NATIONAL QUALITY FORUM

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MEASURE APPLICATIONS PARTNERSHIP
MEDICAID TASK FORCE
IN-PERSON MEETING

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FRIDAY, JUNE 6, 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 8:30 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, Disparities
FOSTER GESTEN, MD, FACP, National Association of Medicaid Directors *
NANCY HANRAHAN, PhD, RN, FAAN, Care Coordination
MARC LEIB, MD, JD, 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, Mental Health

NQF STAFF:
HELEN BURSTIN
MEGAN DUEVEL ANDERSON
LAURA IBRAGIMOVA
KAREN JOHNSON
SARAH LASH

ALLISON LUDWIG
ALEXANDRA OGUNGBEMI

ALSO PRESENT:

KATIE ADAMEK *
SEPHEEN BYRON
LAURIN DIXON *
REBEKAH GEE
SARAH HUDSON SCHOLLE*
JULIE KUHLE *
MARSHA LILLIE-BLANTON
ALICE LIND *
KAREN LLANOS
DORIS LOTZ
D.E.B. POTTER
MARSHA SMITH

* present by teleconference

A G E N D A

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

8:45 a.m.

CHAIR PINCUS: So who's on the phone?

MS. KUHLE: Are we on the line?

CHAIR PINCUS: Who is that?

MS. KUHLE: Julie Kuhle with Pharmacy Quality Alliance.

CHAIR PINCUS: Okay, thank you. Anyone else on the phone?

MS. DIXON: Laurin Dixon with the Pharmacy Quality Alliance.

CHAIR PINCUS: Thanks. Anyone else? So we have a couple of new faces around the table, so maybe we might just go around again just to have everybody briefly introduce themselves.

I'm Harold Pincus from Columbia University and New York Presbyterian Hospital.

MS. DUEVEL ANDERSON: I'm Megan Duevel Anderson, project manager and NQF Staff.

MS. LUDWIG: Allison Ludwig, senior project manager, NQF.

DR. BURSTIN: Helen Burstin, NQF.

MEMBER HANRAHAN: Nancy Hanrahan, University of Pennsylvania.

MS. LOTZ: Doris Lotz, Chief Medical Officer with Medicaid, New Hampshire.

MEMBER LEIB: Marc Leib, Arizona Medicaid Program.

MS. JOHNSON: Karen Johnson, NQF.

MS. LILLIE-BLANTON: Marsha Lillie-Blanton, Chief Quality Officer for the Center for Medicaid and CHIP Services and Director of the Division of Quality.

MS. SMITH: Marsha Smith, Medical Officers, CMS Center for Clinical Standards and Quality Measurement Health Assessment Group.

MEMBER SULLIVAN: Ann Sullivan, Commissioner of Mental Health, State of New York.

MEMBER SAYLES: Jennifer Sayles,

Associate CMO, L.A. County Department of Public Health.

MS. GEE: Rebekah Gee, Medicaid Medical Director, State of Louisiana.

MEMBER SIDDIQI: Alvia Siddiqi, Medical Director of Illinois Health Connect PCCM, and I'm representing the American Academy of Family Physicians today.

MS. LLANOS: Karen Llanos, I'm a Technical Director at the Center for Medicaid and CHIP Services.

MS. LASH: I'm Sarah Lash, Senior Director, NQF staff.

MS. OGUNGBEMI: Alexandra Ogungbemi, NQF Staff.

MS. IBRAGIMOVA: Laura Ibragimova, NQF Staff.

CHAIR PINCUS: So we had a remarkably productive day yesterday. Oh, Cindy, sorry.

MEMBER PELLEGRINI: Sorry, I was

getting my coffee. Cindy Pellegrini from March of Dimes.

CHAIR PINCUS: So I thought we had a remarkably productive day yesterday. Really had in-depth discussions, covered a lot of ground. And, really, I think we all got a much better understanding of the program, the intent of the program, and how it's been operating and the responses from the States and the experience so far.

And I think one thing that sort of came very clear to me is that this is really kind of the very beginning of, it's almost like a pilot program to sort of see how this works. And it's really a period of extensive learning.

And it seems as if what's happening is that CMS and the States are learning a great deal. And it's really working in many ways the way it was intended to actually be a period so that we can try things out with no risk and to really learn how to do this well.

And the ability to have this kind of back and forth where we can re-look at how things --- how different measures were chosen, how we can refine it. I think is exactly the right way to go.

So Sarah's going to review what the highlights were for the previous day just to remind ourselves, and to also inform the people that weren't able to be here yesterday.

MS. LASH: Okay, so yesterday we had quite a bit of discussion. Keeping in mind that the intent of our measure review is to help CMS achieve its goals for this Medicaid adult core set and the associated reporting program.

So there was a lot of discussion about strategic issues, about how the program should be positioned and its intentions. How to encourage you know, as many States as possible to participate in reporting. And to increase the number of measures reported by each State.

So feasibility, feasibility, feasibility. There was a need for ongoing technical assistance support from CMS in refining technical specifications to enhance the ability of States to be consistent in their approaches to reporting with sort of the goal in mind that people would like measures to be used for both internal quality comparisons to one's own State over time.

And also external comparisons, that there is a desire, as Doris strongly advocated, for comparing results across States and sharing best practices about who is being able to show success and improvement in quality measurement. And then giving the other States the ability to learn from leaders.

We heard directly from a number of States who discussed challenges they're facing related to diverse population, service through Medicaid, various programs being implemented and many different types of benefit arrays and

program structures that they're operating within. We recognized that there is quite a significant burden of reporting when States have small and/or strained budgets.

Dollars spent, you know, on data management and things like that aren't spent in other areas. So to really keep in mind, especially when looking at measures that require chart review, what we're really asking when we're asking for those measures.

And also, if you look to alignment with other State and Federal reporting programs like meaningful use, Medicare Shared Savings Program, Medicaid Health Homes demonstrations, things like that. You get sort of two for one, or three for one types of fulfillments of those requirements.

And then we sort of have this underlying tension of fit for purpose where we want to use standardized measures across programs and across states to enable

comparisons, like the HEDIS measure set, but also the need to have measures that are fitting the context of Medicaid and it's particular benefits and other design features.

So the group spent a significant amount of time reviewing measures in the core set. And we documented some great feedback to those measure stewards about updating them in small ways to being more in step with current guidelines.

We recognized the interdependency of the adult measure set with the children's set. And there's need for a more deliberate crosswalk of those measure and measurement opportunities as we track individuals from one age group to the next in Medicaid.

So also, some bigger questions raised about the future of measurement, the first being what's the best approach to risk adjustment. I think that's possibly not a question that we'll be able to solve in this

room today. But you have some good parameters and recommendations that can be further explored.

Again, really noting the collection burden in keeping in mind the mode of data in our recommended measures that we want to be forward thinking, and capitalizing on electronic sources like registries and electronic medical records and exchanges. However, that might not reflect the current state of practice in much of the country.

Also to look to measures that can show a return on investment and really drive quality improvement activities at the local level. And to find a way to better incorporate the beneficiary perspectives about what quality means to the individuals receiving the care and benefits. And is the quality measurement reflective of their underlying goals.

Does anyone what to add any things

Harold?

CHAIR PINCUS: I think one thing is that really became clear to me is how we need to think of this in terms of creating sort of a balanced portfolio. That given the diversity of the heterogeneity of states and how the operate the different distribution of managed care versus fee for service, the different eligibility requirements, the different populations, and so on.

You know it's been very hard to have this measure set be all things for all states for all people. And that to think of it terms of having a balance portfolio, that you know to strive so that, for many of the measures, that it would apply to all states and that they would all be able to report in a similar way.

But to realize also that there -- we should have some that are more cutting edge, that it would be where states can have -- that have unique capabilities might be able to

report. And that would push things forward.

To have a balance in terms of thinking about structure process and outcomes, have a balance between just thinking about obviously the different sort of content areas, the different conditions. Although with an emphasis on those conditions where A, and this came up in a discussion I think we're going to give a slide on that, of the most frequent causes for readmission, for example, as being something that would be an area to focus on.

And that also balances across different other categories in terms of chronic diseases, acute diseases, different populations of behavioral health measures, measures that might be more relevant for pregnant women and so on.

So to keep the notion of balance in mind. And that we don't have to get perfection for everything for everybody.

MS. LASH: And to follow up on that,

I ask that we sort of look at the relationship of the adult core to the children's core set. We've used arrows to indicate those measures in the children's core that are related to our measures in the adults.

So the chlamydia screening measure, follow up after hospitalization for mental illness. Medication management for people with asthma was a recommended addition yesterday. And the timeliness of prenatal care is sort of the other side of the coin to the postnatal care in the adult core.

So many of the other measures wouldn't be appropriate to include in the adult core because of their pediatric focus. But I think, you know, with potentially four measures carrying through, that's a nice synergy.

With that, I think we're ready to begin today's measure by measure review. We're going to start with the middle chunk of measures that had about 15 or so states

reporting each.

So significant uptake, but by no means everyone and explore some of the feasibility challenges and consider whether those measures should be retained to enhance the stability of the set over time or if we need to look at some alternative measures.

So Megan will lead us through this section.

MS. DUEVEL ANDERSON: So just to remind everybody the structure of how we are going through the measures. We'll consider this section of measures because of their overall level of reporting in the first year of this program.

And these measures have, what we call, kind of moderate levels of reporting. And the question of the task force isn't very different from what the question was yesterday.

Is the question -- are the measures the best measures, and should they be

maintained? And if not, by exception, are there suggested changes to the application of the measures or any suggested alternative measures.

You'll see a variety of different issues in these measures, but a lot of them are addressed through technical specifications and updates to the measures.

We'll also review some of the measures by kind of topic area. So as we saw yesterday, the measure that we're going to look at next is a mental health and behavioral health type of measure.

There are other related measures in the set. And we've adjudicated some of them already and we'll actually go through some of the others as well later this morning.

So just to remind everybody, these are kind of a moderate level reporting. We're going to talk about behavioral health measure. These are some other related measures in the

set.

Okay, so the first measure is 1879, adherence to anti-psychotics for individuals with schizophrenia. We've talked about the value of this measure a little bit yesterday already, but this is an NCQA measure and NQF endorsed. It is in HEDIS. It is actually an ambulatory-sensitive measure. And it is the percentage of individuals within the measurements period with schizophrenia or related disorders that have been prescribed an anti-psychotic medication with adherence to the medication as defined as a portion of days covered of at least 80 percent.

It is collected -- endorsed to be collected through claims or also electronic data from the pharmacy and it=s a process measure.

The implementation feedback that was received from the states, 15 states reported this measure, all using the same

specifications. It was reported for two different age groups, and the question about coding was received but a very nice simple response, as was provided by the technical assistance provider, and that was a simple link to a list of drug codes.

Fourteen states did provide reasons that they didn't report it, and it was because it was not a key priority.

CHAIR PINCUS: This one section, I think it says it -- I think it doesn't require medical record review. Yes. So that's --

MS. LASH: I think that might have been reported as a challenge, but it's not maybe actually reflective of the way the measure is designed.

CHAIR PINCUS: Yes, and it may be a state that doesn't have a linkage to pharmacy claims.

MEMBER SULLIVAN: Question. Is there something -- is there something different

about the way this would have been collected, versus the antidepressant, because the antidepressant was picked up and that was in the first group right? That more states picked up antidepressants?

I'm just curious, is there something different in the way you collected it? Because if they could pick up the antidepressants, I'm just curious why they wouldn't just do the anti-psychotics.

CHAIR PINCUS: I think it has to do with the antidepressant measure has been around for a long time as a HEDIS measure. I do not believe this is yet a HEDIS measure.

(Off microphone comment.)

CHAIR PINCUS: This is now a HEDIS? But it's relatively recently that it's been.

MS. LLANOS: This is new.

MEMBER SULLIVAN: Oh, it's new, so I guess it would have required more work then to put it in in some way.

CHAIR PINCUS: Yes, I think that's the reason that this is, that there's been less experience with it in HEDIS.

MEMBER SULLIVAN: Okay.

CHAIR PINCUS: But maybe it conforms with a -- actually I co-chair the medication management endorsement committee for NQF, and in that we sort of laid out kind of best practices for medication management measures. And this conforms to that.

MEMBER SULLIVAN: Okay, so it would be good if we you know, encourage people to put it.

MS. LLANOS: So I can just add that it's -- so we know states have limited budgets and they have to make trade offs, so if they can pull out some of these, I wonder if maybe the 0418 got more uptake because it's been around longer and maybe we're having more of the population. It's hard to know why one measure was picked first over another.

CHAIR PINCUS: Did they -- Doris or Rebekah or Mark, any thoughts about, is there something special about this that makes this different from the other medication management stuff?

MS. LOTZ: Yes, the data aggregation is a little more complex in that you have to look at the medical claims for things that have been billed under J-codes, as well as the pharmacy claims. So your injectables for example might be billed under the J-codes.

And that would be in the medical data set, the administrative data set. But also, for you folks at the agency and at community mental health centers, the funding mechanisms may be difficult.

And they may be working under a different budget from the -- you know from your Office of Behavioral Health, or whatever you might have. And so that data may not be as easily accessible.

Not -- in New Hampshire, not for the point of sale, you know the outpatient pharmacy claims. We do see all of that. But what's done within the CMHC, the community mental health center, is something that we don't have access to.

And so it looks like it's oh, it's just you know an ICD-9, or some way to find the folks with the diagnosis and then you narrow that to pharmacy claims. Not so in this regard.

The pharmacy is sort of all over the place. And you have to coordinate multiple data sets and you have to dig out the one that you may not have the easy access to.

MEMBER SULLIVAN: Would it be more difficult though to do this than the antidepressant? To do this and just a caveat, it=s in the antidepressant, because that's what I was wondering about.

MS. LOTZ: Yes. Again primarily

because the injectables, and because you know, with the anti-depressants, the vast majority of that is being practiced in primary care.

MEMBER SULLIVAN: I was just wondering if it was including injectables. It's a little more complicated.

MS. LOTZ: Yes. And the severity of the diagnosis puts people at different points of serv -- you know, places where their site of service is.

MEMBER SULLIVAN: Okay.

CHAIR PINCUS: Yes, actually I sort of my own personal experience with this is that I for many years I was a psychiatrist one night at week at a community clinic in Alexandria, Virginia. And Virginia provides, actually, for medications for people that have been hospitalized in the public hospital.

And so it comes through the state, not through a regular pharmacy. And the record keeping is at a -- and that applies to both the

injectables and the pill form.

And so I don't know many other states had some rule like that. But you know, particularly this is unique to the injectables.

Any other state experienced at that?

MEMBER LEIB: I'll just echo what was said. Our behavioral health department is actually a separate agency, not just a separate division within the access program. It's a whole separate agency.

They are responsible for all the -- taking care of the severely mentally ill, which would include all the people who are on anti-psychotics. And this is a difficult data collection point because it's completely different systems.

MS. GEE: From our standpoint this is a very important measure because this is a population at high risk for readmissions and not adherence, non-adherence. And so the

other issue is also that we have segregated managed care into behavioral health and physical health.

And this measure is important because it gets at the coordination between those two. And so it might be somewhat challenging, but I think it's a very important measure.

CHAIR PINCUS: And I can also say from the work -- some work that we've done in an evaluation of mental health services within the VA, comparing it to private sector health plans, that nationally, it's performance is really poor. It's about 35 percent.

MEMBER SULLIVAN: So I think it is a very important measure. But it's also -- and I guess the data we're getting on antidepressants doesn't include a segment population either. Because there's those depressed patients that sit in the same community mental health centers as -- in the

same bucket. So it's just interesting.

CHAIR PINCUS: That's because a lot of the antidepressant stuff is in primary care.

MEMBER SULLIVAN: Yes, but what if it isn't, it's not in the bucket, that's all I'm saying. It's out to, you know.

CHAIR PINCUS: Yes, no, I think that that's you know, again it's a chunk of people who are seeing a specialist have to list the medications.

MEMBER SULLIVAN: Not in the antidepressant table.

MS. LOTZ: You're going to get your antidepressants from your pharmacy, not necessarily from your you know, primary care provider. Maybe you'll start with a sample pack. Maybe you know, maybe they've got a small dispensary, but by in large, they're going to get that from a retail pharmacist, the antidepressants. So we'll get that data, it's just where the data flows.

MS. LASH: Please use your microphone. Please use your microphone.

MEMBER HANRAHAN: So this is a conceptual question for the panel. Adherence to anti-psychotic medications, is this really a measuring adherence or is it measuring a management of anti-psychotics?

Because you know, from my experience, adherence to anti-psychotics, the only way you can get really good data about that is if you give somebody a pill and watch them. I mean that's the reality of it, if they have true schizophrenia, or serious symptoms.

But adherence to anti-psychotics, you know, is hard to balance that.

CHAIR PINCUS: So I mean the reality is that you know, you really can't measure adherence unless you have direct observation. Even if you've had you know, pill boxes that have an IT component to be able to know whether they've been opened.

But you know, several years ago, there was at NQF, an endorsement committee focused on medication management and Helen could make a comment on that.

And we, I was on that, and we looked at the multiple different ways by which quote, adherence was measured. And think of this more as opportunities for adherence you know rather than direct measurement of direct adherence.

And we recommended sort of a more standardized way to do that, and you know, to measure that in terms of days covered.

MEMBER HANRAHAN: So, Harold, it is a dissonance conceptually that we can't really measure adherence but we could measure that that was managed.

CHAIR PINCUS: Well, we're measuring that in fact a prescription was picked up.

MEMBER HANRAHAN: Or dispensed.

CHAIR PINCUS: Or dispensed, yes.

MEMBER HANRAHAN: Correct.

CHAIR PINCUS: Yes, that the pills have been dispensed. So it's --

MEMBER HANRAHAN: Which indicates that there's some management happening.

CHAIR PINCUS: Well, yes.

MEMBER HANRAHAN: Oh, there's lots of reasons why people don't -- would go back from work --

CHAIR PINCUS: Right, this is not specific to schizophrenia. I mean this is across the board that this is the same for everything, whether it's hypertensive meds or anything else.

MEMBER HANRAHAN: Well I just think there's a dissonance conceptually with this measure.

MEMBER SAYLES: I could just add that you know, it is a standard approach. And you know Medicare has this in their Part D ratings.

But I think from a Medicaid perspective, I could say that when we look at our rates, both in dual-eligible and the Medicaid populations in Los Angeles, just the fill part, just the days covered, is really low. And it's a real issue. Transportation barrier and --

So to your point, your right, it's not necessarily measuring behavioral aspects to adherence, do I take the pill every day. But in terms of kind of identifying where there are gaps in you know basically adhering or getting access to a medication and coverage for medication to treat a clinical condition, I would just say that there is in this population, this is actually a big area. Even though it's not as far downstream as we might like.

MEMBER HANRAHAN: I totally -- I couldn't disagree with, I don't disagree with that. I just, when you put adherence, the word adherence in there, in the measure, this is

management of anti-psychotic medications. I think that's what we're really doing here, which is important.

But to adherence what there is some implications there that the patient is taking the medication.

MS. GEE: They have different connotations. When I hear management, I think are they being appropriately prescribed? Is the patient being seen in the office?

When I hear adherence I think is the patient getting the medication. And there's been a lot of literature on this, it's not perfect. And people have done things with oral contraceptives for example putting computer chips in it and every time the pill pack opens.

So you can get very specific with it. But if people are going to go through the trouble of going to get a refill, unless it's a VA where they're regular and they just get mailed, and that's a harder system to know, if

it's just an automatic pilot.

But if you actually have go get it, that's pretty good indication you're using it. And there's a large body of literature on adherence, you know, just that word, it's kind of like unintended pregnancy, it has -- it's not a great, maybe it's not a great terms, but there's certainly a lot of utility to it.

CHAIR PINCUS: Doris, do you have a comment?

MS. LOTZ: Building on the complexity, and again, as long as these things are bound, not to discount the merits of it, or the importance of it, of you know, making sure that folks are taking their meds. This is a real high bar to calculate.

Just on the long acting injectables, calculate the number of days, count for the numerator, for the long acting injection, using the days supplied specified in the table. For multiple J-codes for the same

or different medications on the same day. Us the mediation with the longest day supply for multiple J-codes or NDCs on the same or different medications on different days with overlapping days supplied. Count each day for the treatment period, only once for the numerator.

That's one of six boxes. And these are -- you know these are analysts that are not clinical And they see something like that. And I can't sit there with them and pour through this you know, every data element for the hundreds of -- yes, hundreds, hundreds of patients.

And we're a small state. It's just a very challenging thing to try to calculate.

MEMBER SULLIVAN: Perhaps if it is that complicated, then maybe we need to look at that part of it? I don't know, I mean I realize how you measure injectables is a question. But maybe they could be simple -- all in the same.

Because I think there's a reason people didn't pick this one up you know. And I do think it's very important, that why I was asking the question.

CHAIR PINCUS: On the other hand, 15 states did report it. So let me make an assertion. I think that there's --- just to summarize --- I think there's agreement that this is an important measure, and that we should give feedback to the measure stewards that is, if there's a way to make this less complicated and to sort of standardize it, so it's easier for states to program, that that would be our communication. Is there any objection to that?

Okay, so why don't we move on to the next one.

MS. DUEVEL ANDERSON: So now, again within moderate measures, we're going to look at two measures that address chronic disease and care coordination issues.

There's 0018, controlling high blood pressure, and on also the adult BMI measure. We previously discussed the measures below on the section.

Okay, the controlling high blood pressure measure is an NCQA endorsed measure that is in HEDIS. And it's also in the exchanges. This is the percent of -- I'm on the wrong slides. I'm on the wrong slides. It's hard to read no matter where it is.

There were not enough patients 18 to 85 who had a diagnosis of hypertension and who's blood pressure was adequately controlled with a less than 140/90 during the measurement year. There are some exclusions for ESRD and pregnancy, but also non-acute inpatient settings.

And it's identified as an outcome measure. It's ambulatory sensitive and has both administrative claim, but also electronic clinical data and medical record as potential

sources for the data.

It was reported by 15 states, and there are two different age rates that were available. There were no challenges reported with the use of this measure. However some states did not report it because it requires a medical record review and wasn't identified as a priority.

So are there any questions or concerns about the application of this measure to control high blood pressure in the adult core set?

MS. GEE: It would just be nice if you had integrated medical records and you could do quality reporting. I mean in the future we will be doing that, so in the present it's just a difficult measure because of the chart review necessity.

CHAIR PINCUS: I would actually be interested if any of the states that did report and collect this and see how they overcame some

of the barriers. Do we know from the experience that the communication that CMS has had or that Mathematica had in the states that were successful in reporting this?

MS. LLANOS: So it is just a matter of paying for a record review. It's a hybrid measure, so I think it's just a matter of how much resources the states had. And I can say that this is probably the one where we got the fewest number of questions related to that if any.

And then I think the other piece to note is that this is the measure that's been identified by the Million Hearts Campaign, which is the National department reducing heart attacks over a number of years.

So this is -- and that piece wasn't listed under the alignment, but it's -- and it is a huge department push to use the same measure across all barriers and agencies.

MEMBER ANDREWS: Yes, I was just

going to point out again that unfortunately this is a very important measure, simply because it impacts conditions that, again, most if not all of the population has. And it ties to a lot of the cost that no matter what age you are, it.

At the same time though, two things is the issue of medical record review. Additionally, it's the issue of the reading that needs to be reported, which again you can be well controlled during the year, and you're a little upset or tense when you see your doctor or whatever on the last visit, and your reading is high, which can happen.

So there are some challenges with this measure, but I still think it is an important measure to consider.

