NATIONAL QUALITY FORUM

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MEDICAID AND CHIP SCORECARD COMMITTEE IN-PERSON MEETING

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THURSDAY, JANUARY 10, 2019

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The Committee met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street N.W., Washington, D.C., at 9:00 a.m., Richard Antonelli and Harold Pincus, Co-Chairs, presiding.

PRESENT:
RICHARD ANTONELLI, MD, Boston Children's Hospital, Chair
HAROLD PINCUS, MD, Columbia University, Chair

ORGANIZATIONAL MEMBERS (Voting)
RHONDA ANDERSON, RN, American Nurses Association
SHAYNA DAHAN, BSN, RN, MSN, National Association of Pediatric Nurse Practitioners
JOY HAMMEL, PhD, American Occupational Therapy Association
ENRIQUE MARTINEZ-VIDAL, MPP, Association for Community Affiliated Plans
ELIZABETH MATNEY, National Association of Medicaid Directors
MARK RIZZUTTI, Ohio Department of Medicaid
JOSH ROMNEY, MD, Intermountain Healthcare
CLARKE ROSS, DPA, American Association on Health and Disability
CAROL SAKALA, PhD, MSPH, National Partnership for Women and Families
SALLY TURBYVILLE, DRPH, MS, MA, Children's Hospital Association
STEPHANIE A. WHYTE, MD, MBA, Aetna Medicaid

INDIVIDUAL SUBJECT MATTER EXPERTS (Voting)
KAMALA ALLEN, MHS, Center for Health Care Strategies
LINDSAY COGAN, PhD, New York State Department of Health
CAMILLE DOBSON, MPA, National Association of States United for Aging and Disabilities
DAVID EINZIG, MD, Children's Minnesota
KIM ELLIOTT, PhD, CPHQ, Health Services Advisory Group
AMY HOUTROW, MD, PhD, MPH, University of Pittsburgh, Children's Hospital of Pittsburgh
DAVID KELLEY, MD, MPA, Pennsylvania Department of Human Services
SREYRAM KUY, MD, MHS, FACS, Department of Veterans Affairs
STEPHEN LAWLESS, BS, MD, MBA, FAAP, FCCM, FSMB, Nemours Children's Health System
JILL MORROW-GORTON, MD, MBA, Office of Clinical Affairs, MassHealth
ELISABETH OKRANT, MPH, MSP, PhD, Beacon Health Options
LISA PATTON, PhD, IBM Watson Health
KENNETH SCHELLHASE, MD, MPH, Children's Community Health Plan
JEFF SCHIFF, MD, MBA, Minnesota Department of Human Services
MARISSA SCHLAIFER, RPh, MS, OptumRx
JUDY ZERZAN, MD, Washington State Health Care Authority

FEDERAL LIAISONS (Non-Voting)
LAURA JACOBUS-KANTOR, PhD, Substance Abuse and Mental Health Services Administration
SUE KENDIG, JD, WHNP-BC, Health Resources and Services Administration *
KAREN LLANOS, Center for Medicaid and CHIP Services, CMS
KAMILA MISTRY, PhD, MPH, Agency for Healthcare Research and Quality *
MARSHA SMITH, MD, MPH, FAAP, Centers for Medicare and Medicaid Services

NQF STAFF:
SHACONNA GORHAM
JORDAN HIRSCH
MIRANDA KUWAHARA
DEBJANI MUKHERJEE
ELISA MUNTHALI, Senior Vice President, Quality Measurement

ALSO PRESENT:
SEPHEEN BYRON, National Committee for Quality Alliance
RENEE FOX, Centers for Medicare and Medicaid Services
LISA HINES, Pharmacy Quality Alliance *
JUNQING LIU, National Committee for Quality Alliance *
VIRGINIA RANEY, Centers for Medicare and Medicaid Services *
COLLEEN REULAND, Oregon Health and Science University
JANICE TUFTE, Patient Advocate

*** present by teleconference**

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

9:09 a.m.

MS. MUKHERJEE: Hello, everybody. We're going to get started. So this is a quick reminder.

And so my name is Debjani Mukherjee. And I'm the Senior Director for the Medicaid and CHIP (MAC) Scorecard Committee.

And this is our first day of our two-day in person meeting. So I would like to take this opportunity to welcome everybody in the room as well as on the phone.

And with that, I'm going to make a quick few announcements. Please mute your phones. We have a packed agenda for the next two days.

And if you need to make a call, you can step out in the hallway and there's some chairs out there by the elevators. Restrooms again, are past the elevators on the right down the hallway.

So with that, I'm going to turn it

over to our Chairs for some welcome remarks. Rich and Harold?

CHAIR ANTONELLI: Good morning. And Happy New Year to you all. I'm Rich Antonelli, a general pediatrician, Medical Director of Integrated Care at Boston Children's Hospital.

I'm very grateful for the opportunity to convene this group, to co-chair it with Harold.

The work is incredibly exciting and timely. And there's a lot to do. A lot of children and families and adults depending on the work.

So thank you for joining with us.

CHAIR PINCUS: Let me also sort of welcome everybody. We're delighted to be here. Many of you have been at this table before.

Though this is technically a new committee. And so, you know, so there's some differences that we'll go over about how this process works.

A bit differently than some of the

processes we've had before. But again, I'm delighted to welcome you.

MS. MUNTHALI: Good morning everyone, my name is Elisa Munthali. And I'm the Senior Vice President for Quality Measurement at the National Quality Forum.

And on behalf of the National Quality Forum, I wanted to welcome you and thank you for being on the Committee.

Today we will combine disclosures of interest with introductions. And they're going to be done in two parts, because we have -- can you hear me? Okay. Sorry.

We have a court transcriber in the back. So he was raising his hand. So that's a reminder to all of us to speak up to the mic so that he can capture everything we're saying.

We are going to be combining the disclosures of interest. We have two types of representatives on the Committee, the organizational representatives, and subject matter experts.

We're going to start with the organizational representatives. You received a shorter form. We just wanted to know if you had earned any money that was related to the work in front of you in excess of a hundred thousand dollars.

I will go over the subject matter disclosure of interest process, which it was a lengthier form for all of you. But, because we're so many here, I have a few more instructions.

We have about 15 organizational representatives. And I think the majority of you are participating in person, with the exception of one person.

And Clarke just stood up. And he's the first person who's an organizational rep. So we'll start with Clarke.

We're going to ask also Carla, Carol, Elizabeth, Enrique, Josh, Joy, Julie, Mark, Rhonda, Sally, Sarah, Shayna, Stephanie. And then I'll go to Sue on the phone, who's an

organizational rep.

And then we'll start with the subject matter experts. So as you're introducing yourself, let us know who you are, your organization, and let us know if you have anything to disclose.

So I'll start with Clark.

MEMBER ROSS: Hi, I'm Clarke Ross. I work for the American Association on Health and Disability.

I'm the liaison for the Consortium for Citizens with Disabilities, which is a 45 year old D.C. policy coalition of 113 disability organizations. And I'm the father of a 28 year old son with co-occurring disabilities.

And I have no declaration.

MEMBER ANDERSON: I'm Rhonda Anderson. Good morning everyone. I'm with the American Nurses Association.

And I have nothing to disclose.

MS. MUNTHALI: Thank you.

MEMBER EINZIG: I'm David Einzig. I'm

with Children's Minnesota. And no disclosures.

MS. MUNTHALI: Thank you.

MEMBER KELLEY: Good morning. I'm Dave Kelley, Chief Medical Officer for Pennsylvania Medicaid.

And I have no disclosures.

MEMBER HAMMEL: Hi, I'm Joy Hammel. I'm representative for the American Occupational Therapy Association.

And no disclosures.

MS. MUNTHALI: Thank you.

MEMBER WHYTE: Good morning. I am Dr. Stephanie Whyte. I'm the Aetna, a CVS Health Company. Oh, it's not on? It's red.

MS. MUNTHALI: Is that better?

MEMBER WHYTE: Yeah. Well, maybe I was touching it. You're not supposed to touch and speak. A note to everyone else who goes.

So good morning, I'm Dr. Stephanie Whyte. I am with Aetna, a CVS Health Company on the Government Services Aetna Medicaid side.

And I have nothing to disclose.

MS. MUNTHALI: Thank you very much.

MEMBER SCHELLHASE: Good morning. I'm Ken Schellhase. I'm a subject matter expert. I'm a Medical Director at Children's Community Health Plan in Milwaukee.

I have two possible disclosures. I don't think they're terribly important. I'm a researcher as well.

I hold two community engagement grants that relate to improving immunizations through pharmacies. And reforming how prescription labels are printed on bottles so people can actually understand how to take their meds. Thanks.

MEMBER LAWLESS: I'm Dr. Steve Lawless, subject matter expert. I'm the Chief Clinical Officer for the Nemours Pediatric Healthcare System.

MEMBER RIZZUTTI: I'm Mark Rizzutti, Performance Analytics Manager for Ohio Medicaid. I'm actually representing Dr. Mary Applegate, who's the Ohio Medicaid Medical Director.

And I have nothing to disclose.

MS. MUNTHALI: Thank you.

MEMBER ALLEN: Hi, Kamala Allen, Center for Healthcare Strategies. I have nothing to disclose.

MS. MUNTHALI: Thank you. And I think we've completed the organizational representative disclosures with the exception of Sally and a few people on this side.

So we'll start up here.

MEMBER DAHAN: I'm Shayna Dahan. I'm with the National Association of Pediatric Nurse Practitioners.

And I have nothing to disclose.

MS. MUNTHALI: Thank you.

MEMBER MARTINEZ-VIDAL: Hi. I'm Enrique Martinez-Vidal, Vice President for Quality and Operations at the Association for Community Affiliated Plans which is a trade association of nonprofit, safety-net health plans serving Medicaid.

Nothing to disclose.

MS. MUNTHALI: Thank you. I think Sally might be next.

MEMBER TURBYVILLE: Good morning. I'm Sally Turbyville. I'm with the Children's Hospital Association.

And I have no conflicts of interest to disclose.

MS. MUNTHALI: Thank you Sally. And Sue, if you're on the line, if you can introduce yourself. And let us know if you have anything to disclose.

Sue, you might be on mute. I think we see you on the web platform. If you can speak now, that will be great.

If not, we can come back to you. Oh, and before that, we will go to Carol. I think we missed you the first time around.

MEMBER SAKALA: Yes.

MS. MUNTHALI: Sorry about that.

MEMBER SAKALA: Good morning. I'm Carol Sakala. I'm with the National Partnership for Women and Families.

And I have nothing to disclose.

MEMBER MATNEY: Hi. I'm Elizabeth Matney. I'm with Iowa Medicaid. I'm representing the National Association of Medicaid Directors.

And I have nothing to disclose.

MS. MUNTHALI: Okay. Thank you. So I -- oh, Josh. There's Josh.

MEMBER ROMNEY: I'm Josh Romney. I'm a Care Transformation Medical Director for Intermountain Healthcare.

And I have nothing to disclose.

MS. MUNTHALI: Okay. Great. And I think we're done now. So now we'll go to the subject matter experts.

You received a lengthier form. We wanted you to tell us about any of the activities that maybe related to the work in front of us that maybe paid or unpaid.

Just a couple of reminders, just because you disclose, does not mean you have a conflict of interest. We do so in the interest

of transparency.

And unlike the organizational reps, you are not speaking on behalf of your organization. You are speaking because you are a subject matter expert.

So I will start with -- to my left, SreyRam? Oh, into your microphone, please?

MEMBER KUY: Good morning. I'm SreyRam Kuy. I previously served as the Chief Medical Officer for Medicaid for the State of Louisiana.

I currently serve as the Deputy Chief Medical Officer for the Department of Veteran Affairs, VISN 16, the South Central U.S. And I don't have anything to disclose.

MEMBER HOUTROW: Hi everyone. My name is Amy Houtrow. I'm a Pediatric Rehabilitation Medicine Physician at the University of Pittsburgh, Pittsburgh Children's Hospital.

I do a lot of research in health services for children with disabilities, and have funding related to that. But none of it related

to any of these projects.

And I'm delighted to be here.

MEMBER EINZIG: And I'm David Einzig again. And I introduced myself in the wrong segment.

I am with Children's Minnesota. But I'm not representing Children's Minnesota. I'm a Child Psychiatrist and Pediatrician by training.

And I have nothing to disclose.

MEMBER MORROW-GORTON: I'm Jill Morrow-Gorton. I'm the acting Chief Medical Officer for the MassHealth, which is the Massachusetts' Medicaid Plan.

I'm also the clinical lead for the Office of Long Term Services and Supports where I spearhead the quality program. And am involved in the ACO quality programs and what not.

But, I don't do any research around quality measures. And I don't have any money related to quality measures either.

So I have nothing to disclose.

MS. MUNTHALI: I can't see it. It

might be Steve or who's -- oh, Steve, go.

MEMBER LAWLESS: Yeah. Steve Lawless, I did the same thing. I introduced myself at the wrong time.

So I'm the Chief Clinical Officer for Nemours Healthcare System. And I'm a Pediatrician/Pediatric ICU Doctor by training.

And nothing to disclose.

MEMBER SCHELLHASE: And I'm Ken Schellhase. I also introduced out of order. Medical Director of Children's Community.

MEMBER ALLEN: And this Kamala Allen. I'm going to keep that theme going. I also did the same.

(Laughter.)

MEMBER ALLEN: I follow. I follow. I'm Director of Child Quality at the Center of Health Care Strategies.

And nothing to disclose.

MEMBER PATTON: Good morning everyone. I'm Lisa Patton. I'm a Clinical Psychologist and former Division Director for Evaluation and

Quality at SAMHSA.

And currently with IBM Watson Health as the Senior Director of Behavioral Health Policy and Research. And nothing to disclose.

MS. MUNTHALI: Thank you.

MEMBER ZERZAN: I'm Judy Zerzan. I -- for those of you that knew me in my former role, I'm now the Chief Medical Officer of the Washington Healthcare Authority.

And I also sit on an NCQA Behavioral Health Advisory Committee Measures. So we talk about the same thing.

MEMBER DOBSON: Good morning. Camille Dobson, Deputy Executive Director for the National Association of States United for Aging and Disabilities.

We're a membership organization of State Aging and Disability Directors who deliver home and community-based services to Medicaid consumers.

We are a measure steward for the National Core Indicators for Aging and Disability

Surveys, which is a Quality of Life Survey for older adults and people with disabilities, which may come up for discussion at some point.

So I wanted to make sure I disclosed that.

MS. MUNTHALI: Thank you.

MEMBER COGAN: My name is Lindsay Cogan. I am the Division of Quality Measurement at the New York State Department of Health.

And I don't think it's a conflict of interest. But I did put on my disclosure form that as a State, I was the PI on a grant from CMS to work on the development of the contraceptive care measure.

