Technical Assistance Webinar:
Calculating the Multiple Concurrent Antipsychotics Measure in the Child Core Set
August 23, 2016

Technical Introduction

Hello, everyone, and thank you for attending today's technical assistance webinar, "Calculating the Multiple Concurrent Antipsychotics Measure in the Child Core Set."

Before we begin, we wanted to cover a few housekeeping items. In order to encourage collaboration among participants, we are excited to provide attendees with the opportunity to join the discussion through an open mic forum format for Q&A. If you would like to participate in the forum, please dial into the audio portion of this webcast using the call-in number and access code provided on this slide and during registration. To comment or ask a question during the webinar, please press five star (5*) on your phone after dialing in and listen for your cue to speak.

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Now I'd like to introduce Renee Fox of the Center for Medicare and Medicaid Services.

Renee, you now have the floor.

Welcome and CMS Updates
Renee Fox, MD, Medical/Health Policy Advisor, CMS

Thank you, Brice.

Welcome to today's webinar, "Calculating the Multiple Concurrent Antipsychotics Measure in the Child Core Set."

I'm Renee Fox from CMS. The Center for Medicaid and CHIP Services, Child and Adult Health Program Group, Division of Quality and Health Outcomes' focus is on improving the quality of care for children in Medicaid and CHIP and on developing quality measures through our Pediatric Quality Measures Program, PQMP, and providing technical assistance to states in reporting on the Child Core Set so that we, at CMS, are able to provide you a look across states' performance on measures that reflect pediatric quality care.

CMS is deeply concerned about the safe and appropriate use of antipsychotic medications, including the second-generation antipsychotics, by children covered in Medicaid and CHIP. The DHHS Office of Inspector General and the Government Accountability Office have produced reports on the use of these medications in children for Medicaid and CHIP. The American Academy of Pediatrics and the American

Academy of Child and Adolescent Psychiatrists have published guidelines for the appropriate indications for use of these powerful indications. Many states have worked on these issues, including work by the Medicaid Medical Directors Learning Network.

CMS began the Antipsychotic Drugs in Children Affinity Group this spring to help participating states develop strategies that work in their particular environments and to leverage the previous work done by other states in the field. We currently have 10 states working on different aspects of improving the monitoring of these medications, including improving metabolic monitoring in children on antipsychotic medications, prior authorization of use, and behavioral health interventions. This webinar is one of our scheduled all-states meetings. We have opened it up to all interested parties to help disseminate this new Core Set measure.

To better assess the appropriate use of these medications, the 2016 Core Set of Children's Health Care Quality Measures through Medicaid and CHIP, colloquially known as the Child Core Set, added a measure, Multiple Concurrent Antipsychotics in Children and Adolescents, which is the measure developed through our CMS/AHRQ Pediatric Quality Measure Program by NCQA.

During this webinar, the Center for Medicaid and CHIP Services will introduce the new Child Core Set measure. NCQA will provide background on the measure and give technical assistance for calculating the measure. Medicaid Medical Directors from Pennsylvania and Wyoming will describe their states' efforts to calculate and use the measure to improve the appropriateness of antipsychotic use among children and adolescents in Medicaid and CHIP. A 'Question and Answer' Session will allow you, the listeners, to ask questions at several points.

CMS's contractor, Mathematica, will provide technical assistance resources to help states calculate the measure for reporting into MACPro system later this year. Our first year reporting goal for this measure is to get 25 states reporting this measure to us. This will be very tough to achieve, but we feel that starting to work on getting the nuts and bolts of how to collect and report their data is critical for us achieving our goal.

Let me now introduce Dr. Sarah Scholle, Vice President of Research and Analysis, and then followed by Emily Morden, MSW, Senior Research Associate in Performance Measurement from National Committee for Quality Assurance, to give the background and details of this measure. Thank you.

Go ahead, Sarah.

Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC): Measure Overview
Sarah Hudson Scholle, DrPH, MPH, Vice President, Research and Analysis, NCQA

Hello, everyone. Thanks so much for this opportunity to talk with you about this important measure that addresses a significant problem for children and adolescents, especially those in Medicaid and foster care.

Let's go to the next slide.

The use of antipsychotic medications in children and adolescents has been growing, and there are a number of concerns about the use of these medications. They're powerful medications. They have specific indications for a limited range of conditions for children and adolescents. But they're often used for reasons other than those concerns. And there is particular concern about when the medications are used over long periods of time or when they're used in tandem, when there are multiple medications of the same antipsychotics at the same time.