MEMBER SAYLES: I would just add, it's clearly an important measure and it sounds like very aligned with where CMS is going in a lot of, you know, sort of nationally where

things are. Having had experience with the measure myself, I would say that I mean that it's heavily hybrid. It's all chart abstraction. You just don't get this information through any administrative claims.

And the other thing that you know, as George points out, the other issue, it's one reading, and usually your most recent reading is at the end of the calendar year, which is right around the holidays. And you -- it's this kind of cyclical --- you know I just, when I look at the you know, our charts that are added, and I sort of wonder what are we really reflecting here because this is -- so anyway, it's just that a technical point.

MEMBER ANDREWS: So again, a recommendation. I mean as physicians treating patients, I mean if anybody came to my office three or four times in a year, and their blood pressure readings were good except the one, you know.

So maybe the steward can consider redefining what that is. An average, or if you're going to do a medical record review, you may as well capture a few readings that you have a sense of whether it is controlled or not.

CHAIR PINCUS: Any other suggestions in terms of -- oh, Sarah, you had something?

MS. BYRON: So I believe there were suggestions about adding age. Was it around adding ages to this?

MS. HUDSON SCHOLLE: So right now, the way the measure works is you choose the most recent blood pressure in the record. And I understand your concern that at any given visit, that it could be abnormal.

But I think that it's a little unusual in a clinical setting for people to take multiple blood pressure readings on the same day, and record the lowest. So the lowest recorded on that would be the one that is used,

but it is the most recent. And that's just the way that what we did to try to standardize which blood pressure, because we had to say something about which one. So the most recent one would indicate whether it's in control at the end of the year.

MEMBER ANDREWS: Yes, but in a clinical setting, if you started treatment with an anti-hypertensive with every patient that happened to have a blood pressure of 144/92 on the first time that you saw them, just because that's the one reading that you have, it would not be appropriate.

MS. HUDSON SCHOLLE: So you would not, that first reading, would not get someone into the denominator, if I'm understanding you. They have to have a diagnosis, a preexisting diagnosis of hypertension.

So that the diagnosis of hypertension has to occur either before the measurement year or in the first half of the

measurement year. Then we take the most recent blood pressure.

So it's not going to be just one blood pressure that's out of range that's going to get you into this denominator.

MEMBER SIDDIQI: So I just think in terms of a technical standpoint, this is really challenging if you're talking about doing a chart review on all of these patients. But if there could be some guidance where you could do a sample chart review of certain select number.

And then sort of some guidance on what that number would be based on analytics, that may help states to probably report this where their chart reviews would be sort of limited rather than every single patient in that age group range.

And then the second point was I think you did mention the age part. And I do think, and am kind of looking at my cardiologist friend here, as well as a colleague, I think

there are some newer guidance and evidence that we do not want to totally control the blood pressure so in the elderly population. So we may want to change that age range and maybe match it more to what states are reporting on other age ranges as well.

CHAIR PINCUS: Is that something that --

MS. HUDSON SCHOLLE: Okay, so I was just going to get to that. So first of all, the way that the specifications read, it does ask to take a sample of patients. And the sample is 411.

And so it's 411 patients. And I do understand from states that's a large sample, and that's expensive. But as someone else noted, it's the only place to get the blood pressure results is in the chart.

This measure has been -- there are changes that have been recommended to this measure that will appear in HEDIS 4-20-15, that

do have different specifications or different thresholds depending on age. So for patients age 18 to 59, the blood pressure control is less than 140/90.

For patients age 60 to 85, with a diagnosis of diabetes, the blood pressure is less than 140/90. And for patients age 60 to 85 without diabetes, the blood pressure is expected to be less than 150/90.

So that change to the specification was just approved last month. And it will be published shortly.

CHAIR PINCUS: So let me see if I can summarize. So it sounds like people obviously think this is an important measure to report, even given the additional cost. And that there probably ought to be some mechanism I guess they -- any kind of mechanism by which this will be updated based upon the NCQA revision of it.

And I assume that then it's passed

along as a -- for the state reporting program.

MS. LLANOS: It does, I mean Sepheen and I were talking about this yesterday. I think it's -- they're talking about HEDIS 2015, where in HEDIS 2013 for the tech specs right now. So we're always going to be a year or so behind.

But the goal is obviously to align with the HEDIS is going to reflect the most important.

CHAIR PINCUS: Any objection to moving ahead?

MEMBER CHIN: I'm just going to point one more thing. It's also from a developmental standpoint, it makes a lot of sense to have this measure in that if you're going to try to start pushing the envelope with more medical record collection, especially with the MR penetration, blood pressure's got to be one of the relatively easiest ones to think about solutions to.

And so there's a lot of reasons for having this in.

CHAIR PINCUS: It's a number. Okay, Doris?

MS. LOTZ: Just one quick reminder about this measure and that also in your summary statements, Harold where we talked about consistent age spans that would be so helpful to states.

Nothing against this measure, but it does have yet another age span with a less then 59, 60 to 85 and then you know, with and without out diabetes. I'm think oh gees, you make that much difference between 60 and 65? Couldn't we standardize those age bands. It would make it so much easier for the analysts.

CHAIR PINCUS: I think of the issues is that the specific guideline recommendations have a specific age. Cindy?

MEMBER PELLEGRINI: Just a question, kind of bigger picture. Looking at

this, it's making me realize that perhaps not all chart reviews are created equal, and that that's something to keep in mind on burden. And so this -- my question is, correct me if I'm wrong.

I understand there's a certain basic level of burden, there must be to putting together the team to do the chart reviews, to actually obtain the charts. And to set aside the time to do them.

But it seems like there is a qualitative difference perhaps between something where you're just looking for the reading and then record that, versus something like the early elective deliveries chart review, where it actually probably reading much more of the record and it's exercising some level of clinical judgment. Is that accurate?

MS. GEE: Just wanted to say but we made a decision that that we were going to try to realign some of our resources in the Office

of Public Health and train our public health nurses who were doing fewer clinical activities, to do chart review and be engaged in quality improvement.

And so for the initial period, the cost would have been the same no matter what type of chart they were looking at. But I agree with you that a lot of this can be done by a fax, or just having a provider send a number in, and it's a lot easier if it's one single field, then if you have to do a comprehensive look back.

So I agree, I think it would be easier. And just a question, is there any state that's able to use medical records through Medicaid reporting? I know Maryland is very far along in terms of having an HIE, but are we aware of any state that's able to use EMRs for reporting?

CHAIR PINCUS: I don't know if you can say exactly what numbers. But we know that here's I think probably small states that can

be done. Not a large.

MS. GEE: But it would be nice to figure out what they're doing and share it with others. If they're able to do it, I would love to know how. So that would be a good exercise.

CHAIR PINCUS: Marc and then let's move on.

MEMBER LEIB: Just to echo a theme of not all chart reviews are created equal, it depends on how you're program is constructed. If your Medicaid program is one in which patients are seeing primary in a safety net situation like FQHCs or something like that, then maybe you've got a record that includes a lot of things in one place.

We don't have -- we don't utilize FQHCs very much in Arizona. Our members are integrated in the same doctor's offices that I go to.

So when you walk into a physician's office, you don't know if it's a you know,

BlueCross/BlueShield, Medicaid/Medicare, except for the color of the hair. But you really can't tell the difference.

And so for us, our members they have five, six, seven different physicians for various problems, seeing specialist and everything else, all in different locations. How do we figure out which chart we're going to pull to review to do a chart review for this? It's going to be very complex type of thing, which is why the hybrid and the chart review methodologies are very burdensome for us and our system.

CHAIR PINCUS: So let's move on, next one.

MS. DUEVEL-ANDERSON: So the next measure is adult BMI assessment. This measure is not currently endorsed. It was withdrawn from consideration for endorsement.

And we've heard from the steward that they intend to advise and re -- revise and

resubmit, and it's the percentage of Medicaid enrollees 18 to 74 who have an outpatient visit and who's body mass index was documented during the measurement year, or the prior year.

It does exclude patients who are pregnant. And it has both administrative and electronic and paper medical record data. It is aligned with HEDIS and the Health Insurance Marketplace Quality Rating System.

16 states reported this measure, and there is a challenge we have talked about already extensively this morning, about data source and the burden of collecting hybrid measures. The concern is that administrative data alone, does not accurately report the BMI because of the codes are not always recorded. So it does require a hybrid specifications to address that under-reporting, which is more costly and burdensome.

Several states did not report it, because it was identified as a key priority.

MAP made a recommendation on this measure in the fall 2003 review. And recommended that the measure should be updated or replaced with an endorsed measure.

An alternative was identified measure number 0421, preventative care and screening for BMI screening and follow up. This was identified for its merits, and it also complies with the current USPSTF task force recommendations.

So also 0421 is an administrative or electronic medical records. And was identified for feasibility issues.

MS. LLANOS: Megan, just to clarify that NCQA wants admin or hybrid as well, it's not both.

MS. DUEVEL-ANDERSON: So this is the slide for 0421, preventative care and screening for screening and follow up. This was an NQF endorsed measure. It is reported within normal parameters. And it was seen as

really important because of the screening and followup component in the previous review.

It is not dramatically different in kind of the data source in that they're both process measures. So I don't know if the group wants to discuss maintaining the BMI measure, or supporting the previous recommendation to use 0421.

MEMBER SIDDIQI: So I recommend using 0421. It's definitely more meaningful to see that a plan -- it's actually documenting the plan. Yes, I'm trying to think in claims data, you know again where would you find this, or how could you find this.

I mean you could find it from the obesity diagnosis, or you know the fact that it's added to the problem list. But again that doesn't necessarily mean that a plan was actually documented.

I just think this one is probably a hybrid, because to look back six months of

charts to search for that plan, is probably burdensome. But I think it's still a very effective measure, especially compared to the prior one.

CHAIR PINCUS: I just wonder if we and hear from NCQA and where are they in revising or resubmitting the previous measure?

MS. HUDSON SCHOLLE: So currently, we have the project underway where we have respecified the 0421 measure for reporting for sub-populations under a contract to ASPE. So we've actually tested it with health plans.

But we don't actually have current plans to revise our adult BMI measure that is currently in HEDIS, but that is something that might be considered based on the testing work that we've done for the serious mental illness population in our experience using this with the health plans.

I would say that the measure would have to remain a hybrid measure. And with

chart review because of the problems that were noted right now that the codes that could be used for screening and follow up, in the claims data, were just -- we don't see those.

And there is a challenge of applying measures like the 0421 measure. Those measure right now, it's specified for the provider level recording. So the focus of the measure is what happens at the visit.

And that's one of the things that we've been trying to address in the ASPE project that I think D.E.B. Potter is going to speak about shortly. But trying to think about how a measure changes when you change the level of responsibility in reporting from the provider to a population reporting by a health plan or a state.

So we've started to look at those questions in this ASPE/SAMHSA-funded project. And will be taking that back to the NCQA team to decide what about HEDIS, but also relevant.

CHAIR PINCUS: Sounds like there is not a current alternative then the CMS measure. So it sound -- just to summarize, it sounds like we're recommending that the BMI assessment that was withdraw, the measure that was withdrawn, be replaced by this new measure.

MS. LLANOS: I will just recap what Sarah said. Two really important things that I heard her say is that the data source is exactly the same on both. So it's going to be a challenge if we are going to go ahead with hybrid review on this one. It's going to be the same issue on the 0421.

And the other thing I heard is like reporting unit purportedly one is at the provider level, whereas this is a health plan level. And we've encountered some issues on the PQRS measures in the past.

So I would assume we would encounter the same things in 0421 as under -- we still need to modify 0421 is what I'm saying in order for

it to be used at that health plan level.

MS. DUEVEL-ANDERSON: 0421 is endorsed for levels of analysis including providers, for both group practice and individuals. But also population level for country, city, national, regional and state. That is how it's endorsed.

CHAIR PINCUS: So Karen, do you think that you would have an objection to replacing it, or?

MS. LLANOS: So I'll leave my objections or not objections. I just wanted to state I think that the challenges that we're facing with this one in the state uptake, would be the same challenges in the other one.

And then to kind of Harold the conversation of yesterday, which was let's not modify the measures, you'd have to modify 0421 to serve the purposes of state reporting.

DR. BURSTIN: Just one point I guess at a state level of analysis, the follow

up is not quite as relevant as in looking at specific providers and did they do follow up. So I think one could make an argument at a state level, the assessment of BMI might be reasonable, especially if the measure already works, and this one would need to be adapted to make it work.

MEMBER SIDDIQI: So I think the first one though is only looking at assessment of BMI being documented in the chart, which is almost like an automatic thing that everyone is getting done now, as part of their vitals. Usually the EHR calculates it for you if you stick a weight and height in there.

But whether or not it was addressed is the issue.

CHAIR PINCUS: I mean, just from my own perspective, I tend to be very skeptical of screening measures alone, as compared to screening with some indication that some action was taken. So I would you know, be in favor of

actually feeling it's sort of worth the effort to try to retool this for that.

Other people?

MEMBER SAYLES: I just wonder, we have a whole slew of medical record review hybrid measures. And I think, I feel like when we started, we said we wanted to try and have some parsimony and kind of look at just practical pieces in addition to, in a few focused areas pushing the envelope.

So I don't know, personally I'm a little torn because this is a -- obesity is a obviously a huge issue in the population. There's sort of no doubt about that. But on the other hand, I feel like we've just sat through measure after measure where we've talked about the challenges of hybrid chart review. And this one has some technical issues in addition to just being a hybrid review.

So I guess my question would be is, I mean would one of the options be to not include

it this year, or is it just -- I don't know, I'll just throw that out.

MS. GEE: And then the question is what do you do about it. I mean that I'm much more in favor in looking at childhood obesity as you know as a measure. And looking at an intervention there once you know, it's just difficult to know what you're going to do about it versus blood pressure and the other ones that are hybrid measures.

At this point I wouldn't prioritize this one.

CHAIR PINCUS: Marshall, George and Doris.

MEMBER CHIN: I guess the question is for CMS is then what's the future plan in the sense that we could basically do whatever's feasible, which leaves us with a lot of process measures, which are some of the least meaningful of some of the different measures on the spectrum.

But when you get to the session in a moment of with like well the voice, and things like patient experience and care coordination, et cetera, so on a national level, you know part of it too, I mean this is a voluntary program. So that if we think that it's important and then something like the hybrid is like the best measure, I mean why not sort of push the envelope right now?

Otherwise, we're going to be basically you know in a race to the bottom, and we're not going to keep on advancing with the different measures. So what is the plan then over time then where we should see in terms of balance of feasibility, timing of getting towards of what people would want to have as like a you know, in theory, an ideal data set.

MS. LLANOS: I can start and I think in terms of how the mix, we've always tried to strive with aspiration grounded in reality. And I think we've heard a lot over the past

couple of days. As well as over this first year of reporting from states saying we like that approach, but it's really hard to do anything that's not admin right now.

So I think that's the struggle where we want to be looking forward, but we also want to make sure that we are putting forth a measure set that will have uptake. So I think it's tough. I mean you guys have a tough job in front of you.

But I would say I think look for this kind of broad snapshot of adult health. And I think as Harold said this morning, we kind of want to aim for the middle.

So try to look at this set together, and also think about states can collect measures in addition to the core set. This is kind of what we consider the starting point for the work. And Marshall I don't know if you've got more.

MEMBER CHIN: One thing like I

said, this is an amazing group here around the table. But actually of the NQF panels I've been on, this is the least diverse that you know, it's mostly sort of people actually running sort of Medicaid programs.

So you don't have like consumer advocates and other stakeholders where almost always when those folks are on the panels, they push then for the more meaningful measures. And so you know, I'm just a little bit worried that we're being too timid here.

MEMBER ANDREWS: My perspective is that you -- we only have about 16 states that are reporting. And the others are not for reasons. And right off the bat, as we're trying to create something where all states are reporting, are reporting on a number of measures that can be compared, I think we need to -- we don't have to make everything perfect right now today, tomorrow, next year. We can always revise and change.

So adding to the burden of medical record review, when again, if we were to change it, I don't see that as an option right now. I think that you know, having the measure being reported by all is a start. It is not perfect. It doesn't provide us with a good solution in terms of any management. But that would be for subsequent revisions and changes.

MS. LOTZ: When I talk about measures for Medicaid, I can't tell you why, but this is one that always comes to mind that people complain about. You know it's like oh, my God that BMI one, why?

But if you take the complaint as touching a bit of raw nerve or an opportunity, it's doing some good as it is. So I would be inclined to -- I would recommend that the group keep it as it. It's getting somewhere.

The more advanced measure, while it absolutely has merit, to each what Rebekah said, we don't provide any services for adults.

We do for kids. But, so you find them in Medicaid, you make the referral to what? It's not there.

And you know, again, that's not a good scenario to be in. It will evolve over time. But I think we are evolving over time just by saying are you measuring the BMI, and that already provokes something in providers that I think is good. So I would keep it as is. And over time evolve towards a more demanding measure.

MS. LILLIE-BLANTON: Let me just say I think Doris sentiment is exactly mine.

CHAIR PINCUS: Restate what I think is now the summary is that we recommend continuing it, but strongly urge that more work be done to look making this a better measure more feasible.

MEMBER SIDDIQI: Can I just ask, what is it in the child core set? The BMI plus the follow up plan, or just the BMI?

MS. LLANOS: I think in the child core set, we only have the first part, it's the assessment piece.

CHAIR PINCUS: So does that make sense as a recommendation? Okay, let's move on.

MS. DUEVEL-ANDERSON: So we're going to move on to CAHPS surveys. So we're going to take these three together, the CAHPS health plan survey as included in the current core set, as well as two measures that are as a result and come from the results of the CAHPS survey. So they're based on questions in the survey.

So what we've heard is you know, if a state collects CAHPS, then they would also kind of have a three for one, because they would also be able to get the other two measures.

MS. LASH: I just wanted to quickly clarify, to try to let you know that the current textbooks are using Version 5.1., if that

matters.

MS. DUEVEL-ANDERSON: And I think this flu shot, this slide didn't get updated. The flu shot measure is now endorsed. But the next slides will be updated.

MS. LOTZ: And it's also all ages, it's not.

MS. DUEVEL-ANDERSON: If the age group is expanded, the title is a little different and it's endorsed. It's number 0039. Well talk about it third. So sorry about that confusion.

So the CAHPS health plan survey, this is an NQF endorsed patient recorded survey that addresses as patient's experience in engagement. Health plan level analysis, and it's alliance with Medicare trust savings and the health insurance quality rating system marketplace.

It's four global questions of overall satisfaction, plus five composite

scores and a summary rating. The CAHPS survey, results were reported by 16 states. 11 states used 5.0 and 4 states used 4.0. One state used the CAHPS designed, a CAHPS like agency designed survey that is not administered by a vendor.

There were challenges in the data source in the difficulty in getting a vendor to conduct the survey. And the information was not always reported because it wasn't identified as a key priority, or because the states decided not to collect the survey.

So are there any questions or concerns about the application of the CAHPS survey in the core set? Nancy?

MEMBER HANRAHAN: It's just a clarifying question for me. So CAHPS is a patient satisfaction survey, that's what it does, right?

MS. DUEVEL-ANDERSON: Experienced care.

MEMBER HANRAHAN: Okay. We also have, and that's being embraced by the NQF as a measure, which I think is a great idea. But in that same line, then why wouldn't we think in terms of using the PROMIS systems that were developed by NIH to measure various conditions and perceptions of health? Is that a direction that is being sought?

MS. LLANOS: So CMS as an agency is considering the PROMIS tool. I'm not sure that there's any measures that are ready for prime time yet is my understanding. But it would certainly be sure to report outcomes in addition to patient experience surveys is the direction we want to go into.

MEMBER HANRAHAN: Yes, because the -- one of the major issues that keeps coming up is how we collect the data. And the PROMIS system actually has that handled in that they have this whole infrastructure for collecting data. And that it could be used by providers

to collect the data, so the actual person collecting the data is managed as well.

And it would give us some pretty useful, some good useful information about health status that could be aggregated up to the state level. That could be useful hopefully in comparison, from state to state, so.

DR. BURSTIN: We just did a lot of work on pros over the last couple of years. Actually worked very closely with folks at NIH and PROMIS and there's a lot of activity currently thinking about how to build what is really a tool into a performance measure.

So we don't yet know how to take that as a tool of saying my fatigue, my anxiety and how it then reflects provider performance. So I think that's the challenge, but there's been a lot of work on thinking about moving PR based tools into PR based performance measures.

But it isn't a one for one with patient experience, which is still very

different then function or health status.

MEMBER SAYLES: It will be CAHPS 5 though, that I mean it says 4 here, but it would be 5 moving forward.

MS. LLANOS: It's been 5 for --

MEMBER SAYLES: Oh, it's been 5, it just say 4 here.

MS. LLANOS: Since last year, yes.

MEMBER SAYLES: Okay.

MS. LOTZ: I think it's great. It's a you know, there may be other opportunities emerging, but right now it's the best thing in the market, and I hesitate to say well, don't say anything then Doris, but I have to say something good.

I just think it's great. We all do it, however we came to doing it, whether we had to, or you know, whether we like the tool. It's the closest best thing we have to know what's going on inside a patient's head.

And I'll say the same thing in

advance so I don't have to put my table tent up again. The tobacco one we did, there is a lot of information in asking them about their tobacco use, where they've been advised to quit, how often the smoke, you know what their attitudes are about quitting. It's just fabulous for this moment in time.

CHAIR PINCUS: So let me get, why aren't more states using CAHPS?

MS. LOTZ: It costs about $60,000 at least to produce. If you do sub-populations, you have to resample in a different sample. And so as I said yesterday, the cost can be somewhat additive and you can run up an expenditure fairly quickly.

It's best done by someone who is a NCQA certified to do the survey properly. So it means contracting out. Although you see one state tried to do it on their own. So it has some logistic complexity to it.

But again, it's -- some of the

burdens of you know, getting into the maintenance of effort, you know, it's being done already, so if we say we need another $60,000 or $120,000 to do a CAHPS survey, there's little push back, because the political acceptance is already there for the report.

CHAIR PINCUS: Marc?

MEMBER LEIB: We've done -- recently done CAHPS surveys you know, we're using a vendor for adults to children in Medicaid. The children in our CHIP program, et cetera. And the cost of doing that, it's been tremendous. I know we won't be doing this every year. We might do it every three to five years. But at that kind of cost, we certainly won't be able to do it every year.

MEMBER SAYLES: Okay, can I just ask a question for this? For states that are heavily managed care and have MCOs I mean the MCOs, most of them would be doing this already.

So are you -- I mean the way that

this is reported up to CMS, I mean is there not the ability to maybe, can they aggregate or average, or weight scores to what -- because I'm just trying to think like in California -- well, anyway.

There's ways to do it that would leverage what the health plan already has to do in those states where that's relevant. I just didn't know if that was an opportunity to address things or not.

MEMBER LEIB: Yes, we could push this down to our MCOs, some of whom are NCQA certified and would do it. Ours don't have to be. Our health plans are administered through us, not our department of insurance. So they are not necessarily NCQA certifiable, but we're moving in that direction.

But even if they are, if we push this to them as a requirement, then we end up paying them to do these surveys. There's no such thing as a free lunch in managed care. We still

have to give them money to do what we ask them to do.

So that just because we push it down to the plans doesn't mean we can't ignore the fact that it costs them $60,000, or because there's multiple financial, we have 15 different plans, you want all doing the surveys. The actual costs would explode in that total cost of the plans to do it would be more than the cost of the state to do it in total.

