PINCUS: So, you're saying that there is an opportunity to sort of add additional measures over time if it meets some sort of criteria for the state as being significant enough.

MS. STANLEY: Exactly.

MS. ROBERTS: Also, if the Governor of --- or if a Governor has a particular focus. We had Tim Kaine who was very focused on child health. We added measures at that time. We're working now on the expansion. We presume that if we get the expansion that we'll be more focused on more adult measures, because we tend to go with where our governor's focus is.

MS. LOTZ: And from a New Hampshire point of view, the rationale for the measures not chosen are what I call the Goldilocks reasons. You know, they're either too expensive, they're too hard, there's too little information, they're too confusing, you know. And by and large actually reflects the conversation you had in your webinar on August 28th, you know, and I'd probably say that if we could we'd measure them all. You know, the folks that are engaged in quality improvement generally gravitate toward more data is a good

thing, and letting our subsequent actions be guided by what the data shows us. But as Virginia was saying, as well, you know, you get your governors who say well, I want to see this. And, of course, that becomes among your highest priorities, so I think ideally we'd measure them all. We can certainly change it over time. We can build it into our contracts for our Managed Care programs, as Virginia said for their Quality Strategy, and then subsequently embedding that in the contract. But there were some artificial, not artificial, there were some unique considerations of the grant that we had to make sure we weren't double-dipping, so to speak, in our quality improvement initiatives with what our Managed Care Organizations were doing, so we had to find quality improvement projects and the measures to go along with them that we could make sure that, you know, the federal dollars weren't being inappropriately used in that regard. So,

we chose to just steer wide and clear for our Managed Care Organizations completely.

Ideally, going forward outside of the grant, I would guess that most states, certainly New Hampshire would do what Virginia is doing and say all right, how can we work synergistically? What are our MCOs' priorities? Hopefully data-driven again, but also reflective of their politics, clever ideas. And we'd want to work in collaboration with them because the rising tide floats all boats.

CHAIR PINCUS: Other questions?

MEMBER SAYLES: I think I might just have a summary comment. It seems to me that one of the big themes is, I appreciate feedback, is alignment, and that I know when we're going to go through our measure by measure analysis, one of the key things on the table is who else is, you know, looking at this measure, who else is using this measure? And, I mean, I could imagine

as more and more Medicaid is in Managed Care and Managed Care Organizations continue to play a really big role, there's some very selective pressures there with NCQA accreditation and what measures have been set up in that context. So, thinking about --- it seems like it's a little bit of a puzzle, but sort of thinking about where while it might be a great measure, if nobody else is looking at it, and it's hybrid, and it's got other data constraints, probably there's some real practicality that needs to be taken into account, and that that alignment piece of things is probably what this group could really contribute also in terms of thinking through measure by measure when we do things this afternoon.

CHAIR PINCUS: Actually, I like that idea of a crosswalk because I think that kind of cross walked makes explicit, you know, what's out there and what are the differences, and how might they be used, and are the

difference justified?

MS. LOTZ: And we went ahead, and Virginia had a slide, where they showed us a bit of their crosswalk. When we put together in New Hampshire our initial website, our Medicaid Quality Indicators, this was before the grant and what opportunity that brought to the table, we looked at it, and we looked for those synergisms, you know, what's a meaningful use? What's a part of any other program to look across where we could get basically the biggest effect for the resources that we could bring to the table?

It still has to be balanced against where there may not be a whole lot of resources but there's still a whole lot of need. But I think you need, you know, a body of data to start telling that story, and then making the case to allocate some attention and resources to something that's not necessarily on that synergistic list. So, it's both, and where you

may have to start from a very practical point of view, I would go back to, you know, my last couple of slides. But what we have right now is not good enough for where I think we ought to be, so I would encourage a group like this to think expansively and not just by bounded by what's practical. We have to be bounded by what's practical, but I think ideally we should be planning for what's down the road. So, what are the recommendations for things that don't exist right now, and to not take your eye off things that are hard. We need to work on how to make them easier to do because they have merit in and of themselves.

MEMBER PELLIGRINI: Just a quick clarification. I want to make sure I'm understanding what we're talking about a crosswalk here. When we get these type of grids from NQF there's always a column, it's called --- it's about two-thirds of the way over called "Use in Federal Program," which is actually one

of the ones I find more helpful because it does show you what other programs a given measure is in.

Are we thinking about adding state elements, or something like that to this field, or is there something else about a crosswalk that I'm missing?

CHAIR PINCUS: I think it's also C-- and I think it's going back to Slide 80, and I don't know if we can sort of move to Slide 80, but looking at which programs it's being used, and which programs it's not being used in, or for which it's been modified in some way.

MS. LOTZ: I don't think you could possibly add all of the state variations there. It's already a big help as Virginia has on their slide that we've got up now again just to know what's happening at a federal level. You know, we'll figure out at the state level, but to see it on a federal levels helps a lot because oftentimes there's dollars allocated to

federal initiatives as there was with meaningful use. Oftentimes there's, you know, those measures and the clinical issues, or the other issues that they're drawing attention to are based on some other program, or some other initiative going on. So, you know, getting that synergy to say this is an issue, let's do it, you know, it just helps us to know where else --- where our providers, where other resources are going to be distracted, and how can we decrease their administrative burden, and maintain their attention and engagement, you know, to know that well, you have to do this for Medicare so we're going to do it exactly the same way for Medicaid, so this is a good thing. So, I think at the federal level it's sufficient.

MEMBER HANRAHAN: I'd just like to see if I'm processing this correctly. There's one issue that keeps --- I hear keep being discussed, and one is about the architecture of

the data. So, how does that architecture get constructed, and then promulgated among the various parties, the entities that we're looking at, to get uniformity in what we're doing. And that can also include --- at this time there's a high degree of activity happening in the business world around how to work data, and how to do the kind of predictive modeling, but even beyond predictive modeling, advanced modeling using this data in its simplest form, and its cheapest form is what I hear you speaking a little about needing.

The second part is high-value targets. And high-value targets, because we're swimming in a lot of detail, and a lot of detail that comes out of the hard work that's being done here. Such great examples, these two states, and what they've done. I would recommend that we're look at, if we're looking at high-value targets, that we look at it from a systems level. And one of those targets is

accountability from the Affordable Care Act, and more specifically continuity of care. We know that continuity of care and the abruption of care when there's a need identified, to that need then going away, that we have a huge piece of work to do in this direction. So, that would be a high-value target that I would imagine working toward. And it's also related to accountability, it's one aspect of accountability, but it really is pretty tangible. We already have measures that are operational now, and have been selected by these two states to follow.

The other part of this is in the analysis of it, these high targets. We want to look at cost, you know. Are we driving down cost by using this, and these are the meaningful measures, the use of meaningful measure? And are we driving down cost, and are people most satisfied with their care? And those are kind of the three aims of Medicare, you know, the

cost reduction, quality improvement, and satisfaction. So, you know, that's how I'm kind of getting this all squared in my head, but I would advise us to really separate out this issue of architecture, data structure, and data science, and how we manage that really well with what we, then, come out of this saying what targets, high-value targets we'd want to recommend that we move forward with. And there are some really good measures in the group that I think we could go forward with.

CHAIR PINCUS: I think we have an opportunity to communicate that in terms of the gaps recommendations that we're going to be making. Yes, I tend to think of coordination of care, sort of reframe it as a sort of ruthless follow-up.

Questions or comments? So, why don't we move to public questions and comments, and I guess we also have to open up the lines for that, as well. And, also, for individuals

here in the room.

OPERATOR: Okay. If you want to make a public comment, please press star then the number 1. At this time there are no public comments on the phone line.

CHAIR PINCUS: Okay. Anybody here in the room that wants to make a comment?

MS. POTTER: Hi, I'm D.E.B. Potter. I'm from AHRQ. I'm a member of the MAP Dual Eligibles Work Group and Post Acute Care Work Group. I wanted to ask the speaker who talked about New Hampshire, she had a slide on measurement gaps, and she included long-term services and supports, and home and community-based services, and behavioral health. I wonder if you could say a few more sentences about that?

MS. LOTZ: About what specific measures we'd like to see? Obviously, not in the detail because I'm not a measure scientist.

MS. POTTER: Or the problems you're

seeing that you somehow want to be able to measure or improve?

MS. LOTZ: So, long-term care services supports home and community-based care. I don't think we have measures. To go back to what was just said, and one of my slides does say we need to do a better job of measuring what's important to patients, to members, beneficiaries, they're all patients to me. How do we know what they want, and how does anything other than what they want really matter? You know, we do have a CAHPS survey for home- and community-based care. I'm not intimately familiar with it, but I do think that where that would get at patient satisfaction a little bit of experience of care, I don't think we have good measures that maybe talk about what's important to them from some of the other domains that get outside of clinical domains, you know,

looking at their social circumstances perhaps, looking at their environment, you know, looking at some of the barriers to care that they perceive, looking at --- you know, again, I'm struck by a couple of things. From the point of view of my elderly parents, how absolutely adamant they are of what they want, and it's not the maintenance of their physical health necessarily. And yet we presume, somewhat paternalistically that, of course, everyone wants to be healthy. Well, yes, but at some point people make their peace with what they have for a physical limitation, or even a cognitive limitation, and their priorities shift. And how do we capture that and honor that and make sure that we're not beating them up because their LDL levels really ought to be better than they are, but they're really 90 years old and don't really care one bit. So, there is some interesting work I think going on in measurement science, and also in

recommendations around preventive care to say okay, when do we stop? And I think we need to capture that a little bit more in patient preferences, particularly in the long-term care and community-based services. There are some things that I think they don't want us to do, and we don't know what they are. Or maybe I'm wrong, and maybe if we gave them a chance to say they would say absolutely, I want every aspect of my physical health restored at all costs to everything else. I kind of doubt it, but without measuring the alternatives, or asking a question about their priorities, we're not going to know.

Let's see, that was the long-term care question. What was the other question you asked? I think it had to do with substance use, maybe. I don't know, but I'll just go back to just briefly saying neonatal addiction, I have no idea how to get my hands --- number of babies. Okay, great, but what does that tell me about

how to solve the problem? It kind of starts to overlap with what's happening around perinatal care, prenatal care, in particular. How do we manage inside the home? Again, sort of what is --- I was very struck by when I was doing my residency at a county hospital in Los Angeles, sort of this newly minted Midwestern intern in --- you know, again, in the warzone of LA in the early '80s. And what mattered to me really did not matter at all to the patients I was working with without going into the detail. It mattered not at all, you know, about the good clinical care. It mattered about their environment, and 30 years later I'm glad to see that we're starting to think about that a little more formally. And I think we need to start measuring that so we can say where we're good, say where we're bad, and hopefully where the measures will point out where the barriers are that we need to remove. Because until you get a patient on board with everything else that's bothering

with them, you're not going to get them to address their physical health.

CHAIR PINCUS: Other public comments or questions? Okay, so why don't we stop for lunch. And it's going to be a quick lunch. You'll be able to go get lunch and get back here at ---

MS. LASH: There's lunch for the entire task force and members at the table in the back. If you are in the public comment area and you'd like some direction for resources and places to eat in the area, we'd be happy to provide that as staff. We do have one more state actually at 12:30, so we want to make sure we get to them on time, so please --- I'm sorry that you have to go get your food and bring it back, but we'll have plenty of more time for discussion later this afternoon, and we promise there will be a break. So, thank you.

(Whereupon, the above-entitled proceedings went off the record at 12:21 p.m.,

and went back on the record at 12:36 p.m.)

MS. DUEVEL ANDERSON: Okay, thank you so much. So, Eddy Meyers is from Louisiana and he's on the phone and we're so grateful for your time. We'll have another presentation from the State, and more questions, and then we do have additional time for an overall panel discussion and so, go ahead, Eddy, whenever you're ready.

MR. MEYERS: Okay, thank you. I'm Eddy Meyers. I'm from the University of Louisiana at Monroe, the Office of Outcomes, Research and Evaluation. And we partner with Louisiana Medicaid to do data analytics and quality measure reporting.

And Dr. Rebecca Gee was also going to be presenting along with me, but she, unfortunately is unable to do so because of a funeral. But she will be able to attend the conference later on. And let's move on to the third slide. Let's see, one more slide forward

please. Okay. What I wanted to point out from here is just a little bit about Louisiana.

In Louisiana there's a population of around 4.6 million people and of that, around 1.4 million are enrolled in Medicaid. So that's around 30 percent of the population are enrolled in Medicaid.

And then something else I wanted to point out here is Bayou Health. That is Louisiana's Medicaid Managed Care program. And that was rolled out during calendar year 2012. It was a staged rollout in regions of the state and across that calendar year. And there are five managed care plans that make up Bayou Health. And so in the recent years, it has been a time of transition for Louisiana and Medicaid from a previous, you know, completely fee-for-service model in 2011, and prior to managed care.

And then there is still a small segment that are still on legacy

fee-for-service Medicaid. And let's move on to the next slide, please. The adult quality grant measures that were selected, there are 19 here, and one minor correction I want to make note of on the second column, the second one down, antenatal steroids, that one should be replaced with smoking and tobacco use. Antenatal steroids is one that we looked at earlier on, but ended up not doing that.

But like I said, we reported on 19 of the 26 measures and the way those break down is there are three capped survey measures, the smoking and tobacco use, flu shots, and then the overall capped health plan survey.

And then there was one chart review measure that we did and that was postpartum care and we also did that measure with administrative data but then we, you know, did it as a hybrid to supplement it with chart-review data, and that was something we had not done before.

And then there was one measure that we used, a combination of vital records data and claims data which was the early elective deliveries measure, and then the remaining 14 measures all used administrative claims data.

And we, in looking at the managers and evaluating the feasibility of them, there were, you know, some other measures that were of interest but were not chosen due to the burden of collecting the data through chart reviews. So examples of those are pair transition, adult BMI, controlling high blood pressure, and antenatal steroids.

And the adult BMI measure, it's a measure that's been collected, or we have programmed and tested and found such a low rate through administrative claims because the codes used in that are not ones that providers commonly bill upon. And so it's really not useful from an administrative data standpoint. So that one would have required chart review.

And the populations that we used, we used what we call the Medicaid only population where we excluded Medicare dual eligibles. And then we also used calendar year 2011 data because we wanted to do a pre-Bayou Health rollout picture there, because calendar year 2012, when Bayou Health was rolling out was a year of transition and so we wanted to look at pre-Bayou Health and then follow it up with post-Bayou Health. Then moving on to successes on the next slide, please. Thank you.

Prior to the adult Medicaid quality grant, we collected 18 HEDIS measures and 10 CHIPRA measures, and we began reporting HEDIS measures for Louisiana Medicaid way back in 2002. We started out with just asthma and diabetes and then over the years, we, at VHH's request, have programmed additional measures, addition HEDIS measures, and then also had already started doing some PQI measures.

And the grant helped us to really ramp up the number of measures we report. And so, you know, like we mentioned on the previous slide, we're able to report 19 out of the 26 adult core set measures.

And prior to the adult quality grant, of these 19, we already reported on 7 of the HEDIS measures and 3 of the PQI measures. So we were able to, you know, add nine additional measures there.

And I wanted to point out on the PQI measures, when we reported on those, we did them on a per-member basis, and I know the updated specs shows for 2014 that they are to be done on a member month basis. And there's been, you know, some discussion about that and that's our, you know, would be our plan to report on it on a member month basis, you know, going forward.

And another big success of the adult quality grant is that it allowed us to create

a Medicaid vital records matching process which allowed us to do the early elective deliveries measure electronically using claims data and biorecords data without having to do chart review.

And in 2010, Louisianan Vital Records, there was a big update that -- they started collecting additional data, a lot of additional fields on early deliveries, and so because of that, you know, it helped facilitate this and, you know, it appears that for our state, there's not a real need for chart reviews for early elective deliveries. Because of that matching process, we're able to collect gestational age, able to collect other variables like spontaneous rupture or membranes, active labor, et cetera.

So that has been a big success is the ability to do that and we are able to use that biorecords matching process, you know we will be able to use it going forward in collecting,

you know, data for other measures and, you know, for other initiatives. And then next slide, please?

And then another success is we gained experience with the chart review process. This was something that we had not done before either, and so to do the postpartum care measure, the hybrid chart review piece of it, we collaborated with the Louisiana Office of Public Health nurses and they helped collect the data, you know, review the charts and that was a really good experience for us.

The reason why we did choose to do chart review on the postpartum care measure is that we already collected the data administratively, through claims, but we believe the rate was too low because of bundled billing of deliveries and postpartum care, you know, billed at the time of delivery.

And the HEDIS presentations for that measure, you know, the postpartum care has

to occur in the right time frame, and so we were, you know, not able to count those through administrative claims data. But after doing chart review, we were able to do that and were able to increase the rate quite a bit there.

And then, you know, another success is that we utilize administrative claims data measures, you know, where possible to streamline data collection, because we had already been familiar with collecting administrative claims data and reporting on HEDIS in other measures that use claims data, and so we were able to leverage that to programs and deliver many of the additional measures.

And so that's, you know, that's something that I think is very useful for, you know, all states using their claims data to look at quality. Next slide, please?

For challenges, we initially identified the measures of interest and then we revised, you know, our list after accepting

feasibility and data availability issues.

One example of that is care transition measure. That was a measure we were interested in collecting, but it would have required chart review, and we replaced it by planned all-cause readmission measure because we already collected that measure and, you know, we were beginning to see that through doing char review on the prenatal postpartum care that there was a lot of time and expense involved in the chart review measure, so we were trying to keep that to a minimum for this you know, initial year.

Some other measures that we were interest in that I mentioned earlier, controlling high blood pressure, antenatal steroids, adult BMI, you know, those are ones that were discussed but were eventually not chosen, because of the chart review burden.

And another challenge I want to point out was the planned all-cause readmission

measure and it has been discussed earlier, you know, that measure does not have Medicaid wait for risk adjustment, and we chose to use the commercial weight due to -- several years ago, when we first started programming this measure, we had a conference call with NCQA and at that time, you know, since Medicare and commercial weights were all that were available, they suggested that commercial weights would be more applicable than, you know, Medicare weights to the Medicaid population, and so we chose to do that.

And, you know, one thing that I think is important for all states going forward on the risk adjustment method, because I know there's been discussion about it, is that, you know, whatever method is used, whether it's commercial, or if HEDIS will eventually come out with Medicaid weights, or it there's some other risk adjustment methods used that all states, you know, use the same methods so the

data can be, you know, compared across the state or either, you know, the states just report their unadjusted weights.

And then another challenge was matching the Medicaid data to the vital records data. This took quite a period of time, and took several months to work through the issues of data use agreements, getting access to the vital records data, learning the data, developing the matching process, testing it.

So that was something that did take quite a bit of effort and time but, you know, in the end, it resulted in a big success in being able to do that.

As mentioned earlier, another challenge on the next slide, please, was creating and implementing the chart review process. You know, that, as mentioned before, is extremely labor intensive, and one challenge we had in there is the provider contact information in the Medicaid database was not

always current or correct and so there were challenges in the public health nurses, contacting the right provider, not having the right phone number of fax number or even address.

And then just the logistics of it: it does take a lot of time and it was a lot of expense to collect the data for that postpartum care measure. Another challenge was just getting clarification on some of the measures from the specifications. Like, one example is on the HIV measure. We had some questions about when should age be calculated, beginning of the year, end of the year? What about the timing of diagnosis of the HIV denominator related to the timing of the numerator, et cetera.

And so we emailed and we did get clarification but it did just take, I think, maybe a couple of weeks to receive that clarification. And so, you know, that was just

something we were kind of waiting on while we were programming.

And then also on the early elective delivery measure, there are clarifications that were needed to the specifications, but then the technical specifications updates that were issued in November for early elective delivery helped clarify many of the questions we had before and helped to resolve those.

So I understand it's just a process in adapting, you know, these measures for use with the Medicaid population, and so that's just some of the issues that do take time to work through. Okay, next slide, please?

And looking at how collecting the adult quality core set can drive quality improvement: it can enhance the capacity for analyzing and reporting quality measures across all programs of Medicaid. This data can drive Medicaid policy and interventions to improve health outcomes which, of course, this

is a huge thing. Based on the results of the measures, it can help Medicaid see where the biggest gaps, where do resources need to be directed? Where do policies need to be changed?

And so this can certainly help the use of Medicaid -- help Medicaid efficiently use their time and resources to focus in the right areas, to improve the care of the population of Louisiana.

And this also added capabilities that can be used in other measures or initiatives. For example, vital records matching process, that can be used to do other pregnancy or early birth measures. And so that's something that can be leveraged there in other areas. And then also the chart review process, we learned a lot through that and, you know, that is something that we can use going forward in a limited manner, just due to the expense and time burden of doing chart reviews.

And let's move on to the next slide for our recommendations. And as I was just saying, our first recommendation is to try to help limit the chart review burden by utilizing measures that use administrative claims, or other accessible electronic health data where possible. And I've talked about that, about the expense and time of chart review.

Another recommendation is to enhance the process for obtaining clarifications about the technical specifications to minimize programming delays. Just an example, or an idea there would be possible web page with frequently asked questions, so as states ask questions, maybe they get posted there, so other states can go to that web page and see if that question has already been asked. Because I would assume, in the areas where questions arise, that it would typically arise across the board and all states would have some similar questions.

Another recommendation would be consider additional measures that impact large segments of the population. For example, asthma. We have a lot of people in Louisiana with asthma, so asthma medication ratio measure would be one suggestion. Adult's access to preventative or ambulatory health services, that would be another possible measure.

Let's move on to the next slide. And further recommendations are to incorporate more electronic specifications for clinical quality measures from the Meaningful Use Program. And then next align the core measures where possible with the Physicians Quality Reporting System to avoid duplication of efforts.

And so both of those recommendations are to address looking at where states are, or will be in the future years, collecting data and reporting data and what measures are going to be used by states or by

providers to assess quality, and try to align them so there's as much overlap as possible between the measures that are looked at, so each different initiative is not looking at separate sets of measures and that there's not too much duplication of effort to collect similar types of data, that everything gets aligned as much as possible.