So the funding went to the New York State Department of Health.

MS. MUNTHALI: Thank you.

MEMBER OKRANT: Hi. My name is Elizabeth Okrant. I am the Corporate Vice President of Beacon Health Options.

And I also do some health services research affiliated with Brandeis University.

But I don't have anything to disclose.

MS. MUNTHALI: Thank you.

MEMBER SCHIFF: Hi, I'm Jeff Schiff. I'm the Medical Director at the Minnesota Department of Human Services.

I have worked on some quality measure development one. But, no financial conflicts.

MEMBER ELLIOTT: Kim Elliott. I work for Health Services Advisory Group, an external quality review organization.

And license organizations for performance measure validation for NCQA. I have been there about three years.

Prior to that I worked about 15 years at the State Medicaid Program in Arizona, where I led all the clinical programs, including all the quality improvement work.

And prior to that I worked about 15 years at various health plans that did commercial Medicaid and Medicare business. And also in the quality line of work. Thank you.

MS. MUNTHALI: Thank you.

MEMBER ELLIOTT: Sorry, no disclosures.

MEMBER SCHLAIFER: I'm Marissa Schlaifer. I'm a Pharmacist and Vice President of Policy and Regulatory Affairs for OptumRx, a prescription benefit management company. A part of United Health Group.

I do represent the Academy of Managed Care Pharmacy when I sit on the MAP Coordinating Committee. But today, I don't represent anyone other than myself. Not my company or AMCP.

And I have nothing to disclose.

MS. MUNTHALI: Thank you. Your Co-Chairs are also subject matter experts. I'm going to turn it over first to Rich and then to Harold to introduce themselves and let us know if they have anything to disclose.

CHAIR ANTONELLI: Rich Antonelli. Medical Director of Integrated Care at Boston Children's.

I have developed a measure of patient experience of care integration. It is not under

consideration either of these two days.

I implement measures as part of my day job. I actually sit on the DSRIP quality subcommittee for Mass Health as well.

But again, have no conflicts of interest to disclose.

CHAIR PINCUS: I'm Harold Pincus. I'm a Professor and Vice Chair of Psychiatry at Columbia.

Also a Co-Director of the Irving Institute for Clinical and Translational Research at Columbia. And also a staff psychiatrist at the New York State Psychiatric Institute.

I'm also an Adjunct Senior Scientist at the RAND Corporation. And I have consulted for Bind Health Plan, as well as Mathematica Policy Research.

I have a number of grants from various foundations and from the Federal Government. And I sit on the Quality Council for the American Psychiatric Association.

MS. MUNTHALI: Thank you. In addition

to the organizational representatives and subject matter experts, we also have federal liaisons that are non-voting members of the committee.

And I would like them to introduce themselves. Kamila, Laura, Marsha, and Karen is here as well. So Karen perhaps we can start with you.

MS. LLANOS: Good morning everyone. My name is Karen Llanos. I am the Director of the Medicaid Innovation Accelerator Program and also the Program Manager of the Medicaid and CHIP Scorecard Initiative at the Center for Medicaid and CHIP Services.

MEMBER JACOBUS-KANTOR: Hi everyone. My name is Laura Jacobus-Kantor. And I'm the Chief of Quality Evaluation and Performance at the Substance Abuse and Mental Health Services Administration, SAMHSA.

MS. MUNTHALI: I think Deter can't make it. I'm not sure if Marsha is here.

Great. Thank you. And Kamila I don't -- she's on the phone? Kamila, do you want to

introduce yourself?

Are you on mute? Well, she will be participating. And we wanted to welcome everyone.

Before I conclude the disclosure of interest process, I just wanted to remind you at any time, if you believe you have a conflict of interest, we want you to speak up. You can do so in real time, or you can approach any one of us on the NQF staff or your Co-Chairs.

Likewise, if you believe one of your colleagues on the Committee is acting in a biased manner, we want you to speak up.

So thank you. And I'll turn it over to Debjani.

MS. MUKHERJEE: Before we get started, I just want to do quick staff introductions again. I'm Debjani and I'm the Senior Director for this project.

And with that I'm going to turn it over to Shaconna and the rest of the team.

MS. GORHAM: Good morning. I'm

Shaconna Gorham and I'm the Senior Project Manager staffing this project.

MS. KUWAHARA: Good morning everyone. My name is Miranda Kuwahara. And I'm the Project Manager for this work.

MR. HIRSCH: Hello everyone. My name is Jordan Hirsch. And I'm the Project Analyst on this project.

MS. MUKHERJEE: And we also have Ashlie Wilbon and Michael Abrams who are consultants and are part of the team as well.

CHAIR PINCUS: So as I said before, this is a little bit different for those of you that have served on the previous incarnation of this Committee. It's a little bit different.

Basically we are convened to make some recommendations around what should be on a Medicaid scorecard that States would be reporting quality measures on.

And basically, the focus is, you know, having had all of you go through the recommendations of what should be, or what is

currently on the, I guess, draft scorecard, is to make some determinations about what types of gaps exist in terms of, you know, particular areas that are not on the scorecard that should be.

As well as to consider whether there are measures that are being put forward that probably should be removed from the scorecard.

And so the bulk of what we're going to be talking about is going to be discussing the specific measures with regard to what might be added and what might be removed.

But in addition, we're going to be spending some time with the people from CMS. Also think about the longer term strategic issues around the implementation, and maximizing the benefit of such a scorecard.

Any questions about what our task is?

Okay. You have something?

MR. HIRSCH: I'd like to announce that Maura Maloney is representing Suma Nair and HRSA at this meeting.

MS. KUWAHARA: Thank you everyone. So

I will be taking this time to provide an overview of our measure selection criteria.

Sure. So the MAC Scorecard Committee is charged with evaluating the existing child and adult core set measures to inform their measure recommendations for the next iteration of the MAC Scorecard State Health System Performance Pillar.

Committee members received Federal Fiscal Year 2017 State core set reporting data and the 2018 adult and child core sets to support their measure recommendations for both addition and removal.

Reflected on this slide is the MAC Scorecard 1.0 categorized by CMCS' domains. Committee Members in the room with us today have a hard copy of this slide to refer to throughout the meeting. Next slide, please.

We have presented on this slide some descriptive characteristics of the MAC Scorecard 1.0. Please note that characteristics are not mutually exclusive.

There are a total of 13 measures on

the first iteration of this Scorecard. The measures are split between the adult and child populations.

Most are NQF-endorsed, and are process measures. And finally, most measures are claims-based measures.

The chart on this slide reflects Federal Fiscal Year 2017 State reporting data for the child core set measures. The bars indicate how many states reported each measure in Federal Fiscal Year 2017. And the stars indicate the measures currently included on the scorecard.

Similar to the previous slide, this chart includes Federal Fiscal Year 2017 State reporting data for the adult core set measures. And again, those stars indicate which measures are included on the scorecard.

So I'd like to give some background on our measure review process to reorient everyone. Our measure review process began with a compilation of the 2018 adult and child core set measures, excluding MAC Scorecard 1.0 measures.

We provided this Excel file to Committee Members along with a comprehensive list of MAC Scorecard 1.0 measures. NQF solicited measure recommendations for both addition and removal from the Scorecard Committee.

Members used the previously mentioned files along with Federal Fiscal Year 2017 State reporting data to inform their decisions.

Staff then conducted preliminary analyses of each measure recommendation for addition which are included in the discussion guide.

And all of the resources that I just mentioned, are -- were distributed to Committee Members via email.

They are also available to the public on our public SharePoint site, which can be directly accessed via the foremost link on the agenda for today's meeting. Or you can visit the website directly by typing in public.qualityforum.org.

After the Committee provided its

input, NQF staff received a total of 50 submissions. Nineteen unique measure recommendations for addition, and six unique measure recommendations for removal.

With respect to measure recommendations for addition, after accounting for two Scorecard 1.5 candidate measures and 11 measures with fewer than 25 States reporting, we were left with six measures to review today.

And I'll highlight those Scorecard 1.5 candidate measures as well as the measures that did not meet the State reporting threshold in just a moment.

Presented on this slide are the measure recommendations for addition we will review today. These are also included on your discussion guides.

And here we have measures recommended for removal categorized by CMCS's domains. Please note that measures can and do fall into multiple domains.

On this slide are the measures we will

not discuss. Because they are included as Scorecard 1.5 candidate measures.

Similarly, the measures presented on the next two slides will not be discussed. These measures did not meet the minimum reporting threshold.

And with that, I will turn it over to Rich to facilitate discussion.

CHAIR ANTONELLI: Thanks. Thanks a lot. So I guess first, by way of housekeeping, I did forget my binoculars today.

So especially for those of you down there, if -- when you put your tent up, that's how you'll get in the queue.

But, if you could sort of aim your name toward Harold and me so we can see them, that will be much appreciated. And I will apologize ahead of time, if Enrique you happen to put yours up before Elizabeth and I miss it, I will get to you.

So that's the housekeeping in that case.

CHAIR PINCUS: And not only can't we see far enough to see the names, we can't even recognize your faces.

(Laughter.)

CHAIR ANTONELLI: That's -- that's exactly right. I think next time the Chairs maybe should sit in the middle.

So that said, let's sort of open this up. I think before we sort of move into content, pausing a little bit to see are we - general understanding about the process and what's expected of us.

So I saw David first, not surprisingly. And then Kim. And it looks like Carol.

So, David, to you please.

MEMBER KELLEY: So just more of a process question. Two of the measures that did not make the grade because not enough States reported them, were CAHPS questions.

But there are two other CAHPS questions that are on the scorecard. So did

States not do the complete, or report the complete CAHPS?

I'm a little bit -- I don't understand why two CAHPS questions can be on and two that were proposed, were not -- we're not going to discuss.

So I'm just wondering about the process. And the States did the CAHPS survey, but didn't bother to ask those two questions about immunization?

CHAIR ANTONELLI: Yeah.

MEMBER KELLEY: And the immunization and some other things?

CHAIR ANTONELLI: Yeah. Karen will field that.

MS. LLANOS: So for the two CAHPS questions that you're referring to, are you talking about the ones that were in 1.0?

MEMBER KELLEY: The -- yeah, that were not -- that are not included for today's discussion because they didn't meet the threshold.

MS. LLANOS: Sure.

MEMBER KELLEY: The number of States reporting. My question is, there are two CAHPS survey questions --

MS. LLANOS: In the original scorecard.

MEMBER KELLEY: Yes.

MS. LLANOS: And that's because they were based on 2014 data from the National CAHPS data. And that means almost all States reported on that one.

We're not doing a national survey. Or we don't have access to national survey data for this coming release.

So we don't have -- we are not meeting that threshold for reporting for those particular measures.

MEMBER KELLEY: Okay. Thank you.

CHAIR PINCUS: So Karen, maybe just to, you know, to expand on that a little bit. So is it -- is what you're saying is that there's a difference between what data is collected versus

what data is reported?

MS. LLANOS: Yes. So the threshold for reporting varies from year to year. So we almost have to make those decisions on an annual basis.

And the reason why the 25 or more States reporting thresholds is our main parameter, is because that's what triggers at our center, public reporting when it comes to the core sets.

So the -- we didn't have this issue in 1.0 because we compiled data that we had available. But it was 2014 data when it came to the national CAHPS survey.

So when we go to look at what's available, we -- for those particular measures that are tied to CAHPS, we don't see that number for hitting for 25 or more States.

CHAIR ANTONELLI: So I had Kim, Carol, Amy, Clarke.

MEMBER ELLIOTT: Karen did answer part of my question. But, I guess it was just a very

challenging process with the 25 States reporting.

One of the things that I think all of us that work with Medicaid for a long time have recognized, is if you don't report it, you don't measure it. If it's not on a scorecard or something else that's really critical or important to a State, there isn't a lot that influences them to report those measures.

And I think that we're possibly eliminating quite a few things that really need that quality improvement work. Or really need that additional boost to encourage States to report.

So it's a little bit of, I guess a little less unhappiness with not being able to consider things that aren't in that set. I understand the parameters though.

CHAIR ANTONELLI: That was a comment.

MEMBER ELLIOTT: It was.

CHAIR ANTONELLI: Yes. Okay.

MEMBER SAKALA: Another comment about the context for this work. I'm just reviewing

the Notice of Proposed Rulemaking for the Medicaid Managed Care organizations.

Comments are due on Monday if you're interested. The quality rating system there says that this scorecard set is intended to be aligned with that set as well.

I don't know if you have any other comments on that, Karen. But, it's just a part of the context for this work that I wanted to mention.

MEMBER HOUTROW: So my comment basically piggybacks. Which is that there is -- we're setting up this system of perverse incentives.

So you could have a very good measure that is very hard to achieve. And therefore, many States don't report on it, so therefore we can't consider it.

And so I want us to be cognizant of that kind of bias that we're setting up as we review these measures.

And then I think the question is, or

the ask, from my perspective, is that how do we get to a place where measures evaluated on their merit and importance, not categorized first on whether or not States are reporting on it?

Because I think that makes it very hard for someone who thinks quality improvement is important. And knowing that if something is hard to achieve, it might be the most important measure, because it's something that's very important to outcomes.

But that we don't get to look at it. And I think that's, you know, kind of echoing what Kim was talking about. And I think it feels hard to have that be the case.

And so it would be nice if in the future iterations that we had the opportunity to talk about the value of the measure, regardless of how many States choose to report it, because they might not be reporting it for perverse incentive reasons.

CHAIR PINCUS: Yeah. So actually, I have a comment that builds on Amy's comment.

Because the one question I had is this 25 State threshold, if a measure is not on the scorecard, how will States get to the point of having 25 States report on it?

MS. LLANOS: So I was going to mention this in some of my framing comments. But we can hop to it.

I think the -- so a couple of things. So right now we are approaching this scorecard as public reporting. Which is not to say that this is reflective of only the number of measures that States report. Right?

Because the core set, the child and adult core set are still there. They're still in play.

They become the broader measure set for which states can do quality improvement. And should be doing quality improvement.

That's also not to say that the scorecard doesn't represent quality improvement efforts. But for now, at least for this next version, we are focusing on trying to tell the

story based on measure results versus on getting states to report.

That's just where we are right now. Right? We've had all of these conversations, and Liz can attest to this yesterday in terms of how does quality improvement fit into the scorecard?

It absolutely does. As does identification of best practices. As does broader measurement and monitoring activities.

But, as we have to focus on terms of what -- where we are right now with this scorecard, that threshold is in play currently.

However, 2024 and the mandatory reporting will blow all of this up in terms of there will be more measures in play that the 25 threshold for reporting may not even be an issue. Right?

So as a reminder the behavioral measures in the adult core set are required by all states by 2024. All the child core sets are required by 2024.