And the -- then they would expect that to be in their administrative dollars, the things that they have to do that we require from them. We're glad to do it, please give us the money. So that it's not just that we get to require them to do more and more at no cost.

CHAIR PINCUS: So I think to come back to what our recommendation, it sounds like we would be recommending that this be continued. Okay.

MS. DUEVEL-ANDERSON: Okay, so measure 0039 is the flue vaccination, where it falls with all adults ages 18 and older, this is the percentage of adults 18 years of age and older who self report having influenza vaccination. And it's the result of the 5.0 CAHPS survey.

It's reported in two separate rates. It's again a patient reported survey, and can apply to different care settings, and it is also aligned with health insurance exchange quality rating system and HEDIS measure.

12 states reported this measure, and here was a challenge with methodology. Again, if you collect CAHPS, then you would also be able to get this information. There was technical assistance provided on understanding the rolling average, and the requirement that is no longer required by HEDIS.

States didn't report it because it

was not an key priority to collect CAHPS. Are there any questions or concerns about the continuation of this use, of this measure in the set?

CHAIR PINCUS: So I assume that we're recommending again as we did, that this is probably kept and we're just going to continue it. Cindy?

MEMBER PELLEGRINI: Just a quick technical question. I don't -- can anybody tell me, is there any way when using this measure, to separate out pregnant women? Just because we're involved in some efforts right now to really emphasize the importance of the flu vaccinations for pregnant women. And one of the things that we've been struggling with is that there isn't a focused measure on that issue.

So I assume not, but if somebody could enlighten me, I think that would be great.

CHAIR PINCUS: I don't think CAHPS

asks if your pregnant.

MS. BYRON: What's the basis? No.

(Off mic comments)

CHAIR PINCUS: Okay, so let's move on.

MS. DUEVEL-ANDERSON: And so the MAP recommendation in 2013 is reflected in the current specifications in 2014. And it now includes all these age ranges.

So 0027, medical assistance with smoking and tobacco use cessation. This measure has three different components. It assesses different facets of providing medical assistance with tobacco -- smoking and tobacco cessation, both advising smokers to quit. Discussing medications and discussing cessation strategies. And it is self reported. Patient reported information.

And it aligns with PRQS, HEDIS, and the health insurance exchange marketplace. 15 states reported this measure, again, it's going

to be the same concerns that if states reported CAHPS, they were able to report this measure.

And the reason that it was not reported by all states was because it was not identified as a key priority. Are there any concerns about the continuation of the use of this measure in the core set?

CHAIR PINCUS: Any comments? So it sounds like again, a positive response as a part of CAHPS. Let's keep it.

MS. DUEVEL-ANDERSON: Okay, so we also have one measure with moderate level of reporting that addresses women's health and related topics. 0469 is elective delivery. There are other related measures that we've discussed.

This is an NQF endorsed measure by the Joint Commission. It's a measure that assesses patients with elective and vaginal delivers and elective cesareans sections at less then 39 weeks, or equal to 37 weeks.

And it does have administrative and electronic data collection, but also paper medical record or medical record review required. It's a hospital level measure and it's reported in IRQ and Meaningful Use for Hospitals.

There are related measures included in the core set and in CHIP as well, or sorry, not CHIP, it would be the child core set. The cesarean section rate, and also the antenatal steroids.

13 states reported this measure and there was a significant challenge with medical record review required to determine the numerator/denominator. There was a challenges with sampling the medical records using vital data records. But we've also heard about some successes with using that kind of information.

And CMS and CDC have ongoing assistance in collecting and using Federal

records. Then they're doing a training series on the data linkage. So this is reported as very helpful, and I think we have some people in the room that can probably speak to the usefulness of it.

Some reasons that it was not reported is because of the medical record review and the data linkage, but also because of the priorities in the state. Are there any questions or concerns about the continued use of this measure? Rebekah do you want to go ahead?

MS. GEE: Yes, so we modified our states vital records so that we can collect the PC-01 through our vital records. It's something we'd like to see other states do it.

It's worked out very well and we've validated the measure against PC-01, and we'll be doing payment/non-payment for elective delivery stating September 1st along with BlueCross/BlueShield. That's something that

South Carolina has done, but not using vital records.

It think vital records is an excellent resource for this. And I think that as we look to the future using public health data, and that's a theme that Eddy might have brought up yesterday, we're doing that for viral load, we're doing that for the cesarean section rate and it's something that is working very well for us for our state that links.

I would say for the future of the next five years, this is still an important priority, but if you look at the curve, I'm not saying take it out, but I think in five years this will be irrelevant, and I think the cesarean section PC-02 measure will become much more important. It's something that we're very focused on now.

CHAIR PINCUS: I think this is an example where I think this program has really helped states to really create a data linkage

infrastructure and capacity that wasn't there. And you know obviously it looks like and sounds like that's expanding.

Other comments? Oh, Doris?

MS. LOTZ: This is one that we took a very deep dive into as you may recall. We did link the vital records, that is good. The vital records are still very spotty with the data and the accuracy. The date in there, so linkage isn't enough.

You're still going to have to do record review, because the vital records, while they're probably most important in giving you the gestational age, they don't adequately elaborate on the medical reasons that went in to do an early elective delivery. That's still going to require a chart review.

I would say to all of my CMS colleagues here in the room, this is probably something we wouldn't want to do every year because I still think it's going to require

pretty aggressive chart review.

Where it does align with the hospital inpatient measures, they're allowed to do a sample that is not likely to include enough Medicaid patients for it to be an adequate sample for us. So we're going to have to resample on top of that.

Which we can do, like Rebekah, you know, this is trending down. Our real rate was 4.6, not great yet, but you know certainly better than the 25 we would have reported with the measure as currently written. And another example of why we shouldn't go public with these until we've you know, really gotten the kinks out.

And there was one more point, but I think that's enough. So you know, this measure is also very important, but has some problem -- oh, the last point was about the psycho-social reasons, so that would just be a recommendation to the measure developer, that

for application in Medicaid you may want to consider what the burden of that is, and whether it legitimately or not contributes to a delivery between 37 and 39 weeks.

So we did do it this year, it cost about $10,000 to do 91 chart reviews. So it's a little bit, you know a little bit more than $100 a chart because it had to be a physician reviewing, it couldn't even be a nurse. So we kind of got her cheap actually.

MS. GEE: Just to say, I think what we did with the vital records was a great idea. Because hospitals love it, they already had to do the vital record. The fact that we're paying based on their inputs has cause the vital records quality go up dramatically.

We've created check lists, we've done groups around the state to talk with physicians and vital records birth folks about how the date should be entered in the definitions and then we work with our community

around the definitions.

And we've added the ACOG reasons as well as one other that seemed legitimate. And it's worked very well. But I think that vital records piece is very important.

And we keep saying we'd like to share that methodology with other states. Because it doesn't cost much money. It us $30,000 to change the vital record system for the entire state, and now we have better data. And what's even better about it is it's for every delivery under 39 weeks.

And now we have very specific quality data on why the preterm births are happening in our state. Because now we have other reasons including spontaneous -- the big one that's missing in claims is spontaneous labor. And that's the reason by in large most women have a preterm birth.

So we have better data, it was a great partnership, the hospitals love it, they

don't love that we're not going to pay them, but we spent two years of kumbaya prior to this and our rates were very high. They were legitimately, in one hospital 60 percent, and in the majority of the state 30 percent. And now we're at the four percent range.

So we've made dramatic progress. And data was only a small piece of that. And I'll say that, and this is true for all these measures, that reporting is one thing. Having a process, improvement project, and getting collaborative effort around improving it is the piece that's really important.

But having good data was essential for us.

CHAIR PINCUS: Great. Other comments? Oh, Helen?

DR. BURSTIN: Just one comment, really cross referencing both Doris and Rebekah's great comments. I think it is really important that that learning get shared and

that those tools get shared. But I also very interested in making sure that you're learning Doris about the substance use mental health issues you talked about yesterday as driving a much higher rate.

And be curious to see where there's actually some cross collaboration, to actually see whether with the data you have in Louisiana, can you begin to pick up whether in fact, some of the higher rates were due to mental health and substance use.

In which case, we can work with the developer to see if there's ways to enhance the measure to clarify it. I mean these are really important issues and I don't want to just leave them on the cutting room floor here and say this measures good to go, let's move on.

This is such an important measure, and I would hope the C-section one as well, we'll have probable have similar issues as well, so it's great to see.

CHAIR PINCUS: And I think in that discussion, it would be interesting to understand exactly what is the linkage between the behavioral health issues and the elective deliveries.

MS. GEE: Yes, just as an obstetrician, I'm an obstetrician, and I would say the behavioral health plays into it, but I would say minimally. I mean certainly substance abuse plays into early delivery, et cetera. But in terms of the decision do to an elective delivery, and largely it's a decision.

That decision should be a physician's decision and the hospital's decision. It should not be driven by the patient. Because it's --

DR. BURSTIN: Just reflecting on Doris' analysis yesterday, she shared with us some new just for cross pollination there to learn about what the issues were, where they found really high rates, and when they pulled

out those patients, they plummeted.

MS. LOTZ: We don't have to repeat that during the course of the meeting. I could share that with you afterwards Rebekah.

CHAIR PINCUS: That would be useful, I'm just saying that that's the kind of thing that would be worth exploring you know in terms of feedback for people like what are the factors associated with this? Not so much as a measurement issue, but more as an improvement issue.

MS. LILLIE-BLANTON: So let me just say, in our experience, and we've done a lot of work with this, I would agree with Rebekah, that there's not, while certainly there is some mental health and substance abuse issues involved with early deliveries, that has not been defined as a major driver. I mean it really is about making sure obstetricians and gynecologists are following best practices of ACOG in terms of waiting for 40 weeks, or --

So not to say that it wouldn't have some impact. I mean maybe a physician is concerned about the health of the child, so they might deliver early. But that's not been a major issue, so I wouldn't raise that as an issue to the developer, which is the Joint Commission.

CHAIR PINCUS: But again, it's something worth exploring, to identify, to try to understand what's going on there.

MS. GEE: Just on a separate note, and we're going to have some time to talk about gaps, but I think the gap here and where substance abuse and mental illness comes in is the low birth weight first.

And this is something that we need a much better measurement strategy around Louisiana has created and we'll get a chance to talk about this later, a progesterone measure because we feel that prevention of prematurity is like a critical area where there's a huge

measurement gap.

And you know, this is a pretty cut and dry medical decision and hospital policy issue. But when it really gets interesting is where you get into the drivers of prematurity.

CHAIR PINCUS: Well we're going to get to that in a couple of minutes after this next set of measures. So I'm assuming, Doris?

MS. LOTZ: I don't want to leave the committee or CMS with the impression that we thought this was okay. That we just reported out what they put in the chart, that's all.

And I agree with Helen, we are going to explore further. That's just where we are at this moment in time. I still have all those charts in my office. All 91 of them that we can keep pouring in and looking at.

It's not to say that it's okay. But it is to say what does the measure need to say? It's a very process-y kind of presentation is what I wanted to leave the committee with, not

with any clinical assessment of what should or should not happen, so.

CHAIR PINCUS: so I think the recommendation is to continue this measure. But we -- there's an important thing that we'll get to when we get to the gaps and priorities in terms of thinking about low birth weight.

So now we have a batch of measures that were very relatively rarely reported by states.

MS. DUEVEL-ANDERSON: So there's a measures with a few states that reported or where they have significant challenges that were experienced with reporting. And there's a question on the task force that's slightly different for these measures.

It's whether or not these measures should be maintained in the core set. And if there are changes to the application of those measures. And there is a question about the state technological capacity to support the

increased reporting of these measures. And whether or not there's too much burden with higher data collection in general.

There -- we'll go through three. The fourth measure that you see, the HIV viral load suppression, this is the first year that it's going to be reported in federal fiscal year 2014, so we don't have any implementation information. And it's actually a success of MAP is providing feedback that was well received by CMS, so it's an update to the core set.

So we'll talk about PC-03, antenatal steroids, very highly related to PC-01, elective delivery. Measure 0476 is an NQF endorsed Joint Commission measure. And this measure is patients with a risk of preterm delivery greater than 42 weeks and less than 30. Excuse me, 24 weeks, and less than 32 weeks, receiving antenatal steroids.

It is administratively collected,

but also has clinical data through registries. And paper medical records. And it is a hospital level measure. Similar to how we previously discussed, this has related measures in the child core set for the cesarean section measure, PC-01, and the early elective delivery.

There are five states that reported this measure with significant challenges, consisting of medical record review, and they use of the vital records. That is, CMS and CDC training on data linkage is also useful for increasing the reporting of this measure. And 25 states did not report the measure, primarily because of the medical record review and the priorities in the states. But also the data linkage. Sorry, don't know why I advanced. Okay, so if there are any questions or concerns about the continued use of this measure, again there were only five states that were able to report this measure.

MEMBER SIDDIQI: I'm just curious, going back to the prior measure, when we talked about data linkages, has the data linkages between vital records, for example Louisiana, has that helped with reporting on this one? Because our hope is that we could probably continue this one, and again encourage some of that technical capacity to occur.

MS. GEE: So to speak to this, and then I want to speak to HIV quickly. But the progesterone data is from the -- and vital records, not that you can't use it, but you can certainly use claims data for steroid administration. Vital records helps somewhat, but you can use it to validate. And then with HIV viral load, it was something that we haven't had to focus on in the past, or the ability to do, but we're going to use it as a --

CHAIR PINCUS: Well get to that in a minute.

MS. GEE: Oh, I thought we had

passed.

CHAIR PINCUS: No, we just doing the antenatal steroids. So are there other, I mean what is the sort of additional incremental barrier that one hits with this one, as compared to the one that we just talked about? I'm trying to get a, sort of, an understanding of that from a state perspective. I mean, it's you know it's the same data linkage issue, and chart review, but much fewer states reported on this then reported on the previous one.

MS. LOTZ: I am not an OB, but this is -- I am, Rebekah you are an OB. These are given I'M, right?

MS. GEE: Yes.

MS. LOTZ: And I'm just looking at the measure specs. I know this was another one that my team said no way. I said okay, fine whatever. Well we all ended at 15 or 16, and you know you can't discuss them all at great length.

But be that as it may, I'm looking at the measure specs, it says there's no NDC given for steroids. So that already means that your data collection, again, when you go into the data, having a specific NDC makes what you are searching for a lot easier. If it is IM, which it appears to be, it's going to be hard to find, you know if you're doing this in the doctor's office, it could be you now, buried in a more comprehensive charge.

If it's given in the hospital, it's going to be buried in a DRG, or -- we don't get codes for drugs that are given inside of the hospital, you know during the hospital stay of any kind. And I'll leave it at that just to introduce some of the barriers to getting at this data.

You could do chart extraction, of course. But you'd have to -- you may have to read through the chart to look at the med record given. Again, if it's important enough you do

it. But on the vital records part of things, I'm looking at the exclusions, and even if you have this document in your vital records, it probably would be an affirming documentation, you know steroids were given for this preterm birth.

But the exclusions, say, document the reason for not giving antenatal steroid therapy. And I'm thinking I don't think the documented reason for not giving it would be that in vital records, which means you're back to a chart review again, even if you do have pretty robust vital records linkage, accuracy in vital records, and you've got the fields that you want to try to capture, so. I think there's a lot going on with this that make it a complicated measure to do. And I'll leave it at that.

CHAIR PINCUS: Rebekah?

MS. GEE: If my memory serves me, the measure has been simplified, though. I

think initially this measure was the completed dose of either the 24 hour doses, or the four doses. Now it's initiations. I think that's a much better end point to see, you know you could have initiated, you don't have control over how long she's going to be pregnant after initiation. So it's just that one data point. And so it's fairly simple, but it's such an important -- there's such strong data that it makes a big impact on outcome.

So I think it's as very important measure. You know you can have a J-code for administration. I don't know what -- why it would be -- I don't see, for us it has not been difficult. I don't know what would be -- why it would be hard to pick it up, if other folks might want to mention that. Cindy do you have, have you --

CHAIR PINCUS: Is this something that came up on the sort of technical assistance efforts that you're aware of?

MS. LLANOS: I think that it was a lot of working with the Joint Commission, and I think Katie's on from MPR. But I think we needed to clarify a lot of -- so if I'm remembering correctly, the Joint Commission tech specs seemed to be a lot higher level then some of the other ones.

So it was a lot working back and forth to get a level of clarity. And I think the new tech specs, currently, I think clarified a lot of the how you calculate the denominator, some of the sampling issues. I think that piece that we were able to track down is that there is no NDC, and I think that was probably the piece that is challenged.

But there's no --

CHAIR PINCUS: No NDC?

MS. LLANOS: NDC list, out of the Joint Commission provides. So I think that I would assume might be challenging. But I would say, five states actually is not a bad start for

a measure. We've had one state report on the kids one, and now 12 or 15 states report. So I would say, if this is one of the tougher measures, we know that this is a priority area. I would say, I think this is one that we could continue to clarify. Katie I don't know if there's anything that you wanted to add from the TA perspective/

MS. ADAMEK: I think you covered it. I think you're correct that the specs this year include a lot more detail. So hopefully more states will be able to report it. Especially when it comes to determining the denominator. But the NDC code I think is the only issue that I can think of that might come up.

CHAIR PINCUS: So is it --

MS. ADAMEK: And medical records review, as we've talked about at length.

CHAIR PINCUS: Is there a solution to present -- requesting that there be an NDC

code for this?

MS. ADAMEK: We've asked the measure steward if they'd provide them, and they say that they don't. States have asked if they could use like NCQA as a list of NDC codes, but that would have to be a discussion with CMS and the measure stewards.

CHAIR PINCUS: So Cindy and Doris? No, Cindy.

MEMBER PELLEGRINI: So this is a critically important measure. I mean, this one is literally life saving, right, when done properly. So and the -- while it's a process measure, it's so proximal to the outcomes that it's almost an outcomes measure.

The only other point that I want to make is that this issue is not going away. As Rebekah knows from data that she collects in her state, and that this conveys to lots of others, the rate of appropriate administration of antenatal steroids is very low. And I think

we're going to be hearing more and more about this right now.

Just the fact that a few states are doing it now, it's a good start, and hopefully is going to pave the way and provide models for lots of other states to do it. But I think we're going to see a lot more emphasis on this issue in the next several years. So I'd argue strongly for keeping it in.

CHAIR PINCUS: So it sounds like the summary is that this is an important measure. It should be continued. There should be continued efforts to clarify how to do it and simplify its, sort of, its data collection process and to also look in for you know, can you get a NDC code that can actually facilitate that? Okay.

MS. DUEVEL ANDERSON: So the next measure is the last behavioral health measure, and it's a screening for clinical depression and follow up, 0418. This is an NQF endorsed

measure. And it is the percentage of patients aged 12 years and older screened for clinical depression using the appropriate age standardized tool, and follow up plan is documented.

Several exclusions, including a referral with diagnosis with depression, participation in ongoing treatment. Those with motivation to improve, such as court-appointed cases, and those with severe mental or a physical incapacity.

It does have administrative claims, electronic health records, and paper medical records, and it can be reported from a clinician level, and rolled up for the population level. It is aligned with Meaningful Use stage two of eligible processionals, Medicare insurance savings program and PQRS. And it can be reported from a variety of care settings and ambulatory, inpatient, but also inpatient rehab facilities, long term care hospitals and

nursing home care.

The adaptations for this measure adjusted the age rate, which we heard yesterday was not a significant or a substantive change for the measure. And there were two G-codes that are reported in the technical specifications for the Medicaid adult core set, versus the original six and the numerator to identify screening, and if positive follow up plan for documentation on the same day.

Five states reported this measure. Four states reported the Medicaid adult core set specifications, while one state reported an alternative PCMH measure. And it includes screening in 24 months, but not a follow up plan.

The challenges on questions to the TA box were about coding and calculating the numerator and denominator. There were questions that resulted in the clarification of the G-codes, the numerator is screening -- is

encounter should include on the same day, while the denominator requires a medical record review to determine the exclusions.

We've noted that CMS is developing the hybrid specifications for future use of this measure. States didn't report the measure, and 25 provided reasons why they did not, but those primary reason were because of the medical record review and because of the state priorities.

MEMBER SIDDIQI: So this reminds me of what would have happened if we had 0421 and the other CMS measure that looked at a follow up plan in addition to BMI assessment, we may have had four or five states that reported on it. Requires chart review. And I was just curious about two things. One is what is it in the child core set for the depression screens, do you know?

MS. DUEVEL ANDERSON: So we don't have this measure on the report.

MEMBER SIDDIQI: Okay, and just, probably why the age starts at 12 I think with this one, 12 and older. But the adaptations you can see reported by two age groups, again to be more consistent, as Doris has mentioned, so 18 to 64 and 65 and older seems to be an adaptation that was recommended.

But I was just going along the lines of is it possible, or is there another measure that is in NCQA, or another steward measure that basically only looks at the screening for clinical depression? Because that is something that could potentially be pulled from the EHR charts. Especially a lot of the EHR records have now the PHQ-9 and all these different depression screening measures built into their EHR systems, so maybe that could be more easily reported. And so this is one where if there is another measure that's a little bit simpler to require, it may be a better one to choose, in my recommendation.

MS. LLANOS: Can I just give like two seconds of context? So this was one of the, I think, most challenging measures for us to implement in this first year. And I would say it's probably because it was one of the PQRS measures.

So what we spent a lot of time, thanks to our great feedback from states, was clarifying the G-code issue. And, I think, so this measure was set up for incentive payment. We're not using it for incentive payment in our program. So that's how we went from six to two codes.

This is also part of the HHS agencies depression measure. This is like the one that they use across all of the department, so just wanted to emphasize that. We want to pair the screening and the follow up together, understanding that it's a hard one. Katie, is there anything else? I know we worked a lot on clarifying the technical specifications for

this one this year.

MS. ADAMEK: Yes, I think it really was the G-code issue, that was the largest problems. Some states said that they don't collect them at all. So even the inclusion of just the two I think will make it difficult for some states to report. But that was the biggest issue with this measure. Bailey is on hold, so I don't know if she's got anything to add.

CHAIR PINCUS: So one question I had is with the slight retooling it sounds like you did, does it still require a medical record review for denominator exclusions?

MEMBER SIDDIQI: The follow up plan documentation probably would require medical record review. It's not just the screening part.

MS. ADAMEK: Yes, it does require medical review.

CHAIR PINCUS: For both the

inclusions and for the follow up plan? I thought the follow up plan was included in the G-code.

MS. ADAMEK: Yes, just for the exclusions. And that was the feedback from the measure stewards.

CHAIR PINCUS: So one question I had that sort of just you know, one of the issues is there a way to sort of eliminate the chart review for exclusions? And to some extent, and it's based on a study that you're doing, that Wayne, Kate and I did. When we looked at, we had a large sample of patients who we had PHQ-9 scores and claims data.

And we found that the places where there were the highest PHQ-9 scores were people who were actually under treatment for depression. Which when you think about it makes sense, but it also suggests that there's a sort of a big problem with a failure to intensify treatment to try to achieve

remission.

And that -- and so one somewhat radical thought is that why are you excluding people currently you know, under treatment that, maybe, they ought to be included. And that could be something that you know if they are, you know remain depressed, that there's some action being taken to intensify treatment. Doris?

MS. LOTZ: Yes, not discuss the merits of it, but just to introduce for the committee's deliberation where the technical challenges are, the other exclusions are, there's no way you can do this without a chart abstraction, and I'm thinking as well that some of this requires a pretty deep understanding of the clinical circumstances even to do that chart review.