And then another, final, recommendation is to add a potentially avoidable emergency room visit measure because for the Medicaid population, emergency room expense is huge. And something to look at that and measure and try to find ways to act upon potentially avoidable emergency room visits would be a great benefit.

And next slide, please? And that wraps up the formal presentation and I'd like to open it up to questions now.

CHAIR PINCUS: Questions?

MEMBER ANDREWS: Hi, this is George

Andrews.

CHAIR PINCUS: Move closer to the mic.

MEMBER ANDREWS: Can you hear me? George Andrews. A question, your recommendation regarding emergency room measures. Certainly to be able to determine appropriate views or inappropriate would require more than just a claim. So, yet in your report, you were recommending more use of claims based measures that would improve the visibility and capture all the information.

So I'm curious how you see your recommendation and the barrier to that? And I'd say a follow-up question is access to care, again, is a key item that places emergency use, particularly the Medicaid population. And how, or what, are you doing in terms of addressing that barrier to mental health care in particular?

MR. MEYERS: Okay, let me address

the first part of your question. And you're right, we do think the chart review measure, the burden should be minimized but we're not saying that there aren't appropriate places, or needs for chart review measures. We just want to use them in a smart, efficient way to collect information that is really needed and actionable.

And so, we want to minimize the number of measures that we collect chart review on. But we still may need to do that in the near future until electronic health records are in place and widely used. Then some measures may still -- may make sense to do chart review on some that could have a really big impact, and emergency room visits could be one of those.

And then on the second part of your question, it was breaking up and I could not hear it. Could you repeat the second part of your question?

MEMBER ANDREWS: Yes, the second

part has to do with tying the emergency room high utilization by the Medicaid population that ties to either lack of access to care, and addressing that. And particularly as it relates to mental health and access to care.

MR. MEYER: I'm sorry I lost the last part of it. You said in particularly and then I couldn't hear anything.

MEMBER ANDREWS: Mental health, depression, et cetera.

MR. MEYER: Okay, well, I can only speak very generally to that, because I would not be the best one to speak to that question. But I think states in general are looking at ways of providing appropriate access of care, so people can get care they need and not have to go to the emergency room for outpatient care, or after hours clinics, or urgent care clinics can serve that need.

And to that question, like I mentioned earlier, Dr. Rebecca Gee, the

Medicaid Medical Director will be attending the conference later. She'll be at tomorrow's session, and you may want to follow up with her with that question and she could provide more information.

CHAIR PINCUS: Cindy?

MEMBER PELLEGRINI: Thank you. We've heard a couple measures mentioned more than once as being very challenging to deal with, because you do require the chart review, antenatal steroids being one of them, and that's one that's near and dear to the March of Dimes. So I think it's important for us as an organization for us to think about how that can be -- what kind of things we need to do to make it easier for states to report on that.

But it really points for me to a larger question which is that payment models seem to be going in one direction, which is taking us away from granular data. You've got --

(Telephonic interference.)

MEMBER PELLEGRINI: -- based payment and bundling and things like that. Meanwhile, we want our data to be more and more granular, which means we aren't going to be able to get it from the claims, and so we have to develop other systems. Is it the EHR or is it something else? And how can we start pushing the system to evolve in that appropriate direction now? What do we need to be doing now to anticipate this --

MR. MEYERS: Okay, it was breaking up as you were asking the question and I could only hear pieces of it. Can you kind of summarize your questions?

CHAIR PINCUS: So, I think basically the question is, and I'm not sure what the question was, but it was a almost more of a comment, but sort of posing it to you, I think also to other people as well, that given the fact that payment systems are moving towards

bundling of payments for a whole sort of cocktail of services, that's going to eliminate the ability to get granular data that -- individual services.

How do we align our plans for measurement to a world where things are more bundled, and there's less availability of this granular fee-for-service type data? And how are you preparing for that?

MR. MEYERS: Yes, I mean that's something that we, and other states, and other organizations will kind of have to work with over time, to see how bundled billing does impact and there may have to be other ways down the road as electronic health records data becomes more widely used, that may help that.

MS. LOTZ: Well, I could just try to take a stab at answering these questions. As he said earlier, I have to plead ignorance on what e-measures are. Really? I didn't know that.

But that may provide an answer. It's not quite ready to go now, but I think where there can be the access of clinical data in an electronic way through an exchange, that might help, because the challenge of chart review, as has been said by all of the state presenters, is the cost to get somebody there. It has to be someone with a fair amount of clinical background.

It's pouring though the documents, whether they're secure electronic records, or whether you get to still work with paper copies. When we did our chart review from the hospitals, we're still working with paper copies. And it's just time intensive and it has to be done by someone who has a certain skill set.

But once you go through the work of gathering the data, that becomes just data elements to work with, like anyone else. So I think the electronic exchange will help with the gathering of the data and will markedly

reduce the costs and the resource needs. So that's one potential solution.

But I would offer as well, while we do want our data to be granular, the reason I would propose we want our data granular is because we want to be able to move to action. So if we had measures that illustrated where there might be opportunities for improvement, that might help us.

Maybe we're, again, thinking about the wrong kinds of measures. We need different kind of measures that point toward where the barrier is. Maybe we don't need granular data for a more focused on outcomes, because there may be many, many pathways to the outcome and it really is all about the outcomes.

So again -- and then the last, the fourth point I would make is I was very struck with the AHRQ article out of Health Affairs that I referenced earlier. Some measures speak to activities that have a greater impact on health

outcomes. So if we have to prioritize them, then we should clearly prioritize those on top and not lose a lot of time and effort getting things that are only going to have a very marginal impact on the health.

CHAIR PINCUS: Other comments? Oh, Ann?

MEMBER SULLIVAN: Hi, I just wanted to ask you, since you're starting up with a new managed care plan that is also getting started at the same time that you're doing all this work on measures, how are you working with that plan on the measures? What are your thoughts about how you might prioritize with them? What kind of incentives might you use with them in terms of trying to use these measures to include quality care?

I was just wondering about the interface between the measurement that's going on and the set up of your managed care plan.

MR. MEYERS: Okay. Louisiana has

established as set of measures to be used by the managed care plan to assess the quality and there are some HEDIS measures and some PQI measures there. And those are measures that have already been collected in the past for the states and at least in most of them, and then, are being collected by the state and also by the plans to measure their quality.

And there is some overlap of those measures and these measures and going forward as the state moves into new contracts for managed care plans and the measures can be reviewed and adjusted over time. There could be the possibility of more alignment between these measures and measures that are used to measure the quality on the managed care plans. But keep in mind, a lot of measures that we're not talking here that are used overall are the children, you know the CHIPRA-type measures, because such a large percentage of our population is children.

CHAIR PINCUS: Other comments, questions? I had a question actually that is to some extent to you, Eddy, but also I think goes to other people in the room as well, maybe Karen.

And something that we may want to talk about a little bit later, but your suggestion about sort of incorporating measures from PQRS and from meaningful use and to think through what are the sort of the up sides and down sides from Medicaid directors' point of view of doing that?

MS. LLANOS: This is Karen, I can start. I can tell you that for the Medicaid EHR incentive program, we are trying to --

(Telephonic interference.)

MS. LLANOS: -- in the children's side but it's gotten the core set finalized for the past three years to take measures to try to develop electronic specifications for them. I think the challenge is they have to be at the

provider level, and our measures must --

(Telephonic interference.)

MS. LLANOS: So in an effort to align the two programs we're actually --

(Telephonic interference.)

MS. LLANOS: So that's the thing to think about. I think finding these --

(Telephonic interference.)

MS. LLANOS: -- leveraging the Medicaid patients and different groups is part of our program. We see them as one and the same. And on the adult side, we've got lots of opportunity to do that. I think to the extent I think some of our measures are already in some of the earlier stages of meaningful use.

The piece there to comment on is, I think what we have heard from states, and I think some of the states today, probably represent some of the states with different thinking. We've initially put out electronically specified measures for

consideration has been ones that we've been asked to kind of stay away from, and looking at the 26 measures that were reported last year, I think is a transition measure with is only an e-measure is the least measurable of the measures, that were before us, so that's something to think about.

And then I think in terms of PQRS, Physician Quality Reporting program, we've got some Medicaid adult care providers already part of PQRS, and that was actually the reason why we selected them in the first place is because understand that many cases a provider was reported -- was participating in both programs.

I think some of the early challenges for this, we can pull more of that out during the measure discussion is --

(Telephonic interference.)

MS. LLANOS: -- so in the technical specifications for --

(Telephonic interference.)

MS. LLANOS: -- not all states have access to it. It varies in terms of the use of the G codes. So that's the other thing to think about. And again, I think would we need to modify the PQRS measures in order to be collected at a state level? I think we're still kind of figuring that out.

CHAIR PINCUS: Eddy, did you have a comment about that?

MR. MEYERS: I could not hear most of what was said there. I think there might be some microphone issues there. So I'm sorry, I wasn't able to hear most of that. Would anyone maybe briefly summarize that?

MS. LLANOS: So, Eddy, this is Karen at CMSA. Harold had asked us to comment on, I guess, the impact or the consideration given to alignment with the electronic meaningful use program, measures that align across both the Medicaid adults core set, and the EHR incentive program. And in then the

same question for PQRS, the Physical Quality Reporting System, I think. You mentioned those actually in your slides, specifically, which I think is what Harold was pinging off of.

I mentioned that at the CMS experience and what we've heard from states is it's a double-edged sword in some cases. Yes, we want to align, but I think the capacity for all states to access electronic health care record data to populate the EHR measures are difficult. And related to the PQRS measures, some of the codes for the specifications, for example the G codes can sometimes be a barrier for state reporting. I'm not sure if you've had the same experience in Louisiana.

MR. MEYERS: Okay. And we are just in the beginning stages of looking into the potential of electronic health records and hopefully, we'll be doing some pilot projects in the near future. So you know, I can't address any specific issues, because we have

not done so so far, but that's something that our state is wanting to move toward is more widespread use, and the ability to report using electronic health records there.

CHAIR PINCUS: Other questions, comments for Eddy? Well thank you so much. This has been really helpful, and we'd be delighted if you want to stay on the phone, if that is possible and be able to make some comments later on and respond.

MR. MEYERS: Okay. Thank you, thank you everyone for your time and for your feedback.

CHAIR PINCUS: And we're looking forward to having Rebecca join us tomorrow. So, now let's turn to Allison, who is going to talk to us about the states that did not choose to participate in the program.

MS. LUDWIG: So this came from our request from you all on the web meeting to hear more from states that elected not to

participate. And unfortunately, we didn't have the best luck in connecting with all of these folks, but I can share our conversation with one state and we also have Dr. Lieb here who can share his perspective on the State of Arizona also not participating in this program.

So the one state that we spoke with was initially interested in reporting but when they did not receive the grant, they elected not to report or participate. So some basic elements of this state, they consider themselves a frontier state, and who is not very well resourced. They have challenges specifically around the workforce. They have very few mental health providers. There's some geographical distances between primary care providers as well. But they are doing many things.

One of the efforts for quality that they're focused on is the patients that are in medical home initiatives, so they're doing that

across the state. And they're also very interested in what we've been talking about related to the meaningful use and PQRS, and aligning those measures and those efforts.

So we asked them the question about what they would recommend to this task force and this core set and what would helpful for them. And given their challenges and resources, but also their interests and their priorities within that state.

And so they mentioned that the more fundamental measures surrounding diabetes, depression, blood pressure management were really important, and easily implementable measures and measures that are electronically reported would also align with their interest and the meaningful use. So that's a quick summary. Sorry we aren't able to bring forth more information on the nonparticipating states, but I think that's still an important voice to try to bring forth, and I hope Marc will

be able to just share his thoughts as well.

MR. LEIB: Thank you. Yes, I will share what went on in Arizona, and around all this, because we did not even apply for a grant so it wasn't that we didn't get one, we never even applied. And I will go through the decision for that.

And we chose not to report for a variety of reasons. I'll cover both of those. The not applying for the grant was the easier of the two. We'd been 100 percent managed care since the inception of our program in 1982, so we have nothing but managed care programs, with the exception of American Indians who can receive services on a fee-for-service basis, because they are a sovereign nation and we cannot force them into managed care.

So we have been measuring quality for at least 30 years across the managed care plans. And we take it seriously. We not only measure the quality, we set standards in

contracts with them and those standards are changed and elevate each year. And if a plan fails to meet the standard -- at least, we can do it every year, but we usually choose to, if they don't meet it one year to give them another year to see if they can meet it.

If they don't meet it two years in a row, we levy significant sanctions against them, financial sanctions. And with the number of measures we have, it can actually amount to well over a million dollar sanctions to the plans who fail to meet the thing. So it's not that quality is not important. However, all of our measures have been homegrown. We describe them and HEDIS-like, but we don't a HEDIS-certified system and because we measure, our reporting period has always been different than the HEDIS measures. HEDIS would not let us call them HEDIS measures, so they're HEDIS-like measures. And we've called them that for at least 20 years.

We carry out things like performance improvement projects where we have two a year that we usually put in. Some years we've cut it down to one. But that means there could be as many as six or eight of those projects going on at any given time for our plans. So all of that is said in the background of saying quality is important.

Now why didn't we apply for the grant? It's actually a pretty simple decision. There was no -- the probability of us actually achieving all the requirements of the grant, you know, getting the number of measures reported in the manner in which it was to be report was so low that our director felt that taking grant money to do something he knew we would most likely not be able to achieve was, in his mind, unethical. So he would not even allow us to apply for the grant. We continued to do our measuring our way as we did.

We could not implement any new

hybrid measurement programs, due to budgetary constraints, as you've heard from several states. Hybrid measurements are very expensive, time consuming, both at our level at the plan level and if we make the plan do it, we have to give them enough money to do it.

So it's not just that we give them a set amount of money and go do more things with it. Every time we ask them to do more, they in fact, want more money. So we were challenged in not being able to institute any new hybrid reviews.

Our measure sets were done even though, like I said, we tried to emulate HEDIS-type measures. They were in our system that -- and our measurement was very old, had been programmed years before and the numerators and denominators no longer matched exactly. And although we were trying to update them, we did not think we could get them done in time to make our system match what was being asked for.

And we were in the process of looking for external data measurement sources so that we could have our data validated by external validators who could then do it and keep the measures up to date. And since that time of this, we have now signed a contract and we will be having all of our measures done externally, as well as internally.

But because of those differences, our measures would not necessarily translate across state lines for comparison with other programs. In some cases, we may look much better, but in reality, not be. In other cases we may look much worse and in reality not be. Because of the variation in the measurement criteria that we were using, we just weren't sure that it would be valid.

So that was the grant and not reporting comes down to a lot of things we weren't doing. Some of the measures, at the time that this was coming out, we were in year

three of having had a severe cutback in services to our adult members. Children, of course, get everything under EPSDT.

But our legislature had cut out well-person exams in 2010. So, we were not even allowed to pay for a well-person exam. It's hard to collect data that is most often collected during that kind of exam when you're not doing it. And the plans, of course, said you can't measure us on something that we can't even have our providers do because we can't pay them for it. So a lot of the measures that should be collected, we weren't even doing it.

In addition, we had cut our enrollment. Again, the fiscal crisis caused us to cut our adult enrollment. We had had an expanded program of everyone up to 100 percent of federal poverty level, childless adults included. The legislature froze that program so between 2010 and 2013, we lost over 200,000 childless adults.

So as you measure across different years, the measurements were no longer valid because the your population was changing, not just in the individuals but the actual types of individuals that were in the program were changing so that we didn't think the comparison would be very good.

We actually had frozen our CHIP program also and lost a significant number of children, but that isn't necessarily pertinent to the adult measures.

We do have a separate ALTCS program, long term care program, Arizona Long Term Care System that is all managed care. We do even have quality measures across that. Some of them are medical and some of them are the home- and community-based services because someone asked a question about that. But when you talk about home- and community-based services, every person is unique in what they need so it's hard to pick out something that

measures a specific service so we measure things like time from enrollment to time of the first service being delivered, whatever those services are, not medical, but the home- and community-based services and have that be a standard that really is 80 percent of new members have to be receive their initial service within 60 days of enrollment, something like that.

So there are ways to measure these things that we do but they're not comparable across the adult measures that we're being asked in this.

So those basically are the reasons we didn't apply for a grant. We didn't have the money to then implement these things and trying to report measures that we weren't sure would be comparable across programs and we're changing because of our changing financial situation was something we chose not to report.

We have since restarted our

well-person exams so I can give you that good news. We have signed a contract with an external data validator to do our measures for us with our data warehouse stuff and without us having to reprogram every year because we, frankly, didn't have the programmers to do it in the language in which it had originally been done and to start from scratch would have been many hours and very expensive.

So we hope on a going-forward basis to be able to participate with these measures, but we don't have the measures to have previously reported.

And I'll take questions on those decision making.

How is that for baring our soul in front of the people. Yes, I wear sackcloth, yes.

CHAIR PINCUS: I'm glad we provided that emotional catharsis.

MEMBER LEIB: Emotional catharsis.

CHAIR PINCUS: Jennifer?

MEMBER SAYLES: Thanks for that candid response; that was great. You put it all out there.

MEMBER LEIB: Well, I said when they asked me to do it, I said I would be candid. I just didn't want to put it into slides.

MEMBER SAYLES: That's really smart.

So I guess I just had a quick follow-up question and maybe an observation from it.

So was there, I mean since you're primarily or almost completely managed care in your financial sort of model for Medicaid in your state, so I guess, was there any looking at leveraging the plans? Because they already have to. I mean, in the future, plans are going to need to have NCQA accreditation to be able to be part of things in the exchange they already have to.

So there's huge pushes for them to do hybrid data collection and so like, for example, in California where we have that similar model, I mean we basically, at the health plan level pull a sample and we give it to the auditor at the state and we give it to NCQA and we're pulling the sample.

So I guess I was curious if you -- but your measures might be totally different than those measures. And then it's like, well, what's that about?

MEMBER LEIB: Well, much of the measurement is done at the plan level but they do it according to the same way we were doing the measures in our system which was not necessarily, because it had gotten out of sync with the changes in HEDIS measures as numerators and denominators changed over the years and codes change. We frankly weren't keeping up with that.

MEMBER SAYLES: Okay, so like in an

ideal world, you would --

MEMBER LEIB: In a real world, we will and with our new contract, they will be mandated to pull their data and do their own stuff in analytics and then we'll pull samples for that just as you suggest. We'll be doing much of that with the standardized measurement set.

So, yes, we'll be doing that. And they do have the incentive to show us what they're doing because, again, if we can't show that they're meeting our contractually obligated levels, they'll be penalized.

MEMBER SAYLES: Right.

MEMBER LEIB: But they have to meet it according to what we were measuring and what we were measuring has been increasingly out of sync.

So we're going to be bringing that back up into the 21st century.

CHAIR PINCUS: Before you go, I

have just something to build on that.

So I find it interesting that you have a set of measures that you have been using. And I'd be curious as to the extent to which there's overlap or similarity.

MEMBER LEIB: There is tremendous overlap and similarity.

CHAIR PINCUS: What you developed de novo. And so like how many, going to the measure concept level, how many of the concepts that you're measuring are within the measure set that is the current adult core set and so if you could sort lay that out maybe?

MEMBER LEIB: Of the 26 measures that are the adult core set, we currently do 12 to 15 of those measures but maybe not exactly the same way. But we're measuring the diabetic measures, the hypertension measures, the COPD and the asthma medication measures.

We do a lot of the same measures and we're looking at the same things. There are,

frankly, some things on the 26 that we're not doing and we may not be able to implement for a while. But there is a large overlap but we weren't confident in the comparability of our results.

Again, some may appear better, some may appear worse. But if we couldn't be sure about the validity of those to everything else, we had a hard time deciding to report them.

CHAIR PINCUS: I was also wondering about the one, are there others that you do measure that are not in the core set that you think were important?

MEMBER LEIB: I think there are some. To tell you the truth, I don't want to speculate how many, but there are some.

For example, in our long term care which are separate managed care organizations. We have currently three of them, we've had as many as five that do that.

Since that population is very

different than the moms and kids in their traditional acute care plan, there are different measures. And that's why one of the reasons I brought up the example of the home- and community-based service one, but that's also when we have a lot of clinical measures because these tend to be sickest of the sick. So we have mostly clinical measures and then a few of the additional measures to measure the additional services that are provided.

And I can always get a list of those things for you but it's not -- I don't want to speculate which off the top of my head.

CHAIR PINCUS: Well, it'd be good at some point to look at that.

MEMBER ANDREWS: Well, my question is tied to what was already asked, but again, I was curious because most state Medicaid programs require participating MCOs to be accredited by NCQA and for the sake of simplicity and alignment, it would have made

sense to obviously go along with the same measures.

MEMBER LEIB: We have not required until recently that they be NCQA-certified so our measurements were developed initially in a non-NCQA world. And once we had developed them and were comparing year after year among the plans and between the plans, we weren't going to change those and along came this program, of course, which as long as we're comparing plans in Arizona to one another, even with the measures were not necessarily standard NCQA measures, we were using them to compare plans that were pulling their data the same way to one another.

So, now that we're going to be comparing across state lines and with CMS, we have an incentive to get everything aligned. It's just going to take some time and dollars to do that.

CHAIR PINCUS: Other questions or

comments? Doris?

MEMBER GESTEN: Harold, can I get in the queue?

CHAIR PINCUS: Sure. Oh, is that Foster?

MEMBER GESTEN: It is, I'm sorry to not be there and sorry to join late, but.

MEMBER LEIB: Hello, Foster.

MEMBER GESTEN: Hi, how are you doing?

Well, thanks for that. Marc has always -- I've known Marc for a while so you're always candid and always illuminating and despite the differences in states and some of the incredible things that have happened in Arizona.

I think your comment and your experience raises an interesting point and question which is, is it possible to do measurement and improvement without having national benchmarks across states?