And so the concerns have to do with the kinds of side effects that children and adolescents may experience, particularly at a point when they are growing and changing. Side effects include waking metabolic effects and movement disorder effects. These are powerful medications that have a place but

also have potential risk. And the concerns related to management relate both to the proper use of the medications and avoiding exposing children to these risks.

Let's go to the next slide.

Our Center of Excellence in Pediatric Quality Measurement that Dr. Fox referenced is called the National Collaborative for Innovation in Quality Measurement. And we were tasked with developing a set of measures to look at the use of antipsychotic medications in children and to assess the safe and judicious use of these medications. We developed a series of measures that have been developed and tested and were informed in large part by the input from many stakeholders, including states and families and including families used in foster care.

Next slide.

I just want to give a quick overview to this measure that we fondly called APC – that's our acronym – that is looking at multiple concurrent use of antipsychotic medications among children and youth. The purpose of this measure is to try to understand what percentage of children and youth are receiving multiple prescriptions covering a period of time for antipsychotic medications. And so this is a measure of overuse; this is something that we don't want to see happen.

The denominator includes all youth, ages 1 to 17, who are on a continuous antipsychotic medication treatment; and we define continuous as at least 90 days. The numerator is children who are on two or more antipsychotic medications during that time period for at least 90 days. So we're looking at really inappropriate or care that is not recommended, and it's the very tip of the iceberg of problems for medication use.

And we're going to talk some more – my colleague, Emily, will go into the details of how to calculate this measure; but this is a measure that requires that we have access to information on those medical and pharmacy benefits and that is calculated from claims data. And it's complex to calculate, but it's also one where we need to emphasize that what we're looking for is a lower performance; so a lower rate indicates better performance. This is the measure of what should not happen, so we're looking at the proportion of kids who receive care that doesn't really meet these expectations for being safe and judicious use of medications.

Next slide.

If we look at the data in the next slide, please, we'll see that the rate of use of multiple concurrent antipsychotic medications tends to be low.

I just want to check in with folks because I am still seeing the slide; I don't know if it's been advanced to the next slide. There it goes. Apparently we skipped the slide that has the data on it, but I apologize. Maybe my Internet connection is interfering here. Let me just go back to the field test and HEDIS results.

The data that we have to present comes from several years of data that show us – I guess the highlight is that things are getting better because we're seeing a lower average rate of performance on this measure. Again, lower is better. And so the way to interpret this, first, is we look at the first column of data. These came from the initial field test data that we did through our Center of Excellence, where we were using data from 2008 from 11 states and where we found that the average performance rate on the measure was 6%. That meant that of the children who were on an antipsychotic for at least 90 days, about 6% were on multiple concurrent antipsychotic medications.

And if we looked across time, in 2014, the first year of reporting to NCQA through Medicaid health plans, we found that the result was about 4 percent. And in the most recent data that were just reported this summer, for last year we find a performance rate of about 2.5 percent. So we see the trend is going in the right direction of lower use of multiple concurrent medications.

What we do see though is we see continued variation in the most recent data, where up to 12 percent of youth; in some plans are on multiple concurrent medications. So that shows that we continue to have variability in performance and an opportunity to improve.

We'll move to the next slide, and now Emily will jump into the details of how to calculate this measure.

Calculating the APC Measure
Emily Morden, MSW, Senior Research Associate, Performance Measurement, NCQA

Great, thank you, Sarah.

Again, my name is Emily Morden. I'm a Senior Research Associate at NCQA, and I'll be walking through how we calculate the APC measure. We're going to start with the denominator calculation, and then we will go through the numerator.

The denominator for this measure includes children with continuous antipsychotic use, defined as 90 days or more. Some examples that would meet the denominator criteria include a child receiving a single prescription with a 90-day supply or greater; a child receiving three consecutive 30-day prescriptions for the same drug; or a child receiving three consecutive 30-day prescriptions for different antipsychotics.

For the denominator, there are allowable gaps between prescriptions of the same drug, which are counted as days of antipsychotic use if the gap between prescriptions is 32 days or less. And this allowable gap accounts for the short gaps in days' supply that can occur when individuals don't immediately refill their prescription. And we'll get into some more detail about how to calculate it in just a minute.