So you know could a nurse do this, or would it have to be, perhaps, even a physician. Are these even necessary? I like

that line of logic. It would be interesting to explore that a little bit further, Harold.

You know, a patient refuses to participate. Is that even going to be documented in the chart with a screening examine? Why is -- how do you capture that? You know there are number of other exclusions. Again, we don't just take out the people with depression, we also take out the people with bipolar, we take out the people if there is an urgent situation, where time is of the essence.

We take out where the patient's functional capacity or motivation to improve may impact the accuracy. How do you access that? So again, absolutely, screening has merit, but this is a very challenging measure to generate and feel that you've both got the inclusions and the exclusions accurately.

I also just want to put in there for the committee to consider that where states may have responded with their technical

challenges, mean that they already crossed that first threshold of considering the measure. In our state, we wouldn't have considered, you know, we would have been able to assess it on the tech specs that we had, we wouldn't have had to ask for any clarification, because it wasn't going any further.

So those that asked for technical specifications already made at least some commitment to discussing it as a possibility, and the silent majority may have problems that are not being considered for you know, that their concerns never arise to the level of a discussion and potential improvement, so.

MEMBER SAYLES: I was just going to sort of from a -- take a step back, and just say from Medicaid and sort of population health perspective, I don't know if I can think of a more important concept to be measuring. And that effects lots of clinical outcomes, in addition to depression itself.

So, part of me was sort of thinking, is there an opportunity to kind of make a recommendation to the measure steward about looking at the complexity of the technical specifications and the decision criteria? But -- or maybe there's a substitute measure, I'm not aware of one.

But it just seems like we have the tip of the iceberg in our measure set, which is basically, if you're already on a drug, are you, you know are you taking it. But that doesn't really get to what the real unmet, you know, sort of needs and that clinical conditions of the population now with regard to mental health, and depression specifically. So I just would put out that I think it's a very important thing to be looking at.

MEMBER CHIN: Just to follow upon Jennifer's point that, like, yesterday when we talked a little bit about like a fresh look instead of a strategic comprehensive looking

program. I think this like the third topic that's come up where it's just so important in terms of the prevalence and morbidity that you know it has to be on the radar screen, whether it's formally in the measure, or else it's a high priority item.

And depression, we talked about hypertension, we talked about obesity, we allocate more of these different problems. And so you know, we have a lot of measures but I think some of them are topics where you maybe just can't avoid. So that's something where we also note, like, well this really is sort of a high priority topic because of the prevalence in morbidity.

We haven't really done that. And so I think that is a danger again of looking for what you know, is doable and feasible. And then missing, like, huge swaths of territory. Somehow we need to indicate where you know either include or else indicate where you know

the risk of a critical gap that needs to be fixed really soon.

CHAIR PINCUS: Marc?

MEMBER LEIB: Clearly this is you know treating depression in our population is important. There's no doubt about that. In fact, it's so important that for us, even though behavioral health is in a different agency, separate from the Medicaid program, we actually, within Medicaid, encourage our primary care physicians to treat depression if it's -- if they come across it in a patient and there is an established relationship with a patient, and they are open for treatment, treat them.

Don't worry about having to refer them to another agency, unless it's so complex that you need to. So we encourage the treatment. But the measure itself is so complex on screening, and who got screened and who didn't? Who's included and who's not

included? And why weren't they included, that I'm not sure that we can capture that accurately.

We get a number. Oh, I can get a number. But if all I do is generate a number without it being something that is accurate, reproducible, meaningful, actionable maybe, I'm not sure why I would go through that exercise. And so we tend to not do measures that don't produce actionable results, or things that are so complex that they're not accurate results.

CHAIR PINCUS: So, a question. This is a Meaningful Use measure, right? And isn't that a sort of relatively simplified version of this, as the specifications? I mean does it have some of the sort of, like the motivation exclusions?

MS. LOTZ: Well, but the Meaningful Use, again, is at the physician level. So the physician would know whether they were

motivated. The physician would know whether they are already in treatment, he could take them out.

But from a Medicaid point of view, we're not going to know that. I mean maybe if we would allow again, that you use self attestation. So you know, if we would allow physicians -- we wouldn't have to go through all of this, and we could just say hey physician, tell us how many appropriate people you screened? And then we'll roll it up into a state-wide number.

That is an intriguing idea, probably requires a little more technical discussion to say how is that you know, is that really valid? But for us as a Medicaid agency, or a health plan, even, to go into the chart and generate this number is abusive.

CHAIR PINCUS: Right, no, no, I understand that. So I guess my point is that it sounds like, let me see if I can summarize

what I think the discussion is. Is that we think this is an important measure in concept, we you know, five states did report on it. But that we strongly urge that there be considerable efforts to simplify it and make it feasible to do this. You know potentially piggybacking on the Meaningful Use efforts going forward. Is that a reasonable summary?

MEMBER LEIB: And maybe if a way to report. Because we absolutely expect this to be part of a comprehensive physical exam. And you know, whether it be a family practice office, internal medicine, whatever. That asking about, or looking to see if our member is depressed and needs treatment is, we expect that to happen.

We don't know that they're documenting that they were screened for it, but if it's a negative finding, it may not be documented, it may not be something that can come to us in electronic format, maybe you could

simplify it that way, it would occur more easily. But right now the measure is what is difficult, it's, not a lack of willingness to treat, or do things based on this.

CHAIR PINCUS: Nancy?

MEMBER HANRAHAN: Well this comes from a long history of not recognizing or screening for depression in the primary care area. And the preponderance of depression being an issue in our public health agenda. So that we are screening for clinical depression, is really I think a positive move forward. And it's another one of those measures that we're scratching the surface with, maybe not getting all the -- maybe not hitting a home run.

CHAIR PINCUS: But I think, bear in mind, and you know, as Marshall knows, when I lead the RWJ depression and primary care national program, the screening alone for depression is not actually recommended by the

U.S. Public Health Service Task Force. Because there's not evidence that screening alone actually has an impact on outcomes.

It's screening in the context of where there's a capability for follow up in a systematic way that's recommended by the USPTF. So that's you know, just to remember that. That's what makes this more complicated. Because trying to get at that sort of evidence based measure.

MEMBER HANRAHAN: Can you explain to me, then, how do you validate the follow up has happened logistically in this measure?

CHAIR PINCUS: So this is sort of part way there. It doesn't document that the follow up actually occurred. It documents that it was a plan for follow up. So one could argue that there's a lot more sort of measure development issue that should be done in this area. And actually where few things are moving with depression care is something that comes

out of a more of a sort measurement based care concept, similar to hypertension.

Of, sort of, getting serial PHQ-9s over time that can be measured in the context of a web based registry, and looking at not just you know did the measures occur, but did they in fact improve to the point of remission. And there are you know, there are model programs, for example in Minnesota, there's the DIAMOND project that is actually doing this in medical groups where they actually added incentives to achieve remission.

So you know, and so I would recommend that there be a lot more of looking at, sort of, ways of improving this measure. This is a start. It's overly complicated, hard to implement. But it's an important area.

MEMBER HANRAHAN: You know also I think the work, if this were possible to tag a question onto the HCAHPS, or the CAHPS survey that the patient responded to the question,

were -- did somebody ask you about depression? It's still just superficial, it's still scratching, it's still about screening.

You could ask a second question, no you can't, because it's cross-section. But even that question seems to me that that would be a more efficient way to collect data about screening then going into the --

CHAIR PINCUS: She did some work in that area, and it's kind of complicated because that is -- patients don't always recognize that the questions that were posed had to do with depression. So it gets, you know, because a lot of the questions in the screening instruments have to do with somatic symptoms and other kinds of things.

So it gets more complicated. But I think we can make a general recommendation that there be sort of a lot more attention about how to modify and improve measures for depression. And not simply screening, but screening and

implementation of follow-up plans.

MEMBER HANRAHAN: Could I just add one more comment? And that is that I think we've come a long way with the idea of screening for depression and what that means and what that can produce for us. And that, we've been focusing a lot on the provider's side, you know, where did you screen, or will you screen, or how will you screen for depression?

But one area where I think we haven't really gone very far is with the consumer side. And the consumer expecting to be asked that question, or expecting to have that be part of their health care plan, or their health care assessment.

And so if we were to put into the survey, the CAHPS survey, patients, or the person being asked, the consumer being asked, were you screened, or whatever that question would go. Because I think Harold is right on, it's a very complicated, even to mention the

word depression, what does that mean? Or how could that go?

But to have it there with the intention of raising awareness on the part of the consumer about being screened for depression, I think it would -- again, we're scratching the surface about a lot of this stuff, so.

CHAIR PINCUS: Okay, so let's move on to the next one, which, I think we have two more to discuss and then we can get on to talking about gaps.

MS. DUEVEL ANDERSON: So the second to the last measure is 0648, a care transition measure if the transition record was transmitted to health care professionals. It complements some other measures related to chronic disease and care coordination.

So the percentage of patients discharged from an inpatient facility to a home or any other site of care, to whom the

transition record was transmitted, to the facility or to the primary care provider, or other professional within 24 hours. It does exclude patients who left against medical advice and also the deceased.

It is applicable to a variety of care settings, but it is a process measure that can be collected through administrative data, electronic records and medical records. So four states were able to report this measure. There was an adaptation to adjust for an appropriate age range within the population of the Medicaid adult core set.

There was a challenge with data collection identifying the numerator through the medical record review. And 14 states said a barrier to reporting was medical record review, while others cited concerns about the data linkage and the priorities.

So Matt previously made a recommendation on this measure that it should

be used as it is endorsed. It is endorsed as a paired measure and designed to go with 0647, which is the transition record with specified elements received by discharged patients.

Doing so would actually address more of the person-centered concerns, and it is recognized that the measure is designated for the -- specifically for the facility level of analysis, and is more challenging to collect. And so you'll see that reflected in the data collection issues.

Just quickly, to look at the paired measure, this is the percentage of patients that are discharged from an inpatient facility who receive a transition -- who go home or to any other site of care, and they receive a transition of their record at the time of discharge.

So to evaluate 0648, whether or not this measure has any concerns about maintenance in the core set. Are there recommendations to

support the prior recommendation to use it as endorsed with the paired measure of 0647?

CHAIR PINCUS: So what are people's thoughts about this one?

MEMBER SIDDIQI: So I actually think 0647 is perhaps more reportable or more feasible for states to report on. I mean most hospitals do and SNFs need to give discharge records to the patient. It's actually on the track by their electronic health record. I do believe that meets their Meaningful Use criteria.

So I think 0647 which you just presented, is a very good measure. In terms of this one, I think, you know, the fact that 14 states are saying that they're not doing it because it requires medical record review, again speaks to the feasibility of this one. And I just -- I would rather replace it with the other one. But that's just a recommendation.

CHAIR PINCUS: George?

MEMBER ANDREWS: I do think that, and this would come up for discussion with the other MAP committees, I think that again, considering the patient centeredness as well as the importance of involving the patient in decision making, understanding their needs and what needs to happen. And also in terms of the continuity of care, that the providers of care need to be linked, and coordinating that care.

I am in favor of replacing the 0648 with a combined.

CHAIR PINCUS: Other comments? What about the --

MEMBER GESTEN: Can I get in?

CHAIR PINCUS: Yes.

MEMBER GESTEN: Hi, this is Foster. So I don't argue with the theory or the concept that having the two of them together makes good conceptual sense. But I guess I keep thinking about the overall aims of this, and I just wonder whether adding a second component to it,

or even replacing it out with something which, with the other measure, with 0647, is going to result in actually even fewer states reporting this next year.

So I'm just not sure what's served, you know unless something else changes, by making a complex measure, and this is one of the only two measures that we were -- did not report for New York State, making it such that even less states are able to report.

I'm not optimistic that the electronic health records from the hospitals and so on are sufficiently capturing all the information. And that information can be, going back to Doris' point, all collected and reported to the state in order to be able to do the more patient-centered measure.

Again, not arguing against its value, but arguing that making a complicated measure more complicated is going to result in even less states reporting.

MEMBER HANRAHAN: So I'd just like to add that the logistics of collecting this kind of information, in some sense we are not at the place technologically to be able to do it efficiently or effectively. Unless I'm missing something. How did the four states that actually collected the data do it?

MS. LLANOS: So I would say they collected it in a hybrid, I mean I'm not sure, they must have done it according to the specifications, which require medical review. So we know some states can do medical review. I can tell you that, and Foster correct me if I'm wrong, this was our reach measure in the initial core set.

So this was us trying to be aspirational and fit the gap of coordinated care, understanding that this would be a tough one for states to collect. So kind of speaking to you know we want to address the here and now, but also be looking to the future.

So this represents you know, this is a you know, as Foster said, this is a complex measure to collect.

MEMBER GESTEN: Yes, I think it is a stretch measure, and I think there's value to doing that, because we don't know, you know a priori, what states are going to do. But now we do know.

And so there are some you know, the hard decision is whether to keep it and to push people to stretch. Or as we've done with some of the other measures, is there a way in which we can think about trying to measure or evaluate the concept through some other mechanism that may be more practical.

So you know, in my mind, I think that the importance of this topic certainly doesn't go away. In fact if anything, I think it's become more important. But perhaps a conversation about whether there's another means to be able to test collection might be

something worth thinking about maybe at the end of the meeting, or some other day.

MEMBER HANRAHAN: I would argue in favor of keeping it. It's another one of those measures that is pushing continuity of care. And pushing the system to move from this fragmented silo of communication, that really is disruptive and has major effects or impacts on our outcomes, into a new paradigm.

And I think, and Foster I agree with you, that we're not there yet ready for it. But recently, I have been working with at the University of Pennsylvania, it's the whole health care system. They have what's called the Penn Data Store. And what they're doing is they are linking all the data throughout the network system, so they could actually collect this kind of data fairly efficiently and effectively with a lot of ease.

But that's not the norm in the systems. Although big places probably are

doing this. But it does foretell that this is where we're headed, so I would argue to keep it.

CHAIR PINCUS: Let me ask for any of these sort of measure developers or stewards in the room or on the line, I mean where are we with this sort of state of the art in looking at care transitions with regard to measures and ways of improving? I know that there is, you know there's a patient reported CTM screen measure that would require a whole sort of new survey effort.

But are there any other sort of innovations sort of being developed? To sort of look at this issue in a less complicated, and easier, more feasible and potentially more valid approach?

MS. DUEVEL ANDERSON: While you are thinking, I just want to add that it's kind of, the reason that these measures are paired actually is that if you add 0647, it actually makes it easier to collect 0648. And that's

from the developer and how they were designed to work together.

So I think I haven't really heard a strong argument for supporting the previous recommendation. But I just wanted to add that as an answer to some of the feasibility questions.

CHAIR PINCUS: Marc?

MEMBER LEIB: We have a large push going on right now in our small fee for service population, it's mostly with Native Americans, to improve care coordination and especially the transitions between, from a hospital back to a tribal facility. Or if they're going to a nursing home or whatever, it's documented stuff. It's less than five percent of our population in total. But it's an important part.

We're encouraging our health clients to do some of the same things. But there's no way that we really have of measuring

this. It's just an effort to get the hospitals to communicate better with the next step down the line. Whether it be back to a physician office, or a nursing facility, or the tribal treatment center where their patient is going to be going.

And that's what we're trying to do. But there's no way to measure it and to put it into here, other than doing chart reviews. And we've already discussed that.

MS. LASH: I'll also add that the Steering Committee on Care Coordination Measures met fairly recently. We're really looking forward to reviewing some innovation measures and really had very little to go on in that respect.

They did look at a solid measure of medication reconciliation, but I think that's a different issue than what we're looking at here. So unfortunately there isn't a good substitute that we're aware of.

CHAIR PINCUS: And so let me summarize. So I think that the recommendation is that since there were some states that did report on this, to continue that, but to also add the communication with the patient, so 0648 as well. And 0647 as well to that. But to still you know, urge that you know CMS and other measure stores look to finding innovative ways to more feasibly collect this kind of information. Okay.

So we're almost done with the measure by measure stuff.

MS. DUEVEL ANDERSON: So MAP preciously recommended to replace the HIV medical visit with 2082, which is an NQF endorsed measure and it's HIV viral load suppression. This recommendation was taken up by CMS and was announced through a letter to the medical directors. And this is a celebration of success and the new measure is the percentage of patients with a diagnosis of HIV, with a

viral load of less than 200 copies per milliliter during the last test in the measurement year.

And it can be done in any outpatient setting by various levels of providers, and including nurse practitioners and PAs who provide HIV care.

It's collected through electronic clinical data and also paper medical records. It's an outcome measure. So this is just a summary of the update has been made into the tactical specifications. I don't know if anyone has any comments about this measure. But we'll be looking forward to feedback on the use on the measure in the federal fiscal year 2014.

CHAIR PINCUS: Any comments?

MEMBER GESTEN: I have one.

CHAIR PINCUS: Foster?

MEMBER GESTEN: So I know that we've been doing a version of a measure related

to viral load suppression both in our HIV special needs plans and mainstream plans for a while. I think you know, again, conceptually a good measure.

But one of the things that folks said to me about the specifications of this specific measure however, were a couple of different concerns, which I'll just throw out there and maybe in the testing in the next year or so we'll see how it plays out.

One was concern about the denominator which uses a single diagnosis of HIV currently. And in our experience, we found that a single diagnosis for anything, but including HIV, tends to include a lot of individuals who don't have HIV or AIDS, but may be used to code a rule-out or having an HIV test. So some concern about the denominator.

In terms of the specific codes, my understanding is that this measure uses SNOMED codes which are unique as far as we know in terms

of we're not aware of any other measure set that uses SNOMED codes. I'm not sure how, whether that's going to create an issue for us or for others.

And also calls for using LOINC's codes, which I had actually thought we were using, or getting that data in our data set. But I'm told that we have not been. So that may change. I'm not sure. But just a couple of technical issues about the denominator and the use of specific codes that states may run into, we may run into, it's a problem in terms of collecting the measure as it's currently specified.

CHAIR PINCUS: Jennifer?

MEMBER SAYLES: I was just going to make a brief comment on those points. And I just, I happen to know that Louisiana does, or I thought, does linkages between, I think it's between your surveillance data for your monitoring of this, or you can tell me, I guess,

or share with the group if that's the case. Because I sort of remember hearing that a ways back.

But at the end of the day, I don't have the technical details on if it's a you know, a specific type of western blot confirmatory test that's required, or if it's an actual viral load assay that's the inclusion criteria. But there's in terms of, so I can't really speak to that point, but to the point of LOINC codes, and how you're capturing the viral load quantity, I think just like in elective deliveries, there is you know, an opportunity to link with vital statistics.

This is another example where particularly at the state level, linking between the state Department of Public Health and the data available there through surveillance with you know, the state Medicaid plan is something that I know can be done and has been done, and maybe could be a model.

MS. GEE: Yes, just to agree with Jennifer. This is one of the pay for performance measures that we're going to be using for our next round of managed care contracts. We have a philosophy in our department that we want to break down silos between Medicaid and public health and as public health shifts away from direct service provision, they ought to be part of the performance measurement enterprise.

This is a perfect example of how that works well. Although we haven't embarked on this yet, and used this data yet for quality improvement, and so we're taking a little bit of a risk right off of the bat, using it as a pay for performance measure, we're very excited about what this represents.

And I'll just say, Louisiana has the number one and number five highest case rate per population cities in the nation with HIV. It's an incredibly -- and for Medicaid in general,

HIV patients present very high costs, so it's a very important measure.

But I like to see measures where you are using public health expertise and our surveillance systems along with Medicaid.

CHAIR PINCUS: Nancy, did you want to make a comment? Oh, okay that's. So any other comments on this? So it sounds like this is something that is -- has not yet been implemented. It is something that, right, that will be implemented. And we'll learn something for it for next time.

It sounds like this is an important group of -- an important priority to focus on. And it also sounds like there's a capability of enhancing sort of the infrastructure for linkage with public health as sort of an added benefit for including this measure.

But also understanding that it is potentially complex. But there will be something to learn from it. So we would

recommend the continuation of this obviously.

So we're done with going through all the measures. I suggest we take a five minute break, and then we come back and we go through measure gaps.

(Whereupon, the foregoing meeting went off the record at 10:58 a.m. and went back on at 11:08 a.m.)

CHAIR PINCUS: Okay, let's get started. What we wanted to focus on was measure gaps. So Megan is going to sort of summarize what has come up over the course of this day and a half almost, in terms of what we previously identified as measure gaps. And what we want to do is get some feedback in terms of any further elaborations on these and also ones that have been missed.

MS. DUEVEL ANDERSON: So we have some specific questions for the task force that we'd like you to consider. We'll review the previously identified gaps and the gaps

throughout the course of the last two days. We would really urge you to identify gap areas and measures for gap filling that can be implemented in the very near future. And also just two to three of the highest priority gaps for future development, things that there's enough evidence that does exist to develop a measure in the near term. And there's also reasonable data. We've had really good discussion about feasible data and reasonable data sources. Those are kind of the primary questions for the session on gap filling.

Previously identified gaps in the last report included mental and behavioral health issues including substance use and health screening for individuals with mental illness. There's also a gap in disparity sensitive measures and access to care, care coordination, person-centered care and patient activation and engagement and wrap-around services and also individual's goals for their

own care.

I'm also going to go through the measure gaps that were identified and kind of emphasized over the course of the two days. And we want to make sure that we have kind of a comprehensive gap list. At the end of all this, we have mental health, behavioral health, and substance use, specifically outcomes and treatment related to those issues. Access to care and ED utilization and experience of care and specifically under beneficiary priorities for quality of care by getting their experience from the beneficiaries directly.

Cultural competency has been addressed or has been identified as an issue as well as care coordination and transition of care and there's a connection to health and human services and other resources that is missing. And then also cost and efficiency. So there's some measures that we've identified that do address these gaps in a way, but they

may be insufficient or do not fully address these areas and so they may maintain and continue to be gaps. And there are other areas where there really aren't any measures available to address these issues.

So if anybody has priorities they'd like to see, we do have some gap-filling measures available for you to consider and make recommendations on, but if anyone has any thoughts or any glaring gaps they'd like to add to the list.

CHAIR PINCUS: Okay, so Rebekah, Alvia, Cindy.

MS. GEE: So and Cindy, just chime in with me. In Louisiana, we are responsible for paying for 70 percent of the deliveries. It's second highest in the nation and that means 70 percent of the children born are born into Medicaid. We lack maternity measures that are meaningful in the area of prematurity predominantly and so that's why we've created

a progesterone measure. We've discussed this with our colleagues at CMS and March of Dimes that we're in the process of doing this. It's complicated, as you know, to create a measure. We'd love help from our colleagues. It's a huge gap.

If you think about national goals, I don't think there's any one more important in Medicaid than reducing the rate of premature birth from a long-term perspective for outcomes. And so it's an area where we don't have a measure. The low birth weight is okay, but there is so many inputs into low birth weight and there are many things that a managed care company or state Medicaid agency could not impact in terms of the feeders or the logic model as to why low birth weight happens. We like progesterone. Not that we shouldn't do -- I think we should also look in that area of prematurity and low birth rate and other areas of measurement, but progesterone is a

good place to start because it's really the only single medical intervention that we know will reduce prematurity and we know that we do terrible on it in Louisiana. Only nine percent of women who are eligible get progesterone, in Ohio, ten percent. So I think that's the big gap.

Very low birth weight I think is a better measure than low birth weight and I would like to promote the use of that measure. That really gets at when we look at Louisiana, infant mortality variation. The infant mortality is largely explained by the birth of very low birth weight babies, particularly less than 500 grams and this is an area that really gets at inter-conception health and as Medicaid expands, this issue becomes very important. So on the second note, the issue of inter-conception health needs to be better measured.

