



Medicaid Quality Committee Quarterly Meeting
 May 19, 2017 1:00 PM -3:00 PM
Meeting Minutes

Committee Attendance		
SreyRam Kuy, MD, MHS- Chair	LDH	In Person
Harold Brandt, MD, FACP	The Baton Rouge Clinic AMC and LDH	In Person
Bryan Sibley, MD-Vice Chair	Physicians – Lafayette	In Person
Jeanne Abadie	Advocacy Louisiana	In Person
Robert Barsley, DDS	LSUHSC	In Person
Justin Bennett, NP	Rural Health Nursing	Absent
Gerrelda Davis, MBA	LPCA	Absent
Yvonne Domingue, MS, RN	Department of Children and Family Services	Absent
Michael Giorlando, DDS	MCNA	In Person
Rep. Frank Hoffmann	La House of Representatives	Absent
Robin Hogue, MD	LSUHSC-Shreveport	Absent
Larry Humble, PharmD, PhD	University of Louisiana Monroe	In Person
Michelle Hurst, RN	LA Development Disability Council	By Phone
James Hussey, MD	LDH-Office of Behavioral Health	By Phone
Mark Keiser	Access Health Louisiana	In Person
Lyn Kieltyka, PhD	Office of Public Health/CDC	By Phone
Mary Gauthier-Lewis, MD	ULM College of Pharmacy	Absent
Ann Kay Logarbo, MD	United Healthcare Community Plan	Proxy
Senator Fred Mills, Jr.	LA State Senator	Absent
Mary Noel	HCA Louisiana	In Person
Raymond Poliquit, MD	Amerigroup	In Person
Charles Powers, MD	Willis-Knighton Health System, Bossier City	By Phone
Madhavi Rajulapalli, MD	Aetna	Proxy (Lee Reilly)
Laura Richey, MD, FACEP	LSUHSC - Baton Rouge	In Person
Floyd Roberts, Jr., MD	Louisiana Hospital Association	In Person
Alfred Robichaux III, MD	Ochsner	Proxy (Dr. Barrilleaux)
Joe Rosier	The Rapides Foundation	In Person
Beth Scalco	LDH- Office of Public Health	By Phone
Ramam Singh, MD	Louisiana Dept. of Corrections	In Person
Steve Spedale, MD, FAAP	Infamedics	In Person
Shelia Sterling, MSW	Volunteers of America	Proxy (Janet Pace)
John A. Vanchiere, MD	Physicians – Shreveport	In Person
Marcus Wallace, MD, MBA	Louisiana Healthcare Connections (LHC)	In Person
Rodney Wise, MD	AmeriHealth Caritas of Louisiana	In Person

Call to Order

- The Medicaid Quality Committee was called to order at 1:05pm by Dr. SreyRam Kuy.

Welcome, Introduction and Roll Call

- The roll call was conducted by David Peterson of Quality Committee members. Attendees on the phone included: Michelle Hurst, James Hussey, Lyn Kieltyka, Charles Powers and Beth Scalco. A quorum was confirmed.



Review and Approval of the Meeting Minutes

- The previous quarterly meeting was held on Friday, February 17, 2017 at 1:00pm at the Louisiana Department of Health, 628 N. Fourth Street, Baton Rouge, LA 70802 in Room 118. The meeting minutes were distributed prior to the meeting. After review, a motion for the minutes to be approved was made by Dr. Mark Keiser and a second was made to approve by Dr. Robert Barsley. No discussion was had. The minutes were approved unanimously as presented.
- Dr. Kuy announced the new Quality Committee email account, QualityCommittee@la.gov. This email account will be used to disseminate Quality Committee information and is managed by Kolynda Parker.