Next slide.

Now I'm going to walk through each step of calculating the denominator. We first begin by identifying all enrollees in the appropriate age range who are continuously enrolled. Then we identify all their dispensing events for antipsychotics during the year. And now I'm going to walk through how we operationalize the 90 days of continuous use for our denominator.

Next slide.

To determine continuous antipsychotic use, we use the dispensing events to define the length of each drug event. So within each drug ID, we sort all dispensing events for that drug chronologically. If there is more than one dispensing event for the same drug on the same date, we only use the prescription with the longest days' supply.

Next, we search for a second dispensing event for the same drug to see if the drug event continues. If there is no second event, then that drug event ends. And on the slide here, we have instructions for how we calculate the length of that drug event.

If there is a second dispensing event for the same drug, then we will add the days' supply of the second prescription to the days' supply of the first, as long as the gap between these prescriptions is an allowable gap of 32 days or less.

And then we continue assessing the dispensing events for that same drug ID until there is a gap between prescriptions that is greater than 32 days or there are no more prescriptions or we hit the end of the measurement year. And then we continue this process until all drug IDs have been assessed and all dispensing events for the antipsychotics are exhausted.

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On this slide, we have a denominator example shown. You can see that the prescriptions for Drug No. 1 are put in order, and we'll walk through whether we link them all together into one drug event by using the dispense dates and the days' supply. Remember that drug events can include up to a 32-day allowable gap between prescriptions. Testing showed that this amount of time is needed to allow for refilling of prescriptions.

To assess if a gap is allowable, we look to see if the number of days between prescriptions dispense dates is less than the days' supply of the first prescription plus 32. If it is less, then there is an allowable gap; and the days will count towards the continuous treatment drug event.

So in this example, starting with the first prescription, we can see that the second dispensing event occurs before the end of the days' supply of the first prescription; so, clearly, there is no gap. It looks like there is a gap, however, between the second and third prescription. So we will look at the number of days between the 2/7 dispense date and the 3/14 dispense date which, in this case, is 34. Then we take the day's supply of the 2/7 prescription, which is 30; we add 32, which is the allowable gap; and we get 62. Since the number of days between the prescriptions -- in this case, 34 – is less than 62, it's an allowable gap; and so we string the prescriptions together as the same drug event.

So in this example, the start date of the drug event is in green on January 10th; and the end day is in red on May 12th.

Next slide, please.

So after all drug events are defined, for each enrollee we determine the number of calendar days they have continuous antipsychotic treatment. Those with at least 90 days of continuous treatment are then included in the denominator; and again, this could include having continuous treatment across the same or different drugs and may also include allowable gaps between prescriptions of the same drug.

Next slide.

We've determined the children who have continuous antipsychotic use, our denominator; now we'll identify those who were using multiple antipsychotics concurrently for an extended period of time, and this is the numerator. First, I'm going to take us through a couple of examples; and then I will walk through the steps for how to calculate the numerator.

Next slide.

This first example clearly shows a case where the child has 90 days of concurrent use of two antipsychotics. The start date of the multiple drug event, or concurrent use, is the first day the child was on more than one drug. So in this example, once the child starts Drug B, this is the start of the multiple drug event; and the child then qualifies as having 90 days of multiple concurrent use because Drug B is a 90-day supply and completely overlaps with Drug A.

Next slide, please.

For the numerator, there is also an allowable gap of up to 15 days between different drugs because if a child is switching between drugs and there is a small gap between the prescriptions, the child is essentially on the antipsychotics continuously. So in this example, we can see the child has 90 days of concurrent antipsychotic medication use across three different drugs with this allowable gap.

Next slide.

And finally, here is an example that does not meet the numerator criteria because the gap between when the child is on multiple drugs is greater than 15 days.

Next slide.

Now we're going to walk through how to calculate the numerator. We begin by using all of the drug events that were identified with creating the denominator. To identify concurrent use, again, we're going to look for the first date where the child was on more than one antipsychotic; and this is the multiple drug event start date. If the child was on multiple antipsychotics concurrently for at least 90 days, then they are included in the numerator.

Next slide.