So I encourage you, as difficult as it

is, to think of this at a point in time, right now. Understanding that there is an evolution that we starting down the path of that will have a lot of influence factors.

And we're going to have to kind of change and evolve the scorecard approach as we go along this path.

CHAIR PINCUS: So that is a really helpful comment. Because that's -- I think a lot of us have had trouble, you know, making a determination about core sets, scorecard, 25 States, all that.

So understand that A, this is a transition period. And so that's really important to understand that.

Number two, the core set doesn't go away. And that the scorecard is kind of a -- sort of a practice mandatory reporting.

But it's not -- but it's not -- it's not mandatory reporting.

MS. LLANOS: Exactly.

(Laughter.)

CHAIR PINCUS: Yes. Okay. But that's kind of what it is. It's sort of a --

MS. LLANOS: No. I would describe it as --

CHAIR PINCUS: Like an imaginary.

MS. LLANOS: Right now, it's an output --

CHAIR PINCUS: Right.

MS. LLANOS: Base that is based on an ability of us to leverage previous reporting done by our State partners.

And I will note, this is one pillar. There are two other pillars that are not for discussion.

So this is one slice of the scorecard that we want to make sure -- it would be -- it would have been a mistake not to focus on the core sets. Right?

So because of that, we have to kind of put our toe in here. And then see how -- where we evolve next in terms of this.

CHAIR ANTONELLI: So just as a follow

up, and Clark, -- Harold, did you just take yours? So okay. So Clark, then Elizabeth then Sally. That's the queue from here.

If this is going to be in your presentation later, we can defer. But for me the obvious question is, if we sort of think about a developmental trajectory of identifying gaps, either developing or identifying measures to prioritize to fill those gaps, there's the core set.

The core set is the feeder system for the scorecard. And I think many of us are trying to think across that whole spectrum.

So I'm grateful for the candor about this being sort of a transitional. But, suppose we wanted to prioritize a measure of homelessness?

At what point in this developmental trajectory does that happen? Is that the feeder system into the core set? Or somewhere else?

MS. LLANOS: At this point we've got -- the scorecard initiative is -- also includes a

developmental aspect to it.

And I think we want to -- and this is not just the scorecard, our center at large. Right? Acknowledges that there are key gap areas for the Medicaid and CHIP measurement world.

So we've been going down this path as part of the pediatric quality measures program for many years. We've been trying to look at this from a Medicaid Innovation Accelerator Program.

And some key areas certainly our managed care folks have looked at managed LTSS. So the fact that there are gaps that persist, is just an issue that our center deals with.

Where that fits into as a core set, will they be in charge? Is it IAP? There's many different ways of doing that.

I think the important piece is, we need to identify the gap areas. And see where we can -- where that fits the best.

CHAIR ANTONELLI: Okay. So that sounds like that's also a little bit of a TBD.

But, I think that's where many, you know, all of us, I'm sure, collectively are trying to move toward a parsimonious set of high value measures.

Okay. And so thank you. So I've got Clark, Elizabeth, Sally.

MEMBER ROSS: So I have a question Karen on their CAHPS measure. The MAP Coordinating Committee recommended that the CAHPS trademark, home and community-based services, experience survey be included in the 2019 core set. And it's not.

And any insight publically that you can share on why?

MS. LLANOS: I don't -- I'm not part of that process. I wouldn't be able to provide an accurate answer on that.

I will say for -- as we think about the scorecard, we have been working with our -- our group in the Center for Medicaid and CHIP services that handles the HCBS experience of care measure to see if there are any process focused metrics that we could point to.

Certainly that doesn't meet the 25 or more States reporting threshold. But, we're trying to see if there's a story to be told as it relates to States reporting that measure.

MEMBER ROSS: Just a follow up, if I could. So it's my understanding that 16 or 17 States currently use the CAHPS HCBS experience survey.

Also, in the core measure set, there is no measure for long term services and supports. No measure for home and community-based services.

It's roughly a quarter of all Medicaid spending. It is the area that affects people with disabilities and others.

And so just an observation on -- that it's lost in the ether of CMS, causes frustration.

MS. LLANOS: So just to put it into context, you are referring to discussions as part of the core set as part of the scorecard initiative. We use other sources then the core

set for the Pillar 1.

Our most -- our main feeder is the core set -- child and adult core set. However, we are also exploring internal data sources, data sources that other agencies have as well in order to be able to tell a broader story about our Medicaid and CHIP program.

So it's not necessarily lost in the ether. It's just probably trying to get fit into the right buckets of our work.

CHAIR ANTONELLI: Liz?

MEMBER MATNEY: Speaking on behalf of a State Medicaid agency and the National Association of Medicaid Directors, I -- as Karen said, we've had extensive conversations of the gap areas included in the core set.

Especially related to LTSS and behavioral health. And how we can work towards that in the future.

What I would say about the measures and concern about perverse incentives is, we've had discussions about that as well. As a State

that does report almost all of the core set measures, we feel like if we're put -- our data is being put out there, it creates an unfair playing field with States that choose not to report.

However, there are some infrastructure issues that States have in being able to report. They need some assistance.

They need some funding. They need to build up any type of data analytics team that they might need to put these measures together.

And so believe me, when the scorecard initially came out, that put pressure on the States. And they started ramping up in their Medicaid agencies their reporting capacity.

And so moving forward, I do anticipate, and Karen, I don't know what your thoughts are, but I would anticipate a much, much higher adoption rate in the reporting of the core set measures.

So we'll get to a threshold in the next few years where a lot of the measures that

we do consider core priorities related to quality improvement, will be at that capacity of the 25 States or more.

CHAIR ANTONELLI: Thank you. And you made that statement on your NAMD hat in addition to your IUN hat. Okay. Thank you.

And then I think Sally.

MEMBER TURBYVILLE: First Karen, your comments in framing of the scorecard as being a public reporting mechanism that we're running through here was very helpful. Especially from the perspective of the Children's Hospital Association that deals with a lot of very medically complex children.

Or even those who aren't, the low incidence relative to adult world of children hitting the hospital. We struggle a lot with low numbers, et cetera.

So one thing to think about a criteria, and I'm not sure at what point it gets evaluated, is how important it is to be able to detect the differences for the pediatric measures

between states. And what that means for public reporting versus the core set.

And I do think this framing is going to maybe help further shape the intent of the measures on the core set. That perhaps some of them are more quality improvement and some of them really are much more -- oh, what's the word? Much more suitable for public reporting and hence for the scorecard.

I think also, I look forward to a little bit more shaping on the intended audience of action for the scorecard. Because I think the importance of these types of properties, statistical will be important as that is further shaped out.

I agree with everything that my colleagues so far have provided comment or questions about the 25 threshold. And certainly the scorecard, because it's publically reported, I would imagine will divert resources from States to focus on those measures.

Even if they're mandatorily reporting

the others, the accuracy, the data acquisition, I would think, I am not a state, so I don't want to speak for them. But, I would imagine there might be more emphasis there.

So something to think about in the future on how else -- what other kinds of parameters or strategies might be used to signal equal or at least some kind of minimal amount of rigor there. With the acknowledgment that resources are needed there.

I think the only thing I didn't hear necessarily teased out, but I think Rich implied it, is especially in pediatrics, I would say and again, since that's where I'm sitting all the time, we really need novel approaches of measurement in order to get this quality picture right.

The condition by condition approach leaves us consistently outside of preventative care with numbers that are too small to detect differences. And that's even at the State level.

This is not just at the hospital or

the practice level. Even if we rolled it up to the State level, the numbers are often too small for very important populations that are high dollar for Medicaid.

So the impact of as we move hopefully to these different types of measure that may actually require different data capture sources, how to still incentivize the States through these -- the core set and the scorecard, and accompanying it with assistance to really try to get it there.

So we really can start to understand what the quality picture is. Because we really cannot for a good amount of the dollar because of the statistical properties that accompany low numbers.

There's no biostatistician that can then solve that problem. So just something to think about. And of course, we're happy to help think through that if our services could be helpful there.

CHAIR ANTONELLI: Thank you. And then

Rhonda, I'll give you the last word. And then I'm to preserve clock, Karen, you don't have to respond to whatever Karen -- to whatever Rhonda is about to say. Because you're in the on-deck circle for the next agenda items.

So Rhonda, take it away.

MEMBER ANDERSON: As I prepared for this, I spoke to some of the providers and the insurers that are providing the care for the Medicaid populations.

And what you said Rich earlier, in talking about the journey and maybe outlining the journey, I think would really be important as one of the outcomes of this meeting, to have solidified and send out to the public at large.

Because I think all of them are in this space of -- at least what they've said, is they're in this space of we want to do the best. We want to have the most important core measures that we're really focusing on and helping our populations, et cetera.

But then, you know, out comes the

scorecard, or out comes this next piece of information, et cetera. So I just think that journey will be a helpful framework for those that are out in the field and doing the work.

CHAIR ANTONELLI: Thank you. This discussion for me personally has been extremely helpful. I'm just going to throw out a couple of broad observations.

One is, this is an evolving model. Karen, based on what you said, the way I'm sort of thinking about the recommendations of this group into that scorecard is, these are the measures that when those mandatory reporting requirements go live, 2024, this group should be mindful of that as if you will.

It is sort of the on-deck circle for mandatory reporting. That's a different dynamic then for those of us that sat on the core set groups, where we were putting good measures in place to see what stuck at the level of the states.

So I want people to sort of keep that

in mind. Because for me, that suggests strongly that feeding the scorecard needs a level of parsimony, because the -- we have to provide stewardship so the States can allocate resources appropriately.

So those are the two observations that I would -- that I would make. And then I am going to go ahead and transition now to Karen, Director of Medicaid Innovation Accelerated Program and the Program Manager for Medicaid and the CHIP Scorecard for Medicaid and CHIP Services at CMS.

I'm very, very excited to hear what you have to share with us.

MS. LLANOS: Okay. So I'm glad Rhonda used the journey analogy, because I completely acknowledge that we are asking to you come on a very ambiguous journey with us, because this is the year of transition or the year of building.

But before I do that, I want to thank you all for going on this journey with us. As frustrating as I can -- I'm sure it is,

particularly because we're building this as we go along and testing what might be the best process for this, the biggest difference, since I know all of you have lived with the core sets for a long time, is that we are not driven by statute. Right?

So because of that, we have a lot of different options. And we're taking all of this into consideration, along with the experiences of the NQF process, of our own processes at CMS broadly as we think about identification in measure selection.

And then also a giant thank you to NQF and the co-chairs for helping us kind of think through this out loud.

So maybe I'll just do a couple of background comments to ground everybody, if you bear with me. And then I'll go into my update.

So the Medicaid and CHIP scorecard initiative, we released our first scorecard June 2018. So it wasn't that long ago.

Prior to that, we were given a charge

by the administration, this is an administrator led initiative, to identify a scorecard that could promote public transparency and accountability on both the State and the Federal side of the Medicaid and CHIP Program.

We are still in the process of finding accountability. Transparency was easy. Accountability as you can imagine, means a lot of different things to a lot of different people.

So I will say that we are still in the process of figuring out and putting pen to paper in terms of what that exactly means. That also means to Sally's question that the audience is broad right now. All right?

We certainly know that the Federal government and the States, who administer the Medicaid and CHIP Programs in partnership are key audiences. But we also acknowledge that once a public website called the scorecard is online, a lot of eyes and ears are on this.

So again, this is a lot of to be determined as we think through this.

There are three pillars to the scorecard. Pillar 1 is the focus of the NQF work, because it aligns most closely with the child and adult core set.

These are mostly clinical quality measures. And we wanted to leverage and use as the back -- foundation, the child and adult core set work.

Which is why we came to NQF, because you all are most familiar with those measures. That doesn't mean that we're not working with our Division of Quality at CMCS, which leads that core set work.

As you know, those are driven by Statute. There are annual reporting. And there are -- there is language in terms of the types of selection process that must undergo for those selections.

I will note that our Division of Quality is leading a measure selection process that is going to be different this year. I don't -- I wouldn't be able to articulate how different

it is.

But just know that we are statutorily required to do this. So the curation and the updates of the annual child and adult core set will continue on.

In terms of alignment, they are scrubbed into our scorecard initiative. And certainly provide a lot of subject matter expertise as it relates to the data and experiences with State reporting.

The other thing that we are -- that's on the table in case you've got questions, that we're still debating, is the size of the scorecard. Right?

So we've got two other Pillars that have about five measures each. So in total scorecard 1.0 had about 20 or so measures.

Whether it continues to stay small or it becomes larger, are many of the questions that we're thinking about. And that's because of the mandatory reporting changes. Right?

So to acknowledge that we are not

doing perverse incentives or that we want to raise all those and identify areas of quality improvement, we have to acknowledge that there could be a scenario where we have all of the child and adult core sets as part of Pillar 1.

So we have had many heated debates at our center about parsimony versus everything. And the different pieces of that. And every conversation in between.

And we're using a -- the AMD folks, and we're using the NQF process in this year of testing to end the feedback that our public provides, to better understand what's the best scenario that meets the needs of our States, reduces burden, and still provides the picture of the quality of care for Medicaid and CHIP beneficiaries.

That is still in play. Certainly for the purposes of the next scorecard release, we are focusing on a smaller set, because there are a lot of questions that are still out there.

The definition of accountability,

still on the table as I mentioned. Probably one of the hardest conversations we've had internally, and things that we are trying to figure out as well.

And then finally, the process for identifying and selecting. So we're using NQF. We're using the National Association for Medicaid Directors.

We had two public listening sessions. I think some of you were on that as well. We're going really broad this year. As broad as possible, so that we can better understand the bigger universe of feedback.

And then see -- and then take a step back and see what's the most efficient process to do that.

And then as I said, the biggest drop -- backdrop is the mandatory reporting that's in play as well.

So there's a lot of influencing factors in terms of what this looks like in the next release versus the future, because we are

evolving and trying to piece together all of this.

As I mentioned, the feedback process is, we've been working with the National Association for -- from the beginning for release one. And we've had listening sessions and certainly the National Quality Forum.

So we're trying to take advantage of multiple feedback groups as well as this. And certainly from an internal perspective, I just want you to know that we are certainly working with the leads of the child and adult core set.

So where are we with the releases? So I was hinting to Rich that things have changed a little bit in the past couple of weeks.

So we have been, I think when we last spoke with all of you, we had targeted a summer release that would have some of the content changes. And then as we identified additional measures for some of the other pillars, we had a second release that would that would be scheduled for the fall.

We have very recently made the decision to combine all of the content changes. And do one fall release.

And that is so that we can have enough time to finish the work of the other two pillar metrics that are really important to have. And in this case, there will be changes in the summer. They will not be focused on content. It will be, if you've been on our website, you know that we have a lot to work on.