Clearly, I think the answer is yes. You know, you've been able to show improvement and as you say, as long as the measures are the same across plans, they've served the purpose of being able to, you know, your programmatic purposes and most importantly, the purpose to which hopefully all measure is really intended, which is to improve care.

But I wonder how do you see -- and you mentioned that certainly you could have measures that are standardized and that would require some investment. I'm just wondering if you would reflect on the added value of being able to look at national benchmarks. How important is that to you? Have you used other kinds of benchmarks either, you know, commercial health plans in Arizona or something else to help you not only understand how plans in Arizona compare to one another, but where Arizona is all together? You know how important is essentially being able to

benchmark nationally to you, do you think, in terms of your efforts?

MEMBER LEIB: Well, we do like to look beyond our own borders. It's not that we're so insular to say, okay, we're only looking at ourselves. And we do, in fact, each year compare our results, as imperfect as they are, with the national Medicaid NCQA measures or HEDIS measures, I should say, and commercial plans.

And we then track the plans as to in which measures they exceed those and which ones they sort of meet it and which ones they are significantly below. And then we concentrate efforts to improving those, with the asterisk being that we cannot certify that our number, our percentage, is exactly comparable to what we see on those average Medicaid plans.

It is an imperfect benchmark that we're using as a goal but we can't say for sure that our number means exactly the same thing

that the national average number means.

So now that we are getting to a point where we will be doing it in a standardized fashion, we will be looking at what we do compared to other states' Medicaid programs and commercial programs to see how we stack up. And we'll be able to use that data to compare ourselves beyond our own borders which I think is very important.

MEMBER GESTEN: Thanks.

CHAIR PINCUS: Other comments, questions? Oh, Doris, right. I forgot.

MS. LOTZ: Hi, Foster, it's Doris Lotz.

MEMBER GESTEN: Hi there.

MS. LOTZ: So I wanted to make this comment at some point. I'm not really sure where it fits so I'm just going to plunk it in here.

When you're looking at potentially the Medicaid managed care and NCQA

accreditation, would some of these complex measures before the managed care organizations will report them to NCQA and they get embedded in a place like Quality Compass which we use to the extent that we can.

They all get audited. And we don't audit in the fee-for-service world where we try to create these measures as well.

Many of these measures are hugely complicated like the adherence to medication where I mentioned earlier, this is really like at least seven different measures.

Or places where with the antidepression medication adherence, you're looking at multiple points in time and you have to integrate multiple points in time and different patients into a final statewide measure.

In the managed care world, they will either have someone do that for them and/or have all of that audited for its validity.

And when we talked about reporting our managed care measures in New Hampshire they were very concerned that we not release anything until it had gone through that audited process and it makes me say, hmm, why aren't we doing that in the fee-for-service world?

So we talked earlier, I talked earlier about the expense, about the resource constraints that have that. I think we need to consider that as well. These are wonderful measures but where they're very complicated, we want to make sure that we're doing it in the right way and that what we're reporting has validity.

So don't forget about this concept of auditing.

CHAIR PINCUS: Do you have a comment, Marc?

MEMBER LEIB: I don't really have a comment to that except that I agree. The plans beforehand, we were doing them and doing the

auditing of the plans. Now that we're switching over, it will be done nationally and we can have them audited and that's a good to have them done by external organizations with the audit emphasis.

CHAIR PINCUS: Any further comments about the issue of nonparticipating states?

MS. LILLIE-BLANTON: So I think that Dr. Leib gave us a sense of a state that is very sophisticated in their quality monitoring and experience, just for different reasons, you know, largely because, you know, as he described, they weren't using HEDIS measures and the process of trying to report would have been reporting not-comparable data.

So I think that there are a set of states like that. But there are another bucket of states which are really under-resourced, don't have the technical capacity and infrastructure for reporting data and measures

as we have seen with many of the states that have reported.

And I want to make sure that this panel just keeps that in the back of their mind.

And what's interesting is I actually just tried to make a list of some of those and I'm not going to go through them. But we actually tried to get one of those states to come because it's a state where we have a Medicaid medical director who is top of the line, very conscientious, has tried to work with the public health department but the Medicaid agency itself does not have the resources.

I was on the phone yesterday with a state where it's the same kind of situation where you've got -- in that situation, there's no Medicaid medical director but you have a public health department that is trying to help the state with linking its Medicaid claims data with its birth certificate records data to do

some monitoring of birth records.

And the health department is very much engaged. Medicaid is not there. There is a contact, but Medicaid is not really focused and participating with this effort and we actually have a CDC contract working with the states to do this linkage.

So I've actually identified eight states that I put in that category. Interestingly, most of these states are largely rural states, too, and I had never really made that link because I've never identified them in that way.

So some of it has to do with capacity and infrastructure and I just want to make sure that as we think about the measures, even when there's a data system like the MMIS which can analyze claims, we've got to have staff capability. You've got to have staff expertise. You've got to have some resources.

So I just want to raise that just so

that that's in your thinking as you move forward.

CHAIR PINCUS: So before we move into a measure by measure series of discussions, we wanted to discuss just a few sort of cross-cutting strategic issues that we think would be important. And they fall into sort of two categories.

One are those that are cross-cutting really without regard to particular measures but really look at the whole Medicaid adult core set program as a whole.

And number two, those that really we ought to be thinking about as we do go through the measure by measure discussion.

So I've sort of been, and Megan's also been keeping a list of these things.

So let me just go through some things and just see if it captures and people think it captures sort of the issues we think.

So number one is the use of measures, thinking about how they may be used, number one for comparison across states and/or for improvement within a state, improvement over time, how we think about that.

Number two is the whole issue of standardization of the population versus specification of the population. That is, do we expect everybody to apply the same sort of population definitions or to be explicit about what the population definitions are and then find ways to make adjustments.

Number three is and I think this has been an important sort of a cross-cutting thing is how the program has begun to build state capacity for both data linkage as well as for analytics. And the important role for that and to think about in some ways the advantages of pushing the envelope a little bit in terms of expanding capacity.

Number four is the whole issue of

hybrid measures and record abstraction and the associated costs and complexities that get added by that.

Number five is really thinking clearly, and these are in no particular order by the way, is thinking about how we assess the value of particular measures. And this is something that is a longer-term issue but thinking about the values sort of over time in terms of what results do we get with regard to improvement on the measures. Are they actually being used for improvement, and do things actually improve?

Number six is how do we think about the balance of structure, process and outcomes measures across this? I mean do we really need to move much more quickly to outcomes and forget about some of the process stuff or do we really need a balanced portfolio?

Number seven is the whole issue of alignment and, of course, that brings up the

question of alignment with what. Alignment with HEDIS and how do we think about sort of developing a way to more clearly crosswalk with what the measures are linked to and not linked to in some ways.

Number eight is how do we really bring in true beneficiary perspectives into this both in terms of the measurement itself in terms of, you know, patient-reported outcomes, but also in terms of them having more of a say in how we think about developing measure strategies.

Number nine is thinking about measures of Medicaid administration. I think that came up, Doris, in your discussion. And you know, a lot of these are purely clinical and not necessarily looking at the efficiency and effectiveness of the administration of the program. You know, how important is it to look at that as well?

The identification of high value

targets is something Nancy brought up that I think again, how do we think about that. How do we operationalize that concept in a way that can help guide decision making?

Another thing that we haven't discussed a lot about but I think it probably worth discussing is the coordination of the adult program with the child program. How are states implementing one as compared to the other and are there lessons to be learned on either side?

Number 12 I had was the process for providing clarifications, technical assistance, updating, et cetera, and furthermore encouraging state collaborations in implementing some of this. I know that was brought up also in I think some of the discussions from Louisiana.

Number 14 is the impact of bundled payment that Cindy brought up. I think that's clearly a key issue that we need to think about.

And then number 15 is something that I thought of that actually relates to some of the other items including the impact of bundled payments and also the balance and structural process and outcomes. And it's where some of the other sort of measurement efforts are moving towards is the use of registries, and how do we think about that in relationship to this program?

Number 16 is, and this gets to some of the issues of gaps and some of the barriers is how do we think about being more effective and including the dually eligible population and long term supports and services into the process.

And then finally, something that Doris just brought up is the real differences between sort of the managed care sector and the fee-for-service sector of which auditing is one issue that comes up that's built into one and not the other but there are many other

implications to that as well as it's been a common theme through the state presentations.

Now some of these are ones that we really need to think about as we go through the measure by measure and others have more to do with this strategic implementation of the program.

MEMBER PELLEGRINI: Can you just repeat the first couple, because I've forgotten them by now?

CHAIR PINCUS: Okay, the first one had to do with the use of measures like what specifically are the measures intended to be used for. Some have more value for certain types of uses than others, comparisons versus improvement over time.

Number two is standardization versus specification of the population and building state capacity was number three.

We'll put these down and I just want to say if people have other items that they

wanted to bring up in terms of thinking about this.

MS. DUEVEL ANDERSON: And if we also could, if there are some that were particularly resonant with you, you may want to prioritize to the kind of the strategic issues, we want to make sure we are identifying these things up front and we noticed this pattern of the program versus the measure specific. So we want to have plenty of time to continue this discussion about the state experience and maybe some of these programmatic issues with the state experience and then also address them tomorrow and prioritize recommendations about the strategic issues in tomorrow afternoon's session.

So anything that was --

MEMBER GESTEN: Harold, can I --

MS. DUEVAL ANDERSON about this long list and then we will put it up on the white paper.

CHAIR PINCUS: Foster, were you --

MEMBER GESTEN: Yes, first of all, wow at that list. I guess you are a splitter, not a lumper.

CHAIR PINCUS: Yes, you know that I was a Vice Chair of the DSM IV task force, so.

MEMBER GESTEN: And I guess in the spirit of trying to say which of those things really, I mean I'm sort of struck by, I think it was Marsha that was making the comment about infrastructure and resources and I think you hear that from states a lot.

And I was just kind of thinking about the fact that Medicare measurement goes on. Resources are there to make that happen and providers are responding to that because it matters. It matters in terms of payments. It matters because there's public reporting and for a variety of reasons and methods.

The means to be able to report that data, while certainly providers have feelings

about it and may not feel that they have enough resources to do it or are stretched, it happens.

And so I think, I guess going -- the things that you mentioned, I have a few favorites but I think top of the list in my mind is trying to do something that actually the math itself is trying to do which is to better align measures.

And it occurs to me that when the day happens that providers -- that measures are the same for Medicare, for Medicaid, for the exchange plans, for SCHIP and I fully understand the differences between the populations. So I'm not attempting to gloss over the different quality issues or needs that measurement has to serve those different populations.

But, I think it becomes sort of difficult to resist putting in place the infrastructure to measure those things when, in fact, they are very tightly aligned. It's very

few providers, whether they're a health care organization or a practice who's not in substantially in some part of that business, SCHIP, Medicaid, exchange, Medicare.

So I think just in terms of a go-forward that trying to do the difficult work, difficult for lots of different reasons of trying to align those, I think will help related to the resources, the data systems and the capacity to respond because the critical mass will be there, I think, for folks to have to put it in place because it will matter financially, it will matter for their business.

CHAIR PINCUS: Other comments or suggestions? Okay, Marshall.

MEMBER CHIN: I was just going to say, Harold, that's a great agenda for the next month.

But I have a history question as a new person on the committee that in some ways these are timeless questions, some of them are

relative newer, many of them are timeless questions. And I'm wondering to what extent in prior iterations of this core set that they were grappling with and to what degree of systematic, I guess thinking about like the measures of the core set?

So for example, I would bet the answer for example, is that there was a systematic look at things but then a lot of it comes down to, well, measures aren't available, endorsed measures aren't available to fit different characteristics and so there are these big voids and all.

But if you could provide a little bit of that background to what extent have these 16 questions been addressed before? And to what extent really was sort of like we just don't have the measures. It's been like a huge issue of the strengths and weaknesses of the current data set.

CHAIR PINCUS: Well, I can

just -- there haven't been many iterations before. This is really the first, just that one meeting and Foster might want to say something about it since he co-chaired it, in which the pressure was all about we've got this long list of measures, we've got to figure out which ones to do. Let's vote on it and reach some consensus.

And there was not really, at least in my head, a clear understanding of how this all would work. It was more focused on very rapidly trying to come with a list of measures.

MS. LLANOS: And I'll add before Foster jumps on.

I think of the list that Harold talked about and initial core set that was identified two years ago but this is just the first year of implementation.

And in the interim, we did one update using a MAP, the duals MAP, expedited review last summer. And as that process, we

retired one of the measures that had lost endorsement, the HIV measure and replaced it with the viral load suppression.

There were a couple of other -- and I think these are at the end, too. I think we grappled with aligning with the flu shot measure, I think is one of them, smoking cessation as well, took that back to states and a lot of them were kind of half on.

We really like the measure we're currently collecting. We've just invested a year's worth of programming on it. Please don't swap out just yet, maybe in the future.

So would say I think the big takeaways were from last year's process was where can we make incremental changes going forward.

I think the other thing that popped out from what Harold had said was I think two years ago there were fewer outcomes focused measures. Probably not that many more than

now, but I'm certain that there were and I think the biggest gap areas were in long term services and support and care coordination. I would assume they remain to be very similar gap areas now.

MEMBER ANDREWS: I also would like to say that that was a great list of important aspects to consider. But some resonated more with me and when I think of the first presentation that we had today and some statistics that were shared as far as the prevalence of certain conditions, disease conditions in this population such as diabetes, cholesterol, hypertension and obesity, it's a common ground for what we see in other populations. Additionally, it is a place where diabetes and cardiovascular disease consume the highest cost of care and yet we're not doing a great job there.

So it seems to me, again, getting back to the strategy, addressing high-value

targets and disease conditions in specific high-value measures I think is critical.

I think we also heard from the states that one of their recommendations: to be sure that the measures impact a large segment of the population. And again, that will tie very nicely with that.

And last but not least, is the beneficiary perspective. I think that's critical. But at the same time, it brings another challenge to us because sometimes while the beneficiary may think it's good for them, may not be the best thing for them.

And in population, health management where you have to ensure that resources are appropriately used for all. That creates another challenge for us.

But again, I think that your list, Harold, had this and it's a great one to get started and go from.

CHAIR PINCUS: Ann?

MEMBER SULLIVAN: Yes, I agree. I think it's a great list.

The only, when back on those bunch of original slides, one of the things about measures that was talked about was cultural competency. And it's always difficult, I think to think what that means, but I think we just might throw it in the mix here as we talk about this. What does it mean?

It's a little more obvious, I think for the patient beneficiary stuff, but I'm not so sure that it isn't important in some of the other things we measured, too.

So I would just throw that into the list that we should be thinking about that as we go through the measures.

MEMBER HANRAHAN: So you're a list man, are you?

CHAIR PINCUS: I don't necessarily do a tone of lists, but I make lists sometimes.

MEMBER HANRAHAN: You know, I've

seen a lot of changes over the past five years that I never thought I would ever see. And part of those changes have happened because of groups like this, the National Quality Forum, and I have to endorse the Affordable Care Act because we are really pushing to find ways to be more accountable and measure what we're talking about, to be more systematic in what we're doing far more than the previous 30 years that I've been in this business.

So I'm feeling really hopeful and I think that even just the question that gets been gotten raised for this meeting is so you're asking us to give you an opinion about where we think might be the best place to create high-value targets. Where is the high-value target in this scenario?

And I'm going to hang my hat on one area that I'd really like to see become a priority and that is continuity of care. And you know, I see it from my clinical work that

I've done for years and as a person going in the health care system, as a researcher studying people that are really seriously mentally ill, moving transitioning among these silos and fragmentations that we have in our system that, being able to identify measures that could track that phenomenon more closely and we've got a number of them already, one being the follow-up after a mental health hospitalization.

That's really had a terrific impact on the way care is being delivered now. That's a great example of one. And it's not a perfect measure. It's far from being a perfect measure. But it really is having an impact and it has to do with this experience, not only of measure but it's the experience of the individual moving through this fragmented, disrupted kind of experience and making sense of it.

So, you know I would promote the

idea that continuity of care is a really important high target, that it is directly related to accountability. It will drive change and drive quality change in the system, not just that a particular service like a hospital service or an outpatient service, it's really going to drive the system from moving from this siloed space into a much more integrated kind of approach to health care.

The other area I really would strongly underscore that in several of the items that Harold mentioned has to do with the organization and the management of data, the processing of data.

Recently I had the privilege of going through the SAMHSA websites and they've been giving a lot of grants around getting behavioral health facilities or groups the support they need to manage their data, to make their data make sense.

And the webinars and the tools on

their website are actually really quite excellent. We were looking at how could we take a life program which is part of the PACE programs in the U.S. It's a program where older adults that are fragile and you do a capitated program and in that capitation, all of their health care needs need to be taken care of.

And we were looking at how can we improve the efficiencies and the effectiveness of this program. And I went to the SAMHSA website and I really got a lot of information, which was terrific. It's really high-quality stuff. So we don't have to reinvent some of that stuff.

But the architecture and the advanced modeling and the use of data, I can't imagine any state that's going to want to say, they're going to come onto this wagon unless they really see the advantage that somehow it's going to give them better decisions and more

support in making the decisions they need to make around research distribution or targets that they may want to choose to do.

CHAIR PINCUS: If you could maybe communicate to the staff the specific sort of parts of the SAMHSA website that might be most relevant, that would be helpful.

Cindy?

MEMBER PELLEGRINI: I'd like to build on George's comments about, I think he started us with a wonderful list of how to identify those high-value propositions.

You know, absolutely need to be measuring the conditions that are high cost and high prevalence and that have a significant impact, things like that.

I'd just like to put out there for the record that I would continue that list and broaden it further to say that we should also be looking at conditions or issues that may affect smaller populations but with greater

severity.

Conditions that affect people over a greater span of their lives, and of course, from my perspective, that means things like birth outcomes and early childhood because they have lifelong consequences. But there may be other things that are later onset that fall into that category as well.

Equity should be part of the equation. Things that -- conditions that disproportionately affect certain populations more than others.

So to maintain that broader lens so that we don't end up inadvertently overlooking certain populations and just not having any measures that are relevant to them.

So that was my first comment.

The second is, I wanted to bring out this issue around harmonization and alignment of measures particularly around the angle of reducing burden. And I think we need to be

mindful on this and I'm a little out of my depth, I'll admit that.

I think we need to be mindful about who we're reducing the burden on because I suspect that there are certainly, from the provider perspective, you know you can look at these lists of measures and they're only going to be one or two or no measures that are actually relevant to a given provider or institution.

So the question of reducing the burden for the providers who are collecting the data and reporting it, is going to be a very different one from the question of, you know, Doris and her colleagues here, reducing the burden for them in collecting and analyzing that data from all those diverse providers.

So just to -- I think we need to tease apart some of those issues a little bit.

MEMBER GESTEN: Can I respond to that? Hello?

MEMBER SIDDIQI: So Cindy and Nancy

both brought up points that I was going to sort of talk about. But just to summarize from a provider's perspective.

I think the providers are certainly feeling a lot of burden and I think the alignment needs to be there for all the different quality incentive plans that are out there, pay-for-performance plans that are out there between the commercial payers, between Medicare and PQRS and then certainly the Medicaid plans that have their own incentives and that could be different for every MCO that you're a part of. So it can get really complicated and compared to the fee-for-service systems and Medicaid.

But I do think that the measures that we are talking about should be certainly based out of a population health perspective at a plan level.

So for example, I think about the ER utilization measure and how many times that's

come up and I think that's a really important one. But for example, you know, ED use per thousand member-months could be one that we would adopt as part of the core set.

But at a provider level, that could be where the plans are actually measuring follow-up within 14 days from the ER visit which then leads to that outcome of better ED utilization.

So I just think that as much as we want alignment, we do have to think about the population that we're talking about here with Medicaid. We do have to think about from a population health standpoint, what is best for the population in terms of improving triple aim which includes both the quality of care and the patient satisfaction of that care but also cost.

And I do think cost is very important and we should talk about that and look at that because that will help our Medicaid

agencies that are struggling with resources to hopefully have more resources available as their Medicaid budgets come down.

I mean in Illinois, we spend about $16 million in Medicaid which is one of the largest parts of our budget in the state budget. So there's a lot of interest to reduce costs as well.

But I do think, obviously, the quality measures that we're choosing, a lot of them do deal with quality of care and that does indirectly tie in with costs as well.

So I just think it's important to try to align some of the CHIPRA measures because I do serve on the state's CHIPRA work groups as well with the Medicaid measures and then look at the Medicare measures just like our state perspective has been really to try and align some of these measures, make it easier.

And then just the second point was I do think on your list there that the claims

data being somewhat limiting, it is important to note that. I mean we know providers who bill more in the managed care setting tend not to have very good coding and billing that then leads to worse data.

And I think Doris' point about that huge discrepancy they saw in the early elective deliveries was a great point that if we are limited based on the claims data, what measures can be more meaningful knowing that the data's limited? And that's a bit challenging but also one thing too important to recognize is next year we're moving to ICD-10 and how much that's going to impact everything and how much more complicated that's going to become from a provider level.

CHAIR PINCUS: Jennifer then Foster.

MEMBER SAYLES I think Alvia said most of it actually but I just was going to sort of respectfully disagree from the provider

perspective that in most instances, I mean even when you are taking care of a finite specific population with a specialty, I mean you still have multiple payers that you're dealing with and you have your institutional measures and you've got your hospital-based quality initiatives.

So I think that the alignment certainly at the payer level and I mean I would, I guess my other comment was going to be, and I'm not sure if it's included in the slides, so I guess we'll see, but I notice on the worksheet here some of it has federal programs that are alignment.

And I would also add, I mean just given the context of Medicaid in the United States right now with managed care, NCQA, because I think that that drives business for managed care plans.

But anyway, that's all I was going to say.

MEMBER PELLEGRINI: When I referred to only one or two that might be relevant for a specific kind of provider, I was referring just to the Medicaid core set.