Now, as I mentioned, there are allowable gaps for the numerator of up to 15 days; and here's how we determine if the gap is allowable. If the number of days the child is on multiple antipsychotics concurrently is less than 90 days, we then look to see the next day during the year where the child is again on more than one antipsychotic; and this would be the start of the next multiple drug event. If the gap between multiple drug events is 15 days or less, then both of the multiple drug events are combined into one; and we include the gap days in the multiple drug event. If the gap, however, exceeds 15 days, then the first multiple drug event is ended; and we assess the next multiple drug event to see if it meets numerator criteria.

Next slide.

We continue this assessment through the end of the year; and, again, if the child has at least 90 days of multiple concurrent antipsychotic use, then they meet the numerator. And if the child has less than 90 days of the concurrent use, then they do not meet the numerator criteria.

Next slide.

And finally, to calculate the performance rate, we take the numerator of children on two or more antipsychotics concurrently for at least 90 days and divide by the denominator of children who have at least 90 days of continuous antipsychotic use; and this will give us the performance rate. Again, it's important to note that a lower rate indicates better performance for this measure; so we're looking for a lower rate indicating better quality in this case.

And now we will begin our Q&A Session. If there is a question, I believe you press five star (5*) to raise your hand.

Thank you so much.

Q&A Session

You may also submit a question through the Q&A widget on your console. We realize that this is a lot of information; so, please, submit your questions.

We do have one question so far, and it's related to the enrollment criterion and allowable gap for the denominator. The question is whether there is an 11-month enrollment criterion for counting.

For counting—?

For, I would say, eligibility for the denominators. So is there an 11-month continuous enrollment criterion or a different criterion?

Okay, so the enrollment criteria is actually for the measurement year; and there is an allowable gap of up to 45 days in enrollment, where the individual could have a gap but still be included in the measure – as long as it doesn't exceed 45 days.

That's great, thank you. We have no other questions at this time. Why don't we move to our next presenters and – oh, actually two just came in.

So the question: "When calculating the greater than 90 days in the denominator, do you consider the days within the whole drug event period or the actual number of non-overlapping days' supply of the drug?"

I'll repeat that again, "When calculating the greater than or equal to 90 days in the denominator, do you consider the days within the whole drug event period or the actual number of non-overlapping days' supply of the drug?"

I believe that following the specification, the way that you would calculate this, you're not going to be counting overlapping days. And I believe that the calculation, where you're taking the days' supply for the first prescription and then adding the 32-day allowable gap, accounts for that in the calculation.

Great, thank you. There is one other question. We're going to be getting to this a little bit later in terms of the technical assistance. There is a question about whether a SAS code will be available to track this measure in terms of saving time for calculating and coding, and we will get to that later. And the answer is, yes, there is SAS code that's under development. So thank you for your question about that.

At this point, why don't we turn it over to the next question, which is related to state perspectives? And we'll start off with Dr. Bush from Wyoming. Thank you.

State Perspectives on Reporting the APC Measure
James Bush, MD, Medicaid Medical Director, Wyoming Department of Health

Thank you. Can you hear me okay?

Yes, we can hear you just fine.

Perfect, so I'm very pleased to be able to share our experience in Wyoming with this group. We first began looking at these measures back in 2011, and our program started off on July 1, 2011. We have a significant concern because we are the ninth largest state; and in the entire state of Wyoming, we only have 23 total psychiatrists, 6 of whom are child psychiatrists. So we were very concerned about quality.

So beginning at that time, we started a three-pronged approach. First was what we called – and we adopted this from the state of Washington. I think people mentioned our Medicaid and Medical Directors Learning Network. We like to share very much. So we took and modified their program called Too Many, Too Much, Too Young. Too many is five or more psychotropic medications over a period of 90 days, or two or more in the same class. Too much is greater than 150% of maximum FDA recommended dose. And too young was psychotropics in younger than five.

We combined that with -- any child who exceeded any of those parameters had a mandatory secondary opinion with a child psychiatrist at Seattle Children's Hospital, as they are our state medical school; we're a WAMI state.

Finally, we also made available a provider access line so any physician could talk about any child in the state of Wyoming that they had concerns or questions about child psychiatry issues. We have our Pharmacy Benefits Manager, who pulls these lists every month and gives them over to our pharmacy offices to make some referrals to Seattle Children's.