Results of the Quality Town Hall & 1-on-1 Quality Meetings-Dr. SreyRam Kuy

- Many individuals participated in the town halls which included doctors, nurses, behavioral health professionals and providers across the spectrum of health care.
- The 7 town halls occurred across the state in Baton Rouge, New Orleans, Lafayette, Lake Charles, Shreveport, Monroe and Alexandria.
- Who attended the Town Halls?
 - 39-Baton Rouge, 94-New Orleans, 30-Lafayette, 20-Lake Charles, 21-Monroe, 32-Shreveport and 25-Alexandria. A total of 261 people attended all 7 town halls across the state.
 - Among the 261 attendees, 130 completed the surveys which is equivalent to a 50% response rate.
 - The overall majority of those who responded to the survey were involved in direct patient care and the healthcare system (63.6%). The other survey participants were MCO employees or subcontractors and professional organizations. Others did not list their affiliations.
- A key question asked was should incentivized metrics be purely claims based or should they be a hybrid with chart review? The responses were broken down by direct patient care, professional organizations and MCOs with the overall majority voting that the metrics should not be purely claims based and can incorporate hybrid measures.
- Results and metrics gathered from all 7 town halls were subdivided into categories: adult, pediatric, maternal, behavioral health and care processes. The Quality team reviewed the data for the top responses in each category. The questions were asked in terms of which metrics were important, should be incentivized or monitored. All responses were further broken down by respondent type.
 - Adult-Incentivized Top 3: diabetes, hypertension and breast cancer screening.
 - Adult-Monitored Top 3: Adult DMI, patients on persistent medications and tobacco cessation.
 - Pediatric-Incentivized Top 3: well-child visits 15 months, childhood immunizations and a tie between well child visits 3rd, 4th, 5th 6th year and adolescent access to primary care.
 - Pediatric-monitored Top 3: weight assessment, childhood immunization status, and well child visits 3rd, 4th, 5th, 6th year.



- Women's and Maternal Health-Incentivized Top 3: postpartum care, 17P and a tie between C-section rate and frequency of prenatal care.
- Women's and Maternal Health-Monitored Top 3: low birth weight, postpartum care, and a four-way tie between 17P, frequency of prenatal care, chlamydia screening and timeliness of prenatal care.
- Mental Health-Incentivized Top 3: adult follow-up after hospitalization for mental illness, pediatrics follow-up care after ADHD prescriptions and adult adherence to antipsychotics medications in schizophrenic patients.
- Mental Health-Monitored Top 3: pediatric use of multiple concurrent antipsychotics, adult antidepressant medication management, and a tie between adult screening for clinical depression and pediatric metabolic monitoring.
- Care Processes-Incentivized Top 3: ambulatory ER visits, ambulatory outpatient and diabetes short term complications.
- Care Processes-Monitored Top 3: ambulatory ER visits, diabetes short term complications, ambulatory outpatient.
- Top 9 Incentivized measures: hypertension, diabetes, prenatal care/postpartum care, 17P, well child visits, ADHD monitoring, follow-up after hospitalization for mental illness, ED visits, and all cause readmissions.
- Top Monitored measures are listed by category as well.

Proposed 2017 Bylaw Amendments-Dr. Harold Brandt

- The team continues to review the bylaws and have discovered there are changes in agencies or titles which provides the need to update language in the Bylaw amendments.
- By-Law Changes:
 - Article I-Membership, Section 2, item #4-replace name of Bayou Health to Healthy Louisiana.
 - Article 1-Membership, Section 2, item #4-replace name of Louisiana Behavioral Health Partnership to Office of Behavioral Health.
- Dr. Brandt asked for a motion to approve the changes to the By-laws in Article 1, Section 2, and item #4. The motion to accept and approve the recommendations for change was made by Dr. Steve Spedale and seconded by Dr. Mark Keiser. No opposition was noted. The motion was approved unanimously as presented.

Subcommittee Reports on Recommended Quality Measures-Dr. Harold Brandt

- **Adult Medicine-Dr. Harold Brandt (Powerpoint slide)**
 - Recommendations were reviewed and reaffirmed by the subcommittee.
 - Incentive Measures
 - Hypertension with prevalence
 - Diabetes Care with Prevalence
 - Monitored Measures
 - Colorectal Screening
 - Breast Cancer Screening
 - Congestive Heart Failure Admission Rate
 - HIV Viral Load Suppression Rate