So it will be navigational changes, functionality changes. So the ability for at least Pillar 1s measures to have interactivity.

So that will be the focus of our summary changes. There won't be a big release, because it will just be functionality based on 1.0 data. So there will not be a data refresh.

The content and the data refresh all will occur in -- in the fall, in early fall, we're targeting. And that means that we'll be reflecting, or we'll have the opportunity to take into account all of our conversations today.

So it's a win/win for everyone. That's not to say that the measures for -- that we discussed off the last web meeting, those are still all in play.

I think this just gives us an ability to take additional conversations that occur and over the next couple of weeks, into consideration.

And as I mentioned, this also impacts the other two pillars, where we've got other conversations on additional data sources that we want to include.

So hopefully that makes things much, much easier. There's no interim release. There's nothing that -- the boat has not been missed on anything.

In fact, it's still -- it's still there. So to recap, the fall would have the content changes. And the summer release would just be focused on functionality enhancements.

And then the last thing I wanted to note is that as we think about all of this, we

acknowledge that this is an evolution in a transition year.

And we certainly don't want to set anything in stone until we have the ability to take a step back and see what worked in terms of how we went about this.

Once we have the ability to define clearly some of the big questions that we have, and think through the best alignment processes.

So we certainly don't want to create a lot of different silos of work that sounds very similar and is grounded in similar activities. So that's one of the things that we're really taking to heart.

So I began with a thank you. I echo my thank you. I know this is ambiguous. And thank you for sharing our ambiguity journey.

And we welcome your feedback on all of this. It's going to be an extremely helpful rest of the day and day tomorrow.

So just know that we are taking everything that you say into account. And

helping it to shape the foundation of our work.

CHAIR PINCUS: So we're going to open discussion. And if we have some questions and comments about Karen's presentation.

Let me just say a couple of things first. We -- I tell you, I don't envy you in terms of the -- really the immensity of the task and the complexity of it.

And we really appreciate the seriousness with which you and your colleagues have, you know, really gotten to do this. And also your candor about it.

So we really appreciate that. And I could sort of see that there's all kinds of sort of balancing and things.

You know, with accountability and transparency, parsimony and comprehensiveness. You know, and when you think about going, you know, ultimately moving towards some public, you know, accountability, then you know, there's lots of stakeholders have that balance between sort of looking good and going good kind of things, in

terms of how you, you know, make choices about this.

So we really appreciate that. So one question I have is, what's the process with regards to the Core Set?

In terms of how you're thinking about sort of updating, you know, making changes in that?

MS. LLANOS: So I don't lead that work for our center. Our Division of Quality does. And their process, they are required by Statute to undergo an annual update. And to publish those results or those changes on an annual process.

So that work will still continue. As I said, our Division of Quality is focused on that right now.

So to the extent additional information comes into play for this scorecard, we'll certainly update you. But just know that that process continues and it's driven by Statute.

CHAIR PINCUS: And there will continue to be that the scorecard has to be drawn from the core set?

MS. LLANOS: I mean, I certainly think at this point --

CHAIR PINCUS: Or that's unclear?

MS. LLANOS: It wants to be the -- for Pillar 1, right?

CHAIR PINCUS: Yeah, for Pillar 1.

MS. LLANOS: For Pillar 1 it is always going to be the foundation. As I noted, we're also trying to figure out from our reporting burden, what our options are to leverage data that we collect internally.

Whether it's T-MSIS data, transformed MSIS data. Whether it is MDS data. Whether we can work with the Agency for Healthcare Research and Quality to access CAHPS data.

So there are other mechanisms that we're exploring from folks that own other pieces of data sources that can be used to capture some of those metrics. So that's certainly one thing.

I will note, one of the areas that we've -- that we're considering for the summer release, and I believe I did mention this is, so CMS has nursing home compare data.

There are two measures that look at nursing home related measures for nursing home facilities that are produced at a State level. Those are two measures that are under consideration.

So certainly the core set is continuing to be the foundation. But to the extent there are other areas that we want to highlight as part of the scorecard, those would be considered.

CHAIR PINCUS: So one last question that I have is does this Committee have any responsibilities for Pillars 2 and 3?

MS. LLANOS: No.

CHAIR PINCUS: Okay. And just to clarify that.

MS. LLANOS: Yeah.

CHAIR PINCUS: Okay. So can we have

them open the lines also for any Committee Members on the phone that I have.

MS. GORHAM: Let me just -- so I just want to make sure that Kamila Mistry, are you on the line? And have an open line?

Sue Kendig?

Mara Maloney?

Okay. So we'll continue to work to get the three Members on the phone unmuted.

CHAIR PINCUS: Okay. So I have Rich, Stephen, Carol, and Lindsey for comments.

MEMBER MISTRY: This is Kamila. Could you hear me?

MS. GORHAM: Yes Kamila. We can hear you now.

MEMBER MISTRY: Oh great. Great. Thank you.

MS. GORHAM: All right.

CHAIR ANTONELLI: Karen, again, thank you. You stated pretty directly that accountability is being figured out.

And I'm grateful for that. But what

I'm concerned about is depending on whether that's accountability al la ACO with an immediate implication for financial risk at the level of the State and delivery system.

Versus accountability, a glide path to making sure that somebody is accountable for improving outcomes or two different things. And would probably influence how I would vote later today.

So can you give us some guidance about how CMS is thinking about accountability? Specifically with respect to moving measures that potentially are going to get into the space of high value integration, behavioral health, SDOH and the like.

Versus if it lands in scorecard Pillar 1 that immediately States are going to just start holding people financially accountable. Because I'd had to -- the glide path to public reporting to start to infuse a sense of performance punishment.

MS. LLANOS: So we are early on in our

process in terms of defining. I think we had lots of conversations with NAMD and the States yesterday in terms of what that means and what that could mean.

So I wouldn't be able to tell you whether it's capital or small. I would suggest, as we have been when we have these conversations, that it's always helpful for us to hear experts' recommendations on their opinions on how that's to approach the accountability question.

And I'd be open to hearing all of that as well as part of these conversations.

MEMBER LAWLESS: Yeah, thank you. A little dovetailing off of what Rich just said Karen. And your presentation was very, very good.

A lot of these measures, which are process measures, we're going to be looking at the reliability and validity, and using that as a criteria for how whether it should be approved or not.

Is there any ongoing work that's going

to look at the reliability and validity of the measures in aggregate to seeing what the impact has been? A little bit more towards the value question and outcomes versus just a scorecard?

And a burden of the scorecard versus hey look at first year, this is what it's done. Second year, this is what it's done in terms of value to the patient.

MS. LLANOS: Yeah. I think for a lot of our measures, the feedback that we've gotten from States or from everyone after the release of our first scorecard was, will you be able to, or do you plan on displaying a change in trend or a change over time?

Or moreover, what types of --will you be able to dig in and tell a broader story about that?

I will say I think we're -- we'll consider that. And I think the thing that we need to keep into account is, you know, what -- how much of a story is there to tell that's not super complicated when it comes to a State

Medicaid and CHIP Program?

So there's lots of influencing factors that go into a performance rate. Validity and testing of the measure itself is just one piece of it.

How it's collected. The structure of the program. Lots of other things. So I think we -- I think from a data perspective, the trend change over time is certainly something that we've certainly considered.

Whether or how else to dig in and tell a deeper diver story, I think is one that we're trying to figure out what's possible in a scorecard like this.

MEMBER SAKALA: So thanks Karen. That was really helpful and somewhat reassuring around the potential for evolution.

Since you, and I appreciate that you are looking for Pillars 2 and 3 for opportunities to possibly address some of the limitations in Pillar 1. I just wanted to clarify when we will know about Pillars 2 and 3?

Is that that fall release? And we won't have any information until then? Is that correct?

MS. LLANOS: So Pillars 2 and 3 are going to be very similar to the 1.0 release, which is publically available.

So just as a reminder, the two pillars, the last two pillars, one relates to State administrative accountability. And the other to Federal administrative accountability.

So these are metrics that we worked with the NAMD group and with our State partners to better understand how to frame some of these measures.

The types of measures that are included focus for example on the processing efficiencies of State plan amendments, 1115s, 1115 demonstrations.

So for the time being, our initial foray has been into more of the operations process. Trying to gain efficiencies in some areas of pain points that we and the States have

identified that we want to improve.

Or other areas that are -- that are being considered, program integrity, NAJI processing times, potentially looking into expenditures.

So there are areas that are not clinical quality at all. They are on the functions of the operations between the State and the Federal government.

MEMBER COGAN: Thank you. And I -- and Rich, you read my mind. So having -- being able to review measures without fully understanding the application and data set.

So the accountability again, is a challenge. And I don't envy you, Karen. I've sat in your position at a State level. Now having to do that same type of accountability and decision at a Federal level is incredibly difficult.

But, you know, you can have a reliable, valid clinical quality measure. But then in the application of that measure in a

financial risk or a pay for performance setting, it may not fit.

So I just would caution, or echo that I understand that's a challenge. That it's a challenge sitting on this side.

And I'm coming at this from the perspective where I'm going to be sort of at that highest level in my review of measures. To ensure that we're not setting up a situation in which the application of a measure in the scorecard, which then could be used for something else, would somehow lead to bias or a disincentive at a State level.

MEMBER DAHAN: So I'm just wondering from -- somewhat from a provider level, since most of these measures and the data for these measures are collected through claims through, I guess, ICD-10 and CPT coding, which is usually done on kind of the front lines, right?

In many capitated now environments, coding for every specific problem that you address, has become -- there's less emphasis on

it. When before, there was a fee for service schedule, right?

So how will the data that's collected be somewhat accurate? And how do you collect all that data if providers aren't kind of pushed to codify everything?

Like for example, a well visit. You would consider -- the BMI would be in the vital signs. And discussing diet and exercise would be part of that well visit.

So if you're collecting diet and exercise, those have separate ICD-10 codes. But I don't think most providers would think that they would have to put well visit, counseling for diet and exercise, BMI of whatever, 25, in a separate line, because they would assume that the well visit means all three.

MS. LLANOS: So I think the role the providers in the State engagement is one that is -- is common to all of our measures for the core sets. Right?

So it's also part of the standardized

reporting activities that we and our States have been trying to engage over the past several years.

So we know that it is resource intensive to collect any measure. To the extent that there are coding issues, or I will assume there are coding issues at all State levels when it comes to reporting.

So this is one where we know that there are potential inconsistencies or issues with the collection and reporting of our measures. What we get at CMS is one State rate that the State has aggregated across its different providers.

So we don't get to see behind the -- or under the hood as much. And this is one. It's an issue that our State partners have tackled.

And I think that to Liz's point, it's a resource intensive activity. Whether it's one measure or 20, or 40 measures.

MEMBER DAHAN: Thank you.

MEMBER TURBYVILLE: I have a couple of questions. So and I don't think they're going to be lengthy for you to answer. But when you answer one, hopefully I can have an opportunity to ask the next.

So, but I think I got clarity to my first question. But I just want to hear from you, Karen, if I'm understanding this correctly.

When -- you're saying the decisions about accountability have not been met. The level of accountability, which is the State, that -- is that -- that's gelled, right? In terms of the scorecard.

It's at State level we're not looking at any roll down of measure reporting to -- under the State level?

MS. LLANOS: I mean, certainly it's between the State and the Federal government.

MEMBER TURBYVILLE: Right. That's what I meant.

MS. LLANOS: Whether the State makes other decisions, that's theirs.

MEMBER TURBYVILLE: And so what I want -- and then so what's undetermined it sounds like is what the consequences of results are at the State level that are being reported to CMS.

Right now it sounds like it's public reporting. But there could be other financial or other types of incentives or consequences attached to performance in the scorecard.

But that's -- is that what is not yet determined? Am I understanding correctly when you're --

MS. LLANOS: Right. All senses of the word accountability. Right. So one could imagine that for public reporting at large, just the public reporting activity itself is a form of accountability. Right.

So I will say I think these are leadership discussion questions that still need to happen in terms of, how do we put something more specific around the term accountability.

MEMBER TURBYVILLE: So, for today, would I be remiss too only think about the

outcome of the, you know, the consequence of the accountability to be public reporting?

Is that what we should be focusing on? And then if decisions are changed in the future, CMS will either internally or use a committee, this Committee or another committee, to then consider both measures in the scorecard and others in the context of others, like a financial tie to the accountability piece.

So, can we -- can we feel confident that today it's about public reporting? And decisions are to be made.

And then once those decisions are made, CMS will think about the process to ensure their space validity for a measure that looked good for public reporting based on the Committee's recommendation, but maybe does not have face validity or -- in a financial type of accountability framework?

CHAIR PINCUS: Or more then face validity?

MEMBER TURBYVILLE: Right.

MS. LLANOS: I think if that's a suggestion you want to make to NQF, I think it's a good one.

MEMBER TURBYVILLE: It would maybe alleviate some back and forth about the hypothetical of, you know, if today we feel like we're focusing on the public reporting. And yes, understanding that in the future that may change.

But that's an unknown for CMS. And to deal with that unknown might be rather difficult. And could hold back measures that we do think are good for public reporting, but either don't know, or already know are not in other types of accountability approaches.

So I'd like to make that suggestion. Whether we answer that question now. But that would help us, I think, quite a bit.

CHAIR PINCUS: Yeah. No, I think -- I think that's very helpful. I think one of the things people should realize is that we're going to have another discussion tomorrow about sort of future strategy and those kind of things.

So it's best right now, I think, for us to focus on sort of getting as much information from Karen in terms of the kind of decisions that we have to make over the next -- the rest of today.

MEMBER TURBYVILLE: Okay. Thank you. And then my next question is, to what extent is CMS engaging more directly Medicaid beneficiaries?

And that could even involve public reporting if they are an intended audience. But certainly if there are financial consequences to Medicaid programs, they are very important downstream.

And for my perspective, I can think of parents of children with medical complexity, who even if they do or do not have commercial healthcare, may have Medicaid wrap around.

And the consequences of a negative financial impact on measures being selected for the scorecard may really change how we think about things. If we can hear more directly from

them.

So not just the advocates. But even, again, I can easily think of parents who have children with medical complexities who rely on Medicaid again, either as their complete financial support for clinical care or wrap around for their commercial, or those in the military, et cetera.

So I don't know if you've gotten there, but -- and it's a question. And if not, I would really encourage that, if you think about that, as well as the Committee.

Or maybe it's more suitable for this core committee. But, so my question is this.

MS. LLANOS: Yeah. I think it's a great suggestion. Certainly as an agency we try to include the beneficiary perspective.

MEMBER SCHIFF: Thanks. I -- as I'm sitting here, I'm thinking about how we make our decisions in Minnesota about what measures to report.