The people who have exceeded the Too Many, Too Much, Too Young, the providers were 48% psychiatrists and 40% primary care physicians; the 2% were other specialists. The patients were – 37% were 5 or younger; 23% were between the ages of 6 to 12; and 34% were between 13 to 18. Sixty

percent of the time, it was the too much, the too high of dose; 37% of the time, it was for being younger than 5; and only 3% of the time, it was for too many psychotropic medications.

However, we have tracked these over time from the beginning; and over the span from 2011, those who were too young have dropped from 4.06% of all patients on psychotropic medications to 1.56%. The more than five medications have fallen from 0.62% to 0.22%. And I'm happy to say that those who exceed the 150% have dropped from 2.51% to 0.36% -- so rather significant declines over time.

We do all this real time. So every month, we get these; we see how many are exceeding these parameters; and we start doing interactions. One of the things that we have learned and have modified in our program is we can't keep adjusting pharmacy if you want to make maximum impact because a lot of times, these patients were exceeding these and getting on multiple meds and multiple psychotropics because of poor behavior care plans, absence of other therapies. And Seattle has always addressed those, so what we have done is each of these gets referred to our Health Management Program, who then follows up with the physician and the client to make sure that all the non-pharmacologic and pharmacologic interventions have been followed and modified.

So what we are planning on doing with this, however, allowing with the HEDIS measure that has just been described this afternoon, is we're going to pull the HEDIS measure on a quarterly basis to track and see how well it's comparing with our current measure; and then, of course, we'll be reporting that on the annual basis. So in this way, we've tried to set a standard of care and to link collecting the measure with actually achieving better clinical outcomes. And so those children who still exceed clinical outcomes, we at least know every one of them has had a second opinion from a Board-certified child psychologist at our medical school.

That's a brief overview of how we've been doing this program since 2011. And I will turn it over to Dave Kelley to talk about what he's been doing it in Pennsylvania. And then we'll be happy to take any questions after Dr. Kelley has presented his state. Thank you.

State Perspectives on Reporting the APC Measure
David Kelley, MD, MPA, Chief Medical Officer, Pennsylvania Department of Human Services

Thanks, Jim.

I'd like to thank CMS for the opportunity to share what we're doing here in Pennsylvania. We have been looking at antipsychotic medication use in Pennsylvania since 2005, and that was really driven by a very large rise in our pharmacy costs, especially with utilization in children – again, finding high-dose as well as low-dose utilization, as well as inappropriate diagnoses and poor monitoring of potential side effects.

We started developing our own reports, shared those reports with our managed care plans and fee-for-service. We started to add some prior authorization criteria; namely, age edits and dose edits. And we had some programs that we did either direct provider mailings or telephonic outreach to certain prescribers that appeared to be outliers. In 2009-2010, we actually participated in the Medicaid Medical Directors Multistate Analysis that was done; and Dr. Bush has done a nice job of describing that particular study. There were 16 states that participated; that was a study that was done in Rutgers with Steve Crystal. And again, really benchmarked a lot of states' Medicaid programs to benchmark how we were doing as far as the various age groups, high dose/low dose, and multiple and psychotic medication use.

It's still been an ongoing problem, even though we've been looking at this now for over a decade. 2015, working with our Children's Hospital in Philadelphia, we actually had their policy lab do an analysis for us. Happily, we were finding that our utilization of these medications was headed downward, in the right direction. But their analysis still showed that about 56 percent of children that were being treated with antipsychotics really did not have an indicated diagnosis. So that certainly continues to be concerning from our standpoint.

Because of that, we put into place a multitude of interventions that I'll talk about in a little bit. We have been measuring with the HEDIS specifications for 2015, as well as 2016; and happily, I will say that our results trended downward from those two years. And again, I think we're somewhere between the 25th and 50th percentile; so we still have some room for improvement. We'd like to use these measures and other measures that we've developed to work with our – in the state of Pennsylvania, most of the children are covered through mandatory managed care. So we work through our managed care plans to put into place appropriate programs.

So from our standpoint, we've been using -- our plans are required to do the HEDIS specifications; they report them annually. They use their pharmacy data, as well as eligibility data, for obtaining the information per the HEDIS specs. And I think from our standpoint, our managed care plans work very closely with our external quality review organization to make sure that the specifications are done correctly, accurately, and they're done in a consistent fashion. And then what we do is we actually compare our plans one to another, and then we have what we call an average rate that goes across all of our managed care plans.