- **Pediatrics-Dr. John Vanchiere**
 - The Pediatric subcommittee met in March and April.
 - Recommendations
 - Well child visits
 - Vaccinations
 - HPV vaccination should include both male and female as separate identifiable metrics. The Pediatric subcommittee would like the Quality Committee to consider HPV vaccination as an incentivized measure.
 - The subcommittee reviewed the provider panel size information that was sent by the Adult subcommittee but needed data regarding pediatric panel size. Amerigroup has agreed to provide de-identified data for discussion and focuses on how the MCO judge high quality vs. low quality. Providers are concerned about expansion and the scope of practice especially for nurse practitioner's panel size. The subcommittee want to be involved in this discussion to ensure appropriate oversight.
 - Prior authorizations requirements. The goal is to ease the burden on specialists but provide quality health care.
 - ADHD medication initiatives are moving forward.
 - Obesity initiatives are moving forward.
- **Neonatal-Dr. Steve Spedale**
 - The committee discussed a ruling by the State Board of Nursing that will affect the makeup of the neonatal transport team. In 2015, the requirement became that all of the nurses on the neonatal transport team must have a BSN and were given a two year period to comply. The second part of the rule is that a Neonatologist must approve the neonatal transport team. This ruling is presenting a hardship for the neonatal transport teams.
 - On behalf of the subcommittee, Dr. Spedale will be speaking with the State Board of Nursing to ask for a grandfather clause or an extension.
 - Recommendations
 - Most of the recommendations are items that will be put into the contract for managed care organizations. The subcommittee borrowed some language from Ohio because they have advanced perinatal collaborative.
 - The subcommittee want to look at outcomes for the first 12 months after neonatal ICU discharge and track the following:
 - ER visits in the first 12 months after discharge
 - Any inpatient admissions post neonatal ICU discharge
 - Well child visits the first year post NICU discharge
 - Overall medical cost within the first 12 months post NICU discharge
 - The number of infants placed into the MCO high risk care management after an NICU discharge
 - The number of denials for NICU care
 - The subcommittee would like to review neonatal policies from all of the MCOs. The policies should be submitted to the Neonatology Committee for review once per year and any subsequent changes made to the policies thereafter.

- **Fetal Maternal**-*Dr. Al Robichaux, proxy Dr. Scott Barrilleaux*
 - The subcommittee recommends that current measures are retained with no major changes but a few minor modifications.
 - Recommendations
 - The percentage of women 15-45 years of age with evidence of spontaneous idiopathic preterm birth singleton (<37 weeks) who received 1 or more progesterone injections between 16-24 weeks.
 - Have an interest in data that suggest patients who receive 3 or 4 progesterone injections but stop their progesterone are at an increased risk for spontaneous preterm birth.
 - Postpartum HEDIS measures
 - Postpartum care with contraception -endorsed by the NQF in November 2016 as well as adopted by CMS. The measure includes women who adopt the use of a most effective, FDA approved method of contraception such as tubal ligation or long acting reversible contraception. Also interested in moderately effective methods and long-term for oral pills, patches, rings, diaphragms.
 - HIV and syphilis measures –testing patients in the third trimester for HIV and syphilis. The subcommittee would like assistance with setting a benchmark. The subcommittee have questions regarding data, the quality of data and how to receive the data.
- **Behavioral Health**-*Candace Grace, proxy Dr. Kelley Francis*
 - Recommendations
 - Follow-up after hospitalization for mental illness
 - Follow-up care for children prescribed ADHD medication
 - Diabetes screening for people with schizophrenia or bipolar who are using antipsychotic medications
 - Use of first line psychosocial care for children and adolescents on antipsychotics
 - Interested in receiving final validated data when it becomes available in August and would like to weigh-in on the targets for these measures.
- **Emergency Medicine**-*Dr. Laura Richey*
 - The first ED subcommittee meeting will occur next month.
 - Recommendations
 - ED visits-utilization
 - Access to primary care
 - Agree with outpatient management
- **Long term services and support**-*Dr. Harold Brandt*
 - This committee is still being formed and more recently have applicants who are willing to serve on the subcommittee
- **Dental**-*Dr. Robert Barsley*
 - Since the last meeting there has been ~12 individuals who expressed interest in serving on this subcommittee. These applicants are split between dentist and non-dentist
 - Major focus areas
 - Raise the penetration rate in children’s programs above 50%. Most states are above 50%.