And I think that this accountability

issue is important because there's this dynamic that happens in our shop about what should we report? And it's a, you know, it's -- it gets kind of complicated with this accountability question.

Because we really -- and I just want to make everybody aware of it, because we sit around and go, what's the burden of doing this measure? And is it accurate and all that jazz?

But then there's also these things like, if we vote for this measure by reporting it, will we then become accountable in the future for something that we're not all that excited about, because we don't think it's going to move the needle in population health.

And if we don't -- and so, you know, I try to weigh in pretty strongly on things that I really want to move. Postpartum contraception is my poster child for that.

You know, and I vote against things where I think we already have a process in place that having a public -- another measure will mess

with. So that -- and my poster child for that is the long term -- the high dose opioids, because we have a different process around that in Minnesota.

And at the same time, trying to figure out how any of these measures, I mean, most importantly, how any of these measures can be built into our quality improvement structure for our accountable care organizations, or our MCOs.

And so -- and then the last part of this is quite honestly, I don't want to be not a part of the club, because I like being part of it.

We like being here. So we want to measure -- report enough. But I think in some ways, now what I'm hearing is that the amount of measures and work that's measured, it's part of the vote tally though whether it's going to be a part of the scorecard.

And I guess I just -- I don't think that that's -- I understand that that's the transition. But, I'm worried that if that

becomes a foundational block of this whole thing in the future, we will go down a road that we won't be able to turn around from.

And so I think, you know, my comment would be -- I would tell my colleagues in other States to be really careful about reporting, because reporting is voting in a way, so.

MEMBER KELLEY: So my comments are similar to Jeff's in that thinking from a Medicaid Program standpoint.

And always thinking of what are the key measures that are going to hold myself, State officials, as well as our managed care plans accountable for the clinical quality.

And I think we're only really today addressing clinical quality. We're not really addressing those other two pillars.

So when I looked at the current dashboard, I think nine of our measures on the current dashboard are actually in one of several of our MCO payment programs.

And putting something onto a

dashboard, putting something into a pay for performance program, does make health plans and providers pay attention to particular quality measures.

And we've seen that. We've been doing MCO and provider pay for performance for at least 12 years now.

And repeatedly we've seen when we've added something, the performance goes up over time. Maybe not immediately. But it goes up over time.

So I think as we're deliberating today about what goes on and what goes off, I always think in terms of, who is the -- what's the population that we're dealing with?

What measures go broadly across those populations? Or are there also measures necessary for those smaller, sometimes forgotten populations with disabilities and complex chronic conditions?

But in my job I think in terms of pregnant women. Medicaid Programs see a very

high percent, and pay for a high percent of prenatal, postpartum care and delivery.

I call them my kids. We take care of a lot of kids in Pennsylvania, 1.1 million kids. And then those individuals, especially adults and kids, living with chronic conditions, as we deliberate, I think we need to keep those populations in mind.

Whatever we come up with, it's not going to be perfect because there are going to be definite gaps. Especially in long term care support services and a lot of times in pediatric chronic conditions.

But, looking at all the expertise around the room, I think we have the right folks in the room to deliberate. And may -- we walk away with an even better scorecard.

MEMBER HOUTROW: You know, one of the things I'm thinking about, and I think I would like some guidance from the leadership about is, what lens we're taking? And at what perspective that's coming from?

So if our -- we're thinking about the population of children on Medicaid. That's a different lens then if we're thinking about how Medicaid dollars flow and where the high cost utilizers are.

And so in addition, when we're thinking about how the raise to the importance of being in this set of particular measure, are we thinking about that? And which population are we evaluating that in?

So for example, I'm going to use an adult example. So breast cancer screening. It really has relevance to half of a population and not really to the other half.

And so if you're thinking from the entire population that's a different thing. Then you're thinking of women who are at risk for breast cancer.

And I think maybe some guidance about who and when we're -- when we're taking about which populations. Because when we granularize our evaluation of individual measures, we're

thinking about the importance of the measure for that population that it's for.

But perhaps we also need to be thinking about the measure for the meta-group. Because I'm, you know, worried about what Sally was talking about and what Jeff was saying.

And I think that that really is a potential for us to be elevating measures because they're feasible and they're valid and they, you know, do the thing that we want them to do.

And that emphasizes their importance for the entire population in a way that we maybe aren't intending.

And we need to know whether we should be thinking about, you know, the small fraction of kids who are consuming most of the dollars. Or should we be thinking about all of the other kids for which routine preventative care is important?

And the important thing that strikes me about that is that for kids who are relatively healthy, missing a routine screen, doesn't have

that many adverse consequences.

But, the adverse consequences to a child who is not healthy, not getting a thing, can be really detrimental. And so it's a smaller population, but the impact might be greater.

So I think, you know, guidance from leadership about how we take those various levels in the meta-issues into account when we're going through the measures would be helpful.

CHAIR PINCUS: Unfortunately, I think this is an inevitable kind of balancing act that we do at every one of these kinds of meetings.

Of, you know, figuring how to balance between measures that are impactful for a large number of people, versus measures that are really impactful for people that are most vulnerable.

And I think that's the balance we always have. And I think there's no clear answer to that.

I think that, you know, it would be great if we could, you know, create a fact of collect data on a thousand measures and be able

to assimilate all that information. But we can't.

And so we're going to have to balance it. And that's part of what we -- not so much a science, but really the art of what we're doing here, you know. Sally?

MEMBER TURBYVILLE: Just Karen, do you have any clarity as to whether there is a direct intention to compare the performance of the States head to head?

Or is it real -- you know, as a way to evaluate them against each other? Other then what just naturally happens in public reporting.

Or is it all -- is the thinking more around identifying really great performers, poor performers, and/or looking for improvement in these reports.

So and it gets to some of what Amy's saying. So in some ways that if we can't detect differences between States, is that really detrimental? Or is it more about seeing what the performances within a State and then -- and so

then it could be a smaller subpopulation like children with medical complexity.

And looking for improvement, and being able to identify where there's really poor or great performance. Either to spread knowledge or to figure out what's going in the poor performing pockets.

Is there a directional sense from CMS of what that will feel like?

MS. LLANOS: So I think that just by virtue of putting States together, there's a natural State to State comparison. Right?

So there's things that we just can't control. There, you know, is a public reporting and then transparency and the sharing of the data is just one aspect of the initiative.

There's absolutely an importance placed on being able to raise all votes. And to identify best practices that can be shared.

That's just the quality improvement undertones of the initiative at large. So we understand that comparisons could be natural.

We certainly want to be able to point to State examples where folks are struggling with a particular measure and want to better understand. But we've also been doing that as part of our annual Secretary's Report for the past eight years.

So I think the -- this is a culmination of activities that we're building on. It's -- we're just putting it together in a different way.

CHAIR PINCUS: Rich?

CHAIR ANTONELLI: I will not put you on the spot and ask you to either predict the future or make a commitment.

But my sense at this point in time is that this group will continue to have the ability to remove measures from the scorecard, in addition to promote measures. I know in fact that's what the rest of the day is here.

But will that ability stand firm? Is what I'm -- if I have to make a judgment about suggesting the addition of a measure in

particular without really have a solid framework around accountability, it really gives me two options.

One is to say no. the other one would be to say yes, but within an attached condition. I think if we have a sense that if we promote a measure forward today, but that we could come back to it once CMS articulates whether we're talking about small a or capital A accountability, that gives us a little bit more room.

Do you know how solid the commitment is for us to be able to curate bidirectionally the scorecard?

MS. LLANOS: Not at this point. So I'll just emphasize, we are not driven by Statute. And that gives us many, many more flexibilities then other committees would be. Right?

So we are trying to leverage as broad of a stakeholder process. And then to the extent as we take a step back and reflect that we might

need to create efficiencies in certain ways, then we'll have to make that determination.

I will say, I like the idea of the caveats. Because I think all information is really helpful for us, particularly as we think about this.

And I think the other thing I would say is, if suggestions aren't taken this round, that doesn't mean that we don't think about them for future.

CHAIR PINCUS: So thank you so much Karen. I think that one of the points that you made just now is that this occurs all the time.

That while as we move into sort of a voting and reviewing -- reviewing and voting process that in many ways, while the voting is important, much more important are the comments and discussions that occur during the preparation to vote.

That is, in many ways, is more valuable to CMS then the actual vote. And so that's something that's important.

So feel free to make a comment. Put in your caveats and concerns. And you know, arguments both pro and con as we move into that discussion.

So why don't we take a break now. And reconvene at 11 o'clock.

(Whereupon, the above-entitled matter went off the record at 10:43 a.m. and resumed at 11:03 a.m.)

CHAIR ANTONELLI: All right. Before this meeting gets totally away from us, it is the top of the hour. We are ready to get started. I think we go to Shaconna, right? Or Debjani?

MS. MUKHERJEE: I'm just going to quickly kick it up.

CHAIR ANTONELLI: Go for it.

MS. MUKHERJEE: And what I'm going to do in this, before Shaconna starts talking about measure-specific recommendations is briefly sort of revisit our measure selection criteria and add some of the nuances that we talked about.

So if you all sort of look at the

screen, I guess are we going to the measure select? Okay, we're not.

So basically we use a measure selection criteria to think about measures to be discussed in this forum for addition and/or removal.

And some of the things we look at is critical program objectives, meaningful measurement frameworks, program goals' requirements, the mix of measures. And we always know there's a dearth of outcome measures, person and family centered care and services, cultural competency disparities, alignment, parsimony.

What we also do is look at some other characteristics such as critical equality objective gap areas, strongly linked to outcomes, quality challenge. Again, out -- feasibility especially in this venue where we have a lot of State Medicaid representation.

Feasibility and data burden and resource burden is something we talk about. Intended care settings, levels of analysis

populations, maybe not quite so much, because all our measures have been sort of through the process and have been discussed on the core set side. As well as no negative unintended consequences.

And some of that was discussed during our previous presentation and by Karen from CMS. But, some of the things we heard that we sort of will keep in mind and consider going forward is sort of the balance between measures for most vulnerable populations versus population level measures.

So looking at sort of small n when that is applicable to the measure versus sort of a broad -- broad sort of capture. Also clinical meaningfulness in relation to reporting versus reporting for the sake of reporting, best practices.

So what we wanted to do was just sort of -- and also the sort of lens of accountability, whatever it might look like. Data perspective, things like missing data,

coding issues, so as we move forward, the hope is that we sort of keep in mind those measure selection criteria and the analysis algorithm.

But also add sort of this more practical perspective lens and have a more nuanced discussion that focuses more on the balance of the utility of reporting versus not reporting in relation to adding to the scorecard, as well as sort of the clinical impact on sort of the patient population regardless of if the measure focus is a small n or a larger n.

And with that I'm going to turn it over to Shaconna.

MS. GORHAM: Thank you Debjani. Before I get started, I just want to do one more check for the members on the phone.

If you could acknowledge that you have an open line. Sue Kendig and Mara Maloney?

Okay. You also have the opportunity to chat. So if you would like to provide input throughout the conversation, definitely you can use the chat function.

You can also raise your hand if you have an open line. And maybe you're just away from the phone right now. But you have the opportunity to have -- to use the hand raise function. And one of the staff will acknowledge you.

Okay. So that was a good -- Debjani gave a good summary of some of the nuances that you all mentioned earlier in the discussion. So that was a good segue to our measure selection criteria.

And this is not foreign to you. We reviewed this criteria during, I think, Web Meeting 1 and possibly 2.

This is a tool used to assess measure sets. And for the purposes of this review, they're intended to assist and identify what an ideal set of measures would be for the public and reporting -- for public reporting programs.

Also, they are not absolute rules. So some of the nuances that you all mentioned earlier, definitely should be applied when you're

thinking about selecting measures and then voting on the measures.

The central focus should be on selection of high quality measures that of course fill critical measure gaps and increase alignment.

And again, this is the preliminary analysis algorithm that staff uses once we receive your measure recommendations.

For addition, we applied this algorithm to all of those measures. The algorithm highlights usability as well as feasibility. Next slide.

And so this will be very important for the task at hand today. So I wanted to make sure that I'm really clear about the process.

Each measure will be introduced. I will read some brief measure specs, reporting data as well as endorsement history.

And I thought it would also be helpful that you all hear some of the past MAAP discussions, some of the input that you gave in

previous years on the measures.

After that, we will have the lead discussants introduce the measure by highlighting its value to the scorecard and providing a brief rationale for why you recommended that measure.

Lead discussants also have liaised with measure developers to ensure that they are available to answer questions related to measure specifications.

So I'll say at this time, we have developers on the phone and then also in the room. If you are a developer on the phone, you can raise your hand and we will unmute your line.

After lead discussants give that brief introduction, the Chairs will ask Committee Members to weigh in. And once the Committee discussion is complete, we'll take a motion on the measure. And then we'll take a second on the measure. And we'll do that for each measure.

Once all measures are discussed, then we'll open for public comment. And then we'll come back and vote on the individual measures.

Since the lead discussants recommended the measure, they will not be allowed to make the motion or the second of the motion. So if you're a lead discussant, you'll give your point of view and rationale, and we assume that you support your measure for voting.

So we'll begin the review. I'll ask you to open your discussion guide. You received a discussion guide in your meeting materials.

And then I'll turn it over to Miranda to do a quick walk through of the discussion guide and the best way to toggle through the different tabs.

MS. KUWAHARA: Thanks Shaconna. And I will load it up so that members of the public can also follow along.

So as I mentioned previously, the discussion guide can be located in the email that went out this morning for Committee Members. It's also located on our public Sharepoint site.

So for members of the public, you can go to public.qualityforum.org to access this

discussion guide.

Here we have all of the measures slated for review today. You also have two agendas presented on here. We have an abbreviated agenda. We also have a more detailed agenda.

If you visit the abbreviated agenda and the two measures recommended for removal, which is where we are at in our meeting, it will take you to our measures slated for tomorrow.

And for our Committee Members who are joining us via phone, would you mind muting your lines. Thank you. We'll work to get those lines muted.

Back to the tour of the discussion guide. We have the measures recommended for removal here as well as the domains they're categorized under.

You'll notice in the upper right-hand navigation pane, you can jump back to the agenda. And you'll notice later in our day when we discuss measures recommended for addition, you

can click this link, and it will bring you to the measure specifications as well as staff's preliminary analyses.

You'll notice up at the top right-hand navigation pane, if you'd like to look at a comprehensive list of the measures we're reviewing today, you can click on measures, as well as domains.

And if you'd like to link out to the measure repository, which was provided to you all back in November, you can access that Excel file by clicking on the measure repository.

So if you'd like to tee up the first measure for discussion today, you can go back to the agenda. Click on the 11:00 a.m. agenda item. And we have 1517 here.

If you'd like to click on measure specifications, we'll be good to go.