As far as some additional things that we like to do with the HEDIS spec and also with some of the other measures that we do, we think that it's important – as I mentioned before, we look at this by managed care organization. But we also have been very focused – the policy report that I mentioned previously with Children's Hospital in Philadelphia really showed that kids in foster care, these particular children tend to have these medications prescribed at a very high rate. So, again, I would suggest that you do some drill down looking at those children that are in foster care.

Also, I think looking at who the actual prescribers are is sometimes helpful in developing your programs. If these are PCPs, they sometimes may need educational efforts or may need some consultative help, similar to what Jim had described.

We also have, in some instances, looked at race and ethnicity. And we actually have seen some disparities there in medication utilization in this drug category.

One of the things that I know from a technical standpoint – and I think this was brought up during the questions – is that the individuals that are in the specification in the denominator, there is a continuous eligibility criteria. You can only miss 45 days. So sometimes kids in Medicaid fall out; and even though you're reporting a certain measure, it's still important to programmatically take a look at those kids that maybe fall out of the denominator.

From our standpoint, we think this measure is very, very important. I will say that one of the things that we've done is we also take a look at the higher age ban. I believe the specification ends at age 17; I could be wrong at that. But we go up to age 20, and the reason we do that is because of the ACA. Our foster kids continue in Medicaid because we're a Medicaid expansion state, adult expansion; so we're interested in looking at those young adults as well.

So programmatically, some of the things that we've put into place – we do develop a quarterly dashboard that we look at, a whole host of measures with that dashboard. Annually, we actually share that with our managed care plans in comparing the plans. We also look at race and ethnicity; and we're very focused, again, on those kids that are in foster care. And we've developed a specific program, where on a quarterly basis we actually share – we're a carve-out state, where our physical health and behavioral health plans are carved out. So we share information between plans, but we have identified all of those children on antipsychotic medications. We also identify those that are on two or more, but we also look for whether or not there appears to be an appropriate diagnosis and whether or not they've had appropriate monitoring.

So we're very, very focused on those kids in foster care. We've been sharing this data between our physical health and behavioral health plans. And we're starting a pilot to push some of that shared care gap data out to our children and youth agencies at the county level.

Another area that we're very focused on is making sure that these kids get a behavioral health visit because medications are not the only answer. So we're very focused on making sure that there is appropriate monitoring, but there's also good behavioral health follow-up.

The other thing that we just initiated, similar to what Jim described, is a peer-to-peer telephonic consultation service. We actually just started that in July, and we're very, very excited about that. I think it will provide an opportunity for our providers, especially in those very rural areas, to be able to talk to adolescent and child psychiatrists not just about antipsychotic medication needs but other behavioral health issues and conditions. But it provides our primary care physicians with guidance and expertise of how to appropriately use these medications, as well as appropriately monitor the medications.

Again, from our standpoint, we're very excited about this particular measure. Our concerns continue to be whether or not these meds are really being used for the right diagnosis. We also do the HEDIS specification for the monitoring. And I will say that as a state, less than 40 percent of our kids, per the HEDIS specs, get appropriately monitored; so that's still an ongoing concern.

Again, I just wanted to share what we're doing as a state to really look at this issue. And again, I think this HEDIS specification is really a very, very important measure to look at.

Thank you very much.

Q&A Session

Well, thanks to both of you for this inspirational presentation about use of the measures. We do have a couple of questions, actually, Dr. Bush, about whether anything has been published about your Too Many, Too Much, Too Young program – whether there might be some resources online we can share with participants after the webinar.

Yes, we were published. We published the results of that in *Journal of Telehealth*. And I can make that resource available to you all.

That would be great; I think people would really appreciate that.

Dr. Kelley, is there anything related to your program available?

There are two things that are available that I mentioned previously. The Rutgers study that Steve Crystal did with 16 of the Medicare states, that is publically available online. And then also, the report that we had, Children's Hospital of Philadelphia published for us; that is available online. The complete study is available; but that is Pennsylvania-specific, and it's Medicare-specific. So we can get Web links for both of those studies.

That's great, thank you so much. We'll share those with everybody after the webinar.

We do have another question that is probably appropriately directed to NCQA. This is about the specifications of counting concurrent use. And the question is whether Haldol, taken as needed, once every four weeks for a year, count as continuous use of an antipsychotic for 90-plus days under the specifications.