- Fluoridation in the state
- Better oral health measures preferably HEDIS
- Adult dental problems
 - People over 21 who do not have Medicaid coverage
 - People who are long term care and do not have Medicaid coverage
- Distribution and access to dental providers across the State (increase care in rural areas)

Evaluation of Recommended Quality Measures-Dr. Harold Brandt

- Discussion of Measures Recommended by the Subcommittee Chairs
 - Dr. Brandt opened the floor for open discussion regarding the proposed quality measures.
 - Dr. Mark Keiser-recommends consistency across the plans on measures the plans are required to meet. Recommends the term of the metric be greater than 1 year to demonstrate true improvement.
 - Dr. Singh- recommends adding substance use disorder screening to the quality measures and appropriate access to care. The Medicaid expansion program now includes the criminal justice population. New Medicaid enrollees make-up a large amount of newly released offenders whom have never had access to care. DOC is providing education on how to access primary care providers instead of going to the emergency room.
 - Dr. Joe Rosier-asked will trended data be shared on a regular, periodic basis by region and/or other variables with the Committee? Dr. Brandt- The answer is yes. Medicaid wants to be transparent, bring data forward to the Committee and provide data at intervals that are reasonable. HEDIS measures have a measurement year from Jan. 1 to Dec. 31 and incremental reports may be difficult. Although, the monitored measures are claims based so interval reports may be possible. It may be possible to make other subcomponents of metrics available at interval periods. The goal is to remain transparent on reporting but not compromise the means by which the report has to be generated.
 - Dr. Vanchiere- The proposed metrics are focused on physician and patient behaviors; however, 20% of Medicaid's budget goes to hospitals. The Quality Committee need to consider whether there should be a subcommittee that is focused on hospitals and also, if the incentive program should include hospital based metrics as well.
 - Jeanne Abadie-asked for clarification regarding the slide that showed "Adult" follow-up after hospitalization for mental illness and another entry without the word "Adult." She wanted to make sure the Committee is also looking at children, especially adolescents for this metric. Dr. Brandt-there is not a specific HEDIS metric for children. The team will need to perform a database search for this criteria. We will need to revisit this metric for the children/adolescent population. Dr. Kuy-want to stay close to HEDIS metrics as much as possible because of our ability to benchmark and trend the data.
 - Mary Noel- The all cause readmissions metric is very difficult to measure due to the parameters of 7 days, 30 days and all of the different parameters that is used to measure readmissions including the reason. CMS has very clear readmission parameters outlined. Recommends that as a Committee, we look at and follow one of the CMS metrics for hospital readmissions as opposed to all cause readmissions. Asked why opioid use did not make it to the top of the list? Dr. Kuy-Opioid use is a huge priority for the department and was mentioned by one of our sister agencies. The department has been working on opioids



for approximately 8-9 months. The department has participated in the Opioid Commission, Governor's work, Naloxone Standing order and one of the first states in the South that has an opioid prescription limit.

- Voting for prioritization of Quality Measures
 - Dr. Brandt asked for a motion from the floor to approve the incentivized quality measures as presented. A motion was made by Dr. Steve Spedale to approve the incentivized quality measures as presented and a second was made by Dr. Laura Richey. No opposition was noted. The motion was approved unanimously by the full Committee.

Medicaid Director Update-*Jen Steele*

- How has managed care performed on quality?
 - For the 22 HEDIS measures we have tracked since implementation of the program, we have met or exceeded the Southern regional average on 11, substantially improved from the 2011 fee for service baseline on 9, made slight improvement on 1, and regressed on 1 (ED visits).
- What do we want to see in our MCO Contracts for the next 5-7 years?
 - Medicaid is nearing the end of the original 3 year contract term for this second generation contract with two 1 year extension options. Medicaid plans to exercise one of these options and move forward with the RFP which means the current contracts will extend through January 2019. The RFP is set for release in January 2018 and the balance of CY18 would be reserved for contract selections, negotiations, readiness, etc.
 - Preparing for:
 - RFP
 - Contract extension
 - Improvements in the interim
 - Quality focus
 - Clinical outcome objectives-what do we want to achieve in the overall health of our members?
 - Value based purchasing (VBP)
 - Conducted a deep dive in to VBP last year, all plans were surveyed and found there were 74 distinct measures that were being incentivized by the 5 plans, but not one measures incentivized by all 5 plans.
 - Heard from providers about administrative complexity and the difficulty in focusing with so many different measures
 - Medicaid realized the need for more consistency and focus for everyone
 - In the extension and re-procurement, these incentivized measures will be at the heart of what this program is evaluating and what the objectives are.