MS. GORHAM: You will keep the discussion guide open. We'll toggle back to our slide deck.

Just as a reminder of course, the

measure removals will be recommended -- that you all recommended will be from Pillar 1, because that is the focus of our day.

The measure removal recommendations represent measures in three of the six domains. Promote effective communication and coordination of care domain, make care safer by reducing harm caused in the delivery of care domain, and then promote effective prevention and treatment of chronic diseases and -- diseases domain.

Okay. And this slide shows a -- potential reasons for removal from the scorecard. I won't read them all.

But just to highlight a few. Multiple years of very low numbers of State reporting. Measures does not provide -- do not provide actionable information for State Medicaid Programs.

Superior measure on the same topic has become available. Are just a few reasons for removal.

Here you have a list of the measures

that were recommended. Again, there are six proposed today. We'll discuss and a little later have public comment and take a vote.

As Miranda said, we are looking at 1517 is the first measure. And that is the prenatal and postpartum care: postpartum care measure.

The measure is not NQF endorsed. Endorsement was removed from the measure in October 2016 due to lack of empirical evidence and validity issues.

This -- the race of this single measure is split across the child and adult measure sets, core sets. And we are looking at the postpartum care, which is on the adult core set.

So for the purposes of our conversations today of course, we are considering whether or not this measure should be removed from the scorecard.

The description of the measure, the percentage of deliveries of live births between

November 6 of the year prior to the measurement year and November 5 of the measurement year for these women.

The measure assesses facets of prenatal and postpartum care. For our purposes, I'll only read the pre -- postpartum care rate. And that is the percentage of deliveries that had a postpartum visit on or between 21 and 56 days of delivery.

This is a process measure. The data source -- sources are claims, electronic health records, paper medical records.

So for a little bit of history. During the 2017 annual core set review, MAAP emphasized the importance of promoting actionable measures that directly address outcomes. And this measure, the Committee felt that it only focuses on visit counts.

MAAP recommended that CMS remove this measure only if there was a suitable alternative measure.

MS. MUNTHALI: My apologies to

everyone in the room. Apparently there's a reported fire in our building. So we have to evacuate.

So I apologize to Shaconna and everyone for interrupting the meeting. So our colleagues are going to lead us out.

So everyone on the phone, we'll rejoin you when we can. Thank you.

(Whereupon, the above-entitled matter went off the record at 11:18 a.m. and resumed at 11:37 a.m.)

MS. GORHAM: So we'll go ahead and get started. We were discussing 1517, prenatal and postpartum care, postpartum care. And I was going over a little bit of the history.

MAP recommended that CMS remove this measure only if there was a suitable alternative. CMS obviously did not think there was a suitable alternative, and for other reasons did not accept the recommendation, and the measure remains on the 2019 adult core set.

So just a little kind of level-setting

to give you some history. Thirty-eight states reported on this measure in 2017. It is also in the QRS program. With that, I will turn it over to Rich and our lead discussant is Julia -- oh, me, okay. Julia Logan actually sent her talking points in. She apologizes for not being available, she had a family emergency.

But she did send in some talking points for all of the measures that she recommended. So again, this measure was recommended for removal. And some of her rationale, she says prior to May 2018, ACOG recommended that a comprehensive postpartum visit take place within the first six weeks after birth.

In May 2018, ACOG released a Committee opinion stating the postpartum care should become an ongoing process rather than a single encounter, with services and support tailored to each woman's individual needs. ACOG now recommends that all women have contact with their OB/GYN or other obstetric care providers within

the first three weeks postpartum.

The initial assessment should be followed up with ongoing care as needed, concluding with a comprehensive postpartum visit no later than 12 weeks after birth. The new recommendation makes the NCQA postpartum measure obsolete, and thus should be removed from the CMS scorecard.

Effort should be made to add a maternal health measure to the scorecard, as it is a high priority area. So she summarized to say change in clinical evidence has made this measure obsolete. ACOG recommends -- recommendations were updated in May 2018 and are no longer in alignment with the intent of the NCQA postpartum measure.

This measure also lost NQF endorsement. Because removal of this measure creates a subject area gap, efforts should be made to add a maternal health measure to the scorecard. So with that, I will turn it over to Rich.

CHAIR ANTONELLI: All right, so we, I want to just remind people to aim your name card toward me so that I can do that. I'm going to open this for discussion. The - be very mindful of the significant commitment to pregnant women and children for Medicaid. So there's a lot riding on this as a area for measurement.

So I think I've got David, and I'm sorry, I can't see the first name. Yeah, David, Dan, Judy, Carol. All right, did you, Jill, did you come in between those two guys? Okay, one, two, three, I have to get Carol here, so you're four, then five. David, go.

MEMBER KELLEY: So from our standpoint, this is on our Pennsylvania pay for performance with our MCOs. I was part of the NQF discussion about voting it off the island for NQF endorsement. The biggest issue was the gap between the first 21 days.

And my recommendation then was don't throw the baby out with the bathwater. Let's continue to endorse it, but let's have NCQA add I

don't know, five or even zero or one to 21 days to the measurement. NCQA still has not done that, but to me, that's a better fix than throwing the entire measure out.

Health plans do have, in fact, we went back after that NQF meeting, I actually asked some of our plans to run some data to look at. One of the concerns was that a lot of women with C-section, which unfortunately is probably about 28% in Pennsylvania Medicaid, you know, come back before the three weeks.

And we actually some plans do analysis, and even those really were, they were missed opportunities for any postpartum visit. So I think we really, until we do have a better measure, I would advocate that this stay on.

I would also say that I think what was alluded to was an expert opinion that I'm not going to question that expert opinion, but I don't know when NQF looks at the level of evidence expert opinion is fairly low. So even though ACOG has changed their recommendation, I'm

going to say that that's an expert opinion, I highly respect it.

But let's keep the measure on until we have something that is better that can replace it. And one of those things would be to measure that additional gap, that first 21 days. And it would be beautiful to capture some of the things that should also happen within those 21 days.

CHAIR ANTONELLI: Jill.

MEMBER MORROW-GORTON: So David, I'm going to disagree a little bit. I think that having a measure that doesn't really align with the guidance that practitioners are being given in terms of how to practice is a bit of a problem. Because you can have practitioners that are doing exactly what is supposed to be done and they would not get credit for that, because the measure doesn't reflect those recommendations.

I think the other piece of it is just kind of rejiggering the existing measure may in fact not address the reasons for the changes in the recommendations regarding practice.

MEMBER SCHELLHASE: I support removal. and I respect David's opinion about maybe better to have something rather than nothing. But this original measure is also based on expert opinion. There's, you know, it's based on incredibly old historical handed-down knowledge about when you would expect a woman's cervix to close up completely postpartum.

You know, there's not much more to it than that. I don't think there's ever been much evidence supporting this particular schedule. So I agree that we ought to be holding practitioners accountable to what's currently being advocated, I think it'll sow confusion and more frustration to continue to advocate for an older standard.

CHAIR ANTONELLI: Carol, Judy, Jeff, Harold.

MEMBER SAKALA: So support during the postpartum period of high quality is very crucial and important. Yes, our Perinatal and Women's Health Standing Committee did remove endorsement. This did not meet the rising NQF standards around

evidence.

I think we should hear from Sepheen Byron from NCQA, because it is being respecified and she can give us a little update on that. She is here right now.

But my concern about this measure is that it's really impossible to interpret because when it's collected through claims, which is of course the easy way to do it, the nature of the billing codes is such that many people are billing for comprehensive sets of visits that do not give an indication of whether the postpartum visit occurred.

So we get wildly high rates of no postpartum visit. And by the way, I think it's a very low bar, just the fact of a visit.

But we have, in our listening to mother surveys and in other surveys where we ask women did you have a postpartum visit, it's more like around ten percent overall, higher for Medicaid, lower for commercial women. But nothing like what this measure is reporting. So

I consider it to be not interpretable.

That being said, I totally support what Julia said. We have a maternal health crisis in this country, and there's no other measure for this entire population in 1.0, in our recommendations, in the other things we'll be considering. So it's a very serious problem, and I come to this meeting with some anguish about that.

CHAIR ANTONELLI: Judy.

MEMBER ZERZAN: So nationally, Medicaid pays for 40% of births, in Washington state, it's 50% of births. And I think postpartum care is very important. I would agree with Dave that we should not remove this measure.

Could it be better? Yes. But you could say that about every single measure on here, and you could say a lot of things about whether measures are really supporting outcomes and where they are. But I do think even though ACOG has changed their guidelines, it is based on expert opinion, and I'm not sure how that's

rolling out in the world.

I'll also say that pediatricians often see some of what's in the ACOG guidelines as their swim lane in terms of doing maternal depression screenings and things like that.

And so I feel like there's a lot more work to be done in this area about what is the best practice and where, and until all that shakes itself out, this is a decent enough measure and is a very important part of measuring pregnancy, so I'd advocate keeping it in.

CHAIR ANTONELLI: I have Jeff, Harold, Sally, and then unless somebody's going to say something different, because remember, we're not voting right now, we're just at comment. I want to have time for NCQA to come to the floor. So if you could prepare yourself. Jeff.

MEMBER SCHIFF: I'm going to second or third Judy and David. It is a non-perfect measure, but I just want to address a few things.

We have the same issue with the bundle in Minnesota that other places do. I can't, the

only way I can get to the truth is by having this on the list so that we can put some emphasis on whether or not it's really happening, and then go out in the field and actually look at charts. If it gets removed, I'll never know.

The other things then is even though I agree, I understand the ACOG opinion, maternal depression and postpartum contraception are two key issues that should be addressed at this visit. And if there's no effort to be accountable for that, I don't see how we're going to be able to continue that. So thanks.

CHAIR ANTONELLI: Ok, Harold, Sally, Lindsay, Marissa.

CHAIR PINCUS: So mine is more of a question for Karen, sort of a clarifying thing, is that, you know, is there a way in which we can maintain this as kind of a place saver while NCQA works on the improvement. Is that of value to you to do it in some way?

MS. LLANOS: I mean I think, I mean we struggle with understanding the importance of

this population. With recognizing the importance of the population in light of putting a measure in there. So I think if the Committee wanted to recommend a placeholder for a variety of reasons, that's something that we can consider as well.

CHAIR ANTONELLI: Sally.

MEMBER TURBYVILLE: I struggle with, you know, removing it or not removing it in a definitive, because I actually have a couple of questions. But when I do have concerns because of the signal that it might send in terms of the public reporting nature of the scorecard and contacts matters, this is a really important area.

And I also think it's really important to hear that the states do feel they are taking action on it. Because one of my questions in terms emerging guidelines in particular for measure and maybe NCQA has already looked at this, would following the ACOG guidelines reduce performance or maybe improve performance vis a vis the ACOG guidelines?

Are they completely, you know, hitting up against each other? If you're trying to meet the prenatal postpartum care component of the measure as a provider for the state reporting, does that mean that you cannot follow the new ACOG guidelines?

Or is it, is there real opportunity to continue reporting that's work on the measure specification, as well as the implementation of the guideline into practice in the real world, without creating confusion and harm.

I guess I'm not convinced that the providers, unless they completely contradict each other, would be confused about which to follow if they don't actually completely contradict each other. So hopefully I can get an answer to that question.

CHAIR ANTONELLI: So I have Lindsay. Jeff, are you back in the queue, or you're done? Okay, sorry.

MEMBER ZERZAN: Can I add a quick clarifying to that? With the new ACOG

guidelines, many women lose their Medicaid coverage before the end of that new guideline period. And so that's also a problem in terms of measurement.

CHAIR ANTONELLI: Okay. So I have Lindsay, Marissa, and then I think I'm going to invoke Chair's privilege and ask NCQA and come to a microphone.

MEMBER COGAN: Sure, so my comments relate not to the composition of the measure itself but maybe to look at overall balance of the scorecard. So you know, I know I had asked that something like this be provided so that we could constantly be looking at our -- if we remove a measure, we're not down to only follow-up after hospitalization for mental illness and then promote effective communication and coordination of care.

So just another thing to think through. Do we have any measures for addition in this domain coming up later? And we can come back to that question if you want to keep going

with comments.

MS. GORHAM: I'm sorry, yes. In the promote effective prevention and treatment in chronic diseases, we have two measures recommended for addition.

MEMBER COGAN: Actually, it's the domain that's promote effective communication and coordination. I don't believe there's any measures.

MS. GORHAM: No.

MEMBER COGAN: Okay, just confirming, yeah.

CHAIR ANTONELLI: So Marissa, then I will get to you, but if it's okay with you, I'm going to ask NCQA to come forward, and then you'll be immediately following, okay. Marissa.

MEMBER SCHLAIFER: So more of a not comment about that specific measure but about the scorecard and the core set that may help with people struggling as we go through this. And so it's a clarifying comment, but someone can correct me if I'm wrong.

Right now I think it's important that we remember we're talking about whether or not a measure that's already in the core set is in the scorecard. Just because we vote something off the scorecard doesn't mean we're voting it off the core set.

So I think that feeling that a measure completely goes away and no one will ever look at it again, taking it out of the core sets is we're taking it out of that accountability and that we've talked about earlier today. But I think it's really important for people to remember that at least our recommendation today is not saying this measure should not be removed.

Should, our comments today, if we vote to remove it from the scorecard does not mean we're recommending that it come out of the core set. And I think that might help people in voting.

CHAIR ANTONELLI: Thank you. NCQA, do we have the measure developer here?

MS. BYRON: Hi, all right, so there's

so much to respond to. So first we are in the process of re-evaluating this measure in light of the guidelines that came out from ACOG in May of 2018. So ACOG does recommend that early visit, you know, by 21 days, and then the later visit by 12 weeks.

We are looking at, and I can't promise anything because it's in process and we haven't gone to our approval committees yet. We'll be that -- at the end of January. But we are looking at revising that postpartum care timing, because we want to align with the guidelines.

Now, what Judy pointed out is true, about the issue with the coverage, because you know, the later comprehensive visit is being recommended for 12 weeks, and some women lose coverage before that. So that's something we're going to have to grapple with.

But whatever we do get approved will go to public comment in February. So it'll be mid-February to mid-March where you will see, you know, what our own independent multi-stakeholder

committee has approved for public comment. And then the final recommendation will go, will be decided in May.

So what that means is the changes would come out for, it's called HEDIS-2020, which is released in the summer but would apply to this year. Yeah, so there's going to be a little bit of a lag, you know, between, and because then I think that the core set measures are also a little bit behind HEDIS.

So there's going to be lag. So that's for consideration in terms of how you might want to deal with something like a placeholder or, you know, its presence on the core set. But we are trying to revise the measure.