Yes, this is Emily. Likely, this scenario would count towards the denominator criteria if the medication is being dispensed every 30 days. Even if there's a short days' supply, it would likely meet the denominator criteria. However, that's just for the one medication; that person wouldn't necessarily meet numerator criteria. You have to assess for the multiple concurrent use after that.

And we have another question that's related that I just thought I'd put out there as well of how are PRN prescription is counted more generally. It sounds like that would be the same response; is that right?

Yes, essentially we're looking at the days' supply for any dispensed medication, regardless if it was dispensed as PRN or for regular use.

Great, thank you.

All right, well, why don't we move on to our next presentation? We'll come back for more Q&A after this.

Alli?

Technical Assistance Resources
Allison Steiner, MPH, Research Analyst, Mathematica Policy Research

All right, thank you so much, Margo.

And thank you, Dr. Bush and Dr. Kelley, for sharing your state perspectives.

I want to talk a little bit about technical assistance resources that are available for states. CMS has made available a few resources to help states calculate and report the antipsychotic measure.

The first resource available is the Child Core Set Technical Specifications. And this includes the specifications for the APC measure, which we're discussing today, as well as all the other Core Set measures. And that is available at the link shown here on the slide. And within the technical specifications, you'll also find some additional background information and guidance for reporting the measure.

And then next some group and one-on-one technical assistance calls will be available to help address questions as states go about calculating and reporting the measure this year. And states can express their interest in this technical assistance either through the evaluation form at the end of the webinar or through the TA Mailbox, which is shown on the slide as well.

As Margo mentioned before, there is a SAS code which is forthcoming. It's still in development, but it will be available to states through the TA Mailbox. This SAS code, states will be able to adapt the SAS code to their data system to help with calculating the measure.

And then just again, feel free to reach out to the TA Mailbox with any additional questions about this measure. Or you can indicate your interest in technical assistance through the webinar evaluation. And we're also interested in learning if anyone has suggestions for other resources that they think might be helpful to states for calculating the APC measure.

And with that, we'll open it up to any questions that states have about the technical assistance resources, as well as any suggestions on the line about other technical assistance resources that could be helpful.

Q&A Session

We do have a question about whether the slides will be available after the presentation. And they will be available through the link that you registered. In addition, they will be posted on www.Medicaid.gov after the webinar. We will e-mail all the participants further information about that, and we appreciate everybody's interest in that.

We have another question, which I'd like to direct to CMS, either Renee or possibly Megan, whether states are required to report this measure.

Hi, this is Renee. Actually, the Medicaid Child Core Set is voluntary. We'd like to encourage states to report this; but again, it's not mandatory. But, please, consider it. Thank you.

Thanks, Renee.

The next question is whether states can contract with their EQROs to calculate this measure.

Maybe, Dr. Kelley, we could direct this to you because I know you are working with your EQRO on this measure; is that right?

Yes, and what we typically do with any of the HEDIS specifications – or in Pennsylvania, we also have what we call Pennsylvania performance measures that may not be NCQA HEDIS measures. Our plans have the ability to work with our EQRO to ensure that they are correct in how they make their calculations. So our EQRO does work very closely with all of our managed care plans, especially on specifications or new or what may be considered complex. Our plans do work with our EQRO to assure that they are very, very consistent in their approach.

And then our EQRO also then takes each of those results from each of the managed care plans. Those are reported to NCQA, but they also calculate for us what we call our health choices average. It's a weighted average that goes across all of our managed care plans. They also do that for us.

Thank you.

We also have some questions related to data collection and whether there were any barriers to collecting the data that you identified and have resolved.

Perhaps, Dr. Bush and Dr. Kelley, you might have some insights on that and then maybe turn it over to NCQA as well.

I'll take the first stab at it. I think from our standpoint in Pennsylvania, again, most of our pediatric lives are covered by managed care organizations who readily have access to pharmacy data; and this is an administrative measure based really on pharmacy but also eligibility. So all of our managed care plans have an eligibility file; they also have the pharmacy data. And in Pennsylvania, if someone jumps from one health plan to another, we actually provide that health plan with historical data.

So for this particular measure, since as I understand it, it's an administrative measure, we have not heard of any major complaints. It can become a little bit complex in some of the numerator calculations, but we have not heard of any major data challenges.