- Current contract
 - There are 9 “money measures” for quality performance but it is a “stick” approach with a \$250,000 penalty per measure if a plan fails to achieve target. Per the current contract language, this only penalty applies only once during the 3-5 year term of the contract which is insufficient.
 - With the current contract, there is a 2% withhold that is used as an incentive for contract requirements which is a pool for any penalties associated with non-compliance that the money is drawn from.
- New Contract
 - Two things will occur:
 1. Will evaluate the MCO plans quality performance annually
 2. Will no longer be a “stick” approach but more of a “carrot” approach.
 - Medicaid is conceptually committed to a new incentive model moving forward. Though details are still being worked out, the intent is to restructure the withhold as an incentive for plans to work with providers to meet quality targets in order to earn back the 2%.
 - Need to review alignment with Value Based Purchasing component as it relates to hospitals. We have more work to do.
- Summary
 - We need fewer measures, more focus and consistency across plans. Medicaid will be more directive about that moving forward and make a much clearer relationship between quality and payment. The intent of the 2% withhold is to split between accountability around HEDIS measures and meeting the thresholds for value based purchasing.
- Other
 - A request for information went out in the fall regarding Accountable Care Organization (ACO) models. There will be a meeting invite sent to stakeholder for a meeting in late June. The meeting will be used to engage around principles for an ACO pilot within the next MCO contract.
 - United Health Group (America’s Health Rankings)-their team will come to LDH-Medicaid and demonstrate how our state can improve in the State’s ranking by prioritizing specific quality efforts.
- The floor was opened for questions and discussion.

Presentations of special medical topics of interest or clinical studies/activities that improve quality, or detailed subcommittee reports or findings

Opioid Prescribing Limits-Dr. SreyRam Kuy (Handout)

- The Opioid Prescribing flyer has been distributed for review and presentation.
- LDH has been working on the opioid crisis for the past 8 months or so. LDH has worked with pain specialist, the President of the southern pain society, anesthesiologists and other healthcare providers.
- Opioid crisis statistics were presented from the Opioid Prescribing flyer.
- Drs. Kuy and Hussey have participated on the Opioid Commission for the state.



- An Opioid Symposium was conducted in the fall as well as monthly lunch and learns with pain management specialists as guest speakers. The webinars have been full to capacity.
- A website has been developed to show free CME to providers.
- Medicaid Opioid Prescription Policy
 - Jan 10, 2017: Patients in Fee for Service (FFS)- Medicaid Opioid 15 day quantity limits
 - March 22, 2017: Patients in Managed Care Organizations Acute Pain- Implement 15 day quantity limit for opioid-naïve recipients
 - May 2017: Patients in FFS and Managed Care Organizations: Acute & Chronic Pain-Alert to notify providers of upcoming Morphine Equivalent Dosing (MED) at 120mg/day for all opioid prescriptions
 - July 2017: Patients in FFS & Managed Care Organizations Acute Pain- 7 day quantity limit for opioid-naïve recipients or Morphine Equivalent Dosing (MED) at 120mg/day, whichever is less
 - July 2017: Patients in FFS & Managed Care Organizations Chronic Pain- Morphine Equivalent Dosing (MED) at 120mg/day for all opioid prescriptions
 - Exclusions: Any patient with cancer, palliative care or terminal illness are excluded from the opioid limits.
- The Pharmacy team developed a form that is used across all 5 health plans entitled “Opioid Analgesic Treatment Worksheet.” This form will need to be completed to justify longer therapy and is available online.
- Medicaid provider resources are listed on the back of the “Frequently Asked Questions about Opioid Prescribing” flyer.

Dr. Kuy announced the remaining meeting dates for the year: Friday, August 18, 2017 and Friday, November 17, 2017 at 1:00pm

Dr. Kuy adjourned the meeting at 2:45pm