ACOG is putting forward a birth control contraception measure and there's a real need for that. It's politically fraught because of the historical issues of women forcibly being sterilized and being encouraged to use birth control and maybe didn't want to, but it's an important area to explore, particularly with Medicaid expansion. And so that's an area we'd like to see more measurement opportunities, as well as follow up after postpartum care, not just the postpartum visit. And we've talked at the national level as well that the post-partum visit measure is not appropriately structured. The 21 days is a low end, is not appropriate. Some women may get a visit two weeks after the delivery and that's fine for them and their provider. The 56-day endpoint is not consistent with Medicaid where we end typically at 60 days postpartum, so you're missing some. So that should be changed. But beyond that, ACOG and SMFM have

met recently to talk about what a measure would look like that also included the fact that okay, you have pre-eclampsia, you need testing for blood pressure after that, that diagnosis during pregnancy or you had gestational diabetes, you need glucose monitoring and those things should be as we expand Medicaid and women do have inter-conceptual health, taking into account the pregnancy experience into the primary care experience and coordination of that, what happens during pregnancy and making sure that that results in an intervention in a primary care office is very important and there's a need for measurement in that area as well.

CHAIR PINCUS: Alvia.

MEMBER SIDDIQI: Yes, so Rebekah is obviously right about one of the points that I was going to make for Illinois as well and I'm sure you're seeing this with all the other states and in the top ten readmission rates, we

do see that obviously maternity care pregnancy is a big diagnosis for Medicaid clients. Over 50 percent in Illinois of Medicaid expenditure is spent on deliveries.

And again, we don't have enough measures here in this core set I feel directed to maternity care. I think it's helpful we have the timeliness of prenatal care. I think it's helpful we have postpartum visits which is still very important and somewhat indirectly tied to the contraception issue, but I do think it's time to look at measures that are outside the box that are trying to address LARC insertion, trying to address any barriers to LARCs.

So for example, in our state, we're moving towards managed care and we've already experienced where one managed care has said if you fail a Depo shot or you fail a pill, then you can qualify for a LARC. It's really frustrating. I hate to say this, but it's like

you're almost waiting for a lawsuit before the state realizes we need to change this. But we are looking internally at trying to improve policy to try and remove those barriers, but I think it's very important that the intervals between pregnancies, all those measures that I believe CDC has some measures that are more related that we could look at.

And then I do think in terms of priorities here, so in addition to maternity care and everything we just talked about with contraception, I think it's really important to address that access to care and ED issues and ED utilization we don't have even one measure on that right now, but I think that's really important and something we need to move up higher on the list. Again, it does help with overall reductions in cost, so I think CMS would be very interested in it and I think it does help with trying to address all the different barriers and psychosocial factors that lead to

follow up from ER. But then again, it goes down to that provider level and to the plan level to try and improve that access. So I think ER utilization is something we're really lacking here, too that we need to add.

MS. GEE: Just two last things is that we often focus on baby and not mom and so we know that maternal mortality is increasing partly, but not completely, but as a result of maternal hemorrhage and increased c-sections, placenta accreta. We need a measure on hemorrhage management of hemorrhage. We also need, along the line with SCIP, because c-sections are so common in Medicaid, it's probably other than circumcision which many Medicaid programs don't pay for. One of the most common or the most common, I don't know, procedure that we pay for, I would guess, provision antibiotics prior to suction or appropriate, surgical measures related to Medicaid just because it's such a common

procedure. I think we lack that in the core measures.

CHAIR PINCUS: Cindy.

MEMBER PELLEGRINI: Since we're on a theme here, I will be brief because I was going to say a lot of what Rebekah already said about pre-conception care and interconception care, the fact that ACOG is working on this measure on contraceptives, but that isn't only just one part of the question. I'll broaden the aperture just a little bit more to say we need more primary prevention measures that even most of the prevention and wellness measures that are in this set right now are arguably secondary prevention. They're cancer screening. They're tobacco cessation counseling. It's after the fact. So you're detecting cancer early, but you're not preventing it. You're trying to get people to quit smoking, but you're not trying to stop them from doing it in the first place, so we need more primary prevention

measures. And of course, I think particularly since we're talking about Medicaid for women of child-bearing age, that's a critical gap.

CHAIR PINCUS: Marshall.

MEMBER CHIN: Looking at the current topics up there, and anything about how a lot of them fit under some of the changes that are starting to occur with the switch toward global payment. Medicaid and the Federal Government has been -- and state governments have been some of the leaders in the switch from fee for service to the global payment measures.

Some of the disease-specific things are transferrable as measures. They're also -- there may be other measures that we should probably think about that may be a little bit different.

Cindy's point, for example, about more primary prevention is like one example, you know. It's different than secondary prevention and sort of gets to this idea about

keeping people healthy or some of the social determinants of health type of things too that would fit that rubric also. So to sort of think about are we capturing the right to have a metric for the evolving payment systems.

The second question is, long-term care issues I thought to be covered by like a separate dual eligible Medicare standards or -- okay.

CHAIR PINCUS: So I had two comments. One substance abuse. There is no measure in this set on substance abuse. And that's clearly a key issue for this population. Now there's not like there's a lot of great substance abuse measures out there. But it's something that needs development.

Number two is following up on what Marshall was saying that with the move to sort of global payment and those kind of things, as we discussed yesterday, it makes some of the measurement issues more complicated, but to

think about how we might make better use of structural measures, whether built around certain social measures at two levels, one in terms of different sort of care structures whether it's patient-center medical homes or other kinds of things that can be built into it. But also about participation in registries, especially for procedures. You mention the c-section and other kinds of things, people are capturing sort of longitudinal information that captured data about both process and outcomes.

Number one, it may be a way to actually influence care as well as to actually measure care and, then actually also might provide data that could influence our understanding of care. So that's another sort of thought about something. And I don't know why that couldn't be part of a state-level Medicaid measurement process.

Other comments, suggestions? So

Nancy and Doris and Jennifer.

MS. DUEVEL ANDERSON: I urge you to be slightly brief. I'm standing between you and lunch and we have gap measures that we can adjudicate as well.

CHAIR PINCUS: Yes, and you're also going to hear from D.E.B. Potter and Sarah Scholle as well.

MS. DUEVEL ANDERSON: Thank you very much.

MEMBER HANRAHAN: I will be brief. As far as gaps in measures, I think we have gaps in wellness measures, and one could say those are primary prevention kind of ideas, but when I talk about wellness measures, I'm really speaking from a patient-central kind of perspective. And a wellness measurement system probably should start with using the health related quality of life measures that the science itself has quite well developed, but pulling that whole science into the

conversation of developing strict measures through the National Quality Forum and CMS I think really hits the mark around the agenda for the social agenda for change in healthcare in this country, the accountability, the affordability, and better satisfaction.

So when I speak, also I'm going to talk to mechanisms that could be developed and I mentioned earlier PROMIS. I think it's almost similar to the idea of a registry in the sense that what we would be doing is on a national level we would have a mechanism for tracking longitudinal movement towards a goal. And right now, we're really focusing primarily on cross sectional evaluation and making that leap is the question that we all grapple with in research, too. It's really an important question to grapple with and to address.

The other area that I would encourage us to look at is work environments and work injuries around employees. This is a

national public health concern and that creating some kind of measures that address injuries that are incurred in work environments is really important and also addressing optimal work environments. And I'll speak specifically from the research that we've been doing around practice environments for nurses, that there are optimal practice environment conditions that make nurses better employees, better supported employees that have science, evidence that shows that they're related to better outcomes, including lower mortality rates.

MS. DUEVEL ANDERSON: Could you summarize a snippet and tell me what the gap is?

MEMBER HANRAHAN: Well, I don't know that we have any work, environment or work injury or optimal work environment measures at all, do we?

MS. DUEVEL ANDERSON: We have a Workforce Task Force that has the -- will have

a report out for public comment.

MS. LUDWIG: I'm on that project as well and we did a survey of workforce measures and I can't think of measures that we found --

MEMBER HANRAHAN: So you could call it workforce measures? Is that how it would fit better?

MS. LUDWIG: Yes. That's pretty broad, but we can work with that.

MEMBER HANRAHAN: Okay, and then the last is at the systems level. We need right metrics for an evolving system. And this is what Marshall repeatedly said during his time. And I would use the words integration of care and that would embrace the whole continuity of care idea, that the integration of care is actually being swiftly developed by the SAMHSA group on the website and I gave Sarah some of the -- I gave her the URL for people to look at.

Patient centered is another area that we talked about in continuity of care.

But integration of care is an idea, a measure gap area that I think really addresses the mental health/behavioral health substance use outcomes spectrum, but it embraces it from an integrated, non-siloed perspective about the issues that are focused on mental health and behavioral health issues. Thank you.

CHAIR PINCUS: Doris.

MS. LOTZ: I'm unaware of any measures, but I want to take your comment on substance use one step further, Harold, and just to remind folks that we're becoming increasingly aware of neonatal addiction syndrome and something more than a count of would be appreciated.

CHAIR PINCUS: Jennifer.

MEMBER SAYLES: I was just going to make two comments. One was actually a follow up on the substance use area. So there is the one substance use treatment measure that's in the measure set. I think similar to mental

health, the idea of having screening particularly in the Medicaid expansion population where this is a very high prevalence condition is really important and there were no -- I don't know if there's any in the candidate measures, but that's something that really getting to a place of routinely integrating behavioral health screening into primary care is where we need to go as a program.

And then the other was kind of just echoing some of the comments mostly yesterday about access being a domain where there's a lot of issues that maybe, not that there aren't issues everywhere, but that they need to be -- often are particularly pronounced in the Medicaid setting. And I think specifically, the idea of emergency department use, whether you want to call it avoidable emergency department use which is what the measure in California has, or if you want to call it preventable, or ambulatory, or however you want

to name it, the idea of inappropriate use of the emergency department might be a direction that could be looked at or explored that would be really relevant to coordinating care and doing more patients under care in this population.

CHAIR PINCUS: Other comments, suggestions?

So D.E.B. and Sarah, do you want to sort of speak now to the issues about some of this stuff that's going on in your various domains?

MS. POTTER: We actually have some slides. Nope, that's not it. It actually has my name and Sarah's name on it.

I'm D.E.B. Potter from the Agency for Healthcare Research and Quality and yesterday when I talked to you, I was talking to you on behalf of AHRQ because I represent AHRQ on a couple of MAP work groups.

Today, I'm here to talk to you about my other day job which I do two days a week. I'm

on detail to the Office of the Secretary, ASPE, where I'm working on a variety of quality measures projects. And it's one of those I'm here to talk to you about today. So but first I'd like to introduce Sarah Scholle who is a key member of the team.

This work has been going on for almost three years now. It's a joint project between the Office of the Secretary and the Substance Abuse Mental Health Administration. And one reason why we thought it would be useful to talk to you all today is it takes a key focus on comorbidities among the behavioral health population. And you've talked about comorbidities. You've also talked about the behavioral health population, has gaps in it. It looks at them in terms of disparities in care for these populations.

So -- there it is. Thank you. So as I already mentioned, the project has been ongoing for three years. It's a co-project

between ASPE and SAMSHA. The work started out conducting a measure scan. The contractor for the project is Mathematica Policy Research and then NCQA is the subcontractor to the project.

We held focus groups back in 2012 to gather input.

And there was a consensus among the Technical Expert Panel that was -- I don't know why it's jumping around.

Okay, so the Technical Expert Panel reached a consensus that we should focus on comorbid conditions among the substance abuse and mental health population as well as measure for emergency room follow up. And so as you would expect, we looked at the strength of the evidence. We specified a series of measures that were specific to the substance abuse and mental health population. What was unique in what we're doing is we started the work with existing measures and then we stratified those measures to report on the substance abuse or

mental health population.

So the parent measures that we're working with are already existing measures that are being used and I'll go into more detail. So we held a series of Technical Expert Panels. We field tested the measures and we came out of the field in 2014.

So the reason why we focused on what we did is the higher prevalence in the comorbid conditions, the hypertension, the tobacco use, all of these you've talked about in the last two days, the disparities in care, the premature natality among this population, and that there are effective interventions.

And so the goal was to better monitor whether these sub-populations were receiving routine care which we thought that health plans were well positioned to do.

And then we had an ED visit and I'll talk about that later. These are the measures that we had under development. If you look at

the top line, it's NQF number of parent measure. That was the measure that we started with. These are all existing measures and we said okay, if you take that measure and you just report on it for the substance abuse or mental health population. So tobacco -- they all are screening with follow up, tobacco, BMI, blood pressure, alcohol use with brief counseling, depression screening and follow up, comprehensive diabetes, blood pressure.

And there's the typo -- the last one is supposed to 0576.

So as you can see, most of these are specified for the seriously mentally ill population based upon the evidence and from our specific to the alcohol and drug abuse population.

So this is what we started with. The original measure was controlling high blood pressure and what we said well, what is controlling high blood pressure in the

population with serious mental illness? What is comprehensive diabetes care for people with serious mental illness?

The top row are all PQS measures. Those were the measures that we started with. And then we moved the measures up to report on the health plan level for the substance abuse and mental health population.

We tested these measures in a variety of plans and what we found and these are preliminary results. We're still looking at the data. That there were wide disparities in looking at these measures for the mental health or substance abuse population when compared to the Medicaid population as a whole with differences in the range on average of 14 to 18 percentage points differences when you look at the full Medicaid population versus these sub-populations.

MS. SCHOLLE: So we tested the screening and monitoring measures in three

health plans. One was a special needs plan. Another was a plan that included a served disabled Medicaid beneficiaries and the third plan served low-income Medicaid beneficiaries. So very diverse plans and the performance rates were very diverse as well but this was a typical test where the health plan actually connected the chart abstraction and the contract team calculated performance. And then the follow up after ED measures tested in the Medicaid claims data using the state Medicaid analytic abstract.

So we're still, as D.E.B. said, the results are still preliminary, so where we could compare to existing Medicaid health plan data, we did find large disparities and that's in the controlling high blood pressure and the diabetes measures. And that's particularly evident on those measures that look at glucose control, blood pressure control, so really -- and actually, some of the testing

results were very different.

We also saw a lot of room for improvement in the screening and follow-up measures, but we don't actually have a good comparison group because those measures are reported in PQRS and the PQRS data are for Medicare beneficiaries in some of the ACO programs. And of course, there are lot of disparities there but we're not sure it's an apples-to-apples comparison.

But what's contributing to a lot of the low performance is that these populations don't have access to any kind of care and that's the first bullet of -- I'm kind of going out of order, but the first bullet here is that among the plans, 25 percent to 99 percent of the members with serious illness had at least one ambulatory visit. That means in one plan 75 percent of the members did not have an ambulatory visit. And if you don't have a visit, then -- some of these measures have a

two-year look back, but generally, if you don't have a visit, you don't meet the measure. So that's an automatic fail for the numerator. And so the lack of access to care is actually contributing to poor performance.

One of the plans, the SNF plan, actually looked like it had better performance and it was right at the Medicaid health plan average. So what -- this is confirming the work that we had seen before that suggested we find disparities in care and gaps in care and we certainly did find it.

MS. POTTER: So we're still conducting focus groups and we are going to have a technical expert panel coming up soon and then based upon the recommendations from the expert panel, we are going to refine the measures, but our plan are based upon the recommendations from the TEP to submit the measures to NQF for endorsement on the 25th of July.

CHAIR PINCUS: So this is -- from my

point of view, obviously, I'm a psychiatrist and this is a really important population because number one, they are incredibly costly as we showed earlier, four out of the top ten sources of readmission to hospitals are, in fact, mental health and substance abuse issues.

But more importantly, people with these conditions have about a 20-year lower life span than the average person and what D.E.B. has sort of described is a fairly clever, sort of disparities strategy, to sort of think of this as a disparities population and that by looking at it this way, it has several advantages. Number one is that they're able to use sort of existing reasonably well validated endorsed measures, you're simply looking at a subsection performance of a particular population.

And number two is it's not a -- it's a big lift to sort of pull these into potentially the adult Medicaid core list. It

would be useful to look at the extent to which that's feasible as we think about over time and filling in some of these gaps and something for us to think about moving ahead.

But let's hear other comments from other people.

MEMBER SAYLES: This is old.

CHAIR PINCUS: Okay. Nancy.

MEMBER HANRAHAN: This is my area of study and I was just telling Harold that we just finished the random control trial with the transition from hospital to home using a random design that was the pilot. One hundred percent of both groups actually had access to services during the 12 weeks following hospitalization which was a bit surprising when the assumption is that people aren't getting access to services and that's why that might explain why they have this 20 year earlier death rate and problems, the magnitude of problems they have are unquestionable, the comorbidities are very

complicated and highly symptomatic.

And also, my colleagues at Penn, Aileen Rothbard at the Center for Mental Health Policy they studied Medicaid population and this is published. I'll send you the paper and they looked at those in the Medicaid population with serious mental illness and those without serious mental illness and they looked to see are they accessing services? Those groups are -- have a high level of access of services. They have a plethora of opportunity to access services from both mental health and the medical specialty side as well as primary care.

So then why are they so sick and so seemingly under served? I think the question is still to be answered, but one of the questions that we asked was what is the quality of the services that they're getting provided then in these settings in the primary care setting, for instance diabetes. Are they getting the standard of practice that's

endorsed? And those in the Medicaid, both Medicaid and the Medicaid SMI population, the SMI population appeared to be getting better services than those in the Medicaid population, so the quality of services you can provide.

I think where this leaves me as a scientist, a researcher questioning is is access really the issue or is it something else in the configuration of how we treat, how this illness evolves that we've always been thinking in silos about here's a mental health problem and here's a medical problem. Well, maybe in this case what we're really looking at is something entirely -- something you have to examine differently. Maybe it's about -- I'm going to make this up -- inflammation, that this population genetically has a propensity toward becoming -- having autoimmune responses. I'm just getting on the edge here, but I think we're really still at the place we just don't understand what is this phenomena of concern.

Now getting back to the work that you've done, I think the work is great and I love what the progress of it makes and the interface with what we're doing here. I don't think it's going to hurt us to merge these measures into the NQF efforts. In fact, I think it's going to be very helpful to promulgate a standard practice. But I don't think we should think in terms of people getting more access to services really solving some of these problems is realistic.

CHAIR PINCUS: Other comments? Questions? So one question I have is so how would the and maybe this is more to Karen, so how would the or Marsha, in terms of how would the information that's being generated from this effort sort of feed into the Medicaid core set of changes over time?

MS. LLANOS: I can start. I think the general populace would be that the measures aren't ready now, so it seems like a future

annual review is when they would be considered.

CHAIR PINCUS: Would they have to go through the NQF endorsement process first?

MS. LLANOS: Not necessarily. I think we've -- so we know there's NQF selection criteria that the MAP would consider, obviously. I think there's the -- Sarah calls it fit for purpose, is that right? So I think there's that one piece where as you can see in our current core set not all of them are currently NQF endorsed. It certainly lends itself more especially for some to use in a variety of different programs. But I would say I think we would take them when they're ready and as it aligns with our annual report process.

I think the other piece to keep in mind is certainly this is a key target population. I would say a number of measures that would need to be considered as we -- if we consider holding them over time, I think we'll try to keep the core set, obviously, but we

would encourage state uptake.

MS. LASH: And just to add a little bit more on endorsement and our relationship to this review, it looks like they're coming in later this summer in July, so next year at this time we'll have a lot more information to go on about their scientific properties and really to be reexamined in the context of gaps at a future time, so this seems like to me something to just recommend them and keep an eye on, monitoring, the future development of the measures.

CHAIR PINCUS: And I guess maybe one of the questions to the people from the state Medicaid programs, how big a deal -- to the extent that these represent sort of an existing measure where you're looking at a subset of the population, how big a deal is it to do a separate reporting of that subset?

MS. LOTZ: That's something that Mark and I were actually having a sidebar, well you could do a subpopulation analysis on the

existing measure. So no, it's not a big deal.

DR. BURSTIN: I'll just add that we've actually had lots of discussions with Sarah and NCQA about how we bring these in because in some ways they are sort of the sub-population within the parent measure that's already endorsed. So I don't see any real issues in what the endorsement process will bring to the table other than the fact that we need to think through how we handle sort of measures that are really substrate or are they different or are they not?

And sometimes the difference though is really a level of analysis as Sarah can talk to you about, really changes the measure pretty significantly and it's those kind of changes we need to look at, not so much that it's a sub-population.

MS. LOTZ: Although we don't have any follow up for any population, so that's intriguing and touches on other aspects of the

conversation over the last day.

CHAIR PINCUS: Any other -- oh, D.E.B.?

MS. POTTER: Just to follow up, the ED measure that we have been testing is similar to the measure that is already in the Medicaid core set that's the follow up after hospital discharge, so that was sort of the parent measure.

MS. SCHOLLE: Could I just add? So earlier this morning you talked about the BMI measure and there's a desire to have the follow-up component. We talked about the depression screening measure and the challenges of implementing that. Those are two of the measures that we have been looking at, so we've taken the position, the PQRS specifications which are specified for EHR reporting and also for reporting to the PQRS program using claims data, using the claims code.

So we actually used the EHR specification in the narrative e-spec to create our hybrid specification for the health plan reporting and that was -- so we encountered some of the same challenges that you talked about and I think were trying to figure out how to solve that, but that does seem to make it a different measure because you do have to think about different issues like what -- the physician specs really look at a particular visit, what did you do at a visit and as we thought about it from a health plan or population perspective, we've tried to think about well, follow-up could happen at other times. How do you give people credit for that?

The other thing is we are thinking actively about how to build this into a composite measure and I saw that that was a measure that was on your list somewhere about the need for a composite measure and one of the questions will be could we have a composite

screening measure for people with serious mental illness, could it somehow be tied to the diabetes or hypertension measure, given the high -- the high prevalence of diabetes and hypertension in that population, so that you would really just pull one sample for a chart review and then be able to look at a bunch of different measures. It's actually how we did our tests, so that's part of what we're trying to think about as we look at finalizing this measure set.

CHAIR PINCUS: Any final comments with regard to gaps issues? Any other gaps people want to bring up or mention?

Nancy?

MEMBER HANRAHAN: Just a comment that this -- what we're talking about here is a high value target area. It's high value target because this is the high-need, high-cost population and the affordable care initiative is accountability, lower costs, and better

quality. And it fits really well with that initiative. And if we can tackle and get this population better managed with our measurement system, I think we will have achieved some high value.

CHAIR PINCUS: Last word on gaps? Actually, it won't be the last word, because we'll have a round robin and people can bring it up again.

Okay, so why don't we break for lunch and reconvene --

MEMBER SIDDIQI: Can we do a work through lunch so we can try and wrap up on time?

CHAIR PINCUS: That would be great.

MEMBER SIDDIQI: I was just curious because of flights.

MS. LASH: Let me sort of review what we have in mind for the rest of the agenda this afternoon. We can maybe all get our lunch, come back to the table about quarter after and then we will sort of substitute the

item you see on the agenda about strategic guidance for strengthening the core set because I think we've done a lot to capture that over the course of the discussion. We don't need to rehash those same issues.

And then instead we will do a more deliberate look at currently available measures that address some of these gaps raised to the extent that we can, so we have a number of slides prepared overnight that we'll go through in lieu of that discussion. And then have a quick round robin where people can give parting thoughts about their most important priorities to emphasize in the recommendations.

We will have a hard stop at 2:30. I, for one, have to get on another conference call about ESRD measures with some of the folks in the room, so we will allow everyone to get to their planes on time. Does that make sense to everyone? Questions? Okay. Please enjoy

your lunch.