And Wyoming is a 100 percent fee-for-service state. So like I said, our Pharmacy Benefits Manager does the initial compilation; and then we have an Office of Pharmacy Services that does it. Since we don't have any managed care within the state of Wyoming, we have sort of internalized that. It's a pretty straightforward process. The biggest difficulty we've had is, again, compiling and making sure about those 90-day transitions has been a little labor intensive for one of our pharmacy clerks.

Great, thanks.

And, Emily at NCQA, anything you'd like to add?

Well, generally, we have found that plans are very easily able to calculate the measure because, as it was mentioned, it is an administrative-only measure based on pharmacy claims data. The only challenge that we have heard about would be cases where there may be a carve-out specifically for antipsychotic or other behavioral health medications. That would be the only challenge that we've really heard about so far.

Great, thanks.

Now we have a question that is more, I would say, related to quality improvement – a question for Dr. Bush and Dr. Kelley – how providers have responded to feedback about their prescribing practices, whether they've welcomed it or resisted it.

I'll be happy to take the first stab at that. Before we even implemented this program, I did a significant outreach. I mentioned earlier that the entire state is a mental health provider shortage area. And I went to our Wyoming Medical Society and our Wyoming Association of Psychiatric Physicians. We described our concerns and problems. We told them our proposal. We sort of basically asked for their blessing as we were doing this.

And with some of the psychiatrists saying, "Why are you going out of state," we just said, "Do you have time to start taking this on yourself?" And, of course, they didn't because everyone is very, very booked.

Then the second pushback we got was the psychiatrists thought they should be exempt. And we pointed out that in Washington State even the members of Seattle Children's Hospital and the Medical School are not exempt from this if they exceed parameters. And the good has been that once the docs spoke to the faculty at the Medical School, who has been very respectful of the challenges of practicing in a frontier state, this has become very, very popular. And so all the initial resistance and hurt feelings have disappeared, and it's been well received.
That's great, thank you.

We have one final question. And the question is whether the 90-day transition tracking is done manually or whether you've been able to build reports that reconcile all of the details.

In Wyoming, it's all manual. That's our biggest hiccup at the moment. And we're a smaller state, so it's doable. I imagine in some of the larger states – if anyone can come up with a system, we'd love to hear it.

And Dr. Kelley in Pennsylvania?

Can you repeat the question?

Sure, the question is whether the 90-day transition tracking is done manually or whether you have automated the process to reconcile the transition tracking.

I would say, again – this is for the specification – I would say again that our managed care plans are responsible for doing that, and they have the infrastructure to handle it.

Okay, great, thank you.

Renee, that's it for the questions for now. Would you like to do the wrap-up?

Wrap-Up
Renee Fox, MD, Medical/Health Policy Advisor, CMS

Sure, thank you very much.

I just want to thank all the participants and the presenters for today's webinar. I hope this is just the start of the conversation that CMS and Mathematica have as the TA Mailbox to get questions and get reports in.

Our final slide has a reminder that it's a high priority; and if states would report on this, we really are very interested in the data, as are many other people. Many of the states in the affinity group have asked me what their baseline should be. And I think the information that was provided by NCQA, by Dr. Scholle, is a

good example of the fact that paying attention to a problem by requiring reporting shows that once you do that, people pay attention and change practice. So I think it's really important to highlight that.

You've heard from two states, one a managed care state and one a fee-for-service state – very different states in population and size and provider number – that really have worked hard on this and made incredible improvements, maybe not gotten to where they want to be, but are able to show that.

And we're going to open the Child Core Set reporting in MACPro in the fall. Please note that any deviation from the measurement specifications -- such as measurement year data source, as well as any eligible populations excluded from this measure – again, please use our TA Mailbox. And you can either submit specific questions or request a phone consultation for general support. And you may also request TA by filling out the webinar evaluation when you sign off today.

So thank you very much. We really value the time that you've spent in this, and we're going to give you a little time back – almost a half hour. So thanks a lot, and I'm going to turn it over to Brice.

Thank you.

This concludes the webcast for today. Please submit feedback to the presentation team using the survey in your browser window when the event concludes. If you are unable to provide your feedback at this time, you can view the On Demand recording of the event and access the survey widget there. The On Demand will be available approximately one day after the webcast and can be accessed using the same audience link that was sent to you following registration.

Any future topics or discussion points can also be shared with the team using the MACQualityTA@CMS.hhs.gov TA Mailbox. Thank you.