So for instance, if you're a OB/GYN or a -- there'd be only two or three measures that were directly relevant to what you're doing, you're not doing cardiovascular care, you're not doing diabetes management so much.

MEMBER SAYLES: But still there will be, I mean, parsimony, I still think is -- because it's for really thinking across the spectrum so even if there are only a couple for OB/GYN, I would say and primary care which is the majority of this now and where Medicaid is going. That's not so much the case at all, but yes, I hear what you're saying.

Thanks.

CHAIR PINCUS: Foster and then Marc.

MEMBER GESTEN: Real quick, I think

that the point that Cindy was making about trying to be more precise about both understanding the burden and who it falls to I think is a good one. I think we could do a better job of really understanding that and facing it trying to decide whether it's worth it or not.

But I want to echo what everyone else has said following that which is the biggest complaint, the most vociferous folks who are complaining about all the multiple measures and requirements are providers and all kinds of providers. It doesn't seem to be too many people who feel untouched by this.

You know, the burden trickles down to them and it certainly is at the health care organization level, ACO and hospital and insurer and clearly at the state level, as well.

And the demands are not just even the ones that we've been talking about, but board certification demands and accreditation

bodies and recertification and privileging and so on, payments as people mentioned on the commercial side for pay for performance.

So I think it's a really huge issue we need to understand it better and more than understanding it, we need to start addressing it because it's an area I think of significant waste.

CHAIR PINCUS: And it also goes back to the issue like what's the relative value we're getting from the burden?

Marc.

MEMBER LEIB: I just want to clarify one thing that was said about managed care may be driving less-than-robust coding about things whether it be CPT codes or ICD-9/10 codes, et cetera.

It's not managed care that drives that, it's the payment system within it. Even though we have all these managed care companies and capitate them, the 99 percent plus of all

the services that are provided through those companies are paid on a fee-for-service basis. So we have robust CPT codes, ICD-9 codes, soon hopefully, the ICD-10.

The problem comes in with the bundled payment systems whether at the hospital level, the ACO level, those things because we see that in our pregnancy stuff. They get a bundled payment, they don't record every prenatal visit. It's tough to even know when the first prenatal visit might have occurred and postpartum visits are almost never sent in as a separate code. So unless you go and review the chart, you don't know that they occurred and that becomes a huge burden on the plan or on us.

So it's the payment system, not so much the coding system or the managed care system that drives that.

CHAIR PINCUS: I guess one question I had is to what extent is it the payment system or the coding system that limits that? Because

there might be ways in which one could design coding systems that do capture the information, especially with the ability now to have sort of electronic support, assistive support in doing the coding.

So that's something to think about in terms of how to do that.

I mean I've been involved with developing the ICD-11 which is -- well, WHO is developing the ICD-11 to come out in 2017 and the rest of the world has been using ICD-10 for over 20 years and it's being built off an informatics infrastructure to think about how, with the assumption that there will be drop-down menus, there'll be natural language processing and those kinds of things. Then for SNOMED link to LIONC and other kinds of elements of that.

And that there's some strategies to think about particular use cases, quality and patient safety, disability, morbidity

reporting, mortality reporting, those kind of things as way to sort of strengthen the coding system to be more specific, reliable and valid without adding burden so that there's a coding strategy but that there's also -- it depends on how that coding is used within the context of payment.

MEMBER LEIB: It might not be until 2030 that the U.S. adopts ICD-11.

CHAIR PINCUS: Although I've got to say that ICD-10-CM is closer to ICD-11 than it is to ICD-9. And so the two systems have been developed with the knowledge of each other and there are methods to actually influence over time, ICD-10 to make it closer to ICD-11 over time without having to have a wholesale readoption.

MS. LOTZ: Just to put another thought out there, you can get whatever you contract for. The contract is a legally binding document and when we contract with our

MCOs knowing the challenges that other Medicaid programs had encountered in trying to get data back from the MCOs, we put together right from the get-go a very extensive list of data elements we wanted back. There were well over 450 of them.

And it was something that we in the quality area we're willing to fall on our sword for. Although there was a lot of pushback and a lot of comment that you will never look at all that data so why do you want it.

So regardless of what the payment strategies are going forward, you have ways of asking for the data. I would ask certainly for that as a consideration but first and foremost, just get the best measure out there that you can and then the logistics of whether they're ICD-11, whether it's a contracting strategy, whether it's extraction from an EMR, we'll try to get there.

And I think that to go back to some

of the very strong start that CMS had in envisioning this grant, I mean everyone didn't have to do everything. You did what you could with the minimum threshold granted and where those states are ahead of the game in being able to execute on the more challenging measures, great. We'll either teach others if we're in the group or we'll learn from those that went ahead of us.

So, I wouldn't let that be a deterrent. I think it's a consideration but kept in perspective as well.

CHAIR PINCUS: Alvia.

MEMBER SIDDIQI: That's fine. I mean I think Doris's point is very true and this is an initiative, this has just started. I would hope that CMS will eventually tie some incentive to the reporting for the states so that there can be more interest and energy and resources used to make the data work for them and so that they can report on the measures.

I was just going to add that, again, back to the Medicaid population and the billing and coding piece, just to add another nuance to it is all the federally qualified health centers and ERCs and rural health clinics that also bill under a more bundled payment system, again, a lot of times those providers are not billing and coding as correctly, again as a private provider and private practice whose incentives are basically their entire payment rests upon billing and coding effectively.

And so one piece to look at especially if we're talking about measuring certain measures, is within Medicaid for example, for our state, we actually have a postpartum depression screening code that you can bill for and get an additional incentive for. So you get paid additionally for it as part of that postpartum visit. So it would be a measure we could report on. But I'm sure every state does things differently.

And again, if you don't tie any incentive payment to that specific measure, it's just difficult to get the buy-in for both the providers, the institutions, the hospital systems, there's a lot.

CHAIR PINCUS: Other questions or comments?

Steve?

MR. CHA: Just, I guess as you go into your measure by measure consideration, I just, two thoughts occurred to me.

One is that I think there is some great discussion here and I think you have a fantastic framework for approaching this to the degree that you're trying to -- this panel wants to make modifications and adjustment.

I guess the request from this side would be to ensure that the rationales and the reasoning, there's a framework here that is easily communicated to our state partners in thinking about that. So that would be one

piece. I know you're working on that but as you make this transition to just to put a finer point on that.

The other piece is just picking up on a few comments made today. I think with regard to alignment, I think there's a both-end approach toward some of the comments which is that to the degree we're measuring similar concepts, we absolutely should be aligned and I think that's part of what we're looking to you in terms of making those decisions between metrics.

And so, for instance, readmissions continue to struggle with how to track and measure that as best possible and I think that's going to be an evolving place for some time.

At the same time, there are certainly domains thinking about our program that we have very different domains of care. It is not simply as to some degree Medicare can be simpler in some respects. They're sort of

a chronic care management model and approach that we can think about.

Our challenges and populations are much different. And so a slide that I carry with me was a paper from AHRQ analysis of HCUP data looking, and I think this comes to pick up the care coordination theme. What's the outcome we're looking around care coordination? We think rehospitalizations is a key outcome to look at in terms of looking at that care coordination.

So the paper looked at the top ten causes of rehospitalizations by payer and Medicare, as you might expect, CHF, septicemia, pneumonia, COPD, the usual. For Medicaid, it is in fact, mood disorders, schizophrenia, diabetes, complications of pregnancy. It is a much different set. Pneumonia, cardiac arrhythmias, AMIs, not even -- there you go, exactly, that's the exact paper.

But I think putting that side by

side with the Medicare data I think is telling because I think the point here is that we keep on as we continue these discussions around the MAP, I think it's hard for, and I include myself in this when I came to Medicaid two years ago, to get out of a frame of thinking about delivery reform in a certain respect. It is much different.

And so if you look at those diagnoses, it is in fact, some of these measures apply to very specific sets of providers, picking up Cindy's point. And as you think about your challenge, it is much more challenging than certain domains to really try and cover the spectrum across all these.

But clearly, there's a theme here around behavioral health and maternity care, about domains that haven't been picked up and really about the coordination aspect in terms of how to think about that.

So I'm glad you have that slide and

I'm sorry if I was out of the room and missed that discussion, but to me, I think this is really reorienting our thinking about how do we approach our quality measurement framework.

CHAIR PINCUS: Nancy?

MEMBER HANRAHAN: Thank you for saying that, Steve.

What that brings me back to is what we started with in the sense that a lot of these disorders are probably on this list because they're associated with poverty. And that when you associate poverty --- when you associate poverty with the conversation about what measures to do or what measures to choose.

For instance, hospitalization. Hospitalization or rehospitalization is not a good measure for somebody who has schizophrenia, a mood disorder or some of the other mental disorder diagnoses because a lot of the issues they have are not associated with their illness, it's associated with their

social needs and those social needs are imbedded in the fact that they are from an impoverished population.

So what's my point? I mean I guess that's the point, you know, that it kind of circles around in this kind of conundrum about what measures are the best measures to address and I think that always keeping in mind that poverty is a confounder in this selection and that particularly in the disorders related to mental health or mental behavioral disorders.

It's really not necessarily give you the leverage you want with some of the measures specifically around rehospitalization.

MEMBER SIDDIQI: Just a question about the data that we're seeing right now. Is this ranked at all in your paper in terms of from most to least? So that is the ranked list? Okay.

MR. CHA: This is. I didn't put

the slide together. I didn't realize you all had this data. But this is in order and maybe my slide was prepared wrong, but I thought this was rehospitalizations not just hospitalizations.

MS. LASH: It's readmissions. Sorry, we were in a hurry to translate this and slip it into the slide deck just a few hours ago. And we'll send around the whole paper.

MR. CHA: But I think the other piece is that it's seven, eight and nine, CHF, septicemia and COPD, those are the only ones that overlap with Medicare. The rest are -- and the other way to think about it is that all the stuff that Medicare's focusing on is not what we need to focus on.

CHAIR PINCUS: Ann?

MEMBER SULLIVAN: Did somebody say about the comment about those intricate needs of -- just take patients, for example, with schizophrenia, I have a question here. For

example, in the New York State, we got a waiver so that Medicaid will provide for things like social skills training and pre-employment training and getting a lot of patients with schizophrenia out of that poverty kind of cycle.

But I don't know that that's a universal thing. So when we think about a measure that we want to put out there, I guess my conundrum is if you put something in like employment rate, which is what we're measuring, employment rates for schizophrenics who are in Medicaid, I don't know that you can ask other places to kind of deal with that right now unless their Medicaid benefit is going to cover that.

So I don't know the chicken or the egg here. I don't know that the measurements should push something that's -- I mean I think there'd be a lot of push back from people on that because maybe the Medicaid benefits and other

places aren't.

So I truly appreciate what you're saying because I do think that that's where the Medicaid benefit in some way needs to go. It's really wellness for the mentally ill is different than wellness for some others in some ways.

I mean, well and some of the needs, you have to have social supports, et cetera. It's not just poverty, some of it's the illness. But I don't understand whether that's something that we want to deal with now or not. I mean in terms of time and space because I don't know how you can go across 50 states and expect everybody to be doing that.

It's just my question.

CHAIR PINCUS: No, I think you're absolutely right and that's something that we need to deal with continually and need to think about it as it applies on a measure by measure basis given the heterogeneity that we're

dealing with of the programs and the populations.

So Doris and then George and then we're going to take a break.

MS. LOTZ: So you asked the question I don't know how we can ask that and I would answer or if it should be asked, I would answer yes, go ahead and ask.

I think that to speak to a point that I may have blown through very quickly out of my slides, I think we need to understand more about what drives some of the outcomes and maybe even some of the other aspects of what we're trying to understand. And I think that understanding the social environment, the lifestyles, the genetics, the individual person, their behavioral health, all of that is important.

If you put a measure out there that looked at employment or another one, housing, or some of these other important environmental constructs to patients. No, it's not just in

Medicaid's jurisdiction but it might ask me to reach out to the folks in housing and say, can we look at who in Medicaid doesn't have housing or can we think about those social services and incorporate them into our care coordination and our care management?

I would encourage you to think expansively, not every state has to adopt every measure but if we had a measure that said, let's look at how our S&PI, our severe and persistently mentally ill Medicaid patients are situated as far as employment, well employment probably not very much. But you know, in some of these social constructs and some of their environmental constructs.

It would say a couple of things. Number one, if you had the aptitude to go there, you had a measure that you could then have some comparability across.

And number two, oh wow, that's important for a Medicaid population to think

about? Yes, it is.

Not everyone has to adopt it but putting it out there, right, it begins to put a priority out there that I think you know, maybe over a five or ten or twenty year event horizon we might get to everyone saying, absolutely those are important for our population.

As a matter of fact, those kind of things are the key drivers that create our population and keep them in poverty. So be bold.

CHAIR PINCUS: George, did you have a comment?

MEMBER ANDREWS: Yes, I was, and actually I'm changing it a bit.

I just want to make sure we're all clear on what this slide is showing. It says top ten causes of hospitalization.

CHAIR PINCUS: No, it's actually readmissions and it's in order of the frequency

by which there has been a readmission within 30 days.

No, so it's in order of the frequency of the number of readmissions within 30 days and there's another version of it that looks at it as the cost which has the same list except in a different order.

MEMBER ANDREWS: Okay, because that's where I was going with this because an earlier slide that we saw today in terms of acute care costing 65 percent of the cost, and a lot of these diagnoses would not fall in the acute care. So I just want to make sure that we're all on the same page on this.

The second is, getting back again to this issue of readmission and how to control this, and I'm going to get back to an earlier comment I made which is something I see in my current work that when it comes to mental health disorders and follow-up plus hospitalization whether it be seven days or thirty days, it's

pitiful.

And the barriers that I hear is that there is not enough access, not enough access whether it be provider to availability to support those needs so the patient has no place to go.

CHAIR PINCUS: I mean we should stop and take a break, but I couldn't agree with you more that the -- only about two-fifths of people who are hospitalized have a visit within seven days, and we're talking about if they get hospitalized now for a mental disorder is a very high threshold. So you have to be really, really sick and to not see any -- you know to have, you know three-fifths of people not be seen in seven days is amazing.

And the other thing is the access issue, another big piece of it is that we published a paper in JAMA Psychiatry a couple of months ago showing that 40 percent of psychiatrists don't take any health insurance

and a much greater proportion don't take any Medicaid so that's part of the issue.

Anyway, we'll take a break. Let's reconvene at quarter of. Okay?

(Whereupon the foregoing matter went off the record at 2:35 p.m. and resumed at 2:51 p.m.)

CHAIR PINCUS: So, we're going to begin the process of going through these measure by measure. And just to check, who's on the phone?

MEMBER GESTEN: Foster is here.

CHAIR PINCUS: So, Foster, you're here, great. Hope you're feeling better.

MS. ROSENBACH: Margo Rosenbach from Mathematica.

CHAIR PINCUS: Anyone else on the phone? Okay, great. So, Megan is going to sort of lead us through this. We've tried this --- the staff has tried to lump them together according to certain characteristics to help

guide us through the process of then coming to some resolution about recommendations for how we think some of these should be either continued, retired, adjusted, improved, and so on.

MS. DUEVEL ANDERSON: Okay. So, we have a slide that we've seen a little bit before about the number of states that are reporting each measure. The measure by measure review is going to be organized by this. We have kind of found that there are some measures that have high levels of reporting, and that many states have been able to collect and report those measures; therefore, there's administrative processes in place and infrastructure that they have built up to do so. And there's definitely a voice about kind of maintaining certain things over time so you can compare your own results internally throughout improvement with the potential in the future for comparing to others.

There are 16 of those measures with high level reporting. Then later this afternoon we're going to talk about measures with moderate level reporting. There are nine of those measures. These are measures that may have some significant challenges that maybe have issues that are primarily going to be able to be addressed through Technical Specifications, or they have not been prioritized at the state level.

There are also measures with lower levels of reporting. These measures we may get to this afternoon or might work on tomorrow morning, and these measures have not been able to have a lot of states report on them. And they'll be kind of a different question about are these the right measures, is this the right method to get this information?

Within each of these, we've also tried to group the measures by topic area, so you'll see measures related to women's health

and other related topics. There are six of those measures. Mental and behavioral health topics, those are five measures. Chronic disease, cardiovascular, and diabetes, and there are 11 of those measures, and the CAHP survey measures are kind of grouped together. So, that's how we're going to go through, first by the number of states that were able to report the measures, and then within those sections kind of by the topic areas.

MS. LILLIE-BLANTON: Hi, this is Marsha, I would like to join.

MS. DUEVEL ANDERSON: Great. Thank you so much.

So, the first group is the measures with high levels of reporting. The primary questions for this section are should these measures be maintained in the Core Set considering that the infrastructure is largely in place to do so for many of these different states. And are there any suggestions to

application of the measures. We've talked a little bit about PQI measures, and we've talked about follow-up after mental illness briefly, so we'll get into this for a second.

Does anybody have any questions about the process or kind of the question that's being asked of you? Okay, hearing none.

CHAIR PINCUS: So, just to be clear about the process for a minute. So that, basically, you're asking us right now to make a determination that --- essentially, to sort of reach a consensus about continuing these measures as they're currently defined. And it's not like we're going to come back to this later, we actually want to make a decision now about that.

MS. DUEVEL ANDERSON: Yes. We're going to have two slides on each measure, and those slides will briefly go through the overall kind of topic of the measure, and how it's made up. And then there will be a slide that

incorporates the feedback from the states that was received. And that complete set of feedback is available to you in your materials, but there's specific and some truncated information on the second slide. And at that point, we would like to have either consensus around the room, or if we have to take a vote to say yes, maintain this measure. Or, if not, these are by exception, if not then what would be the recommendation to CMS?

So, we're going to start with women's health and related topics. There are four measures that we're going to talk about now that have high levels of reporting. We will discuss in another section two additional measures.

So measure NQF #1517, prenatal and postpartum care. The postpartum care rate is reported in the Adult Core Set. This is the percentage of deliveries with live births in the measurement year and the prior year. And it

assesses the percentage of deliveries that had a postpartum visit between 21 and 56 days after delivery.

This includes non-live birth. The measure is actually specified to have different data sources, including administrative claims, electronic clinical data, and also medical records. It's a process measure, and it's an ambulatory-sensitive measure with the clinician care setting. It is traditionally reported at the Health Plan Integrated Delivery System, and it aligns with HEDIS, and it also aligns with the new beta set of Health Insurance Marketplace Quality Rating System measures.

CHAIR PINCUS: And this is actually two components. One is prenatal, one is postpartum?

MS. DUEVEL ANDERSON: And the prenatal care is reported in CHIP.

MS. LLANOS: It's not CHIP, it's the Children's Core Set Program.

MS. DUEVEL ANDERSON: Sorry.

MS. LLANOS: So, that means that states would be --- who have a Medicaid or CHIP program, and a Medicaid CHIP program would be --- would have the option to report the other part of the measure, as well. And in many cases these are the same state agencies to conduct some of these burden of reporting.

And I think the other piece to note is --- I should have mentioned this before in terms of alignment. There's an HHS-wide Measurement Policy Council, and as part of that we've identified groupings of measures that we are committing to aligning so that across the departments we're collecting similar measures on similar topics. And this is one of those measures.

MS. DUEVEL ANDERSON: Okay.

MEMBER CHIN: For the measures as we go through them, can you let us know also if there are any problems that were raised about

these measures, were there any ceiling effects, that type of thing?

MS. DUEVEL ANDERSON: So, the next slide is implementation, great question. I hope that we can answer some of that.

There were no adaptations listed and no major changes to the measure for --- from the original specifications for reporting. Twenty-eight states reported, and they reported based on those specifications. There was a challenge with methodology, and we've heard from the states already that there is some under-reported --- issues of under-reporting with administrative data, and that's partially because of the postpartum visits. And using hybrid data collection is more costly and burdensome, though we've heard of good results and better information as a result of doing that additional data collection.

There are some reasons that the states did not report it, and some of the

reasons are that the information was not identified as a key priority, budget constraints, and staff constraints, medical record review, and data linkage.

So, the question to the Task Force is should this measure be maintained in the Core Set? So, this is by an exception. Overall, there were 28 states reported it, so pretty high levels of reporting. Challenges are primarily with methodology.

CHAIR PINCUS: Cindy?

MEMBER PELLEGRINI: I think I'm obliged to say yes, that it should be maintained, but I'll do it just for the record.

MS. DUEVEL ANDERSON: Okay. Anyone have any reason why this measure should not be maintained? Okay, any other feedback for CMS on the use of this measure in the Core Set?

MS. LOTZ: Well, pregnancy was a condition for Medicaid eligibility pre-ACA. I think this can only improve post-ACA where

we're looking more at the FPL level, so we --- one of the issues with the prepartum --- no, that's not correct. Prenatal, thank you. Oh, man, I've been up since 4:00, so it's going to be a long day. Is that sometimes women wouldn't self-identify as being Medicaid eligible until the third trimester. Okay, that's good, but it would have been nice to have known that six months ago. So, this measure should only improve over time.

MS. DUEVEL ANDERSON: Great.

CHAIR PINCUS: What's interesting to me is that despite some of the issues in terms of being a hybrid measure and so forth, it is among the most reported. That in itself is ---

(Off record comment.)

MEMBER ANDREWS: I do have a question. I understand is may vary from state to state, and depending on the --- but what is the incremental yield that we see as an under-reported error that we capture when we do

the hybrid review? Is it 20 percent, 30 percent, 5 percent?

MS. LLANOS: I think if you're asking for an actual ---

MEMBER ANDREWS: What I'm asking is, I have a pregnancy that a global payment, services have been provided, but because of the lack of the distinct code to distinguish the pre and the postpartum visit, we now go to the medical record. So, my question is, is it that we find that 95 percent of our searches yield a positive hit when we do the review?

MS. LLANOS: I'm not sure I'm able to give you an actual number because it would vary by the state rate in terms of that.