(Whereupon, the above-entitled matter went off the record at 11:54 a.m. and resumed at 12:31 p.m.)

CHAIR PINCUS: So let's reconvene. We had neglected at the end of the discussion about gaps to provide an opportunity for public comment, so why don't we do that now? Are there people on the line who would like to comment, or in the room?

OPERATOR: Okay. At this time to make a public comment, please press star, then the number one.

Okay. You have a public comment from Alice Lind, with WA State Healthcare.

CHAIR PINCUS: Okay. Can you make sure that the volume is there? It's hard to hear.

MS. LIND: Hi, this is Alice Lind. Can you hear me okay?

CHAIR PINCUS: Yes, that's good.

MS. LIND: Okay, great. Hi, here am I back living the life of Medicaid, and all of the issues that folks have been bringing up over the past day-and-a-half are certainly front and center for me as well.

I just wanted to make a small plea for not throwing out the baby with the bath water in terms of some of these really critical things to measure, like body mass assessment and depression and substance abuse and care coordination. These are things that have come up over and over again for us through legislation and governor's directives and through health reform efforts that we're making in our state. And honestly, I would just as soon try to measure these the same way that the rest of you are trying to measure them than try to come up with strategies on our own.

Even knowing some of these challenges that you have described are certainly very present challenges for us as

well in terms of having to get in there on the charts, et cetera. We're going to have to do it for the duals demonstration plans. We're going to have to do it for health homes. Again, I'd just as soon have consistency of measures across these various CMS programs as opposed to us struggling to find this path on our own. So thanks very much.

CHAIR PINCUS: Thank you. Other comments from the public?

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

CHAIR PINCUS: Anybody from the room wish to make a comment?

(No audible response.)

CHAIR PINCUS: Okay. So let's move ahead. I think there's a few things that we need to tie up toward the end, and part of it is sort of making sure that we've touched on all the strategic issues.

We need to circle back and look at

a couple of things in terms of some of the recommendations that we made for additional measures and to set some priorities within that. And then we want to make sure that we go around and everybody gets a chance to give their two cents, or even more than that, with regard to what they think are the priorities for follow-up.

So Megan, do you want to --

MS. DUEVEL ANDERSON: So we would like to kind of conclude the gaps discussion by reviewing the three measures we've recommended to be added to the core set, recognizing the significant expense and effort that's required to add measures to the core set with infrastructure from both CMS and the state sides and consider a priority for those three measures. Which of them is a priority?

We will also look at the readmissions that we discussed yesterday, the top 10 readmissions and the available measures that we have to

address those and potentially reconsider those measures in future convenings of this Task Force because of the kind of effort and carefulness that we'd want to have with providing detail, review and recommendations on the use of those measures in the set. Then we'll have an opportunity to ask each and every one of you to give one gap priority area. And so that's how we're going to go through the remainder of the gaps.

The Task Force recommended 0059, Comprehensive Diabetes Care, for the hemoglobin A1c for a control measure. This measure is an NQF-endorsed NCQA measure that's well-aligned across programs. It has been presented of members 18 to 75 years old with diabetes 1 or 2 that have had an A1c level during the measurement year that was in what's considered poor control of a 9 or greater, or the result was missing if the A1c was not done.

This is an outcome measure that is

collected through both administrative and electronic clinical information, so we'd like to kind of hear your priority for the use of this measure. I'll go through the other two first.

0647, the transition record with specified elements received by discharged patients. This is a measure that we discussed this morning. It's a complement and a paired measure to a measure that's already in the core set. It includes significant challenges that we've discussed about implementation and the kind of burden of doing a medical record review and it's a facility-level measure. However, it --

CHAIR PINCUS: It would be paired with the --

MS. DUEVEL ANDERSON: Yes, it would be paired with 0648, and these measures are intended to be used together and are endorsed together.

So consider this as a measure that

you'd like to prioritize along with the third measure, which is Measure 1799, medication management for people with asthma. We have a PQI asthma measure that this one would complement, would be addition to that measure. This is a measure that is in the health insurance marketplace and also HEDIS, but it's also in the child core set. It has two components, and one is the asthma controller medication at 50 percent of the treatment period and the other is the asthma controller medication at 75 percent of the treatment period.

So those are the three measures we'd like you to consider and for you to provide feedback on specifically which measures you would like to prioritize for inclusion in the core set and implementation.

CHAIR PINCUS: What we want you to balance in this is -- because it is a significant list for CMS to add an additional

measure. There's a whole set of activities that have to flow and then it carries on down to the state level as well. And so, to think about this in terms of both the importance of these measures in terms of filling a gap as well as sort of the feasibility and the amount of effort that it would take to actually implement.

And I don't know, Karen, if you want to make any comments about that?

MS. LLANOS: No, I think it will just be really helpful for us to understand where in the priority list the new additions fall in so that we can -- as Harold said, when we take into account additional burden on states, the infrastructure that we'll need on both sides to support additional measures, it will just be really helpful.

CHAIR PINCUS: So comments?

MEMBER PELLEGRINI: Just a quick question.

CHAIR PINCUS: Cindy?

MEMBER PELLEGRINI: Was the -- I'm just looking at my notes from yesterday. Was the diabetes care one to replace 0063, or was it in addition to?

MS. DUEVEL ANDERSON: It's an addition.

MEMBER PELLEGRINI: In addition to.

CHAIR PINCUS: Nancy?

MEMBER HANRAHAN: Just a clarification. Harold, medication management, across the board, is one of the measures or the quality processes that we want to endorse. Why put -- why focus on any particular illness or condition? Why not have one that's across the board that we would measure and track?

CHAIR PINCUS: Well, there is one that involves multiple conditions.

MS. DUEVEL ANDERSON: We have the

medication management, which addresses three different medications for chronic conditions. This is a separate measure because the admission measure was not, kind of, sufficient.

MS. LLANOS: So we do have -- right, so as Megan said, there's an annual monitoring for people on persistent medication. This is the one that folks talked about a lot, I think yesterday, in terms of whether the medication is correct or not. And I think that one was tabled for re-review, if I'm remembering correctly. So I think -- and I'm looking at Helen -- and the NQF's team who knows the broader swath of things. I'm not sure there's a general medication management measure. It usually ties to a particular condition.

MEMBER HANRAHAN: Would the policy be, or would the direction -- it would seem parsimonious to me to make a medication management measure process that you would monitor versus break it down into these various

conditions and maybe identify high-value targets for managing medication, but for consistency's sake and to keep the management of measures, the numbers down. I'm just really trying to understand the system a little.

CHAIR PINCUS: So Helen and then Alvia?

DR. BURSTIN: Yes, I think ideally we'd love to have more cross-cutting measures. They're pretty hard to do in areas like this where you have to tie it directly back to the evidence, and these were specifically selected among the lists of the ones that were most likely to cause admissions and readmissions, I believe. And so actually having some of that targets therapies that would actually reduce admissions potentially seemed like a logical tie-in, even if it is condition-specific.

CHAIR PINCUS: I think also that ultimately, in terms of collecting the data, these are different medications and they're

different conditions. So even though they may roll up to be a single measure, this involves a lot of the same kinds of collection procedures, and in some ways ultimately the implementation of a response may involve focusing on the individual populations. But it does provide consolidation. It also provides -- it's a reasonable way to observe these things.

Alvia?

MEMBER SIDDIQI: Sure. So it sounds like even though we've sort of proposed the addition of all three measures that may or may not be very feasible, especially in terms of the cost and that CMS may incur, and then also all the additional burdens of rolling it out to the states -- and so the way I would prioritize the three would be the first being this one. So, I like this medication management for people with asthma. No. 2 being the one about the discharge. So, I think that was 0647. And

then No. 3 being the additional diabetic one.

And the reason I would rank it that way is because for this medication management for people with asthma it is in the child core set, and so hopefully as states are reporting on the child core set, it's not a huge additional burden to now expand that into their adult population. It is a medication management one that -- especially with asthma that does affect readmission rates. I know it's not listed as the top 10. COPD is. But in terms of asthma, it is one of those conditions that essentially medication management adherence can help prevent future hospitalizations and increased morbidity. So it's something that we can do something about.

The other reason that I don't -- or I sort of pushed the diabetic one, hemoglobin A1c over nine, even though I really like that measure and it is outcome-based, to the third is because again it does rely on lab data. And

I know in the State of Illinois, we would not be able to move that measure. And I'm assuming that there's a struggle for lab data in a lot of other states as well. I think pharmacy data and prescription data -- so pharmacy and prescription data and claims data is what's the primary -- sort of the primary data sources that states can use, so that's why I think it would be feasible and easier to remove this one.

CHAIR PINCUS: Marshall?

MEMBER CHIN: Yes, I wonder if NQF staff can just summarize. What's the void each of the three is designed to fill? What are the closest existing measures already in the data set that would be the comparators?

MS. DUEVEL ANDERSON: So, I'll kind of go backwards through the slides. 1799, medication management for people with asthma is -- would be an addition to the asthma admission measure, just as the PQI measure with the per 100,000 member-months. And so that is

an outcome, but it's a result of a complication.

0647 is an attempt to add a second measure to address care coordination and use a paired measure in the way that it's endorsed. We've had a lot of discussion about care transition, care coordination and patient engagement, so this would be one way to address those issues.

And 0059, comprehensive diabetes care would be a complement to 0057, which is a part of a suite of measures. The measure that's currently in the core set is about screening and screening only. This would be a core control to address a very common condition that has a pretty big impact on the population.

CHAIR PINCUS: Jennifer.

MEMBER SAYLES: So, I guess I want to make sure I didn't zone out. We don't have to only pick -- I mean, these are the proposed new or additions. We're vetting those. There's not a -- you can only pick one?

MS. LASH: We'd like to give CMS an indication of where to start.

CHAIR PINCUS: Right.

MEMBER SAYLES: So only one?

CHAIR PINCUS: Yes. No, no, no. To put them in order of priority.

MEMBER SAYLES: Okay. So I'm going to -- then if we're doing that, I think, I feel like population health and prevalence in this Medicaid arena is important. Diabetes is I think by far the most prevalent chronic comorbidity, in at least most of the data I've seen.

Asthma, it was interesting -- I mean, I would have really have liked to see the rates because I remember Doris saying -- too bad she's not here -- it was 14 per 100,000 admissions. That's an incredibly low rate. I don't know how you even look at improvement. Well, it may depend on the state, but I guess it's a rate, so it's still -- it doesn't really

matter the n. So I guess I feel like if there's a lot of asthma work in the -- it's most prevalent in the Medicaid child population, it's well covered in the child measures. At least personally, I would vote to put that one at the bottom of the list. So I guess I'm totally disagreeing with Alvia.

CHAIR PINCUS: Okay. Rebekah?

MS. GEE: Yes, so I would agree with Jennifer that -- I mean, if you look at the obesity map, Louisiana is now the fattest state, so we can be proud of that.

FEMALE PARTICIPANT: Congratulations.

(Laughter.)

MS. GEE: So we won that race. So we -- obesity and diabetes are linked and obviously it's only getting worse. Diabetes is only getting worse. Asthma is a major problem if we look at our admissions for asthma, they're much lower. So I would prioritize

diabetes just based on numbers.

CHAIR PINCUS: Other comments, suggestions?

MEMBER SULLIVAN: Just this little one on the care -- could you just explain a little bit more what they're actually asking for in that care transitions, what they're asking the provider to do?

CHAIR PINCUS: So what this asks -- the other one looks at whether the information was transmitted to the next level of care.

MEMBER SULLIVAN: Right.

CHAIR PINCUS: This asks whether -- looks at whether the information was transmitted to the patient. Am I right?

MS. DUEVEL ANDERSON: Yes, the percentage of patients, regardless of age, discharged from an inpatient facility, including hospital inpatient observations, skilled nursing facility or rehab facility to

home or any other site of care or their caregivers who received a transition record and with whom the record -- the review of the included information was documented at the time of discharge, including at a minimum, all the specified elements.

The numerator is the following elements are for inpatient care, a reason for inpatient admission, and major procedures and tests performed during inpatient stay, and summary results, and a principal diagnosis at discharge. Post-discharge or patient self-management components include a current medication list, and the studies pending at discharge, and any patient instructions. An advance care plan would include advance directives or a surrogate decision maker documentation or documented reasons for not providing an advance care plan. And then also contact information and a plan for follow up with care, which is a 24-hour/7-day-a-week

contact information including physician for emergency related to the inpatient stay, and contact information for obtaining results for studies pending at discharge, and plan of follow-up care, and the primary physician.

The denominator is any patient discharged from the inpatient facility to home care or any other site of care. It does exclude patients who left against medical advice and patients who died. It's not risk-adjusted and it's frequently a process measure at the facility level, but it is tagged to address the national quality strategy of effective communication and care coordination.

MEMBER SULLIVAN: Yes. You know, I think all those things are kind of really important, so I -- it depends on what your systems are, could be a bit of a burden, but I think that's an important point that patients get this information. That's not as universal as we think. Now, whether what they do with

it -- even just basically getting the information. So I think it's worth considering that one. I mean, it goes into a level of detail which I think would be helpful in the care coordination. It's not just saying any kind of discharge summary. It's saying what has to be in it. And I think that that's kind of actually kind of good. And if you're going to really affect readmissions, that's probably one of your biggest pieces.

Now, I don't know what the collection is. You just have to say -- is this a chart review, though? That's the only -- I'm assuming. And that can be burdensome, unfortunately. It's got to be chart review, I think.

CHAIR PINCUS: One question I had is -- so the different elements that are captured, how different is it than the elements in the third measure except that they differ with regard to whom it's transmitted? So it's

the same information that needs to be there. The issue is to whom it gets transmitted, if I'm not mistaken.

MS. DUEVEL ANDERSON: And one is at the time of discharge and the other one is within 24 hours.

CHAIR PINCUS: Right.

MEMBER SIDDIQI: Right, and most hospitals should be doing this with the discharge, so that's why I think 0647 is actually easier to collect, because it's something they can capture through their EHR systems that how many percent of their patients on discharge received the discharge paperwork. And it's actually when it's printed, it's recorded, so whereas the other one, 0648, is talking about coming back to the PCP office, which definitely requires a much higher chart review process.

MEMBER SULLIVAN: An easier one to do, in a way. Is that what you're saying, I

think?

MEMBER SIDDIQI: 0647 I think would be, but the key is that it's linked with 0648, so I guess it would be interesting to see again in the years to come what states end up reporting on. Do they just report on 0647 because it's easier?

DR. BURSTIN: Just one comment on the measure itself. I mean, they actually have the same data elements you have to document, so it actually wouldn't be as simple as saying a check box, did somebody get discharge instructions? Because if they get discharge instructions, that included the following key elements, like the tests, you got the results. So it's not --

MEMBER SIDDIQI: But all of that is tracked through the EHR systems --

DR. BURSTIN: Yes.

MEMBER SIDDIQI: -- to be able to say that each of these components have been met.

DR. BURSTIN: Yes, you have to build that. Yes.

MEMBER SIDDIQI: So it's still something that you can pull --

DR. BURSTIN: It's not that simple.

MEMBER SIDDIQI: -- through the EHR system.

DR. BURSTIN: Yes.

MS. LLANOS: I mean, I think I would add if they are doing it. And we have four states that could actually try to do it. And we looked up the reporting. I think one did admin, one did hybrid, one did review, one did other. So it's -- right, so I think there is -- it's -- right, so I think obviously success of the additional one would be based on the ability to collect the current one.

MEMBER SULLIVAN: To be clear, then what you're saying is that they haven't found this very practical to do? Is that what you're saying? Then maybe it's not ready yet, the

time to push out. Maybe we have to respect that a little bit.

CHAIR PINCUS: Other comments?

(No audible response.)

CHAIR PINCUS: So I would -- let me step out of the role of Chair for a minute. My own view is that I would put the A1c ones first, I'd put the asthma one second, and I'd put the discharge one third. And my reasons would be that I think that the A1c is important given the scope, I would agree with Jennifer, but also because it also sort of pushes the envelope a little bit with getting to outcomes. And so thinking about this is sort of like compiling efforts to try to enhance the infrastructure for states. Even if initially it's not every state that's going to report this, but the ability to do that initially I think would be something that's worth sort of putting out there.

I think the reason for putting the

asthma in second is because it's probably the easiest one to do because it's already being collected by trial. And I think that the marginal value of the additional discharge one beyond what's already being collected versus how much effort is required is it is lower. And I always worry about sort of documentation versus reality in those kind of things.

So that would be my recommendation. Marc?

MEMBER LEIB: Well, first of all, I agree with your order because for me, diabetes is a huge problem. Asthma in the adult population is much farther down than that, than the diabetes. And the third being the collection.

For those of you who are more familiar with it than I am, is there by chance a PQRS reporting, some either category 2 code or a measure that is report on the claim to designate the A1c level?

CHAIR PINCUS: I think there is.

MEMBER LEIB: Okay. I mean, I don't know.

CHAIR PINCUS: I think there is.

MEMBER LEIB: I mean, I just don't know. Because if there is, then you can do things like require --

CHAIR PINCUS: I think there is a G code.

MEMBER LEIB: -- a physician to report that with a claim for an office visit for where diabetes is the primary diagnosis and you can start collecting data administratively by using a small subset of PQRS. Would have to be Medicare, but we can -- that makes data collection doable and relatively easy compared to a hybrid or chart review, if there's such a thing exists.

CHAIR PINCUS: Yes, it would be worth looking into that. I think -- in the back of my mind, I think there may be a G code for

that. Okay. So that we can look into.

So what do people think? Is there any objection to going ahead with that order that I mentioned?

(No audible response.)

CHAIR PINCUS: Okay. Good.

MS. DUEVEL ANDERSON: So now we have one more ask related to gaps. I think unless there's a clear sense of the priorities for that long list of gaps that we have, we would like to go around the room and give you an opportunity to state one measure gap as your priority. We will count them all up and we will communicate that in the report.

You seem to be kind of excited about this, so go ahead.

(Laughter.)

MEMBER SIDDIQI: I'm going to say ED utilization. It's time. ED utilization.

FEMALE PARTICIPANT: One more time?

MEMBER SIDDIQI: ED utilization. ER utilization. Emergency room utilization.

(Off mic comment.)

CHAIR PINCUS: Anything.

MS. DUEVEL ANDERSON: You have to use the microphone.

MS. GEE: Oh. Progesterone and prematurity, and then ED utilization.

MEMBER SAYLES: I'm going to agree with Alvia. ED utilization.

MEMBER CHIN: Care coordination.

MS. SMITH: Care coordination.

MEMBER LEIB: Avoidable ED utilization rather than -- would be the way I would -- a gap that I'd like to see addressed.

MEMBER PELLEGRINI: Can I vote for maternal health and kind of encompass things that Rebekah said along with pre-conception/near-conception care?

MEMBER HANRAHAN: So I'm going to say care coordination slash integrated care.

And that really pulls in the mental health/behavioral health piece, but not isolating that to that sector, but really looking at it as a part of the full picture of what we're doing in health care.

MS. DUEVEL ANDERSON: Wonderful. Thank you so much. Oh Harold, I'm so sorry.

CHAIR PINCUS: I'm glad not to do it. No, so I would say substance abuse, but the problem is that the current sort of measures that exist for substance abuse really suck, and so that they're not really very good. And so I would go with coordinated care/integrated care.

DR. BURSTIN: Just a follow-up question. This is for -- I'm sorry, you should do your gap.

MS. DUEVEL ANDERSON: Please use your microphone.

MEMBER SULLIVAN: If we're talking about measures we want to develop measures for,

then I would second substance abuse. I think it's -- and it's huge in the Medicaid population and I think it is not addressed in the way that it needs to be both from the screening perspective and an outcomes perspective.

The second, I would still stick with -- and then I would think of behavioral health, behavioral health with substance abuse. Remember those top diagnoses again for the readmissions and the problems? So I think that while -- I just think those -- well, those would be my votes for the gaps.

MS. DUEVEL ANDERSON: Okay.

DR. BURSTIN: Just one comment on gaps. It's often so difficult. I mean, everybody says care coordination and things like that. It would be really helpful if you could also even get a level down and say what you mean within sort of the concept of what would be useful to Medicaid in particular around care coordination. It is a very

difficult area to measure. Actually, a friend of mine actually refers to care coordination measurement as the Bermuda Triangle of measurement. Many have gone in; few have come out. But it's really difficult to come up with something that's actually meaningful with the exception of trying to get from the voice of the patient through CAHPS and other items.

But so, a real sense from you of what that means would be very useful I think to try to impart this to developers. They all know care coordination is at the top of every list, so it doesn't necessarily help to kind of pass on this. We need care coordination. So any thoughts there would be welcome.

MEMBER HANRAHAN: I suggest that we look at -- when we're looking at care coordination, that we look at mental health substance use measures that indicate that the person has been integrated into the health care system effectively. So the care transitions,

care coordination are heard to measure, but there is one measure that we have that I think has really made -- has some leverage, and that is the follow-up after a hospitalization. So care coordination in that regard is moving from hospital to home.

CHAIR PINCUS: So in some ways, what I think that D.E.B. and Sarah were presenting earlier was kind of backing into the care coordinations, because to perform well on the measures they describe would by their nature require greater care coordination, especially in behavioral health. So I think that that is a way to get to sort of a level deeper.

MEMBER SULLIVAN: And on the behavioral health side, I agree. And I think that the care coordination post-hospital, that I would spread it out over time because real care coordination should be a continuous engagement, but continuously again pushing

past just that first visit, which substance abuse does a bit in one of the measures. But in mental health as well, putting it out over time that somebody stays engaged in treatment, that's a proxy that basically that must be care coordinated if that's the outcome.

MEMBER HANRAHAN: Could I also just add that I think one of the things that you said, Harold, that I think is really important is the longitudinal nature of these outcomes that we're studying to -- that that is a gap, a glaring gap in the quality of the measures that we've got. How we're going to tackle that, where that's going to go and where that's going to break. We've got some development that Helen was speaking about around Coumadin that captures a level of -- the blood level, clotting level over time. So you've got a time factor that's associated with an outcome measure, right? I don't know where to put all that, but I think it's a really important piece.

CHAIR PINCUS: This may fall back on the development of registries that are able to capture sort of the essence of sort of coordinated, measurement-based care longitudinally that -- and the assurance of follow up in a consistent way. So that's really I think what we ultimately need to drive to. And by the very nature of establishing that, it's sort of a set of structural process and outcome elements that fall together over time.

MEMBER GESTEN: Can I throw one out, Harold --

CHAIR PINCUS: Sure.

MEMBER GESTEN: -- before you close this?

CHAIR PINCUS: Yes, sure.

MEMBER GESTEN: It's kind of in a different direction, thinking about what's missing. And this is a hard one and I'm afraid that Helen's going to ask me to be more precise,

which --

(Laughter.)

MEMBER GESTEN: -- I may not be able to answer it. But it strikes me that there -- really have no measures related to cost or efficiency or resource use, which is the third part of the third rail, if you want, of that triple aim.

So while there are some existing ones that have to do with specific conditions, and those are potentially one area to explore, I think it's not quite the Bermuda Triangle, but there are a lot of challenges in trying to do this. But again, I think of interest both nationally and to states is how can we achieve high levels of quality while at the same time be mindful of resource use and do it with the least amount of resources? And this may be a strange comment coming from a state like New York, but I think we're all struggling with how do we get -- how do we maintain and improve

quality with finite resources? So that would be one area I'd throw out there for -- as a gap area.