You know, this is a measure, I'll just note, of access and availability of care. I think it's difficult because we all want to see effectiveness of care measured, and we are looking at other measures to be able to do that. Right now, we actually also are developing a perinatal depression screening measure.

This measure particularly is about access to care. And so we are looking at visits. It's where we are today, it's not where we want to be tomorrow. And so we are trying to sort of we have one foot, you know, in what's feasible today, and we're trying to get us to go forward to what happens in the future to get to better measures that look at content of care.

CHAIR ANTONELLI: If you could stay there for a second. So before we go on to the next comment, I want to come back to this group, including the folks on the phone. I'm assuming that we either have open lines or at least hand-raising ability for the Committee members? Okay, good. So does anybody want to ask NCQA a question because you need more clarification? Sally.

MEMBER TURBYVILLE: Just getting back to my question before just based on how the ACOG measure is described, it sounds like performing well on this measure does not mean that you would perform poorly on meeting that ACOG guidelines.

Other than the coverage issue being a real one, I don't know how that's going to sort out.

But if it's just access, it can be not comprehensive, which I know is always one of the challenge. If it's moving to more comprehensive at a later date, by a later date, or am I incorrectly thinking about that? Are they so different that if you follow the ACOG guidelines, your performance would drop on the current existing measures?

MS. BYRON: If you follow the new ACOG guidelines, then the measure as specified today, yes, your performance would drop. Because you, yeah, you could be getting somebody in, you know, after work or you could be doing it earlier. And this measure says don't come in too early, right.

Because in the past, there was concern that the wound checks were something that we didn't necessarily want to capture with this measure. Because what we wanted to see was more of that comprehensive visit. And the concern at the time, you know, by our measurement advisory

panels, was that you could get just a quick pass with the wound check and was that really what we were trying to get at.

Since then, though, the guidelines have evolved and we understand that contact with the healthcare system is important. And so I think our thinking has changed around that. But this is a measure that was developed a long time ago. I think we're probably even in more dire straits at the time, right.

And so, you know, which is why I bring up that this is an access to care measure, right. So we are looking at visits. Are we measuring whether it's comprehensive? No, this measure cannot do that. But we want to get to better measures later than can do that.

CHAIR ANTONELLI: Dave, just, not a new a comment, do you have a question or a comment for the? Okay, so any other comments or questions for NCQA before I move on to our next question or commenter? Okay, please stand by, thank you. SreyRam.

MEMBER KUY: So I really liked Harold's idea about having a placeholder, because I think this issue really is a conflicting one. One, we know that maternal and health maternal mortality and prenatal care is a huge, huge crisis in the United States, and we cannot afford to not have that be on the scorecard.

And I know that even if it was off the scorecard, it'd still be on the core measures. But the scorecard has so much power. When you say something is on the CMS scorecard, if you're a subject matter expert like the people in this room, you understand the nuances.

But the people who are policymakers who do not understand the nuances, the lay public, the lay press, they grab onto the scorecard. And those are the things that really bring a lot of attention and puts a lot of pressure on state and federal entities to pour in resources and pour in funding to focus on those things.

So what we put on the scorecard

absolutely has an impact on the amount of attention and resources that that issues gets. So I agree that this measure is flawed.

I see how ACOG, which is the expert on maternal health, has differing opinions. But we can't afford to not have it on the scorecard. So I love the idea of having a placeholder that says this an important enough issue that we can't neglect maternal health.

CHAIR ANTONELLI: Thank you. Are there any hands raised? No. Okay, so is there a motion from the Committee? Jill.

MEMBER MORROW-GORTON: I just want to ask a really quick question. I really liked the last comment about a placeholder, but how do we vote for a placeholder? I mean, just a little clarification about how that, can that happen, how does that happen. And just so we know how to vote when we go to that.

MS. MUKHERJEE: So you wouldn't vote. What would happen is when we write up our summary, we would say that the discussion for

this revolved around issues of maternal and perinatal and postpartum care, and that we realize it's a flawed measure, and we sort of list the reasons why.

However, we're keeping it on the scorecard as a placeholder till we have something better. So that would be captured as a content, it wouldn't be sort of a voting.

And then when you do sort of do a motion for voting, it would be just so that we're clear, a motion to vote to suggest removal for this section of the scorecard measures.

CHAIR ANTONELLI: And just to sort of add the context, what we're talking about right now is not the vote, it's does anybody want to make a motion and then second that motion for Julia's suggestion that this be removed. We're going to take any measures that meet the mark of a motion and a second.

We're going to open for, take public comment, and then we will move forward with a vote later on. So we're not in the voting phase

right now.

All right, I think it was Stephen, Kamala, Rhonda, Elissa.

MEMBER LAWLESS: Great. I can make a motion, but one more comment before this. One of the other NQF committees I'm on, the Safety Committee, we had a very similar issue with a society appropriating a measure and another society changing it or having issues.

And we asked for the two societies to get together, reconcile, and then come back as a unified measure, and it worked out very well. It took a while, but it was very nicely, so NCQA with ACOG, work it out, guys, and come back. And it seemed to flow.

So my motion, whatever else, is that the two leaders of the guidelines, but one group, two groups involved in this, go and reconcile the measure and then bring it back for consideration.

CHAIR ANTONELLI: Okay, so that was a motion that you just made. Okay, does anybody want to second that motion?

MS. GORHAM: So let me just clarify. So the actual motion would be not to remove from the scorecard, and the rationale when we write up the report, and we'll caveat so that Stephen just said that ACOG and NCQS reconciled the measure.

So that would be one of the things that we would add to the report. So the actual motion would be not to remove, someone would second that, and we're not taking a vote on it.

MS. BYRON: May I make a comment, since NCQA's been in both? Just to clarify, we are not a guideline organization. We are a measure developer, and so the guideline is developed outside of us, and then once the guideline comes out, we take that and operationalize it into a measure.

So you know, I just want to be clear because before we go down the road of the two of us will work it out, I don't think it's really NCQA's not going to come up with a guideline. We're just going to take the and respect what the guideline developers have done and try to

operationalize that into our measure the best way we can, balancing our attributes of scientific soundness, feasibility, usability, and that sort of thing.

CHAIR PINCUS: But presumably you do involve ACOG in those discussions.

MS. BYRON: We do, but more because they are subject, in a subject matter expert way. Yeah, we are very much in contact with them and we understand what their guidelines say. They might help us interpret it, but we don't tell them how to do their guideline.

CHAIR ANTONELLI: Kamala.

MEMBER ALLEN: Thank you, and the two last two comments that were made were exactly the comments that I was going to suggest. Both that the vote would really be not to remove the measure first, and then clarify what I understood NCQA's role to be. So thank you.

CHAIR ANTONELLI: But let me just ask for the staff, I don't think we need a vote or even a motion to not remove the measure. The

only potential motion here is to agree with Julia's suggestion that it be removed, that's what we're looking for. So the null is that it stays.

And just to take it to Stephen's suggestion about alignment, that would just be a recommendation, that doesn't even have to be voted on. That would be a condition or a caveat of a comment of the Committee, right. So really, so let me bring this thing back, then, and I'll look to Shaconna.

I don't know whether we just actually formulated a motion from Dr. Lawless that we now have to address. Or if we're still in null territory and I need to come to back to the group to say does anybody want to make a motion to support removal of this measure. So are we still, I think we're still in null territory. Yeah.

All right, so let me bring that back to the group. Does anybody want to make a motion to, Lisa, okay, I'll pause.

MEMBER PATTON: Sorry, this is a, this should be a relatively quick question for NCQA. So for the larger long-term planning purposes for this group, I was curious about, I know you're going to take the potential respects of this measure back to your group in January.

What would the timing look like on those revisions? I mean, what are we looking at? You know, is that going to be available sooner, later, yeah?

MS. BYRON: So if they are approved, they will be published in our July specification, which is July 2019. Let me make sure I got my calendars right. And it would apply to the 2019 measurement year.

So but the core set is a little bit behind that. So I think you have to factor in, I think the core set might be a year behind that. So we could probably get more information on exactly how the timing would come out.

CHAIR ANTONELLI: Okay, Josh, Jeff, Kenneth, did you -- okay, Josh, Jeff, Kenneth.

MEMBER ROMNEY: I just want to clarify I liked the placeholder idea. I love the idea of having quality measures be up to date with clinical guidelines. But what providers hate the most is a guideline that's out or a quality measure that's out of date.

What I'm hearing is that NCQA can update their measure and that following that, there would be a process for the core set to be updated before the scorecard could then be updated. So we may be two years down the road before the scorecard is updated, but at least there is a process. Is that correct?

MS. LLANOS: We're basing it on what the, if it's deriving from the core set and it's still in the core set, the specifications I think as it relates to the scorecard might not actually have to follow a two-year trajectory.

MEMBER ROMNEY: Okay.

CHAIR ANTONELLI: Okay, Jeff.

MEMBER SCHIFF: So I'm going to, this is a little bit of a continuation of what Josh

said, but I'm a little uncomfortable with this group that doesn't have, that we're being asked just to vote up and down these and have nothing else on the record as a motion from this group.

Because I think that I know when I start to look at minutes of meetings and I'm short on time, I only look at the stuff in bold that says this is what this group moved. So I'm going to ask if we can, and I don't want to open this up to the world of measurement because we'll be here for weeks.

But I will ask that we consider the opportunity to acknowledge some of these measures that we're not comfortable with as placeholders for important topics. Even if we, so the null is to leave this on. And I think many of us, you know, are comfortable with the null, but would rather say that with the caveat to Josh's point and have that on the record as a motion of this committee.

MS MUKHERJEE: So when we do write up these measures, all the measures are usually

bolded, and then we have a discussion of what happened for that measure. So this measure would, you would see the measure and then the discussion would say that it's either a placeholder and it's a placeholder because the new measure's under development.

These are some of the points made by the Committee, so we would capture it and it would be in a section that would have all the measures that were potentially discussed for removal, but because of certain points made by the Committee weren't removed. And the caveats would be presented. So that would be captured by the measure.

CHAIR PINCUS: it would look the same as, all the measures would have a, you know, sort of an indented, bolded thing. It wouldn't distinguish between --

MEMBER SCHIFF: But how will we know it's a placeholder if we go around the room and five of us spoke about it and we think that's good idea if we don't vote to find out whether

the majority thinks it should be a placeholder? And it's just the opinion of, it's not the group, it's just sort of a reflection of comments.

Sorry to make it difficult, but I think it's pretty crucial, because these measures are going to be looked at by so many people, and I think that if we don't acknowledge in the process that --

CHAIR PINCUS: I mean, it's kind of a technical thing. I mean we could have, I guess we could have a vote on sort of the state, you know, it's not so much an on or off kind of thing but like do people agree with this notion of having it as a placeholder.

MEMBER SCHIFF: Yes.

CHAIR PINCUS: So we could do that. Okay, is there a second for that?

MEMBER TURBYVILLE: The placeholder is to, though, keep the measure in, noting that it will be replaced with a better measure, or the placeholder is to put a title of prenatal postpartum measure coming?

So I just want to make sure what, I think what I hear from most is that the placeholder is to keep the measure in. I just want to, and as-is, with results in everything, not to replace it with a label that then has no data associated with it.

CHAIR ANTONELLI: So I vetted this with the senior staff here. There's no need to vote if we want to capture these conditions and comments about the measuring staying in. And they will be captured and they will be included in the report.

And as Karen and CMS have said, oftentimes the comments is where all of the richness is. So that is absolutely fine, and we will capture that. And we can formulate to make sure we have that right so nothing gets left out.

I'm going to have, I think its Ken and then Amy. And then I'm going to basically literally call the question does anybody want a motion that supports removal of this measure. So I'm going to call that question as soon as Amy

finishes speaking. Ken.

MEMBER SCHELLHASE: I was just going to offer to make a motion, that's all.

CHAIR ANTONELLI: Okay, so hold that thought. Amy.

MEMBER HOUTROW: I just want to make sure I understand what just happened. I had heard that someone had made, we called a motion to maintain it in the set. But what we're trying to do is get the opposite of that.

CHAIR ANTONELLI: That was the null, it's the opposite.

MEMBER HOUTROW: Yeah, so the null stands without motions, correct.

CHAIR ANTONELLI: That's right.

MEMBER HOUTROW: Okay, and so the only motion that matters here is for someone to say I make a motion to consider this for removal.

CHAIR ANTONELLI: Exactly.

MEMBER HOUTROW: And then it needs a second. And then once it gets a second, it goes through a process of awaiting public comment, and

then this committee would vote at that point, is that right?

CHAIR ANTONELLI: Which is about an hour, hour and a half from now. So that all would happen with this and then the other measures.

MEMBER HOUTROW: Okay. And there would be no nuance to anything about this as a placeholder or not, that's all just captured in the comments.

CHAIR ANTONELLI: In the comments, even absent a motion, and a motion that gets seconded for removal. So all of these comments and questions, the notion of the placeholder concept, the notion of Stephen's suggestion about alignment between NCQA and ACOG, all of that will be captured and does not need to be voted upon.

MEMBER HOUTROW: So the threshold to get a vote for a nay is the person who has brought it up and then two additional people who think it's worth voting.

CHAIR ANTONELLI: No.

MEMBER HOUTROW: No?

CHAIR ANTONELLI: Literally, they think I'm just going to grab the gavel back. Does anybody want to make a motion to support the removal of 1517 from the scorecard.

State it, please.

MEMBER SCHELLHASE: I move that we remove this measure from the scorecard.

CHAIR ANTONELLI: Okay, is there a second?

MEMBER HOUTROW: I'm willing to second that, it's Amy.

CHAIR ANTONELLI: Okay. So what we're going to do is we'll go on to the -- okay, so the process is we're going to go on to the next measure. And then after we go through the measures selecting motions and seconds, then we will consider them as a set. All right. The second measure.

MS. GORHAM: All right, and I just want to bring attention to something that, I can't remember who brought it up, but at your

place you have a list of the scorecard measures in totality so that you can look at the measures as a whole picture as you're going through this. I just wanted to mention that.

Okay, so the next measure is use of multiple concurrent antipsychotics, ages 1-17. And again, we would like to direct your attention to the discussion guide.

The description of this measure is percentage of children and adolescents ages 1-17 who were treated with antipsychotic medications and who were on two or more concurrent antipsychotic medications for at least 90 consecutive days during the measurement year.

Note just a lower rate indicates a better performance. The data source is administrative data. This is a not-NQF endorsed measure using administrative data, and it was added to the child core set in 2016. The first year of reporting of course was FY 2016, and 32 states reported the measure in 2016, and in 2017, 35 states reported the measure.

I just want to make sure I said that right. So 32 states reported the measure in FY 2016, and 35 states reported in 2017. So reporting has increased.

A little history of the measure. In 2015, MAP recommended this measure for addition, pending NQF endorsement.