MEMBER SAYLES: I was just going to add, I'm sure that's incredibly locationally dependent. I mean, I know in California, and where I've been in LA, it's around 20 percent, so it's not nothing, you know, the delta, if that's what you're ---

MEMBER ANDREWS: Yes. I guess my question is are OB/GYNs doing the deliveries, but yet truly they don't follow their patients within the 60-day time window postpartum, or are they --- all of them, or 99 percent, or 98 percent of them doing it. It's just that we don't see it, that we have to go through the medical records?

MS. LLANOS: I think that's a hard question to say generally. I think it really depends. I think what we have found in hearing back from some of the states is that if it is a global payment it's hard, and sometimes it's hard to track the person down within that particular window that it says in the specifications. But I can't give you an actual number.

MEMBER SAYLES: I think the timing of the maternity payments are such that within the --- they often are received before the six-week postpartum visit window for any particular

patient, so there really isn't, as you're pointing out, much of a financial incentive, so that definitely becomes a financial challenge to align with the measure.

CHAIR PINCUS: One question in terms of the recommendations we make. Can we make a recommendation that we recommend that it be continued and that also that over the course of the next phase of implementation that one --- that CMS collects data to actually answer these kinds of questions. Is that a reasonable thing to include in a recommendation?

MS. LLANOS: I think if it's not something that's part of the numerator/denominator, it's hard for us to get from the voluntary program. So, what we're able to access is the numerator and denominator, and then if a state --- whether or not that state used the admins only or hybrid. That we can ascertain. What the actual delta was I'm not sure --- we don't have the capacity in CARTS to

collect that type of information. Not to us ---

MEMBER GESTEN: But my guess is that NCQA might have that data.

CHAIR PINCUS: What was that, Foster?

MEMBER GESTEN: My guess is that NCQA likely has that data. I don't know whether they have it segmented for commercial or Medicaid, but oftentimes in the testing or evaluation of measures they may know that answer.

MEMBER SAYLES: I mean, I think where you're going, Harold, is sort of just trying to understand is there any ability to kind of track with this measure set, what an admin rate is, and what the hybrid rate is, and then we can know where there's ---

CHAIR PINCUS: Right. I guess, I'm not saying that it necessarily has to be a universal tracking, but that to gather data to know --- and this just being an example. As we

go through this, if there's some issues that we think given what we know now it makes sense to continue this. But it would be great to have some information to guide us the next time around.

MS. LLANOS: Yes.

CHAIR PINCUS: So, that's what I meant.

MS. LLANOS: Thank you. That helped me understand your question.

CHAIR PINCUS: Yes, I didn't mean necessarily that we need to track that continuously, but that we sort of put that as a priority for gathering additional information to inform decision making the next time around.

MS. LLANOS: Right. So, this year we're not presenting rate data because it's the first year of reporting, and we literally just closed. However, in future years we would have, depending on what the state submitted to us, an

admin rate or a hybrid rate.

CHAIR PINCUS: Okay.

MS. DUEVEL ANDERSON: Okay?

CHAIR PINCUS: So, are there any other comments or recommendations on this measure? Okay. So, I'm --- Alvia?

MEMBER SIDDIQI: I was just thinking for the provider community. I'm not representing ACOG today, but certainly there's a huge emphasis on this one with the gynecologists, obstetrics, and those specialists. So, they actually are always investigating looking to try to eliminate barriers to postpartum visits because we know a lot of the social determinants of health that Nancy has been talking about really directly correlate with this. So, it's just one of those that actually allows a plan to really --- and the agency to focus on outcomes and trying to improve those barriers that don't allow a woman to have a postpartum visit within that time

period.

CHAIR PINCUS: So, I'm assuming that there's a consensus that we recommend this continues. Okay.

MS. DUEVEL ANDERSON: Okay, that's wonderful.

CHAIR PINCUS: Doris?

MS. LOTZ: I just wanted to ask, and I realize I'm a guest here, so if I ask a few clarifying questions now it'll help me as I continue to listen.

So, two things come to mind. Would the Committee consider, you know, again, this is not an outcome measure. I don't think it is. It's a process measure. You know, looking at birth weight, which arguably is not an outcome measure either, although it's probably closer, and/or second --- you know, what is the Committee's thinking, or CMS' thinking on combination measures, you know, looking at developmental delay, and then, you know,

somehow telling the story looking at birth weights and looking at perinatal care, and that sort of thing? Is that just way beyond the scope, and I should just think about that for some future point, or are those things that could be deliberated or considered at this time?

MS. LLANOS: Yes, so I'm going to -- Marsha is not there, so I will speak for her. We've got across both of our Child and Adult Core Sets, we've got what we call the Maternity Core Set, and we've got low birth weight in the Children's Measure Set. So, I was telling Sarah, I think it's going to be hard to figure out where we draw the line in terms of that, so we've got this one in here. I'm not sure if you're talking about adding measures? I don't know if that's --- we could put that on our list, or I don't know if you're entertaining new measures at this point.

MS. DUEVEL ANDERSON: We are

entertaining measure gaps and potential new measures.

CHAIR PINCUS: Yes, we're going to be talking about gaps, but also sounds like that would be a gap for the Child ---

MS. LLANOS: So, we've got low birth weight already in the Child Core Set.

CHAIR PINCUS: --- Core Set. Yes.

(Off microphone comment.)

MS. LLANOS: Right. So, it's --- right. So, that's what I meant by it all kind of draws in together. Sometimes as you know, Dr. Lotz, the same agency, same people collecting all of the measures within that. I think just for the purposes of --- we had to kind of draw the line at some point, and we do have the postpartum care here, the prenatal care in the Child one, low birth weight there, EED here, but I --- you know, ultimately, the vision is to weave together that and tell the story from the state's perspective on how they're

improving maternity care.

MS. LOTZ: That's a little bit ahead of where the deliberation is at this time, this idea of even telling the story, or putting out some sort of combination, or even just juxtaposing them in a more meaningful way. We have these siloed measure sets and ---

MS. DUEVEL ANDERSON: I think that would be a great topic for the strategic discussion tomorrow afternoon, the interaction between the Adult and the Child Core Sets.

Okay. So, the next measure is Measure Number 0032, cervical cancer screening. This is an NCQA NQF-endorsed measure, and there's a percentage of women who are 21 to 64 years of age we're screening for cervical cancer. And there's administrative claims, electronic clinical data, and paper medical records. It's a process measure. It's also ambulatory-sensitive, and it aligns with Meaningful Use Stage 2 for eligible

professionals, PQRS, Physician's Quality Rating System, HEDIS, and the new Health Insurance Marketplace beta measure set.

CHAIR PINCUS: Any comments?

MS. DUEVEL ANDERSON: The second slide ---

CHAIR PINCUS: Okay.

MS. DUEVEL ANDERSON: --- on cervical cancer screening ---

CHAIR PINCUS: Sorry.

MS. DUEVEL ANDERSON: --- talks about implementation. Again, there was no adaptation for this measure, and a number of very high level of states reported, so it's 27 reported for the Fiscal Year 2013. The challenges listed were determining an eligible population, and the denominator should include the ages of 24 to 64 at the end of the measure year to account for a three-year look-back period. This is a clarification, and it's a challenge that was experienced by the states,

but challenges like this we would expect to be resolved in the new updates to the Technical Specification manuals.

The reason the states didn't report was the information was not collected because it was not identified as a key priority.

Does anybody have any questions or any opposition to this measure continuing in the Core Set?

CHAIR PINCUS: Could you say something about the recommendation about the change in the denominator?

MS. DUEVEL ANDERSON: I don't think it's a change. I think it's a clarification that was requested of the TA box, and we listed it because it's something that the states experienced in the implementation aspect. And challenges like this going forward would be expected to be resolved in the Technical Specifications. And I don't know if CMS or the TA Support wants to say anything about this type

of feedback.

MS. LLANOS: So, I can start, Margo. I will just say I think --- so, for many of these the challenges were reported by one state. I think that's the piece that's missing from some of these slides, so it was drawn from a Technical Assistance request that could just be representative of one or two states. I think this might be the case. Margo, I don't know if you want to add anything.

MS. ROSENBACH: I think that's exactly right, but it was confusing because of the three-year look-back. It's ambiguous whether you're talking about ages 21 to 64, or 24 to 64, so there were some clarifications regarding how to specify the age range, and particularly aligning the language exactly with the HEDIS specification.

MS. DUEVEL ANDERSON: Alvia?

MEMBER SIDDIQI: I was just going to say that that's why I think that challenge that

was presented by the state is correct, that it should be the 24 to 64 look-back for three years. I just think it's an important one.

CHAIR PINCUS: So, I guess the question is, moving ahead, if we make a recommendation that this be continued, it would be continued with this clarification.

MS. LASH: We've already made the change.

CHAIR PINCUS: Oh, you already made the change. Okay.

MS. DUEVEL ANDERSON: Yes, there's a Technical Specification manual that's pending, and there's a Table of Changes. We have a few hard copies, but we aren't able to yet electronically distribute.

CHAIR PINCUS: Just to clarify that.

MS. DUEVEL ANDERSON: Okay. Any other questions or comments on cervical cancer screening?

CHAIR PINCUS: Doris?

MS. LOTZ: Sorry, you're going to regret inviting me. I don't understand why you would do 64, especially since you want to allow for a three-year look-back. USPSTS has this going on until 65. It just --- I don't know where 64 comes from.

(Simultaneous speech.)

MS. LOTZ: Sorry?

MS. ROSENBACH: Would that be the point when it's --- when coverage is under Medicare?

MS. LOTZ: Maybe.

MS. LLANOS: Marsha I think, I'm looking at NCQA team, but it's exactly how the NCQA, the measure steward spec'd the age.

MS. ROSENBACH: Right. I was just wondering that's why the cutoff, the difference, because it's for Medicaid versus Medicare, because in the Medicare program often our measures will start with 65.

MS. DUEVEL ANDERSON: Okay. Breast

cancer screening, 0031. This measure is not currently NQF-endorsed. It's an NCQA measure. It's the percentage of women 42 to 69 years old who have had a mammogram to screen for breast cancer.

MS. SMITH: Can we go back to that last point, because now we're talking about 69, and there is a discrepancy with the --- you know, with recommendations by the Preventive Services Task Force, then could it not be that this measure is expanded. And then by program the report is stratified by the population that's applicable?

CHAIR PINCUS: Who's asking the question?

MS. DUEVEL ANDERSON: Oh, it's Marsha Smith from CMS.

MS. SMITH: I'm sorry, I didn't say who I was.

MS. BYRON: Hi, it's Sepheen Byron. I'm Director for Performance Measurement at

NCQA. So, is the question about --- I'm sorry I missed it. Was it about breast cancer screening, and the age group? So, this measure has been updated ---

MS. DUEVEL ANDERSON: So, the question is about cervical cancer screening, and the question is about the specification that the age is until the age of 64 years old, where the U.S. Preventive Task Force recommendation is until the age of 65, and the measure is not consistent with the Task Force recommendation.

MS. BYRON: Right. And I think Karen noted this is correct, that the reason why is because at 65 you switch to Medicare, and so that's why this measure goes to 64.

MS. SMITH: Right, but I'm saying instead of having two different measures that are based, you know, by program coverage, it could be that the measure that is based on the most current clinical recommendation is

utilized. However, knowing that the population would only present individuals that are 64. It's not possible to stratify by age bands knowing that there wouldn't be --- I don't know if that would be burdensome, knowing that there would never be any that are greater than 65, or for the state perhaps they would use it for other purposes, and then the measure would be just more flexible. I just was wondering if the group could just make that recommendation, even though we're saying that it should be continued, but just add on that that would help because, you know, in some other programs it's often that the --- we get reports back that well, you know, it's a little different if we're doing it for this program and that program, and it makes hard, versus having measures that could work across settings, and having the ability to stratify by the population and report to the program that's applicable.

MS. DUEVEL ANDERSON: George?

MEMBER ANDREWS: I would agree that the recommendations as it relates to guidelines should apply across the board, and whether they're used for a different sub-population is irrelevant, because a guideline is a guideline, it is based on medical evidence. So, I think it should be based on medical evidence as a recommendation.

Additionally, we already have heard today that the states have confusion regarding their reporting, whether to include Medicaid only, Medicaid plus Medicare duals, and so if at some point we want to be reporting and looking at that, it will be important to have the guideline, at least, be in line with the medical evidence.

MEMBER SIDDIQI: So, I'm trying to look this up right now, but it seems like it's not going to be consistent with HEDIS if we change this. So, it's right now, I think, consistent with HEDIS 2014. And the point being

that states are already working towards --- have incorporated HEDIS measures into their quality reporting.

MS. SMITH: I think just having that feedback on the record would be important for, you know, HEDIS development in the future. Like I'm not sure who was just speaking, but it's really about making sure measures are consistent with recommendations, and then from a programmatic standpoint then we would allow the acceptance --- you know, if they're put in a way that you could stratify by the age that is covered by your program it would be a lot easier than having well, this measure is for this. Do I send, you know, for Medicaid, or Medicaid and Medicare, and what to do.

CHAIR PINCUS: Marshall?

MEMBER CHIN: Yes. I wonder if maybe after we do this one, if you can give us like a quick head's up overview of the full thing. So, in other words, we have X number of

measures. On preliminary review we think maybe it's just three or four that we should take most of the time. The rest you think are very straightforward, or some minor type of things, or this --- the big issue really is have there been things that are omitted in the set right now. I think this is good, but I think that C-- my guess is that we're not really discussing the things we should be discussing of the highest importance ---

MS. SMITH: Oh, sure, absolutely. But I'm just saying ---

MEMBER CHIN: No, I wasn't criticizing you. I was just talking to the group as a whole of --- yes.

MS. SMITH: Okay.

CHAIR PINCUS: The thought was that these --- if the first 13 measures that we're highly reporting would take a minimal amount of time. So, that was the thought about this, so this is taking more time than we thought. But

I think it's useful.

I think one way of thinking about this is clearly that this is seen as an important measure. Obviously, the states did report on this to a significant degree, but we can give feedback to both NQF's endorsement process and to the Measure Steward about sort of getting better clarity of alignment between what the guideline recommendation is and how the measure is specified in terms of the population. So, that's something that we ought to be doing, but that should not, necessarily, preclude us from recommending that it be continued in the meantime. Does that make sense to everybody?

MS. SMITH: Oh, yes. I wasn't saying --- I just was, you know, wanting to make sure that, you know, the point that was raised about being consistent with guidelines was on the record. That's all. I'm sorry for taking up so much time.

CHAIR PINCUS: Okay, so we can make that recommendation. So, let's go back to the breast cancer screening.

MS. DUEVEL ANDERSON: I'm going to derail us just for a 30-second intermission. We forgot to do a count for tonight's dinner reservation, and the restaurant has been calling, so if you plan to join us for dinner please raise your hand.

(A show of hands.)

MS. DUEVEL ANDERSON: I have about eight or ten. Okay, great, thank you.

Okay, so the breast cancer measure. This measure is currently not NQF-endorsed, but I think we have some people in the room that can speak to that. I will go through some additional information before we have any questions or discussion.

This measure is well aligned and it has --- is in use in Meaningful Use Stage 2 for eligible professionals, Medicare Shared

Savings Program, PQRS, HEDIS, and now the Quality Rating System.

The measure is also well reported, 26 states reported this, and it was reported in two different age groups. There was a challenge with determining the age range and determining eligible population. Again, these challenges would primarily be resolved already through the Technical Assistance Box, but this is the feedback that was received from the states for the 2013 Federal Fiscal Year. Some states did not report it, but that was primarily for reasons that weren't clear as they were called "other."

MAP made a prior recommendation on this measure that in the cases when the measure has lost NQF-endorsement, but the Steward intends to resubmit an updated version, use the most current version of the measure. You see that reflected in the Federal Fiscal Year 2014 denominator, should include the ages 52 to 74,

and that will also account for the two-year three month look-back period.

MEMBER PELLEGRINI: Just a question. Does that mean when --- with the updated version women age 42 to 52 aren't going to be measured any more? Is that what that ---

MS. DUEVEL ANDERSON: I believe that's correct, and I believe that is in --- it's consistent with ---

(Simultaneous speech.)

MEMBER PELLEGRINI: Okay.

MS. DUEVEL ANDERSON: So, we understand that NCQA intends to submit this measure with the updated specifications, and the prior recommendation was to continue to use it. Does this group have a different recommendation? Any additional comments?

CHAIR PINCUS: When is it anticipated that it would come up again for endorsement?

MS. BYRON: So, we actually did

resubmit the measure already, and it has cleared the Steering Committee. And I think it might be up for public comment now, but the NQF folks could probably speak to exactly where it is in the process. But the Steering Committee recommended that it be endorsed.

CHAIR PINCUS: Okay. I just wondered where it was in the process. Okay, good. So, any objection to continuing this one? Hearing none, let's move to the next.

MS. DUEVEL ANDERSON: Measure 0033 is a chlamydia screening measure for women ages 21 to 24. This is an NCQA measure that has been endorsed by NQF. It is for the percentage of women in this age group that have been identified as sexually active, and who have had at least one test for chlamydia during the measurement year.

There are exclusions for pregnancy, and it's an ambulatory-sensitive measure that's reported at the Health Plan and

Integrated Delivery System. It's also collected through a variety of administrative and electronic data systems. It's aligned with Meaningful Use for eligible professionals, PQRS, HEDIS, and Marketplace Quality Rating System.

The measure is implemented across 25 different states for the Medicaid Adult Core Set. The only challenge was with coding, and the TA Box provided a link to the NCQA list of the National Drug Codes. So, that was just a pretty simple and easy assistance that was provided.

The reasons that some states didn't report the measure was because it was not identified as a priority. There was also adaptation from the HEDIS 2013 specifications of three rates and a summary rate. Because of the age groups of Medicaid, the ages 16 to 20 were not reported in the Adult Core Set, but those were reported, instead, in the Child Core Set. So, what we heard before was that we should

discuss strategic issues about aligning the Medicaid Adult Core Set and the Child Core Set, so I would say that this concern might apply also to this measure.

Are there any other concerns about measure?

CHAIR PINCUS: Hearing none, then move on.

MS. DUEVEL ANDERSON: We have some measures with high levels of reporting that address mental and behavioral health topics. We'll discuss three of them in this section, and two of them will be discussed in a related section later.

The first one is follow-up from hospitalization after a mental illness. This is a measure that is for discharge of the patients 21 and older who were hospitalized for treatment of mental illness diagnoses who had an outpatient visit, or an intensive outpatient encounter, or a partial hospitalization with a

mental health practitioner. There are two rates reported. There is a follow-up within seven days, and also one within 30 days.

There are exclusions for initial discharge and readmission or direct transfer discharge. There are also other exclusions for direct transfers. We can go into that if you're interested, but primarily we see that this measure applies to a variety of different care settings, including ambulatory care, urgent care, hospital care, and behavioral health inpatient and outpatient settings. And it's really well aligned with PQRS, HEDIS, and the Marketplace Quality Rating System.

The feedback that was received is that the adaptation was that the measure is not reported for ages 6 and older because the Adult Core Set does not include ages 6 to 20, so the age ranges that were reported are 21 to 64, and 65 and older. There are 27 states that reported this measure, and there were not any challenges

reported. So, this measure is well aligned and used across many different states. Does anybody have any questions or concerns about the continuation of this measure?

MS. LLANOS: I just have a clarifying point. So, the reason we have the 21 and over is because we've got the younger age range in the Children's Core Set.

MS. SULLIVAN: Is there one in the Children's Core Set? Same one, okay. And then the second question is in the future --- I think it's a fine measure the way it is, but the way the alcohol one is set up includes kind of a longer progression of engagement, and it might just be interesting to think about in the future. This is only a one-shot visit after discharge, and there's a lot of fall after that in terms of these clients getting lost, so it might be a recommendation to think about looking at it in three months, or six months, whether someone has still had a monthly

engagement in treatment versus just stopping at the --- but that's for the future. This measure is fine, but you might think about something that would be more --- show engagement over time.

CHAIR PINCUS: So, this is an example of where we'd be giving feedback to the Measure Steward about this.

MS. SULLIVAN: Exactly, yes. It's just feedback, but I think the measure as it exists is fine.

MS. DUEVEL ANDERSON: Measure 0105, do you have questions?

CHAIR PINCUS: Doris?

MS. LOTZ: So, this is one that I mentioned in my presentation about where I think is an unfortunate omission to not look at the Institutes for Mental Disease. These are the most vulnerable folks that tend to go to these kind of facilities. There are, essentially, inpatient hospitals of a sort, but

they're not called hospitals which is a little bit of a historical anachronism, and deals with how PMID occurs, and it just seems to me like this measure is not doing what we'd like it to do, which is to make sure that folks after an acute event get their follow-up. So, again, I want to be very sensitive to derailing your conversation, but is that something that at minimum could go back to the measure owner to say this might be something where a Medicaid amended measure, or a companion one, or something of that nature would really tell the better story?

CHAIR PINCUS: So, people that are discharged from acute settings that go to one of these, or that people that are discharged from one of these is sort of longer --- because these are largely longer term facilities.

MS. LOTZ: Not necessarily. There -- and, unfortunately, I'm not expert enough to tell you the history of how this

occurred, but for something that is designated not as a hospital but an Institute for Mental Disease like most of the state psychiatric facilities are, for which you can have both acute and long term stays, there's no Medicaid payment, so they fall off the system.

And this measure doesn't contemplate including those in there, it only talks about, you know, the --- your standard, you know, community-based hospitals and whatnot. It explicitly does not capture Institutes for Mental Disease, so we're not capturing those admissions and, therefore, we're not capturing those patients that are most acutely ill. And the measure is reporting on a less acute population because the more acute population that happened to find themselves having their acute needs attended to by an IMD don't get captured by the measure.

CHAIR PINCUS: So, again, this is something that we should give feedback to the

measure steward, I guess it's NCQA, about looking into that.