DR. BURSTIN: I think you're absolutely right, Foster. This is Helen. And I think there may be opportunities. Maybe Medicaid could look to some of the existing measures that are out there for other populations and see how adaptable they might be. For example, the total cost of care measure that was developed at Health Partners that's now actually being tested in 26 states might be a place to at least start that movement rather than everything going back to de novo development for a specific population.

CHAIR PINCUS: So Foster, I'm channeling Helen. Can you be more specific?

(Laughter.)

MEMBER GESTEN: Well, Helen mentioned it and, I mean, the specific things that are out there -- NCQA has created some

measures, and I can't remember, maybe they are, maybe they're not NQF-approved --

DR. BURSTIN: They are.

MEMBER GESTEN: -- related to resource use for specific populations that are sort of a nice way of trying to couple resource use with specific quality measures that can include, for example, asthma management as well as in-patient hospitalizations and so on. I mean, that's one example that -- again, it has that -- it has some precision to it, but it also has some of the down side as folks have mentioned about, gee, wouldn't it be nice to have a measure on this that is cross-cutting? I think the total cost of care measures tend to be -- are more cross-cutting, but they also have a lot of complexity in terms of what you include and how you calculate costs and so on.

So I mean, I think those are the direct -- two of the things that are sort of on the table currently, Harold, that are

potentially up for discussion. But is that what you were asking, or were you asking me something different?

CHAIR PINCUS: No, that's what I was asking.

Anybody else on the phone or here? I don't see any -- oh, okay. Rebekah.

MS. GEE: Well, so that was Foster speaking. Hi, Rebekah Gee. So just to add to what you were saying, one of the things we've thought about doing -- we're putting it in our managed care contracts, but we'd love to have quality measures around it -- is the Choosing Wisely Campaign from ABIM that's involved many other specialties. And we've asked our managed care plans to select several of those recommendations and to measure the lack of utilization of non-indicated procedures.

So I wonder if there could be a partnership between the Choosing Wisely Campaign and some measurement strategies

because that would be very helpful, and there's a lot of already professional alignment around that.

DR. BURSTIN: ONC actually has --

MEMBER GESTEN: Yes, I --

DR. BURSTIN: -- a contract with Rand to do some of that work now, so again, there may just be some logical connections that make sure that gets over to the Medicaid side, too.

I'm sorry. Were you going to say something, Foster?

MEMBER GESTEN: I was just going to say that I think that I would agree with Rebekah, that those areas really point in the direction of a lot of areas. Our own experience with trying to use them as measures have really run into lots of challenges related to data, because very frequently when you dig into the specific aspects that rely on a level of clinical data to judge whether an EKG or some other test is appropriate for somebody or not,

that that creates some challenges. It's not insurmountable in all cases, but I guess we've been impressed by how challenging it is to specifically implement those either as a measure or even -- or as coverage policy. But I think those are areas to look at around which there's both evidence and clinical consensus.

CHAIR PINCUS: Yes, the problem is if you start parsing the language in those, there's a lot of caveats.

MS. GEE: There are a few though that are more simple, like not doing a Pap smear every year if you don't have dysplasia, and that's a big one right there. So if you could just start with one and then work from there. Because as Foster said, until we really get electronic medical records and we're able to have more sophisticated holistic data, it's going to be hard to do some of them, but you could pick one or two like pap smears that are doable.

CHAIR PINCUS: Alvia?

MEMBER SIDDIQI: So I was just going to say that when we were asked about the gaps, I was more answering the gap question to the current core set, whether there was any gap still missing or what that number one priority gap was. And that's where I thought ED utilization would be a good one because there are a couple of really good measures out there we could incorporate into the adult core set eventually, hopefully, soon, and they do -- with ED utilization that does indirectly and directly affect cost. So I just think that's an important one.

But in terms of gaps where measures need to be developed, certainly I agree that care coordination obviously is a big one, because we could see that even in the care coordination ones that CMS has been a steward for, there's really no alignment, so really there hasn't been this widespread adoption of

those couple ones that we saw today.

CHAIR PINCUS: Other comments on gaps?

(No audible response.)

CHAIR PINCUS: Jennifer, do you -- your thing up there for --

(Off mic comment.)

(Laughter.)

CHAIR PINCUS: Okay.

MS. DUEVEL ANDERSON: Okay. So we have a slide up that is in response to the top 10 conditions for readmission in Medicaid, and these are -- there are two slides, so it's split up a little, and there's rates and costs available in the article that we'll cite in the report. And we wanted to be responsive to this. And we have identified measures that are in the core set that currently address these top ten reasons for readmission and we have identified some potential additions that a task force in the future could consider and

adjudicate for a recommendation to the core set.

You'll notice that we've already -- for diabetes and other related complications, there are three measures in the core set currently and we've already recommended to add one. The Task Force briefly discussed the control measure; however, we saw -- we heard a clear consensus for a preference over core control.

The second slide --

DR. BURSTIN: Could I just explain my addition there, the random adult current smoking prevalence? I just thought it would be an interesting measure for you to consider. It's a state-based measure using CDC data from the Legacy Foundation. It just might be an interesting addition to the mix. I just wanted to at least have Medicaid take a peek at it.

MEMBER SIDDIQI: And perhaps the one that is a measure that's linked to the CAHPS

data on the smoking could be still listed on the right side. Or, it's not on the right side, but I think it's an existing measure, isn't it? So that one actually supports the COPD one, too.

MS. DUEVEL ANDERSON: You're right. We'll update that.

So this is the other half of the top ten conditions, but these are generally related to -- except for congestive heart failure, generally related to behavioral health. So we have some measures currently in the set, but some other measures are endorsed that are available. And we did discuss briefly some of the importance of the screening for people with schizophrenia. And there are two measures that a future task force can adjudicate. And we want to be clear on our priorities, so we've been able to identify three measures for kind of more immediate implementation to the core set, and these can be considered in the future.

Does anybody have any questions or

comments?

(Off mic comment.)

Can you use your microphone, please?

MEMBER LEIB: I'm sorry, I just noticed that there's -- CHF non-hypertension is on -- is located in two different places on this list.

MS. DUEVEL ANDERSON: That was a mistake. It was an overnight table, so --

MEMBER LEIB: Oh, that's okay.

MS. DUEVEL ANDERSON: -- sorry.

MEMBER LEIB: I just wanted to -- trying to figure out which -- where it is in the -- if these are in the top 10 conditions.

MS. DUEVEL ANDERSON: These are not in --

MEMBER LEIB: Oh, they're not in order?

MS. DUEVEL ANDERSON: They're not in the rank order. The first --

MEMBER LEIB: Then never mind.

MS. DUEVEL ANDERSON: -- slide is more like chronic conditions and --

MEMBER LEIB: Never mind.

MS. DUEVEL ANDERSON: -- in general.

MEMBER LEIB: I thought they were in monetary order.

MS. DUEVEL ANDERSON: No, the second slide I wanted to give some sort of logical grouping with overall behavioral health and mental health.

MEMBER LEIB: I'm sorry for noticing it.

MS. DUEVEL ANDERSON: Oh, no, no.

(Laughter.)

MS. DUEVEL ANDERSON: Thank you. We will correct it.

CHAIR PINCUS: These are presented in different orders at different times. Sometimes by the number of admissions, by the

cost of admissions --

MEMBER LEIB: Because -- exactly.

CHAIR PINCUS: -- or by categories of --

MEMBER LEIB: That's why I thought there was a linking that I wanted to make -- figure out where it was.

MS. DUEVEL ANDERSON: No.

MEMBER LEIB: But this is just random.

MS. DUEVEL ANDERSON: No, it also -- we'll make sure that we circulate the information.

MEMBER HANRAHAN: To complicate things some more, sorry, the top 10 conditions for readmission are -- they really separate out the mental disorder conditions and the medical assorted conditions, whereas there was a report called Faces of Medicaid III that articulates these diagnoses more of an integrated perspective that I think is more the reality of

what we're experiencing than these separated out components.

Now, I know that I'm adding something into the mix here, and I'll just leave it at that because I know you're quite aware of that data. So I just suggest we integrate.

MS. DUEVEL ANDERSON: We will continue to evaluate information about the population and the needs and conditions as it comes available and try to use that to inform the evaluation of the core set going forward and updates to it. So hopefully this and other things like the Faces of Medicaid are helpful for that, for achieving the CMS goals and the core set.

Alvia, did you have another question?

MEMBER SIDDIQI: I was just going to say that under earlier threatened labor, perhaps the antenatal steroid measure would probably be added to that section.

MS. DUEVEL ANDERSON: Sounds great. Thanks.

That concludes our gaps discussion. So we wanted to ask you for your round-robin of the most important things that you would like to emphasize in the report and to the Coordinating Committee.

Just to remind you of the timeline. The timeline is eventually coming up. The public comment draft will be available for comments overall and we will have a Coordinating Committee review of the draft report and any comments that are submitted up to a certain point on July 18th during a teleconference. You will be informed of that teleconference; it's from noon to 2:00, and you will be invited to participate.

The final report will be submitted to CMS on August 30th, or potentially a day earlier, but it's due at the end of August. And so we hope that you can provide any comments or

any additional thoughts at this time to help us emphasize different points in the report.

The primary sections of the report will be kind of introducing and understanding the population and the goals of CMS. Then we'll talk about the themes from the state experience in collecting and reporting the measures. You've given us a lot of really great feedback and we really want to thank our friends from the states for their participation and the travel and giving up their very valuable time.

Then we'd like to go into the measure-specific recommendations. We have a lot of very specific recommendations and additional notes. Then we'll address measure gaps and summarize strategic issues and direction for those.

So for the strategic discussion what aspects are most important for your recommendations to HHS? So are there specific

program features that you see as incredibly important to have a final word on? And also, I think we've already had a lot of discussion about the measures and the gap filling. There was a rich discussion on implementation, so if you have any final words to stress implementation concerns or how specific information was informative to your decision making as a result of the implementation feedback. And then we'd like to hear about your thoughts in helping to drive the states' quality improvement. So the core set is really -- the third goal is to help drive quality improvement in the states and how can we really help this core set achieve that goal?

That's a lot to ask. So we have people with plenty of flights and we have about 45 minutes to really get through this. And it's your time, so I really want to hear from you all.

I don't know, Harold, if you have

any additional comments.

CHAIR PINCUS: No, I think that again, this provides some of the broader, sort of contextual, programmatic recommendations that we have in terms of thinking about the ongoing strategy for how this program can be most useful, both at the CMS but also the states. And so we want to sort of make sure that that gets clear.

I know there are a few of you that are leaving at -- you have to leave a bit early. I know, Jennifer, you've got an early flight, so I don't know if it would make sense to start with you in terms of thinking about that.

And we have listed there some of the strategic issues that -- on the -- under the clock. Yes, maybe it might be useful to -- just to quickly go through those. And we're not limited to those, but to think about the ones that we want to -- that people want to emphasize or that they want to elaborate on.

MS. DUEVEL ANDERSON: Okay. So the big strategic issues we've identified are Building state capacities and data linkage; assessing value of measures, including importance of return on investment of using measures; incorporating the beneficiary perspective, both in what's important for quality and quality measures, but also in the measures; a measure of Medicaid administration, and so the value and the importance of understanding the quality of the administration of the program; coordination with the child core set -- we've looked at that today, but I think there is -- we heard a lot more that could be done and was asked for.

Strategic issues regarding the process for clarifying measures; technical assistance and updates that are continued to be provided to the states implementing the measures; and encouraging collaboration -- heard that specifically from

the states. There is implication of bundle payment and how that affects the data that's available and the role of registries. So this is another important component for data and how the measures can continue to adapt and be responsive to that.

Managed care and fee-for-service; auditing and contracting multi-year requirements and deliverables, and there's a big diversity across the states in both managed care and fee-for-service; and then future incentives for stating reporting and how do we really achieve those goals for CMS to increase the number of states that report, increase the number of measures that are reported and drive quality improvement?

There were some measure-specific issues that kind of rose to a little higher level. The use of measures in the core set of comparisons versus improvement over time. Standardization versus specification, so

standardizing measures from the -- at the national level that all states report on versus states having specific measures or making modifying measures and kind of tailoring them to their environments.

The use of hybrid measures and the burden of medical record review. The balance of measure types. Having structures in the process and outcome measures. Alignment across all federal programs and crosswalks with federal programs and potentially also for states. This is important for their own state programs. And then identifying and going after high-value targets. And the last one would be the populations that are included on Medicaid and that are included -- reported in these core set measures really vary across the states.

CHAIR PINCUS: It's one of the burdens of having to leave first.

(Laughter.)

MEMBER SAYLES: It is. So, that was a long list of very important things.

(Laughter.)

MEMBER SAYLES: I guess maybe should it -- would it be useful to say --

CHAIR PINCUS: You're not limited to those. It's a --

MEMBER SAYLES: Okay. I mean, so like --

(Laughter.)

MEMBER SAYLES: Is this sort of what bubbles to the top in terms of personally what I --

CHAIR PINCUS: Yes. Yes, I mean, having sat here for a day-and-a-half --

MEMBER SAYLES: Yes.

CHAIR PINCUS: -- yes, what do you think sort of hits you and also in the roles that you had back home? What sort of -- which are the things that you think that would be the most important advice you can give going forward

with this program?

MEMBER SAYLES: So, I think I can think of just a couple things: I mean, I think this went incredibly well and was a very thoughtful and well-structured day-and-a-half. So thank you to NQF for putting this all together and for the opportunity to serve on this Committee.

So one thing that I think we did but maybe not -- maybe as structured, but that I think is sort of a guiding principle that at least I, and I think Marshall and some others, have kind of seemed to adopt a little later in the review was kind of thinking at a population level about sort of what is most prevalent, impactful or really where disparities between other populations exist and kind of using that as an anchor point for kind of making sure we're covering those areas.

And so obviously in this population we've got -- it's a very diverse actually

heterogeneous population in some states, depending on how many sort of adults are included. But I think that sort of using that sort of framework or lens to kind of come up with and prioritize within the measure set was an important activity and something that should continue, because I think kind of the corollary to that is I think we identified quite a few areas that we feel like are really gaps.

And I mean I would just put out that behavioral health, both substance abuse and mental health, as well as access and some of the social determinants are sort of four key areas that are really at the core of a lot of these populations and that I think in the big picture we're just starting to wrap our hands around some measures for those. So I think in terms of kind of strategically over time those are things that hopefully there will be opportunities to kind of refine over time. So I think that at sort of a high level would be

feedback I have.

I think that the other thing that I think I don't know that I've come up with a full kind of synthesis of but what I heard a lot of was, I mean, really the payment structures are so intimately tied to data and services delivered. And I think that this is particularly pronounced in Medicaid actually just at this transition time the United States.

And so I think that I guess being mindful of that and kind of the fact that there may be -- that's very heterogeneous across states, but there may be certain measures and I think why care coordination is coming up, and why access is coming up, and why addressing some of these other comorbidities is coming up is because a lot of the payment models don't necessarily support that type of care.

And so I think that again that's -- I'm not sure I fully have a silver bullet of how I would address it, but I do think

it's an important backdrop or context that came up quite a bit in this meeting that is probably something just important to kind of continue to think about.

I can't really think of that much else, but maybe I can chime in later if something comes up.

CHAIR PINCUS: No, that's perfect.

Okay. So just move on. Maybe sort of just go around. Marshall?

MEMBER CHIN: Thanks for assembling us all. I think that it's great that you guys are doing this effort.

I sort of had sort of mixed feelings I think over the past couple days that on one hand that I think it's great to make this much progress in a relatively short period of time. This started I guess what in the past year or so. And so in some ways I can see the point about what seems to be incremental improvement in terms of building upon what's already here.

On the other hand, I had a sense the pace may actually move more quickly than we've talked about here. So in other words, when I asked like Karen the first day about what's the use of these measures? What's the -- who's the users that use -- and Karen basically said both the gamut of responses. So quality improvement, which is I guess where you start.

But then she also said that, well, different states will be using this for accountability at some point. And I think it may be sooner rather than later. But I think about like this with the Medicare program and my sense is that they're further along and there is no reason why the Medicaid program would expect that it would be lagging that much further. So even though if we're thinking it may be slow change, my guess is when it comes down to it, when the capital measures and the reimbursement occurs, it's going to be faster than we think. So in some ways I do

think we should probably push the envelope a little bit more. So some of these measures -- in other words, if you're eventually going to be using these for accountability purposes, you should pick measures that matter, that matter to patients, matter to providers, ones that people are going to be -- want to be judged upon. And so that we should teach to the test.

Why have a measure like measurement of A1c, which isn't all that meaningful in the grand scheme of things. The point that people have been talking about regarding sort of increasing outcome measures or Jennifer's point about the head of -- well, if we're seeing more capitated contracts at the state level and what are the measures that are going to be important there?

So I'll just say that, again, I understand the part about being incremental. And if I were a Medicaid state director, I would

probably frankly say many of the same things that people said here, because if it's unfunded mandate, I understand where people are coming from. But I think from a patient perspective -- and we're changing. Probably it's going to be faster than we think. We should be preparing -- or maybe the next iteration of this, that we do come up with in some ways a more optimal list of the different measures, and as Jennifer's saying.

And maybe I think you guys did it initially, but it's maybe worth a re-look in terms of the comprehensive strategic look of are different areas covers, as well as because the marketplace has changed. And so this whole thing about care coordination and goal payments and all, my gist is that the measure set that we'd be looking for is going to be different than we have right now.

I think another thing, too, is that we have the advantage of states of being single

laboratory, you know, 50 different laboratories, so some states maybe be laggards in terms of them not being ready to do innovative things, but there are going to be some that are ready to go full force now in terms of accountability and looking for the incentives to improve care and all. Why not have -- especially if this is a voluntary set and people can pick and choose which ones they pick, why not have better measures that the leading states can use so that they can have the measures for their purposes?

CHAIR PINCUS: Marc?

MEMBER LEIB: Well, the message I'm going to be bringing back to Arizona; because you all heard my tale of woe yesterday and why we didn't have the grant and we don't report measures, but we will be, is that as we implement with our new contractor the measurement, to pick and choose those that don't just produce a number, because whether

the number is good or bad doesn't really matter if we don't do something about it. So it's going to have to be measures that we can actually take an action to -- to take that and that when we measure it again the following year have it be better, wherever we're starting from. So whether we start with the core group or 10 of them, 15 of them, all of them, whatever it is that we are able to measure, I think that our aim will be to pick those that we can actually change something.

Some of these measures are things that I don't think we're going to have much control over initially, and so we may put those off. And the ones that we think we can drive both through our managed care plans and through incentives to providers will be the ones that we pick, we choose to measure, because then we can actually show something for it.

So what I'm going to say is a take-away for this is that as CMS moves forward

and as NQF moves forward to develop these measures for the core set, whatever we're going to do, the core set is going to get larger. And I think as it gets larger the expectation shouldn't be, okay, states, do all of them, but here's your menu. Pick some that you want to work on; and hopefully you'll pick a few more next year, but tell us not just what the numbers are, but how you used them to improve the quality of care you delivered, because ultimately that's what it's got to be about, not just where we are.

CHAIR PINCUS: Cindy?

MEMBER PELLEGRINI: Okay. So, I've been lucky. I've had a couple minutes to sit here and think about it.

I'd like to bring us to an issue here that I think we've touched on a whole bunch of different times, but not really focused on in a concerted way, which is this idea of grounding ourselves really fundamentally around what

beneficiaries consider important to them, that it's really easy for us to -- and I usually am here checking the box of consumer representative, so I do try and think about that consumer perspective at least -- Medicaid is a high-need, high-vulnerable population.

And I think people expect a certain level of competence from their physician. They certainly don't want somebody who's completely incompetent. But beyond that, the patient experience is really central when you read the surveys and the literature about what people want from their doctors. They want to feel respected. They want to be listened to. They want to feel like they're taken seriously when they say they have a complaint. They want to feel like their doctor has their best interests at heart.

And so focusing on, number one, the patient experience, but also on -- when we're talking about the medical-type measures

themselves, what do people really care about? Do they care that they got a discharge paper report or do they care that they understood what they were supposed to do when they went home, which are not necessarily the same thing.

And there's going to be different expectations, I think, and different desires for people who are in different life situations. So a young parent may say I really want to be able to chase my toddler around all day without having to take a nap half way through with them. A middle-aged person may say I want to be able to carry the groceries up the stairs to my apartment. Those are I think the more concrete, everyday, reality-based measures that people have in their own minds and we have to figure out how to translate those into this.

So I'd like to see CMS think about kind of being out there, almost periodically like benchmarking what we're doing with

whether it's focus groups or surveys of different kinds just to say, okay, we're still on the right track, we're still doing generally the kinds of things that people think are important. Because really, I mean, that's -- this is what the program is all about, right? Medicaid is supposed to make people healthier and happier and feel better and be more competent in their -- and capable in their everyday lives and doing the things that they want to do.

CHAIR PINCUS: Nancy?

MEMBER HANRAHAN: Well, I say it's a sign of a well-run meeting that we have these crisp questions to end up with, so thank you for that.

And I want to lift off making a remark just to really build on what Marshall's been speaking to, which is the idea that we are in the midst of a paradigm shift that has never been experienced before, and there is evidence

that there's an acceleration of change that is just mind-blowing. So the idea that you present, Marshall, that in a short period of time we're going to see things really pick up and change, we're probably going to always feel like we're on the other side of while trying to breathlessly catch up. So building into the implementation side of this, the importance of metrics for an evolving system and monitoring that I think is really important so that we get this kind of sense that we are keeping in check. And a lot of what we do now is what are the measures that we're doing? But what Marshall did for me was lift me back out into the ether of the organization, or what I would call the learning system, and that this pace or the acceleration of that is pretty significant.

So keeping that in mind, what I think that this report could do is recommend to HHS that they really think about what kind of

data infrastructures, systems that states could have put in place that it will allow them to process the information, the data to answer the questions that they want to ask. And a lot of what you said is really -- hits home about that. Not to determine like Medicare/Medicaid to say you got to ask this question. And if you don't ask that question, we're not going to pay you.

I mean, that's just really kind of loggerhead versus, all right, we're going to help you set up a system such that you can really think through what are the questions and use all the intelligence in your state, state versus the feds kind of thing, to answer the questions that are most -- that are best answered in your state. And they'll be good questions and they'll be great questions because they're all being driven by how do we do this at the most cost-effective quality and being the most accountable in our health care system that

we've got? We've got that nailed, and Medicare actually began that and pulled that together, I think, a number of years ago. So I would say in this report let's emphasize that technology architecture that's needed in order for these states or whatever the entity we're working with to be able to use state-of-the-art analysis and technology to keep that data moving and alive and be involved in these kinds of forums where the questions get refined and tuned. So, thank you for letting me be here.

CHAIR PINCUS: Great. Alvia?

MEMBER SIDDIQI: So I definitely think this has been just an excellent meeting, very inspirational. I feel recharged going back to my state of Illinois with some new ideas and will certainly be referencing some of the slides sets, so thank you so much for the staff for such a well-organized meeting, but also to colleagues here. I mean, I've learned a lot from this meeting and I think it's important

that we look at both the population health perspective, which is certainly a key buzzword today and it's certainly linked to improving the triple outcome of patient satisfaction and the quality of care delivered to patients, but also reducing overall costs because our Medicaid programs I think around the states are -- I mean, they're suffering. So the fact that many states wouldn't even consider participating, that's very problematic and very concerning.

I think we need to look at the feedback from the states in terms of understanding the applicability of these measure sets and the data that's being received. So I think what we've heard sort of as a trend from the states has been that we'd like to see that data. And so we think about what's driving quality in the provider's office today? It's the commercial pairs contracts as well as Medicare showing you report cards where

you're having to now do performance essentially evaluations that show on profile measures how you're doing in terms of different measures. And I think the states want that information so that they can see how they're doing compared to other states as well.