MS. DUEVEL ANDERSON: Great. So, Measure 0105, anti-depression medication management. This is a percent of members 18 years and older with diagnosis of major depression and are newly treated with anti-depressant medication and who remain on anti-depressant medication. The two rates reported are effective acute treatment at 12 weeks, and effective continuation phase treatment at six months.

This is a measure with administrative claims, and electronic clinical data, and pharmacy data. It's also ambulatory-sensitive, and is reported in Meaningful Use for eligible professionals, PQRS, HEDIS, and the Health Insurance Exchange Quality Rating System.

The measure was reported by 24 states and reported in two different age

groups. Again, this is not a material change. Again, the challenge that was reported by states was for coding, and the solution from the TA Box was to link to NCQA National Drug Codes. Some states did not report for reasons such as it was not identified as a key priority.

So, are there any questions or reasons why this measure should not continue in the Adult Core Set?

CHAIR PINCUS: Just one comment I might make, and I think that NCQA is looking at this measure because there are --- you know, there have been some complaints from the field that a number of the people who sort of drop off from taking it to the full 90 days or 180 days have good justification for not doing that. So, that there's some recommendations around taking a look at that from the point of view of --- again, feedback for the measure steward.

MS. DUEVEL ANDERSON: Okay. 0004, initiation and engagement of alcohol and other

drug-related dependence treatment. This is an NQF-endorsed measure by NCQA. It's a percentage of adolescents and adult patients with a new episode of alcohol or other related dependence who receive both initiation and engagement. So, initiation is the percentage of patients who initiate treatment through inpatient alcohol or drug-dependence admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of diagnosis.

And there's a similar engagement component, percentage of patients who initiated treatment or who had two or more additional services with a diagnosis of alcohol or other drug dependence within 30 days of the initial visit.

This measure is reported across a variety of care settings, including ambulatory and EDs, and emergency services, but also inpatient and behavioral health services. It's

aligned across Meaningful Use Stage 2, PQRS, HEDIS, and Marketplace Quality Rating System.

The measure has been reported in two age groups for the Medicaid Adult Core Set, and 18 states reported this measure. There are --- there's a challenge with the data collection, so any enrollee excluded from the initiation rate was also excluded from the engagement rate, so that's a challenge that was experienced by the states. The primary reason for not reporting was that the measure was not a priority.

MEMBER HANRAHAN: It says the challenge was any enrollee excluded from initiation rate must also be excluded from engagement rate. How is that a challenge?

MS. DUEVEL ANDERSON: It was feedback from the states, and so the identifying those individuals that need to be excluded will just have to be then for both rates, so you wouldn't accidentally pick them

up in the second rate, is how I perceive it.

MEMBER HANRAHAN: Okay, thanks.

MEMBER SAYLES: So, like if they reinitiated treatment again, then they would --- you want to make sure you don't capture that. Is that double count, yes?

MS. DUEVEL ANDERSON: Yes.

MS. LLANOS: I'll add that I think it was a clarification, so I would assume, and Margo can jump in, that probably in the 2013 tech specs it was not clear that you had to pull. And the clarification was made in this 2014 one that you did have to. Margo, is that right?

MS. ROSENBACH: That's right. I think there was some confusion if you would include in the engagement rate denominator, so we wanted to clarify that.

CHAIR PINCUS: Doris?

MS. LOTZ: Again, something perhaps to take back to the measure owner, but my analysts are challenged when they're varying

age spreads for this, so we have to cover under EBSDT and federal and medical necessity definitions to 21. Many of the other measures go 21 to 64, we've talked about the elderly, as well, but why this one would be 18? I realize this is a HEDIS measure and that has a lot of merit in and of itself, but it would be helpful and efficient to have the age bands be somewhat standardized, because no matter what they are, just not have them jumping from measure to measure. It would also help with comparability, I think.

CHAIR PINCUS: And I think that's probably a recommendation we should make across all of these, to have some standardization about the age bands would be very helpful. That there should be --- you know, for similar sets of concepts or conditions that unless there's good clinical reasons why you would have differences, that there should be some attempt to standardize. George?

MEMBER ANDREWS: I do have one question. As far as the other reasons, the entire population not covered, is this now a covered benefit across the board for all Medicaid plans? So, what degree is it not covered?

MS. LLANOS: So, I think this reflects one piece of feedback from one state, so their population was not covered. It's going to vary from state to state whether or not they're covering this benefit or this population.

MS. LOTZ: Well, there's another wrinkle to that, if I could jump in. If you're going to do expansion you have to provide all of the essential health benefits, but that doesn't necessarily work backwards, so that for your existing population you also have to apply --- make available all the essential health benefits, so as a condition of expansion substance use disorder benefits are included,

but that doesn't necessarily mean it'll be extended back.

Or, you know, again, it may be a sequencing thing. We're exactly that scenario in New Hampshire where our expansion population because it's 100 percent federal dollars, is going to receive a robust set of substance use. We are hopeful and will continue to make the argument that the rest of the population needs them, too, but at this moment in time we're going to have two different benefit plans within one state's Medicaid program.

MEMBER ANDREWS: So, how is that reporting going to be comparable across state to state?

MS. LLANOS: I would assume that the state doesn't have the ability to calculate this measure because the benefit is not covered, then they wouldn't report on this measure.

MS. LOTZ: Karen, if I could --- we

are anticipating that as we go forward here that there will be --- that the expansion population will be considered a sub-population that we're going to monitor in and of itself, so you could report it on your --- your expansion population as a sub-population, and then differentiate that from the existing population, so it doesn't have to be an all or none phenomenon. It would just become a different --- a slice of the measure as opposed to ---

CHAIR PINCUS: Let me make a comment about this one. And I'm pretty sure the measure steward is aware of this issue, and they've had discussions about it, but there is an issue that organizations that provide universal screening and follow-up for individuals for substance use conditions may score lower on this than institutions that do not provide screening because they are developing a denominator of people with lower motivation, so it's something that is being looked at, I think, by NCQA.

MEMBER SIDDIQI: I was just going to make the point that in the prior slides, if we just go back one slide, it does state that this measure is trying to target adolescent and adult patients that have the drug dependence or alcohol problem, and so even though we recognize that we do want standardization in the age groups, I'm assuming this one is not in the Children Core Set. So, there is that important age period that would be missed.

CHAIR PINCUS: So, we're assuming that there's, again, agreement that this should continue, but that we should be giving feedback to the measure steward.

MS. SULLIVAN: Just one other comment on what you --- I mean, the substance abuse is getting lower and lower in age, so there's no measure like this on the Children's side? So, it's just something I think then to consider, too, because 18 is a little old. I mean, I think there's a lot going on before 18,

so perhaps the Children's side could think about this in terms of what they need.

MS. DUEVEL ANDERSON: Okay. The next group of measures is still measures with high levels of reporting, and this is a bigger group for those with chronic disease, cardiovascular disease, and diabetes, specifically. We're going to get into a tough one. Those were the easy ones, so now we're going to get into a tough one about plan all-cause readmission, and then we'll talk about annual monitoring for medications. Those are two of the difficult ones.

So, plan all-cause readmission, this is a measure of patients 18 years and older. The number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and predicted probability of an acute readmission. The following categories of the count of index hospital stays, and the count

of 30-day readmission stays is the numerator. The average adjusted probability of readmission is also a category.

This is collected through administrative claims, electronic health records, and paper medical records. It is one of the measures that is specified for ambulatory-sensitivity, but also for population level reporting.

The care setting, it's across all different care settings including inpatient rehab facilities, ambulatory care, and nursing home care. And it is aligned with HEDIS and the Marketplace Quality Rating System.

(Off microphone comment.)

MS. LLANOS: As a Medicare adjuster, and a commercial adjuster, as well, I think it's probably used in the Medicare program with ---

MEMBER SAYLES: I said it's a Medicare Part C measure. I make sure the risk- adjustments, the Medicare

Risk-Adjustment model versus the commercial readmission rate which is an NCQA risk-adjustment, but it is a Medicare measure, right, for Part C?

(Off microphone comment.)

MEMBER SAYLES: Yes, okay. I just thought that was an important alignment.

MS. DUEVEL ANDERSON: So, then the implementation information. MAP has made a prior recommendation on this measure, and the Duals Eligible Work Group strongly supported the plans to work to identify a risk-adjustment model for the Medicaid population. This is, as we talked about earlier this morning, there is no Medicaid population specific risk-adjustment model.

The measure was reported by 18 different states, 14 states reported with the Medicaid Adult Core Set specifications; however, four states used different specifications. Unfortunately, none of them

were the same.

The challenges include the risk-adjustment methodology and the denominator exclusions. States were encouraged, as we heard this morning, to report the unadjusted readmission rate for Federal Fiscal Year 2014 because of the lack of standardized risk-adjustment tables for the Medicaid population, and 12 states provided information as to why they did not report it; primarily, because it was not identified as a key priority, but also because of budget and staff constraints, data issues, and the data source.

So, this recommendation has been heard as prior recommendation. Does anyone else have any additional recommendations or any modifications to the current recommendation?

CHAIR PINCUS: So, one question I had is that this is being used for HEDIS and for --- what was the other one?

MS. DUEVEL ANDERSON: Beta set for the Health Insurance Exchange Quality Review System.

CHAIR PINCUS: But is there another all-cause readmission measure that's being used for other federal programs?

MS. DUEVEL ANDERSON: There are hospital readmission measures.

CHAIR PINCUS: Right. So, why this one --- I mean, given that there's multiple ones being used, why choose this one as compared to the other ones, just to get a sense.

MS. LLANOS: So, I can tell you part of the story. So, two years ago there --- we weren't aware the inpatient all-cause one, the one that's used by the IQR program, that one also doesn't have a Medicaid risk-adjuster, as well. I think it could. We've had internal conversations with those folks to see if it would be the right measure for us. I think we're looking forward to feedback from the MAP in

terms of what the direction for this particular measure, and how it might fit. I think there's just --- it seems like there needs to be work on both of those in order to make it fit.

CHAIR PINCUS: So, I'm just thinking about how that might affect our recommendation.

MS. LLANOS: I can tell you the other one is a hospital measure. This is a plan measure, and this is used, as Jennifer said, in the CM program. It's also targeted C-

CHAIR PINCUS: And that's only for Medicare.

MS. LLANOS: Right, in the beta for Exchanges. On the Medicaid side, it's part of the health core set, as well, which is Medicaid for Chronic Illness. And they're also facing the same issue in terms of there's no Medicaid-specific risk-adjustment right now.

MS. DUEVEL ANDERSON: So, I think we could consider a few different issues. The recommendation could be maintain this measure,

or we could bring the hospital readmission measure to the Task Force to consider if this measure is deemed not the best available. So, any additional discussion on that?

CHAIR PINCUS: Doris?

MS. LOTZ: I'm just trying to look really quickly. Doesn't AHRQ have a preventable hospitalizations readmission, or is it just preventable hospitalizations? I'm not finding it fast enough.

CHAIR PINCUS: I think it's just preventable hospitalizations.

MS. LOTZ: Okay, so it's not a readmission.

MS. LLANOS: There's a variety of other ---

CHAIR PINCUS: Yes.

MS. LLANOS: --- readmissions measures out there besides the ---

MS. LOTZ: That's a perspective that I think on the readmission event horizon is a

little more actionable. I mean, some people are just bad protoplasm and they go in and out of the hospital all the time, and you can try to prevent them, but it seems the lower rung on the ladder is the ones that should be prevented for which there are, you know, well established clinical interventions that should keep them out. So, that's a consideration for CMS to think about, if you want a different measure on readmissions, might be a more actionable measure than this, but maybe not.

CHAIR PINCUS: Ann?

MS. SULLIVAN: I think the hospital readmission has a couple of exclusions. There's not a lot but something like trauma and I think some capacity of transfer. This has no exclusions? This is every single readmission, because there's no exclusions listed. Is that true? Because I think the more you can align in some ways between like measuring for the other rate and this makes some degree of sense. I

mean, if they've got different exclusion criteria it's just going to get confusing for people.

And then I think the other issue is when we talk about kind of adjusting this for Medicaid, what are we talking about adjusting? I mean, we are talking about psychosocial factors, are we talking about using those as an adjustment factor? What are we talking about as possible risk-adjustments? I gather everything, or has anybody done any work yet on looking at this in terms of like if you risk-adjusted for homelessness or something? I'm not sure you should risk-adjust, but if you did, what have people been looking at?

MS. LLANOS: So, I would say --- I don't know if somebody wants to jump in for NCQA in terms of what they may have been thinking, or in terms of the exclusions. That's their measure. We've not gone down the path of speaking specifically on the types of that, but

it would be risk-adjusting for the Medicaid population. We haven't had too much discussions on this mostly because we wanted to hear from folks.

MS. SULLIVAN: Two things. One, I think we should look at the hospital measure, and I think at least that --- that has very limited exclusions, but it does have some, and probably they would fit this just as well.

And then when I think you about risk-adjustment, I think there's a lot of social factors you could. However, I've always heard, and there's a certain validity to it, if you start doing too much of that, then you kind of --- you can kind of cover up what's the problem with the readmissions in Medicaid. So, I think it has to be done judiciously, and I'm not even sure --- I'd like to --- I think you might have to report --- that would be terrible, but I'm just concerned that if you do too much risk-adjustment here you might be covering up

some of the disparities that occur in Medicaid. That's all.

CHAIR PINCUS: So, Alvia, Marshall, and Jennifer.

MEMBER SIDDIQI: So, I agree that there is a need for exclusions. And I would give the feedback to the steward that we look at the same exclusions for the hospital-based one for this one, as well. This is a huge ask, but I think instead of looking at specific, like you're talking about risk-adjustments that could, again, move the focus away from how you get to that outcome and focus too much on the process.

But I do think it may be useful, and this is, again, a huge ask for feedback, but to limit this to the top 10 readmission rates conditions that we just looked at from HCUP, and same for Medicaid, and same for --- I mean, again, realizing that readmissions are not the same as readmissions for depending on the

population you're looking at.

CHAIR PINCUS: Marshall?

MEMBER CHIN: This is just an answer to Ann Marie's question, that right now it's NQF policy that you can't adjust for socioeconomic status, which makes no sense. So, there's a current panel that's specially looking at this issue and grappling with that same issue of trying to be fair to providers, yet not masking disparities. So, it's actually on the website of NQF now, like a draft report that's gone out for public comment, got 630 comments back. It's under revision right now, but your point is right on target. A lot of comments today have been about how this needs to be addressed, and finally NQF is addressing it.

CHAIR PINCUS: Jennifer?

MEMBER GESTEN: But the question is whether or not you need to do that same risk-adjustment when you're looking at comparing state Medicaid programs. The context

of the current adjustment is around adjusting it at the provider level, and it's just an open question about whether one needs to adjust --- the accountable entity here state by state, do we need to adjust. And it could be part of a broader conversation about differences in Medicaid populations across states, but I would just submit it's a little bit different than adjusting for patient mix at hospitals.

MEMBER SAYLES: I was just going to --- well, maybe I'll react to that one comment, which is that I would imagine since the populations vary pretty substantially by state, you know, who's eligible for Medicaid and who isn't. I can't imagine that it wouldn't be relevant to risk-adjust it by state, if you're concerned about, you know, having comparability. But I would have --- I guess I wanted to say that I would prefer the recommendation --- or the Committee could put forth the recommendation to actually look at

risk-adjustment for this measure. This has been talked about year after year. It's great to hear that work is being done. I remember sitting on some webinars where it was getting started. It would be a great model for looking at how do you incorporate some socioeconomic factors into measurement in specific instances where it's relevant with this population, so that might be one potential way to approach it from the Committee perspective.

CHAIR PINCUS: So, actually, there's a question, and I think also it was asked as sort of the ---

MS. POTTER: Hi, I'm D.E.B. Potter from AHRQ. I just wanted to share what the MAP Dual Eligible Group talked about when we discussed the all-plan measure versus the hospital readmission measure.

The hospital measure which is used in Medicare reports on the hospital, and the exclusions include the cancer population, but

they also include most of the mental health and substance abuse population. The all-plan readmission measure here excludes the pregnancy, labor, maternal population but doesn't include the substance abuse, behavioral health population. So, the MAP Duals Group came down on wanting this particular measure because it did specifically include the mental health, behavioral health population.

CHAIR PINCUS: So, this is a little bit different than the other ones because it seems to me that in the other ones we approved it, but we also suggested --- we recommended it, but we also suggested that they go back to the measure steward. This is not a single measure steward. There are multiple measure stewards across the different ones, and there's also at play the issue of risk-adjustment for social factors, and other kinds of things.

And I guess the question I have is, if we were to refer, or make suggestions back,

to whom would we make those suggestions, because it's not just NCQA, because there's also other measures that are different measure stewards, and then there's also the broader policy of risk-adjustment?

MR. HOFFMAN: I was going to point out that NCQA has worked with CMS and Yale along with NQF to harmonize the measures where it made sense, and have differences where it made sense given that one was focused on hospitals, and one was focused on plans. So, a lot of that work we could probably share with the Committee, but a lot of that work in trying to harmonize some of the differences, you know, what's in the current measure set is --- we have some new respects based on that harmonization activity.

CHAIR PINCUS: So, in terms of our recommendation, just to clarify, and I guess I'm not sure who I'm addressing this to, whether it's Karen, or Helen, or Sarah, or whomever, but if we were to say that we think there should be

an all-cause readmission measure, but that it would be important to work out some of the alignment and specification issues, who would we be making that recommendation to?

MS. LASH: We could say that, we could also consider the issues somewhat separately. Is this measure adequate? Would it be better if it had a Medicaid-specific risk-adjustment model, sort of one path of recommendations we could take?

The other being this measure is not felt to be adequate, an alternative would be preferred, and I think many of the others available are at the facility level so we'd need to take into account some of the principles we've been discussing today about consistency in measurement over time, alignment with HEDIS, and also maybe the increased difficulty of rolling up facility-level data to the state, as opposed to from the health plan, which is a little bit less of a leap.

So, Steve asked us to make a really clear rationale for a change, so if we did want to encourage CMS to explore alternative measures to 1768, maybe I think you have a little bit more discussion as to why.

DR. BURSTIN: Just to build on that, you know, again, I think one of the recommendations up front was that there would be --- I know NCQA was planning to do the risk model for Medicaid, so one of the recommendations from this group could be that that work should be put forward. And I know sometimes the limiting step with developers is spending for that work, so I think it's just an important piece of it.

Again, this is the measure. It is NQF-endorsed. The other one is at the provider level, wouldn't be as useful, so I think they are actively working with CMS to harmonize across the provider and plan-level measures, and actually have made great progress.

MEMBER PELLEGRINI: Can I just get a clarification? I thought it was mentioned that either this measure or one of the similar ones excluded complications of pregnancy, as either hospitalization or readmission?

MS. LLANOS: The exclusions for this one are discharges for death, pregnancy, and patients with conditions originating in the perinatal period.

MEMBER PELLEGRINI: Why?

MS. GIOVANNETTI: This is Erin Giovannetti from NCQA, and I can speak to that, if that's okay.

MS. LLANOS: Go ahead, Erin.

MS. GIOVANNETTI: The reason is, is because it's actually very hard to differentiate in --- we had designed the --- at the time we developed it, but that's not the --- for differentiating between the ID for the mother and the child, and so you couldn't tell who the readmission was for, if it was for the

mother or the child. And so because of that reason, we did not include them in the original measure.

We do have plans to include this population when we --- when and if we have the funding to specify this measure specifically for the Medicaid population which would include adding this population back in, and the risk-adjustments specific to the Medicaid population. So, we are aware of some groups that have worked on this, particularly I believe in Harvard where they might have figured out a good solution to this, and we're eager to work with them.

MEMBER PELLEGRINI: Great. Can we put in a statement supporting that work, then, because with about half of all births being covered by Medicaid, excluding that population doesn't make sense.

MS. DUEVEL ANDERSON: Is that agreed upon across the group? Great.

MEMBER GESTEN: Can I just say one more thing about risk-adjustment, speaking as a state, and other folks from states can feel free to disagree, but ---

MS. DUEVEL ANDERSON: Foster, could you speak up, please?

MEMBER GESTEN: I'm sorry, is this any better?

MS. DUEVEL ANDERSON: Yes.

MEMBER GESTEN: I would just say with respect to risk-adjustment, I think for me it's more important looking at other states' rates, not that we clarify that patients in one state or another are sicker or have more complicated concerns, or more poverty. For me the issue about comparability and utility, if that's part of what this exercise is about, which I guess is an open question, but it seems to be in terms of state-based reporting; that the ages be the same, that the exclusions be the same, the definition of what we mean by this be the same.

It is more important for me to understand which groups are included in measures across states, i.e., does it or does it not include duals and so on? But, frankly, you know, trying to sort out whether, you know, Washington, or New Hampshire, or Arizona's folks have more complicated conditions and do that sort of risk-adjustment, to me is less important.

And, again, speaking from one state, but knowing that the ages are the same, the definitions are the same, and understanding, at least being able to stratify and understand when I'm comparing to another state that they did or did not include duals, or did or did not include, you know, SSI population and so on, is really the essence of trying to --- is more important to me than sort of an elegant risk-adjustment model.

And as I understand it, but folks from NCQA can clarify this, that the

risk-adjustment model is really about making plan-to-plan comparisons, and being able to look at that model and presume it's different for different populations. I'm not sure how that's going to roll up or relate to state-by-state comparisons in terms of the risk-adjustment. So, that's one person's view about the relevance of it for this measure.

MEMBER SIDDIQI: I was just going to say that I agree with Foster, and I think it really does vary when you go down to the provider level. So, if that same measure is going to be now used towards a provider's P for P or quality performance measure, then it really does matter, because certainly then the last thing you want is for providers to only cherry-pick the healthiest populations, and that's whole other issue. But I think when you're talking about Medicaid plan to Medicaid plan, in general, Medicaid patients in every state is going to say mine are the sickest, I'm

sure. And you could show state data that supports some of that.

But, you know, I had said earlier, too, again, if we're looking at this measure and trying to drive and motivate QI efforts, it's so grand. It's huge. I think we do need to look at the top 10 or top five, or top three of the readmissions causes, the conditions that are linked to that, and separate them out, so follow-up for diabetes, I'm sorry, readmission rate for diabetes, readmission rate for mood disorders and schizophrenia. So, I just think it's important to maybe weed it out that way. It's just feedback, again, to the stewards about that.

CHAIR PINCUS: Yes, I think so. I think we've sort of --- Cindy, did you have something? So, it sounds like our conclusion is to recommend continuation but to feedback to the steward to look seriously at more focusing this measure to those that are the most

significant causes of readmission. And, number two, to look at the options for risk adjustment.

MS. DUEVEL ANDERSON: There is a slight switch in the slides. We're going to move to Measure 0021, annual monitoring for persistent medications. If you downloaded the slides a couple of days ago, this will be a little off but the content is not different. We have a just-in-time update. This measure is approved by the Safety Steering Committee, and is out for comment, so it was supported. So, the not NQF-endorsed is in the future hopefully NQF-endorsed.

So, I'll describe the measure. The measure is for percentage of patients 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for select therapeutic agents during the measurement year, and at least one therapeutic monitoring event for the therapeutic agent.

So, there are some specific rates, and those are for ACE and ARBs. There's diuretics and anti-convulsants, and there's also a summary rate. There is exclusion that's optional for members on convulsants, and the measure aligns with HEDIS, and with the new Marketplace Quality Rating System.

The measure was reported by 22 states, and was reported in two different age groups, ages 18-64 and 65 and older. There was a question that was received by the TA Box about the coding and referred to the National Drug Codes. Again, we wouldn't anticipate this would be a significant challenge ---

(Off microphone comment.)

MS. DUEVEL ANDERSON: --- with an open line, if you'd like to make a comment? Okay. And some of the reasons that states didn't report were because the information was not identified as a key priority, and some concerns about data linkage.

MAP made a prior recommendation that CMS should retain the measure for the time being, and recommended that the measure should be brought for endorsement. And if it wasn't, a suitable alternative would be found. Again, another just-in-time update, unless hearing from the Task Force that you would like to consider alternatives, since this measure is now NQF-endorsed, we do not have to adjudicate the following four measures.

CHAIR PINCUS: So, it's officially endorsed.

MS. DUEVEL ANDERSON: It's recommended by the Steering Committee for endorsement, so we would anticipate barring public comments that it would be reviewed by the CSAC and endorsed. Marshall?

MEMBER CHIN: Yes, maybe starting to get into the weeds a little bit, but it's kind of a curious measure, so I'm wondering if the Technical Advisory Panel had concerns with it.

For example, for certain sub-populations then there's set criteria, you know, heart failure, ACE inhibitor, but it can be broader populations where it may not make sense. You know, hypertension, maybe you're switching someone from an ACE inhibitor to a different medicine. Digoxin, you know, there's much, much less use of Digoxin now than in the past. Anti-convulsants, I can imagine that if someone was, you know, probably the more specific criteria, but also be on a long-term anti-convulsant, so for each of those different examples there are clinical concerns about the validity of the measure. Did that come up in the measure selection at all, or not?

DR. BURSTIN: Yes, let me just jump in real quickly. So, NCQA actually updated the measure since that time, so the measure specs have changed, I suspect, since you've seen it here. And they worked with, correct me if I'm wrong, the Armstrong Center at Hopkins to do

that. And, actually, I think addressed it, and the Committee was comfortable with the updates to the measure as being scientifically sound. But some of those very same issues were raised.

MEMBER GESTEN: And anti-convulsants was removed. Right?

MS. GIOVANNETTI: This is Erin at NCQA. I can speak to those, if you'd like me to.

DR. BURSTIN: Thank you, Erin. Yes.

MS. DUEVEL ANDERSON: That would be good.

MS. GIOVANNETTI: Yes, anti-convulsants was removed, and the other three medications remained, and we had, you know, colleagues at Johns Hopkins conduct a systematic evidence review to make sure there was strong evidence for monitoring of renal function for those individuals taking those medications. As well as the other change we made was for people taking Digoxin, to make sure that there was monitoring of serum digoxin. So,

really the intent for this is to say anybody on this medication should have at least annual monitoring for adverse drug events that may result from taking those medications.

MS. DUEVEL ANDERSON: Okay. Other -- Alvia?

MEMBER SIDDIQI: Just feedback following Marshall's comments. I'm just curious, are there other medications that are being looked at, I mean, statins and LFTs, or metformin, and renal and liver function, too. I mean, there are so many medications out there that require testing, so it's just interesting again that it's just those three that are looked at.

CHAIR PINCUS: I would ---

MS. LLANOS: Yes. Sorry, go ahead. So, yes, the Hopkins team also conducted an evidence review for other medications that require annual monitoring. I think these three were chosen because of their high utilization.

The other measures that are highly utilized, such as medications for diabetes, a lot of monitoring for those medications is covered in similar HEDIS measures that are monitoring for people who have diabetes.

The one area that we are looking into is the monitoring measure around use of warfarin. And with that, I think we are currently working on some measures right now that are actually e-Measures for that particular area. But these three medications seem to fit well and they're measured together because they're cardiovascular agents and often prescribed together.

MS. DUEVEL ANDERSON: Is there a gap here of measures that the Task Force feels are really --- are medications that the Task Force feels should be really measured, and the management of them that we could identify a high-priority gap, or is this satisfactory?

MS. LOTZ: Metabolic screening for

people on anti-psychotics.

MS. GIOVANNETTI: Sepheen, correct me if I'm wrong, but I believe that's in the measure, isn't that?

MS. BYRON: Let me look that up.

MS. GIOVANNETTI: I believe we have a separate measure for people on anti-psychotics that looks for metabolic screening, which is why it's not included in this. But if I'm wrong about that, then that's certainly something we will consider.

MS. LIU: This is Junqing Liu, Research Scientist from NCQA. We do have the measure but it's not in the Core Set. That's monitoring for cardiovascular disease for people with schizophrenia and cardiovascular diseases.

MS. LOTZ: You had some alternative measures up there, as well. We did in New Hampshire do this measure, and the rates are lovely and high which kind of makes me reflect

a little bit on Marshall's comment. I personally don't think this is really a critical issue in the Medicaid population. I'm intrigued by the concept of medication adherence and what we know about gaps in coverage leading to increased utilization for acute causes, so I'm underwhelmed with this measure. And I think that if we're going to be parsimonious with measures that, you know, again the schizophrenia one I already mentioned, or looking for gaps in coverage. Medicaid Reconciliation might be a second or third, I guess, but this one is just not exciting.

CHAIR PINCUS: So, George, and Ann, Jennifer.

MEMBER ANDREWS: I would agree. I can think of a lot more medications that you need to monitor. I'm a cardiologist. Amiodarone is a very toxic drug, and a lot of people are, especially the ones who have atrial

fibrillation, so the list can get expansive. I'm more inclined considering, again, the prevalence of disease in the population, and diabetes being one, that it's common, it's a cardiovascular equivalent.

To me, the option there of 0546, diabetes appropriate even for hypertension is a very important one because aside for controlling hypertension or controlling blood pressure, which is again a key preventive measure, it also helps prevent diabetic kidney disease. And it is a very easy measure to monitor because it's administrative. And, again, trying to get away from hybrid, this to me is a much better option to go with.

MS. SULLIVAN: I just have a question. Has that been the experience across the people who have been reporting that this seems to be doing well, that people are doing this monitoring? Is it a measure that is --- we're doing pretty well with; therefore, we

don't need, or do we know from the other states who have been reporting whether they get good results, or not so good results with this?

MS. DUEVEL ANDERSON: Unfortunately, we don't have results information, but potentially NCQA could tell us.

MS. SULLIVAN: So, this wasn't in the reporting?

MS. DUEVEL ANDERSON: The results of the measures were not reported to us.

CHAIR PINCUS: Well, what about in terms of this measure is being reported in other settings other than the Medicaid program? I mean, do we ---

MS. LASH: I believe if there wasn't a performance gap it wouldn't have continued to maintain endorsement. Is that an overstatement, Helen?

DR. BURSTIN: There's relatively high performance on the measure, but I think

it's because these are safety events. People thought it was still important sometimes to continue to have some of these to get to higher proportions. I can pull up the rates unless NCQA can do that more quickly.

MS. DUEVEL ANDERSON: So, I think the question is ---

MS. GIOVANNETTI: Yes, I'm working on pulling that up right now.

MS. DUEVEL ANDERSON: I think the question still is, is this the right measure with the kind of information that is endorsed, but there are potentially some high rates. And then once we have determined that, we can move on to alternative, or additional measures.

CHAIR PINCUS: So, I think Jennifer had a comment, and then Alvia.

MEMBER SAYLES: I completely agree with Doris in her comment that this an underwhelming measure and having had to keep up with the measure myself for a few years, I don't

really --- well, I think that particularly when we're thinking about Medicaid, adherence is the huge issue, disproportionate in that population, and really literature would show than others, so I think that's really critical when we're thinking about --- if we're only going to get a couple of shots looking at medication and what impact that has on disease.

If we have high prevalence of disease and adherence being an issue, it seems like neither --- that this measure isn't really getting at either of those issues. And this is, I think, one of the only medication measures that's really in the set, so I just would point that out and suggest maybe we consider some other things even if they aren't the initially recommended one.

CHAIR PINCUS: Alvia?

MEMBER SIDDIQI: So, I was going to say that, you know, if we're looking at this measure specifically at saying, for example for

ACE inhibitors, that it's just at least one therapeutic monitoring event for the therapeutic agent in the measurement year, again, it's very under-whelming.

I think that's very easy to achieve with any diabetic, that you're going to check one blood test for per year. So, I do think we need to look back, again, the top 10 readmission rate conditions, and mood disorders was on them. And Doris is saying there is an actual measure, and NCQA has said there's that one for the anti-psychotics and the metabolic profile, again that may be one that is more often missed by the primary care physician or provider world, and/or the psychiatrist who's treating the patient and not doing that monitoring. There may be some more interesting gaps that are noted there, so it may be a more useful measure to use.

The other interesting point, though, I will say just to play devil's advocate

here, that on the slide after this when you show the number of states that did participate, I was actually surprised that 22 states actually did use it and participated in it. Because it is a HEDIS measure, they're probably using it, reporting it for other reasons, so it behooves the question, you know, do we want to include this one and then add the anti-psychotic one? So, I'm just going to throw that out there.

CHAIR PINCUS: So, it sounds like we have a couple of options about how to handle this. So, one is that we can make --- continue the prior MAP recommendation saying for the time being retain this measure but suggest that CMS really take a whole relook at the whole set of issues about medication management and monitoring in a more comprehensive way. That's one option.

A second option is that we make recommendations for a specific set of additional measures that could capture this

sort of domain for chronic conditions. And I guess my concern with that latter one is that we really don't have in our heads all the options that are out there. So, I guess I would ask Karen, Helen, is there a forum where that could actually happen within the time frame by which we have to make this report?

DR. BURSTIN: I think we've already heard, for example, there are some key conditions, some key drugs you've already pointed out. We could go through the database and pull any other measures that might be ---

CHAIR PINCUS: Will you come back to us, and how would we ---

DR. BURSTIN: Sure. Yes, we could do that, probably could do that today. I mean, it's not a huge list.

CHAIR PINCUS: Okay.

DR. BURSTIN: It would also be, I think, appropriate to put --- and, again, ideally it would be great to have these measures

be ones we've already reviewed, but there are new measures out there that are being developed that also might fit your needs. You know, for example, some of the new anti-psychotic ones that NCQA is doing around pediatrics and anti-psychotics. I mean, there are some really important areas that I think it should be guided by what you think is most important for Medicaid populations.

CHAIR PINCUS: Well, it seems to me that for the time being if we could maybe get that information and we could actually discuss it tomorrow. Would that actually --- could that be done? Okay. So, why don't we do that? Why don't we then sort of hold off on making a determination on this and sort of revisit it tomorrow with some additional information about what alternatives might exist.

DR. BURSTIN: And we could also --- I know Erin was trying to look this up, to do it immediately, but she could also provide it back

to you. I remember there was variation in performance, so I suspect the rates on this were probably lower for Medicaid populations than they were for commercial, so having that differential would be important. Because, again, the Committee wouldn't have put it forward if there was no difference, so I think it was the variation by payer type is my suspicion, but we'll bring you that, as well.

MS. LOTZ: And maybe among the drugs, Helen, because where New Hampshire under-performed was anti-convulsants which were taken out of the measure.

CHAIR PINCUS: So, why don't we move on to the next one?

MS. DUEVEL ANDERSON: I'm moving through the measures that were the alternatives, but we'll have an expanded set for you to review. 0063 is comprehensive diabetes care, LDL screening. The presented member is 18 to 75-years old with diabetes, Type

1 and Type 2, who received an LDL-C test during the measurement year. This is a measure that's in both PQRS and HEDIS. It's also reported at the health plan level, and is ambulatory-sensitive.

The measure was reported in two different age groups, as already --- as part of the Medicaid Adult Core Set, and was reported by 29 states. And, again, it was a coding question received by the TA Box, and reference that can be updated in the Type 1 specifications. Overall very little to say about the implementation of this measure. Are there any questions or concerns for this measure?

MEMBER GESTEN: Yes, I have a question on new recommendations related to lipid management. Is there a continuing need for diabetics to have annual testing of their LDL level?

CHAIR PINCUS: What was the --- you

faded out at the end of your last sentence.

MEMBER GESTEN: With new recommendations regarding lipid management, I'm wondering whether there remains a clinical rationale for actually measuring LDL levels on an annual basis given the treatment ---

MEMBER ANDREWS: Yes, I would say so. The new recommendations are not so keen on a specific target to drive LDL to, but the new recommendations still want to see a reduction in LDL to a certain degree that is dependent on what risk group you fall in. So, knowing where you start and knowing where you're moving is still important to determine whether you're getting the appropriate treatment, or enhanced treatment.

MEMBER GESTEN: I guess I thought being diabetic meant you were --- recommendation was for, as you say, enhanced treatment period regardless of starting or end LDL level. But maybe I

misunderstand the recommendations.

MEMBER ANDREWS: Yes, you are very correct on that. But, again, in the management of the diabetic patient, if a particular statin, for example, isn't doing the job, you still need to know where you are so you can make adjustments or change, too, or something else.

DR. BURSTIN: Yes. I just pulled up the guidelines. It does still say for diabetes with LDL between 70 and 189, they should receive statins. So, I think you'd still want to at least for diabetics check the LDL.

MEMBER GESTEN: I get that they need to have it at some point. I'm just questioning whether it needs to be done on an ongoing annual basis.

DR. BURSTIN: Oh, I see. That's a good point. It's not clear.

MEMBER LEIB: I have a question.

MEMBER GESTEN: And I wonder --- go ahead.

MEMBER LEIB: Go ahead, Foster.

MEMBER GESTEN: I don't know if anyone in --- I don't know if this is one of the issues that may be up for discussion for whatever Technical Advisory Group is looking at diabetes measures, or lipid management levels, measures for NCQA. I don't know if Ann, or --- do you happen to know?

MS. BYRON: This is Sepheen. So, the LDL-C screening rate for the diabetes care measure is being proposed to be retired. Hasn't been approved yet, but this is in response to the new guidelines that have come up and our now focusing on statin use rather than treating to a target. So, this is something that we had put out for public comment just this past spring, and are proposing it for retirement.

MEMBER SIDDIQI: So, then is there a new one that you're proposing to replace it, or that is better that talks about the statin management piece?

MS. BYRON: We are looking at developing a statin measure. This is --- it actually has not been approved by NCQA's Board of Directors yet, so it really is very fresh, new information here, and it's probably just a timing issue, but these recommendations just came out very recently, so we underwent a rapid reevaluation cycle just to make sure that our measure could stay current. So, we very quickly turned around an evaluation of this measure.

We would look to do a statin measure to hopefully replace this so that, you know, this is an area that's very important. We don't want it sitting out there without any measures, and we are doing that this year.

CHAIR PINCUS: Are there any other NCQF-endorsed statin measures?

DR. BURSTIN: It's the same issue across all of them. We actually have a Cardiovascular Committee, and we've held off

doing anything on statins because the dust wasn't settled yet. I do think this --- you know, it makes sense to retire what's not appropriate yet, but I think it's still not completely clear how you handle measures that incorporate discussions of shared decision making and X percent risk with patients into a performance measure. So, you know, I think NCQA, ACC, and others will all be kind of struggling with this in the next year.

CHAIR PINCUS: Marc?

MEMBER LEIB: I just have a technical question. It said here in challenges under coding linking to the NCQA NDC codes for insulin hypoglycemic agents. Why are they trying to link to a class of drug use rather than just looking at an ICD-9 code that identifies diabetes? There are only like three codes, families for diabetes.

MEMBER SIDDIQI: I would assume it's because not all diabetics would be able to

qualify for that, would be high risk enough to need the statin, so if they're on diabetes medication they're not just a pre-diabetic or somebody that has the diagnostic code perhaps used once in their claims, but again could just be pre-diabetic or borderline. That's what I'm assuming.

MS. LIU: So, I think this is related to identification of the denominator for this measure. So, you can --- if you identify that either we're a claim, or we're medications, I think that's where the NDC codes come into play.

MEMBER LEIB: So, it's either. Right.

CHAIR PINCUS: So, I guess the question is where does that leave us, given the fact that the dust hasn't settled? Do we recommend retirement, do we recommend continuing it until the dust settles?

DR. BURSTIN: Just in general, we -- our approach has been that one of the

cornerstones of the performance measurement is the consistency of evidence. And if this is a place where the evidence is inconsistent, it might be reasonable to kind of hold off as we've done from kind of being --- saying ready to change it, do something with it. And I think it's up to this group to see whether it makes sense to just maybe put it on hold for a while.

MEMBER SIDDIQI: Could we see a review of all the different diabetic measures that would pertain to something similar to this that we could choose from the menu of what exist; again, knowing that this one is really underwhelming and retiring.

CHAIR PINCUS: So, again, are we saying to postpone until tomorrow to look at sort of alternative diabetes care measures that we might want to include? That might be unrelated to lipid management since there doesn't seem to be a clear path yet.

MEMBER GESTEN: We have them. We're

going to be talking about other measures in a second, I assume. So I don't understand the question. There's no other lipid management one sitting out there for diabetics.

MS. DUEVEL ANDERSON: I think there might be a cautionary tale here where we can work on language about recommendation to monitor the dust as it settles. And if this is a retired measure, then it should no longer be used in the Core Set. But if it, or an alternative, or an update to it is available, then that should be used when it is updated. That sounds like the recommendation. Okay?

CHAIR PINCUS: Anybody have any objection to that?

MEMBER SIDDIQI: I'm just curious, but isn't this Task Force able to create a measure then, or like a hybrid measure if need be, or no? Or is it basically as this Task Force --- okay. So, I was just curious because in our state we've looked at possibly doing a combined

A1c and LDL testing measure. But, again, just looking back at how every state can do something a little different, I was just curious if we could do that, like create a measure, or recommend a measure that doesn't exist?

DR. BURSTIN: We can put forward other measures that have been reviewed and evaluated that might fit this space but I think you're going to come up to some soon, so why don't we do that first, then see if you still think there's a gap.

MS. DUEVEL ANDERSON: So, on that line 0057 is a comprehensive diabetes care measure. It's hemoglobin A1c testing. And it's the patients' percentage of members 18 to 75-years of age with diabetes who have received hemoglobin A1c testing during the measurement year.

Similar specifications with data source from administrative claims, but also electronic and paper medical records

available. It is reported at the clinician, but also the health plan and the population level of analysis, and it is aligned across some programs.

This measure was, again, reported by a high number of states, 29 states, and there is the same question about coding. It was simple additional information provided to the state that had the question about the coding. So, again, not a lot to say on this specific implementation. Go ahead, Jennifer.

MEMBER SAYLES: I just had a question. Was there consideration of the control measure as opposed to the screening measure, or did I miss it? Is that going to be in here later?

MS. DUEVEL ANDERSON: We haven't discussed it, and we haven't prepared it for the Task Force. So because this measure was highly reported, we didn't present any --- we aren't presenting any alternatives, but we would hear

that from the Task Force.

MEMBER SAYLES: I mean, I would just put out there that, you know, the move towards more outcome-based measurement, this would be a perfect example of sort of --- because in the control measure, and even if you picked a generous target of nine, you know, if you didn't do any screening at all you're not going to --- you're still in the denominator, not in the numerator, so it's accounting for the fact that you haven't screened; plus, it's factoring in control, so I don't know. That might be something to consider.

MEMBER SIDDIQI: Just along the line with what you're saying, Jennifer, I agree. This one is one that is part of our state in Illinois HealthConnects PCCM Bonus Program, and one that we've not changed in three or four years. And it's one that I would love to hear feedback from NCQA, is this one that is potentially retiring, or changing, or moving?

Because, again, it's not very outcome-based, it's very underwhelming, it's very easy to do a hemoglobin A1c test once a year on a diabetic. It doesn't really challenge, I don't think, towards QI improvement. You see a lot of states reporting on it. Obviously, that is a good thing, but I think we need to pick a better measure for diabetes.

CHAIR PINCUS: What is the feasibility of states being able to gather data, actual hemoglobin A1c values?

MEMBER SAYLES: Well, I mean, that's a Medicaid NCQA accreditation measure. I mean, that's a very commonly collected measures in the states I'm familiar with. I mean, it's a lab value, so ---

MEMBER SIDDIQI: For our state we are all based on claims data, so this would not be able to be undertaken. Maybe an MCO plan as we're moving towards Managed Care in our state, that that plan may be able to report on, but from

a state-based level we are using claims data only, and so that's why we struggle with this, because we do --- we cannot use the lab values, so we can't --- we don't get the lab data. So, that's why I was just curious if NCQA is doing updates on this measure, or any new measures that are coming around this room.