And I think what that will hopefully will drive is best practices so we can learn from the different states that are doing a great job. I mean, I've already just talked to our Medicaid director here for Louisiana, Rebekah, and the fact that they were able to do the data linkages between the vital records and into their own data using for their Medicaid claims data, I mean, that's revolutionary, that's excellent, it's something that has -- it seems like there had been a push to develop that just from the first core sets. So overall in a year that has already been sort of a huge new innovative progress that's already occurred. So that's fantastic. And I'm hopeful that as

part of our measures core set in doing this on a yearly basis that that will continue to drive that sort of innovation.

I think a couple of specific comments I have are more about I guess No. 6 and 7, which is the implementation part, so the technical assistance part. I think states need a lot of help, so the fact that the technical assistance grants or some of the grants for that are not going to be there is very concerning to me. I mean, it can be like an FAQ on a Web site to -- for those states to be able to refer to so that they know where to get that information or resources. That would be helpful at least from what has been learned in the last year so all that's not lost.

And I was thinking about how many states could keep -- it's not a key priority, but if you ask that these measures are being asked because they're aligned with the top 10 readmission rates in all of Medicaid and you

link it that way, the way we did on just two slides, these are the measures that correlate with these readmission conditions, I think it just hopefully helps drive states to say, well, you know what, this is important. Maybe it's not a key priority, but it's something that if I'm going to look at it's going to help hopefully reduce my readmission rates, which does eventually inevitably lead to cost-control as well.

And then I was going to say that whenever we're asking in the implementation process states to say that they have not participated on a specific measure, if you could also ask -- and I think I said this on the Webinar call over the past as well, but if you could ask what other measure exists that you're currently doing in your state that could be used in place of this one and/or is there another measure that exists that you think is a better one, just to get some more feedback from the

states, I think we would value that next year looking ahead.

And so overall again, and just in terms of No. 7, which I didn't really touch too much on, but the implementation of bundled payment, to Marshall's point, the move towards bundled payment, first of all from a provider's perspective, especially in the primary care world, that whole gap between primary care versus specialty reimbursement and payments mechanisms, it's something we want CMS to continue to move towards and be forward thinking about. However, right now in terms of our quality data we rely on everything on claims data. And so, there is a disconnect in terms of how the claims data is going to be able to be used for quality reporting in the future as we move toward more bundle payment models.

So I think that is a challenge. I don't have any answer for you, CMS, but something certainly to look into. And I just

wanted to thank everyone again for this opportunity. This has been fantastic.

CHAIR PINCUS: Rebekah?

MS. GEE: So I wanted to agree with the comments of Alvia and my other colleagues at this meeting. I'm very honored to be here today and to be a part of this conversation. I also wanted to invite Eddy -- Eddy, if you have anything to say after I finish, please join in.

But mostly I wanted to agree with what's been said and then really issue a challenge to CMS. Since 1965 there has not been a moment in American history where Medicaid meant more to Americans. The Medicaider, if you just look at the staff -- I mean Steve Cha is not here today, but he has very few staff, not very many people helping him. He's the chief medical officer of Medicaid. We need more infrastructure. We cannot have rapid diffusion of innovation and improvement in Medicaid if we do not have resources as

states to commit to understanding our data, to improving how we do things into learning from each other.

I can't say enough about how much this mattered to us. Not only were we reporting quality measures, but we're training our staff in Six Sigma. We've brought IHI in. They've taught our middle and senior staff about the science behind quality improvement, the triple aim and what PDSA means to them. We've created and hopefully will continue to be able to keep alive a culture shift in Medicaid where we've tried -- this money has allowed us to work with public health and align. And states are hamstringed by the budgetary constraints and the fires they're putting out every year and the political challenges that are very real that at CMS it's hard to understand, and we have back room conversations and discussions with you, but these types of opportunities are critical. And I don't think

we can continue to innovate as quickly if we don't continue to have them. I don't know what that looks like. I know Marshall and I were talking earlier about states being paid to do certain reporting, but that's not a substitute for this.

So I would just say this was priceless. Let's find a way to continue it because the price is too high for Medicaid to fail in states like Louisiana. You have your innovator states like Oregon. They will always be the innovator states. And you'll have your states like Louisiana that maybe aren't, but the states that aren't are the ones with the fewest resources and in need the most of opportunities like this.

On a separate note just to say ask the states. The biggest thing I've seen and the biggest problem I see is when things are done without asking states how does this actually work to implement this? So these

types of conversations. There are very few states represented here. I'd like to see more. But just how does it work for you? What are your challenges? Those conversations are so important. And that's why I think this process was tremendous to take this to states first and say, hey, why don't you try it out, see how it works?

And then finally, CMS challenged you to work with CDC and our public health colleagues to try to figure out how do we use -- because claims data kind of stinks. I don't like it. It's outdated. It's not that great. It doesn't tell us with a lot of granularity about that patient experience or the patient's health. And so we've got to move beyond it. We've got to move into electronic health records. We've got to look into our current public health surveillance data to see what it means to us. And so we've got to do a jump into new ways of thinking, and it's going

to have to require working a lot with our colleagues in public health and in other areas of data where -- whether it's Department of Education data looking at -- for kids or if it's adults, it's the justice system. There are lots of areas where there's already existing data that could be used.

And then finally predictive modeling. So we're looking -- we're reacting to things before they happen. And one of the things -- we had a meeting a few weeks ago to talk about, well, how do you really predict which woman is going to be the best at getting -- have the best reaction to progesterone or which patient really needs that diabetes drug the most? And so thinking about at the national level how do we really predict not just after the fact and say, oh, you had a bad blood pressure or a bad outcome or you were readmitted for asthma, but how do we get to the next paradigm where we're really thinking about

how do we predict who's the most important to manage, to case manage and how do we predict those outcomes because we know more and more about that?

There was an article I read this morning actually about data looking at NICU babies and it's a system that actually predicts before a baby gets a fever just based on variables, very precise biologic variables that that baby's going to get a fever 24 hours before we would normally recognize it.

So being able to predict more with data, not that these are crude measures. It's not that they're bad. It's better than nothing. In Louisiana two years ago before we had managed care we were really not looking at our data much at all. And so this is a big -- but just thinking about how does CMS take a leadership role and trying to drive new ways of measurement, and that will take coordination at the national level.

And of course Medicaid is a fragmented unstructured states rights program in a way and it's nice that we have that, not where you have your laboratories, as Grandise would say, but it's -- we really need that federal help and the feds being catalysts for us to learn from each other. And that's it.

CHAIR PINCUS: Thank you.

MS. GEE: And, Eddy, I don't know -- just from the measurement standpoint -- I don't know if you wanted to say anything.

(No audible response.)

CHAIR PINCUS: So, Foster, are you still on?

MEMBER GESTEN: Yes, I am.

CHAIR PINCUS: Good, well, we'd be delighted to --

MEMBER GESTEN: My turn?

CHAIR PINCUS: Yes.

MEMBER GESTEN: That's great. So

I want to echo everyone's comments about the meeting. I think it was a really great discussion.

I guess I want to give some sort of like very practical recommendations around uptake and trying to really get at what I think is some of the core goals of increasing the number of states that report, increasing the number of measures and increasing its use for quality improvement.

But before I do I just want to say -- I mean, there's a larger context I think in which the reason for this is really key. I think about the origins of this legislation that mandated some core measures for Medicaid, and the current reality is that we have lots of states who have questioned or are not expanding Medicaid who have lots of public statements about questioning the value of Medicaid, at least as it's currently structured. There are states that complain about, make comments about

dysfunction of Medicaid. And at the same time we have lots of experimentation going on throughout the country.

So I think it's never been more important both for Congress or for CMS, HHS and for states and for politicians and the public to understand what's the value of Medicaid programs? And I think that having measures and being able to document what's being able to be achieved and improved is really critical.

The other hat, the other perspective is just my own parochialism. I'm involved in measurement and measures for the Medicaid program which in informed by core measures, HEDIS, and our own priorities involving commercial measure development and reporting in or SCHIP program, in our exchange, in our health home measures, in our waiver and disparate measures, our PCMH measures and our dual measures. And so, the need to be able to create some coherence around those measures is

not an abstraction for me. It's very real. We live it and breathe it each day.

So I really have four very practical things to think about in terms of strategy going forward that relate to implementation. One is as you might imagine from the last thing I said that I think it's critically important that we work to align measures within all those programs and also to the degree that it's appropriate with Medicare and with commercial payers as a way of actually increasing not only uptake of measures, but also being able to create some synergy and really focus on improvement.

The second is the specific thing that was mentioned today and has been mentioned other times is a strategy. I think the notion of doing stratification, population stratification with measures is a really promising one as a way of being able to increase the value of doing measures without necessarily

having to increase in a significant way the burden of creating new measures or new measurement strategies. So I strongly encourage CMS, NQF, measure developers and for this group to think about the role that stratification can play. And we talked about that with respect to the civilian population, but I think it's true for other populations as well.

The third is I would -- again as a practical matter I would encourage us to think about how we can build on survey, patient surveys as a way of getting at what somebody was talking about in terms of patient experience, but we have a number of measures that have been really hard to capture by doing chart review, whether it's electronic or paper. And those include -- we talked about depression, we talked about care coordination, we talked peripherally around functional status and so on. So I would encourage just a strategy given

that CAHPS is something that all the states are using. How can we build on that as a way to try to get at -- from the patient experience of some things that I think are very important and very difficult to get at through chart review.

And then last but not least, I think being able to work on how -- and help states not only collect data, but learn from the experience we've had to date about who's doing -- who seems to be doing well and why are they doing well and being able to have the resources so that states can better learn from one another about strategies not only for data collection, but for improvement. I think that's really what gets most of us jazzed up about this work and doing measures and I think without resources and some attention to having that happen, it doesn't necessarily happen naturally.

So thanks for letting me participate by phone. I'm really sorry I

couldn't be there in person.

CHAIR PINCUS: Thank you, Foster.

I know that Ann has had to go back and forth because there's sort of been an emergency back in New York, so we will get her comments one way or the other.

But I had sort of this -- I have five comments, some of which are overlapping with what people had said earlier.

But first off, I just want to really say that we've had remarkable real engagement in the discussions and it's the enthusiasm that all the members have had in --

MS. POTTER: Just a little louder.

CHAIR PINCUS: -- all the members have had in participating in this. So I think that's just been terrific. But I have five comments, some of which overlap. One is I think that this really has been a remarkable sort of collaborative process for initiating this program. I think the way in which the CMS

and the states have engaged in this to have sort of a back and forth kind of a brainstorming and sort of an open discussion back and forth and collaboration around improving and developing that I think has been really critical. And I think to continue that as much as possible would be really important. In particular now to get into the details of so how are states using these measures? Which measures create the greatest net benefit in terms of the effort to collect the data versus the amount of value and use that it has I think would be an important sort of next step in this process.

No. 2, I agree with Cindy and also Nancy in terms of thinking about so how do we get more sort of input about beneficiary perspectives both on the task force, but also I think more broadly in terms of sort of reaching out to try to get that kind of input, because I think that's going to be really important.

No. 3, and I think I've mentioned this several times, is given the tremendous burden of chronic disease and I think across both general medical conditions and behavioral health conditions to really think about an overall strategy for getting measures around chronic diseases, whether it means registries, employing the sort of measure-based care, action-oriented kind of coordinated approach, but in some ways to really think sort of ahead of the game to how that can be done using the developing technologies that are going to become available I think is a key issue to look to the future.

The other thing that struck me from the very beginning of this is the incredible heterogeneity of the program across states and eligibility and populations and benefits and so forth, and that's both obviously a challenge, but it's also a potential strength to be able to sort of capture that information in some ways

and looking at how that links to some of the measures, because I think it can inform policy.

And so then I think it's really important that as you're collecting the data from the measures to also provide sufficient context to how states are set up and the infrastructure in those states to be able to put that into context as the measures are being collected.

And then I think some of this sort of comes back to, you know, to some extent what Rebekah and what Foster was saying and some other people were saying in that we need to think about how one uses this for marketing in a sense, marketing both to external audiences, but also to the states to continue their engagement.

Many years ago I once sort of wrote an article about how sort of academic medicine needs to use a new marketing model that looked at the sort of basic principles of marketing,

which are: (1) define your product; (2) segment your target audience; (3) assess consumer benefit; and (4) communicate an effective message. And to think about that in terms of how this product, so to speak, of Medicaid as a product -- how to define and specify that, to think about the target audiences that you have both within states, within the government, within sort of the policy and political worlds, and then to think about how one from -- assesses and uses these measures to assess consumer benefit really and the benefits across these different target audiences and then figure out the best way to communicate that. So that's would be my comments.

Any other comments from people around the table that are not part of the official Task Force, our colleagues from Medicaid and the CMS or others?

DR. BURSTIN: That was a great list. That's a fabulous list of ideas, really

great food for thought. I just had a few additional things I thought we could work on collaboratively together going forward. This is such a good set of ideas.

I think again this issue of beginning to understand the alignment both within the public sector and the public to the private sector and how the measures align to health plans as well as Medicaid is something I think is really important and something I think we could probably do some more work on to --

CHAIR PINCUS: Yes, that's a doable thing.

DR. BURSTIN: That's very doable again, and the variability is what's so striking about Medicaid, of course. We have some states where it's, well, it's all managed care, it's all MCO measures, and some states where it's more homegrown. So I think that is one potential area I don't want to lose sight

of.

I think the other thing is this -- there are a set of really interesting methodological issues that we'd be really happy to help Medicaid with as well, and we've raised lots of them today, this idea of sort of parent/child measures -- not mother/baby, sorry, but --

(Laughter.)

DR. BURSTIN: -- sort of the idea of a measure that fits overall and really beginning to understand how we would look at stratification in key sub-populations as well as disparities I think would be another important thing to consider.

And also how you roll measures up and down. If you're at the state level of analysis and you're starting with a measure that's at the provider level, what does that mean? Is that optimal? Is that not optimal? Are there ways to think that through

differently?

And also just in terms of linkages to other data sources, I was really struck by Rebekah's comments and others about what is possible with linking to some of the state-based IT resources, and it seems like there's some natural opportunities there to think differently.

And lastly, I was also thinking about the idea that at times gaps have come forward and I think individual states have some innovative measures they've been working on and it just seems like there's an opportunity there for prospecting of some of those good ideas and not having everything begin with de novo measure development, but say what are you using that's worked for you, that moves the needle in your state? The example you gave of course about progesterone is a great example. Bring that in, think about ways you could get that ready to go more quickly to other states.

But thank you. It was a phenomenal discussion. I couldn't get -- my staff knows I get a lot of work done at these meetings and I couldn't get as much work done as I usually do, much to the distress of my team, because this was just way too engaging. So thanks to everybody. And thanks to Medicaid, really. This is just incredibly important work and we're really delighted to partner.

CHAIR PINCUS: Other comments around the table?

MS. LLANOS: Can I just make a quick comment? I don't know if Marsha wants to jump in or not, but I think -- and I was saying a little bit to Dr. Lotz and Gee, I feel like this year has been a long year of learning, but I feel like we've learned -- or at least personally me about this core set in one year probably than what we've learned in three years in the children's set only because I feel like the

questions that we were getting asked by states were a lot more sophisticated. I don't think the issue of reporting unit of analysis or the data linkages came up as much, and it could be for a variety of reasons. And I think maybe we didn't have our ear to the ground as much. But I also think it represents four years of a lot of focus on quality in Medicaid and CHIP that hadn't been there before. So I think that states are getting more sophisticated. I feel like we're evolving in our learning and we continue to find ways to evolve both of our core sets in a way that is really nice to hear how do these two core sets fit together, because that was not something that we've discussed before because we didn't have the Medicaid adult core set.

So lots of really interesting issues I think brought up and certainly a few that really resonated with some of the challenges that we've had in supporting states.

I think we'll continue to want to find ways to evolve the core set and evolve in ways that we support our state partners in collecting the measures. And I think the emphasis on quality improvement and quality training has come up so much over the past two years related to the grant, so I think we'll continue to do that. I think fantastic feedback.

I do want to point out that even though the grant program is over or is ending this year, our technical assistance for the program will continue on. So we will have an indirect way. And then as part of that we do quality improvement learning as well. So that support will be there just in a different way than it's been for the adult grantees.

And, Marsha, I don't know --

MS. LILLIE-BLANTON: Yes, I actually really truly want to thank all of you all for participating, because I feel like the thoughtful input both from our Medicaid medical

directors and your staff, and of course from those of you from the practice community, the advocacy community and of course academic community really have helped us to kind of understand some of the issues and challenges we're facing and help to begin to chart a path forward.

You know, I just want to give a little bit of context as well, because my sense is that Medicaid has functioned not only in a hyper-political environment, we've also functioned in a very isolated siloed environment. And we're moving beyond that, and I think this panel is one example of our doing that. I mean, I think we've always engaged with our state partners at some level, but I think our engagement with our state partners now is at a much more -- we're learning from you. It's not just that there's heterogeneity. I think that we are learning from you based on your experiences and you are

helping to shape and guide federal policy in a way that has never happened before. And I think that enriches us.

I think that Medicare has been, as others of you have talked about, out front on the issue of trying to make sure that there's greater value for the dollars spent and then what has ever happened before in Medicaid, but while we have lagged behind we are catching up. And it's an iterative sometimes slower process than what we want, but we are catching up. And so I just want to thank you all for helping us.

I have one ask as we move forward, and I got some ideas from my own ask from this meeting today, but as I look at our spending in Medicaid, over half of our dollars are spent on long-term services and supports. And of course some of that has to do with populations with disabilities, whether cognitive or physical disabilities, and some of that of course has to do with the elderly, but I

continue to try to think more about how we can better measure the care that's provided to that population in Medicaid. And of course those who are dually-eligible are being measured in some respects in Medicare, but we have not done -- been very successful in getting Medicare to look at that subset of Medicare, that 9 million who are dually-eligible, who are low-income.

And so to the extent that as you move forward you can help us think about how we measure, what do we need to better measure? And what I got from this was just about -- from today's session was that maybe it's just a matter of taking these measures and stratifying. Maybe it's just capturing some of the same measures. But I don't think it's that easy for this population. So I do want some more intellectual thought about what is it -- what should we be doing in our measurement?

And Karen has been leading or working with our Duals Office to kind of think about that issue. So I do -- it's not as if we're not already thinking about it, but I do think that if you can help us a little bit more think about what should we be doing going forward for the population that really is spending considerable amount of the resources. I mean, we look a lot at moms and children because they represent a large share of our population, but they're not driving the cost in our program. So if you could help us next year -- I'm not saying this year, if you could help us next year kind of think about what that should look like, we would greatly appreciate it. So just thank you. That's my main --

CHAIR PINCUS: Thank you.

MS. SMITH: I just want to say something. In our division we look at quality improvement, and we're looking more at data from the enterprise perspective, knowing that

the patient receives care in a system and that care is delivered in multiple settings. And so getting to Marsha's point, we have to think about the measures and the development of the measures that would apply across settings and so the stratification would be able to be performed.

And I think with states, when I was looking through -- I do appreciate the materials that were prepared in advance. It was really, really helpful in thinking about the reasons that things weren't reported, because there were higher priorities. Does that mean that there were budget constraints and so something else was given the money that was not able to be applied to this, or that it wasn't actually a problem? You don't know. But if we use measures that are used across for all the different accountability or reporting programs, that takes away that burden. And then you could focus on the technical

assistance for having the measure apply to your program. And that's the point that I wanted to make. And I really like the feedback here.

In some of my work that I'm also doing there would be some interaction with the states and I think like they're going to be moving toward -- I don't know, I think Marc said it's moving in the direction that it's going to matter. And I think the marketplace, some of the quality efforts that they're using, a quality reporting system and then the survey information from the marketplace would be useful. And I think that thinking about that for the future, not adding to the set, but maybe at this point thinking about how to encourage that participation by making it mean something and making -- if the measures are important and they're meaningful, I think the states will take those up. And that's what you're seeing in the states that are reporting the measures. And so it's I think taking away the burden,

looking at the alignment would help this process and this program a lot.

CHAIR PINCUS: Thank you. So Marc has a comment and then we did want to hear from Ann in terms of sort of the round-robin final priorities comments and then to hear from the public.

MEMBER LEIB: I just have a question. I think I know the answer to this, but in the rule of law you never ask a question you don't know the answer to, but I'm assuming that the materials that were distributed can be shared within our organization, the quality department and everywhere else that will help us move forward, that there's no embargo on these documents. Is that correct or not correct?

MS. LASH: There's just one slide in your deck that we would like not be distributed, so we will put a refreshed deck on the SharePoint site --

MEMBER LEIB: Okay.

MS. LASH: -- along with some of the other articles about the HCUP data and things that have been cited. Or would you prefer that in an email? Doesn't matter? Okay.

MEMBER LEIB: Either way.

MS. LASH: Yes.

MEMBER LEIB: Okay. And then so I will not distribute this version of it because --

MS. LASH: That would be ideal.

MEMBER LEIB: -- there's something in there that's sensitive. I don't know which one, but something --

(Laughter.)

MS. LASH: And, yes, a few other pieces of information will be forthcoming too.

MEMBER LEIB: That would be great because that way I will -- I have a lot of people within the organization that will help us move this forward, but I don't want to share it until

that's okay.

MS. LASH: Okay. Thank you for asking.

CHAIR PINCUS: Ann?

(Off the mic comments)

CHAIR PINCUS: Yes, just if there's something -- of all the things here just the one that you think you would pick out as the most important that you'd like to just kind of talk --

MEMBER SULLIVAN: I think that the real -- having a really strong set of measures for behavioral health disorders is really important, both substance abuse and mental health.

I also think going forward how -- what effective measures would really do well when we start to integrate behavioral health with the medical side. And I think that some of them obviously cross over things like follow-up after discharge, but I think others

might -- there might be other ways of looking at some things in terms of how their impact of behavioral health disorders on the medical disorders and just to continue that discussion, continue to looking at measures that can push that forward, because I think particularly in this population those are really obviously critical issues.

And the second is something I brought up before, and I really don't know how to tackle it, but I just to keep mentioning it, that I do think cultural phenomena are important here. Many of the members of the -- in Medicaid come from a variety of cultural backgrounds and how that ultimately impacts on the kinds of measures that we're doing and if it does; I'm assuming it does, but and then how we deal with that. So I'm just thinking that that's another thing to really just kind of begin to think about as we develop the measures.

CHAIR PINCUS: Thank you, Ann. So now any public comment on the phone?

OPERATOR: At this time if you have a comment, please press star then the number one on your telephone keypad.

And there are no public comments at this time.

CHAIR PINCUS: Any public comment from people here in the room?

(No audible response.)

CHAIR PINCUS: So I just want to thank really all the members of the Task Force. I mean, just a tremendously wonderful deep thoughtful set of comments/discussions. I think we've heard that it's been very helpful to CMS and to NQF.

I want to thank actually our colleagues from CMS and NCQA and other people who've been here and from other parts of HHS.

it's really been terrific working with you, Karen. Thanks so much for all your

help and guidance on this.

And I particularly want to thank the staff who are amazing at NQF in terms of really setting this up.

Now, we have to say farewell to Allison who's going on to other things, but -- we'll miss you, but especially to really thank Megan and Sarah and really all of the NQF staff who just really have been tremendous in this. So thank you.

(Applause.)

(Whereupon, the meeting was adjourned at 2:14 p.m.)

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