MS. LOTZ: It would be a challenge but that's all right. You know, this one is not a challenge, and that's not all right.

MS. BYRON: Right. For HbA1c we're not making changes to this one, we're focusing on the LDL stuff for now, and the statin use. But, I mean, you know, we understand the challenges.

(Simultaneous speech.)

CHAIR PINCUS: Marc, what is Arizona's point of view?

MEMBER LEIB: From my perspective?

CHAIR PINCUS: Yes.

MEMBER LEIB: We do measure

hemoglobin A1cs. The percentage of patients who get a hemoglobin A1c and they have a diagnosis of diabetes, we also measure the LDLs and a kidney test, and eye test, so we have actually four tests in the diabetic population as part of our quality measures.

CHAIR PINCUS: Are you able to get values of hemoglobin A1C?

MEMBER LEIB: No, at the current time we don't have a way to get the values. We do have a way of making sure that all four exams, but we don't have the values.

MEMBER SIDDIQI: All four together or counted towards one measure, or they're each separate?

MEMBER LEIB: No, each separately over every other year period. The hemoglobin A1C once a year, the eye exam every two years, kidney ever two years, but those are four completely separate measures.

CHAIR PINCUS: Foster, what about

New York?

MEMBER GESTEN: We have --- we get, we get it through hybrid. But I will also make a comment about the context of why the measures appear --- why it was chosen to do this one and not control. It was not there wasn't appreciation initially, I think, of all the working group about the preference of having outcome measures versus process measures. I think the context then, and I think it remains a real issue is, is our goal to have a subset of plans report more --- states report more measures, or have some common measures that we can look across the entire country and think about 50 states, not just 12 or 15 that have a long history of being able to get this data.

So, I don't know what the right answer is, but I just want to reflect that a lot of this was done consciously. There was an active discussion about administrative measures, preference for administrative

measures. It didn't mean that everyone agreed with it, it didn't mean that there wasn't an active conversation then as there should be now about tradeoffs in terms of the work or the resources required to get administrative --- clinical values. But that was the reason why, I think, that there was --- you'll see in a number of these that there was specific preference at least at the starting gate for administrative measures to specifically, hopefully, increase the number of states that would be able to report. And others who were there, and there are many folks in the room there and on the phone who were part of that process may remember that. And if you remember it differently, feel free to jump in. But the --- I think the tension remains the same.

I think folks can get it, and it's not that it can't be gotten, but some states will probably opt out for measures that require chart review, or specific contracts with

vendors to be able to get clinical data. Is it the right direction? Absolutely. I certainly wouldn't disagree with that.

CHAIR PINCUS: Yes, you're actually bringing back my own memories about this. And you're right, I do recall that discussion. And I thought that there was some discussion, also, about having some sort of balance between sort of 50-state reporting and having some where there might be sort of a leading edge that might be able to report on more specific measures. And that's something that may be a strategic issue that we should also bring up about the --- you know, we talked about balance between structure, process, and outcomes, also balance between having everybody be able to report --- every state be able to report and having --- realizing that there are some states that have, you know, some specific capacities to report the measures that others can't. And if they can form a subgroup that can look at

things, that's okay. Doris?

MS. LOTZ: And as all three states reported out, we all said that synergy is good, so if this would be a Medicaid measure and no one else is reporting out on the actual value, then this may be one where when you're balancing across the whole portfolio you say well, it is a good outcome measure, but it would probably be best if it was done in concert with other priorities, you know, coming from other organizations so that whatever the barriers are, the logistics to getting toward the clinical information, they would be sort of collectively absorbed, and providers, or systems changes or whatever was necessary, they would have a large motivation because they'd have to do it for, you know, NCQA, or Medicare, and also for Medicaid. I don't recall what the outcome of this discussion was, whether anyone else is requiring the actual value to be reported.

MEMBER SAYLES: I mean, I can just speak to that, and I totally hear the point of, you know, trying to set a clear common denominator. That makes a lot of sense to me, but just to be clear, I mean, it's an exchange measure, it's a Medicare measure, it's an NCQA, so for anyone who is accredited as a commercial or a MediCal plan measure, control of A1c, so I think it's really out there. I don't know if NCQA wants to comment more, so I don't think it's as much of a stretch. Well, I mean, it may be a stretch, but I'm just saying it is very aligned.

CHAIR PINCUS: Alvia?

MEMBER SIDDIQI: I agree. I think, you know, it's fine to continue this one, but I think it's time to add new. And I think that that one, especially the hemoglobin A1c over nine makes a lot sense for a Medicaid population to try to attempt to gain that knowledge. And, certainly, it's one that would require a hybrid

or chart review probably for most states. There may be some, like in California it sounds like, where the lab data may be available possibly to the Medicaid agencies, but at least there would be a push, there would be possibly a motivation towards achieving that. So, I do think including that new measure would be a good idea.

And just feedback, again, to the NCQA. You know, this is considered a comprehensive diabetes care measurement, and really it's not. I mean, it's a lab test that you're testing on a diabetic without the outcome. But I agree with you, that it's one of many, but they're all screening tests. Like, for example, the medical attention in nephropathy, as a provider from the provider' perspective, I just think it's really important to perhaps link an actual diagnostic code for diabetic nephropathy with ACE or ARBS management, so the medication, the prescription data is there, the claims data,

the diagnostic code is there. Link those two together and create a HEDIS measure. So, that's just something that I wanted to throw out there.

CHAIR PINCUS: So, let me see if I could summarize. Yes?

MS. GIOVANNETTI: Just to clarify from NCQA, this measure, comprehensive diabetes care, is actually as a HEDIS measure is a collection of multiple indicators, including outcome, and testing, and all of the other ones. So, the name is perhaps misleading because we had to get each individual indicator NQF-endorsed, but it's combined with all the others.

MEMBER SIDDIQI: I guess my point is that it's not --- there are no --- not that I've been able to find. Like, for example, the medical attention nephropathy one is just asking for screening test for microalbuminuria. It's not linking that to the management of microalburminuria, which an ACE

or ---

MS. GIOVANNETTI: Yes, that's a good point.

CHAIR PINCUS: So, let me see if I could summarize. So, it sounds like that what might be a recommendation is that this current one be continued, the testing one, that we recommend that the addition of a control measure set at nine, and potentially changing the title of this one, so that it actually, you know, is more specific to what it means, understanding that it's part of a basket. But, specifically, that we recommend the first two things I mentioned, that we continue this, and we also recommend adding a control measure. Does anybody have any objection to that? Okay.

MS. DUEVEL ANDERSON: All right. We have an additional diabetes measure to discuss, number 0272 is a diabetes short-term complications admission rate. This is a PQI measure. We're going to go through four PQI

measures, and there's a common theme throughout that I'll get to, but it is connected to the question on diabetes.

Number of discharges for diabetes short-term complications. Per 100,000 members ages 18 and older, and it is --- does have specifications for the population level reporting. And the rates reported are at two different age groups, and there's an adaptation so instead of per member per month, it's 100,000 member-months. And that is reflected in the update of the specifications for the Adult Core Set. And it's a result of challenges determining eligible population. And states have been able to report it pretty widely, 23 states reported this measure, so overall that's a really good uptake. And the information for reasons why states didn't report it is because it wasn't identified as a priority for data collection.

CHAIR PINCUS: Any comments?

MEMBER ANDREWS: I do have one question here, again. Do we know what is the extent of these complications? Again, there is specific complications listed such as ketoacidosis, coma, et cetera, which are pretty significant complications. In this day and age, how frequently we see this?

MS. DUEVEL ANDERSON: No, I don't have that population information available. I'm sorry.

DR. BURSTIN: Fair amount, especially people don't have access to their medications, or particularly it's reflective of lack of access to regular care.

MEMBER ANDREWS: Yes. If it is still occurring in this Medicaid population to a significant degree then, you know, there is --- I wouldn't object to it. On the other hand, if it happens in 2 percent, you know, 3 percent of the hospitalizations particularly for that, I think there is other things we can look at.

CHAIR PINCUS: So, I mean, Helen, just one question. How --- what's the current length of time that a measure exists before it's re-endorsed?

DR. BURSTIN: Every three years. This is actually going through --- it just went through our ---

CHAIR PINCUS: So, presumably it was looked at in terms of whether there's a gap at some point.

DR. BURSTIN: Yes, and there continue to be a gap, as I recall. Again, we could pull that. This just went through our process again as part of our Health and Well Being Project. And, again, it's at a community level, so it's a little --- you know, it's per 100,000 so it's a little bit different than the usual, so the denominator is inherently created to have it make more sense at a population level. This isn't a provider measure rolled up. This truly a population level measure.

MS. LLANOS: I'll add that this is --- the PQIs are also being considered by the ACOs and a couple of the other innovations into our program, so it doesn't speak to the --- it's not listed under alignment, but it's certainly under consideration. And to channel a little bit about what Foster said before, the PQIs that were selected for the Core Set were really based on --- so you know there's lots more PQIs than what we've got in our Adult Core Set, and these were selected because they had from that Committee's perspective the ability to, one, represent where breakdown ambulatory care is happening as a proxy for care coordination, and it also represented the types of conditions that could be most impacted. So, there's a long-term complication that was not selected for that particular purpose.

CHAIR PINCUS: So, it seems to me that the recommendation would be to continue this. Is there any objection to that? Let's move

on.

MS. DUEVEL ANDERSON: A similar PQI measure, 0277, congestive heart failure admission rate. This percentage of the population with admission for heart failure. This is a population-level measure, and it's noted as an outcome measure. It's also in the Medicare Shared Savings Program.

The same adaptation is applied to this as the other PQI measure, where it reflects that per 100,000 member-months of Medicaid enrollees. It's reported by 23 states, so also a good level of reporting. And the updates to the adaptation will be recorded in the new Tech Specs manual. And some states did not report it because it wasn't identified as a key priority. Are there any questions or objections to maintenance of this measure in the Core Set?

CHAIR PINCUS: Okay, let's move on.

MS. DUEVEL ANDERSON: Another PQI measure, 283, adult asthma admission rate. This

is admissions for a principal diagnosis of asthma per 100,000, and in this case the member-months, and it's ages 18 to 39. It is an outcome measure, and it's reported for the population.

This measure is reported for the population that is specified in the Adult Core Set, and has the similar adaptation. It is reported by 23 states, and was not always addressed as a key priority as a reason that states did not report it.

CHAIR PINCUS: By the way, can I make a recommendation about when --- next time around when CMS gets feedback on this, that this item of information not collected because the measure not identified as a key priority, seems to be fairly meaningless, because the same six respondents seem to ---

(Off microphone comment.)

CHAIR PINCUS: So, we may want to get more specific about that, because it's hard to

imagine that adult asthma admission rate is not a priority. It's worth just rethinking the drop-down item. So, is there any reason --- anybody who objects to continuing this?

MS. DUEVEL ANDERSON: We have provided three alternative measures because of some feedback that was received in the state presentation. In the state presentation it was suggested that we look at the asthma medication ratio, and asthma and medication management for people with asthma. We can consider those measures, or we can maintain this measure in the Core Set, but we wanted to be responsive to the feedback from the states.

CHAIR PINCUS: So, can you say a little bit more about sort of what the problem was with this, as compared to the others; this being in some ways more of kind of an outcome measure?

MS. DUEVEL ANDERSON: I don't know that there was a problem with it, but it was a

suggestion that we look at the medication management for people with asthma. I think it came from Louisiana.

MEMBER SIDDIQI: So, in Illinois in our Bonus Program for the Fee For Service Program, asthma is one of them, so it is linked by whether or not they're on a controller medication, and they have the diagnosis of asthma and how often they refill that medication. So, I'm kind of curious to see, you said there were three measures that could be added or substituted. Could you just do a brief run through of what those three are?

MS. DUEVEL ANDERSON: So, there are alternative asthma measures. Again, this is C-- the primary question is whether or not the measure should remain, and if there is a better measure that would be available, would any of these three suit better?

So, 0548 is sub-optimal asthma control, an absence of controller. This is

reported in two different rates for patients ages 5 to 50-years old, and it's a pharmacy measure. And it's a health plan only, so this is a measure that does have a control aspect to it.

An alternative measure is 1799, medication management for people with asthma. This is a percent of patients 5 to 64-years of age who are identified as having persistent asthma and were dispensed appropriate medications with two rates, and the asthma controller for at least 50 percent of the treatment period. And the second is for 75 percent of the treatment period. It is also in HEDIS and the Health Insurance Exchange Quality Rating System. It's an ambulatory-sensitive measure, and reported for health plans and integrated delivery systems.

The third and last is the 1800 asthma medication ratio, percentage of patients 5 to 64-years of age that were

identified with persistent asthma and had an asthma controller, a ratio of controller medications for 50 percent or greater, so it's a similar measure, just not reported in two rates. And it has similar levels of analysis, the health plan and as applied to a variety of care settings, both ambulatory and inpatient, and long-term care, and it is in HEDIS.

CHAIR PINCUS: Jennifer?

MEMBER SAYLES: I just had two quick comments. So, the first was I'd be curious from NCQA the latter two are both NCQA measures measuring almost the same thing, so understanding one verse the other might be helpful. I think the idea of moving towards how you prevent asthma and sort of ambulatory-sensitive conditions and care versus an overall rate at a very high level at a population level, those are fairly different things. I mean, I think the other advantage, I think, to the latter two would be that their

pharmacy claims data which are pretty doable in terms of capture and other things, so I don't --- you know, there may be some merit to considering one of the latter two.

CHAIR PINCUS: So, any suggestions about how one would choose amongst these if we --- what criteria would we apply?

MS. DUEVEL ANDERSON: The reason that this is brought up as a decision point is because it was recommended by the State of Virginia to consider the asthma medication ratio, so I just want to remind everybody of that. And the recommendation did come from the State of Virginia.

MEMBER GESTEN: I guess I --- I mean, as I think about trying to decide, you know, what to do, I'm struck by the fact that, you know, not knowing what the data shows, you know, across states with the current measures, I guess I'm thinking about your question, Harold, and wondering so what is the criteria? I mean,

part of me would say, you know, on any given day, any given group can look at a set of measures and find them to be wanting, or change them, or come up with different combinations. But, ultimately, it seems like we're trying to understand whether the current measures are doing their intended purpose. And maybe I missed --- you know, maybe you went over some of this earlier today, at which point I apologize, but it's hard for me to understand whether the measure as it exists now gave information to either CMS or to the states to be able to, you know, there's still something useful about trying to improve quality. So, I certainly think there's other measures, and as people have hinted at, I think the goal is certainly to have kind of a nice matched set of measures on the process and outcome side that deal with different dimensions of quality, but I just --- I'm not sure how to answer your question, Harold.

CHAIR PINCUS: Can you say a little bit more about what --- I'm trying to recall what the Virginia objection was to the current measure.

MS. DUEVEL ANDERSON: I don't think it was an objection. I just think it was a suggestion to consider the additional measure, or ---

MS. POTTER: We can't hear you.

MS. DUEVEL ANDERSON: I think there was a --- it wasn't an objection, but it was just a request to consider an additional measure or an alternative measure that aligned with the measure that they were using in their state. So, there was not a huge challenge with reporting. It was well reported across the states, but there are other asthma medication measures, and it's for the Task Force to consider whether or not the measure that is currently in the set is sufficient. And if not, would you have any other recommendations?

MEMBER CHIN: The reasons Jennifer mentioned, I mean all three of the last measures seem to have a fair amount of face validity, so I'm wondering like in terms of deciding among those, start getting into practical issues like which measures have ceiling effects, which have trouble with implementation, coding and all in the different states and all. Whether that may answer the question for NCQA or for people's experience using those measures because face validity is ---

CHAIR PINCUS: I could see a rationale for having in some ways this sort of high-level outcome measure as well as sort of more of a process measure to understand what's going on beneath that, so I could see some value in that. But, again, I have the problem choosing amongst these without having some data about them.

MS. LLANOS: Right. So, I completely --- this is Karen. I completely agree with

Foster. I think we're asking a lot of the MAP in terms of giving us perspectives without the data behind it. This is part of our annual process that has to keep going, so I would say that since we don't have the data this year, you know, consider this as an annual process that will keep going on every year, and the data will get better.

I think the other thing I wanted to point out is that there's a cost to adding measures, and even removing measures. And that's not just to the asthma ones, because I have my own personal preferences on these, but I would say I think certainly states have invested the past two years in programming and costs as we switch, and as we learned on the kid side, it's given --- there's pros and cons to modifying.

I think the one comment I will make about asthma if you do consider making a recommendation about any of those additional

asthma measures, we have the Medicaid Management Asthma in the Children's Core Set and the aging just probably wide enough for both.

MEMBER SIDDIQI: Right. Which one is in the Children's Core Set, do you know?

MS. LLANOS: The Medicaid Management.

MEMBER SIDDIQI: So, it's the second one. Right? The second of the three that were presented, because I kind of like that second one the most.

CHAIR PINCUS: And it's also in the Health Insurance Marketplace, as well.

MEMBER SIDDIQI: Yes. This is the one that I was going to kind of advocate for potentially as being an additional one, but I understand your point about the cost issue, as well. And, again, it is asthma, but I don't recall now, was asthma listed as the top 10? COPD was listed in the top 10 for readmissions

by HCUP. So, I mean, that's something to consider. But the other point in this, so this does exclude COPD patients, as it states there.

MS. DUEVEL ANDERSON: And there is a COPD measure, as well.

MEMBER SIDDIQI: Oh, right. That's right, there's a COPD measure, as well. My thoughts on this was also, are we asking states to select 15? I'm assuming --- so, that was part of the grant program, that 15 were asked to be selected, because sometimes I wonder if like a state like Virginia would like that, or appreciate that because they're already doing it, although they like the ratio one better it sounds like.

MS. LLANOS: Yes, I think that's a huge important point to emphasis. So, the numbers that you see in terms of reporting this year, that will not be supported with grant funds next year because the grant ends. So, hopefully, our hope when we designed the grant

was that we would be building capacity infrastructure, but there's an annual cost to all of these measures, so just kind of keep that in mind. I think the term we used a lot was parsimony, so I think that's some of the things. I think Foster certainly pushed us to think about what were the --- what was the shortest amount of measures that we could do to try to get the snapshot, understanding that states can collect additional measures in addition to the Core Set.

CHAIR PINCUS: So, maybe ask Doris and Marc, just your perspective on this from a state point of view of having --- were we to recommend adding this, what would that mean to you?

MS. LOTZ: Well, just to speak to the measure as it exists right now, we did it. It's easy to do. Remember easy is a big priority. It's an outcome measure, that's good, too. We have a rate, I have a rate for New Hampshire,

it's 14.7 per 100,000. It's meaningless to me as a single data point, so to kind of amplify what Foster was saying, and Karen, as well, I think before we get rid of it we should see a couple of data points to put it in some kind of perspective. I'd love to benchmark it and compare across states, in case I haven't mentioned that yet. But right now it just sort of sits in isolation, and if we change it, it will have never been of really any ---

CHAIR PINCUS: What about the notion of adding the medication management one? Would that be sort of an added burden, or would it be something that you would see useful combined with the other one?

MS. LOTZ: It would be useful. The comment was made by Jennifer, I think, and that's something that can filter into other conversations. Pharmacy data is easy to get, you know. It's readily accessible, it's very specific for the most part, and it's easy to

work with. So, from an ease point of view, you know, it certainly looks like it ought to be relatively easy to do. I like that it matches up with the kids set, as well, because it's nice to follow these folks over time and to think where there's no uniqueness to an age population, let's look at it across many ages because our interventions are likely to be at various providers who will be looking at, you know, various ages, as well. So, from fitting it into a system and effecting some kind of change that makes a lot of sense to me.

CHAIR PINCUS: Marc, I saw you nodding your head in agreement there.

MEMBER LEIB: Yes, in Arizona we use this measure on children, not so much on adults, but on children. We measure that they get controller medications at least twice as much, dispense twice much of the controller versus the rescue to really try to emphasize that that's what we're pushing providers to do. And

we undertook that about eight years ago, and were really successful in changing prescription patterns, and we now periodically monitor.

CHAIR PINCUS: So, would the recommendation be that we continue the current one and add the medication management one? Any objection to that? Okay. Let's try to do one more measure before we leave.

MS. DUEVEL ANDERSON: So, that was --- I was showing the break that's coming up, the break in the actual grouping. CRS 275 is the COPD admission rate, it's also a PQI measure. I think that this is a similar question about the per member per month versus the population. It is an outcome measure reported at the population level.

It was well reported by 23 states, and there was an update to the specifications as was previously discussed, and is reported in two different ages. Primary reason for not

reporting was not being a key priority. Any discussion or concerns about maintaining this measure in the Core Set?

CHAIR PINCUS: So, the recommendation would be to continue this. Any objection? Ready for public comment?

MS. DUEVEL ANDERSON: So, we're going to go to public comment at this time. Operator, could you open the lines, please, and we can take any comments in the room.

OPERATOR: Yes, ma'am. At this time to make a public comment please press *1. There are no public comments at this time.

CHAIR PINCUS: Any comments from the room? Okay. So, I suggest we adjourn for the evening. And what time tomorrow do we get together?

MS. DUEVEL ANDERSON: We're going to bump it up to 8:30. We have some measures that we didn't get through this afternoon, so we had great discussion and a lot of really great

content, so 8:30 tomorrow morning. There will be breakfast available.

MS. LASH: Thank you, everyone, for your hard work.

MS. DUEVEL ANDERSON: We're doing that because we really want to push to end on time at 2:30 because we understand everyone will have flights, and other obligations on a Friday, a beautiful summer afternoon in Washington, D.C.

CHAIR PINCUS: And we also want to remind people about where the dinner is.

MS. DUEVEL ANDERSON: DC Coast, so we'll be there at 6:00. It's at 14th and K. we hope that you all will join us and invite anyone, and if you have traveling companions they're welcome, as well. Thank you.

(Whereupon, the proceedings went off the record at 5:09 p.m.)