This measure was considered for endorsement by the 2016 Pediatric Standing Committee, however it was not endorsed because the Standing Committee felt the measure did not get to the specificity of the individual practitioner's problem with prescribing and did not adequately address situations for which it would be appropriate to prescribe more than one antipsychotic at a time.

The lead discussants for this measure is Laura Jacobus-Kantor and David Einzig. Did I say that right, Einzig? No, I'm sorry. Einzig. And I will turn it over to Rich.

CHAIR ANTONELLI: So is Laura here? Great, okay. So would you like to go first, and

then David, you'll be, you'll follow her, okay?

MEMBER JACOBUS-KANTOR: Sure, I will give a very brief overview of SAMHSA's concerns with the issue, with the measure. So first of all, thank you for the opportunity to discuss the measure.

So I'll preface the conversation just by noting that SAMHSA agrees that the measure represents a very important issue for consideration and for measurement. However, we do have some concerns about its inclusion in the scorecard.

I would reiterate the fact that this is a non-NQF endorsed measure. And a major concern of SAMHSA is primarily the fact that the measure represents a relatively rare event. The latest results are about a median of three percent, with again, lower scores representing better performance.

So we think we're running into probably what mostly likely is a ceiling effect here. Given that a goal of the scorecard and

public reporting in general is to drive performance, we really don't think that there's a lot of room for, you know, for improvement here.

We would also note that the measure is well-supported in terms of clinical guidelines and clinical recommendations that concurrent use of antipsychotics is not a recommended practice.

However, most of those recommendations and clinical guidelines also note that concurrent prescriptions may be appropriate when transitioning from one antipsychotic to another, but they don't usually specify what the length of time that that concurrent prescription would occur.

So some of the concerns that we heard previously about the NQF endorsement and why it wasn't NQF endorsed we think still hold, in that clinical judgment may suggest that an individual psychiatrist would want the concurrent antipsychotics for longer than the 90-day period.

We don't think that that would be a common occurrence, but given that the median rate

is about three percent. That three percent may represent the cases in which the psychiatrist honestly believed that that's the best course of practice for the client. So we just don't think there's a lot of room for improvement here.

We do note that there's, you know, certainly a dearth of child measures on the scorecard. And so you know, we're making this recommendation I think with a little bit of heartburn. So it may be the case that this is a placeholder, but we do have concerns about the measure for this specific purpose.

CHAIR ANTONELLI: Thank you. David, and Amy, are you in the queue? Okay.

MEMBER EINZIG: Thank you. So I was on the Standing Committee when there was discussion and when it was not NQF is endorsed. And my background is I'm a, I see a lot of kids. I've probably, 1,000-1500. I'm a clinician, so I see a lot of kids.

So just a couple points from a clinical perspective. I think the optics, when

you say antipsychotic is, you know, kind of deers in the headlight, people get their eyes really big and get concerned when they're giving their kids antipsychotics.

So people who've heard me speak before know that I think there's a huge stigma about these medications because of the term antipsychotic, when in reality they're dopamine modulators.

And all these medications block dopamine to either higher degrees or lower degrees, but they're dopamine modulators. And so if questions are as far as evidence goes, is there evidence to say that being on one antipsychotic is safer than being on low doses of two antipsychotic, then I don't think there is.

So just a clinical example. If the person's on Risperdal and you got them on three milligrams or six milligrams of Risperdal, which is a potent dopamine blocker, you got the side effects with weight gain and prolactin issues, and perhaps intolerable side effects, but it's

the only medication that works.

You try them on B, C, and D and nothing else works, and so six months down the road, a year down the road, you end up doing some different things. But for the particular individual, it happens to work.

So it may be a low dose of Risperdal in the morning and a low dose of Seroquel at night, and you get the potential benefits of the more potent dopamine blocker and the benefits of, the complimentary benefits of other medications, whether that's for sedation or to help you get by with lower doses of other medications, or whatever the case may be.

Another example would be a low dose combination of Risperdal and Abilify with prolactin issues, where Abilify is the partial dopamine agonist. So if there's too much dopamine floating around, Abilify will block it. If there's too little, it enhances it. And so sometimes, you know, it might help the prolactin issues that you get with Risperdal.

So there's going to be rare clinical examples where it might be a reasonable thing to do, although not very common.

In terms of alternative measures which may be better indicators of what is good quality care, you know, I would encourage putting focus on medication compliance or the measures to monitor for if the person is prescribed medication, are they compliant with their medication? To modify your levels of care, and I think there's better measures to do that.

Or, if they are on two antipsychotic medications, do they have appropriate follow-up with a appropriately trained physician, a regular follow-up with a psychiatrist. I think there's better measures to measure quality of care. That's my two cents.

CHAIR ANTONELLI: Thank you. So just to have it, Amy, Judy, Lindsay, Kim, Harold.

MEMBER HOUTROW: I will be brief, but I was also at the table with David when we did not endorse this a few years ago. But I think

the point is well taken, there are multiple clinical scenarios in which the use of more than one medication is definitively clinically indicated.

And I think we can just name cases and cases where that's true. I think we also need to remember Laura's point, which is that it's already at a very low level, and what is the opportunity for, quote unquote, improvement. I would push that even farther to say I don't think this actually is a measure of quality.

I think it is a measure of prescribing practices. We have no data to say what percentage of children who are on antipsychotics should only be on one antipsychotic.

And I will tell you that cases of the children that I care for, we're saving their lives sometimes. Because we're keeping them from elopement and wandering after the sun goes down, and wandering into the street. Because we're using a medicine that has higher levels of sedating side effects at night, and we're not

using those medications during the day.

And I think to think about just, oh, lower is better isn't a reflection of actually what these patient populations need. And so there's no way that we can assess the quality of what we're providing them if we aren't taking that into consideration.

So while in general I think we all feel like we need to be working diligently to minimize the side effect profile of medications that we give, there's really no evidence that giving one antipsychotic during the day, one at night, when you are using a side effect profile intentionally, is going to be detrimental to a particular child.

And so while it seems logical, this doesn't actually to me reach the measure of a, the metric of being a indicator of quality. And I also think for specific subpopulations that it is almost guaranteed that those children are requiring a very robust engagement with multiple service sectors to try to navigate their issues

successfully.

And when we do that, we are often saving these children's lives and keeping them in their homes, which I think are important.

CHAIR ANTONELLI: Judy.

MEMBER ZERZAN: I also agree with removing this measure. I think this is a great example of QI success. When it was put on and when we were talking about this, there was huge variability, the percentages were much higher. I think now there's very little variability between states.

The number's small, and I think as others have said the right answer isn't zero. There are kids that need a couple. I think there are measures for addition, particularly this is the only harm one on the current scorecard. But I think there's measures for addition that could be added, and I think there's more important places to focus states' energy on kids' behavioral health.

CHAIR ANTONELLI: Lindsay.

MEMBER COGAN: So I was going to take up sort of the same line of thought, that I understand that this is the only measure in this particular domain. But I didn't know if CMS had any comment as to why the use of opioids at high dosage wouldn't fall in this domain. It doesn't, to my mind, it doesn't seem to fit in the domain that you have it in.

And then, again, going back to are there measures for consideration to addition, so we wouldn't want to lose this domain, it's an important domain. Are there measures that could be fit into this domain? If this not the right measure, are there other measures that would be a better fit for this area?

MS. LLANOS: The domain question. So why isn't opioids in there. So I will say our domains match your meaningful measures approach at the Agency. There are some general definitions of what each domain should represent and include, but they're often overlapping. So I think we did our best to organize them where in

terms of domains where we thought they would be most reflective.

CHAIR ANTONELLI: Does that mean that there's a potential opportunity to move a measure to a domain? And would you need to get through a vote or a recommendation?

MS. LLANOS: No, I think that's a comment that you guys can make, I would probably just give you this context. In terms of the domain filling, I think that's one thing to think about. Does this measure represent more than just the domain, or is this a pediatric issue as well. So keep those contexts or issues in mind.

CHAIR ANTONELLI: Thank you. Kim, Harold.

MEMBER ELLIOTT: I agree with removing it as a measure group scorecard, even though I do think it's a very important measure, and I do think that it impacts some segments of the Medicaid population pretty strongly, such as the foster children population. So I wouldn't want us to lose it as a core measure, which we're not

talking about here.

But I do agree that probably is more of a utilization measure, which probably wouldn't make sense to keep on the scorecard.

CHAIR PINCUS: So as usual, I agree with Judy. But one question I have is, you know, have we solved the problem about antipsychotic prescribing for kids? You know, this may not be the best way to solve it, but the question is have we solved that problem. If not, is there something, another alternative measure that might be better?

MEMBER HOUTROW: Definitely we have not solved the problem. And I think your point about the kids in foster care who show up having been on multiple antipsychotic medications is a particularly concerning subpopulation.

MEMBER ELLIOTT: When I think back a little bit on the history of this particular measure and why we had these discussions early on, there was a lot of work, because of the abuse in the foster children's program, and really

developing something that would draw and align Medicaid and other federal and state agencies towards working on a common goal, which was to decrease the multiple antipsychotic use in foster children.

So I've always kept that in mind with this particular measure.

MEMBER ZERZAN: I think we've moved on, though, to the problem of multiple psychotropic medications in kids, and not multiple antipsychotics. So I think, you know, there's talk of four more other things as a measure that isn't on the child core set. But I think this particular one isn't a measure.

Also, I've done a fair bit of work, including personally in foster care, and I do think there are kids that sometimes need medication for a while. They've had very complex traumas and need therapy and medication to get to a stable place. And therapy doesn't work overnight, and disrupting their lives doesn't work overnight.

And so finding the right balance of how to support these kids through some tough times is sometimes necessary. I think the long-term outcomes in use of medications is something that can be looked at, but all of that is not on our agenda today.

CHAIR ANTONELLI: Ken, did you pull out of the queue? Okay, so I've got Stephen, David, then Dave. And then Amy, are you back in? Okay, Stephen.

MEMBER LAWLESS: Yeah, a quick question for the developer. I thought there was another NQF measure out there that would consider it in the safety realm that was use of, looking at the use of antipsychotics in kids less that age five. And I don't know if it passed or is still there or not.

Is there a reconciliation of that one that there was a recommendation in that younger population not to use them? But this is saying you can use one but not more.

MS. BYRON: Right, I know the measure

you're talking about. That one is actually not a HEDIS measure. The other two measures, one of them is in the core set, is the use of psychosocial care prior to, you know, whether, really the measure is looking at whether or not psychosocial care was tried before prescribing.

We also have one that is not in the core set but is in HEDIS, so it looks at metabolic monitoring for kids who are on antipsychotics. The less than five was something we had considered early on in development, but it was, at a health plan level, just the numbers were too small. And so we ended up going with the other one.

So really, we have the three in the set, because our thinking is first you want to make sure that you are discouraging inappropriate use, which is why we have the multiple concurrent measure. And then we say that well, if you're going to be on it, at least try psychosocial care. And then if you must be on antipsychotics, which some kids need to be, then you should be

doing monitoring of their metabolic symptoms.

CHAIR ANTONELLI: David, then Dave.

MEMBER KELLEY: So I would agree with removing this measure. As a state, we're at 1.5% last year. I will say probably ten years ago, I don't if we were measuring it that long, I know we were looking at internal data. It was significantly higher, and we've done a lot of work working with our providers and really bringing that number to perhaps a more appropriate level.

So I do think that, I hate to, there is nothing else that's quite in the domain that's on the scorecard. But I think with, again, this being fortunately a fairly small percentage of the population that is on these medications in general, I think there are other things as we look to maybe add to the scorecard, that this could come off.

Maybe take a victory lap, maybe. I doubt it, but we still need to, as Medicaid programs, we still need to be monitoring this

domain. And there are a whole host of activities that can be done outside of quality measurement and working with your providers to make sure that these children are getting the care they need, but they're not also getting over-utilization of certain medications.

CHAIR ANTONELLI: Dave.

MEMBER EINZIG: Real quick. So just to reinforce this, what we're trying to do is improve the quality of care for these kids. Again, what these kids need are support, and the focus should be more on the psychosocial aspects. If they're going to be on multiple medications, are we sure that they're getting the right supports that they need.

And so in terms of improving outcome, I would encourage the focus on this measure is not looking at that.

CHAIR ANTONELLI: Amy.

MEMBER HOUTROW: Yeah, I think that is exactly where I was going with my comment, like have we solved this problem. We have not solved

the problem, but we are not potentially measuring the things that would be valuable to measure to get us there. Because we have exceptionally poor access to sets of services.

And we also, you know, have no measures of looking at housing instability or food insecurity or other markers of significant household dysfunction, which are directly correlated to these kids' behavioral outcomes. And so, I mean, we have a lot of work to do. I think we're just at the place where this measure is just no longer doing the thing that gets us to the place we need to go.

CHAIR ANTONELLI: I'll do Shayna then Rhonda and then I'd like to call the question of a motion. If something hasn't been said, I will respectfully ask you to weigh in. But we don't need to hear more repetition, I'd like to get ready to call the question. So Shayna, then Rhonda, then call the question.

MEMBER DAHAN: I also think that this measure as far as saying that it's addressing

reducing harm in care delivery sometimes can actually do the opposite. Because sometimes these patients are putting themself or others in danger, and that is the reason why they're on multiple medications initially.

I think swaying providers to be scared or somewhat not wanting to do that to put others at risk, there's also children that can't go to school, there's kids that are at risk of being abused with their parents while you're working with the parents. And sometimes you just can't, we're looking at the family, and we're looking at doing what's best that we can right now.

So it's not immediate that this kid needs to go back to school so the mom could go to work or that we think that, you know, if this kid isn't a little calmer at home that something bad's not going to happen to them.

So I wouldn't sway providers away from that. I think most providers don't want to be giving out a million antipsychotics without having their arm twisted, and that they're in a

bad spot to begin with.

CHAIR ANTONELLI: Thank you. Rhonda.

MEMBER ANDERSON: I actually was going to call the question. It sounds like there's consensus, and so I'd like to move that we remove this from the set.

CHAIR ANTONELLI: From the scorecard.

MEMBER ANDERSON: From the scorecard.

CHAIR ANTONELLI: Is there a second?

MEMBER HOUTROW: Second.

CHAIR ANTONELLI: Okay. So that goes into the voting consideration parking lot. What I'm going to do now, and I guess I'll check in with Jordan. Do we have any committee members with their hands raised right now? We don't, okay.

So here's the plan. I'm going to pause here, open it up for public comment. We're going to -- is the food here? Okay, we're going to get lunch. You won't have to go outside for it, unless you want to. But we will be working through lunch. We'll allow people to have 15

minutes for any, you know, biological activities or checking in to your respective home, mother bases, we'll do that.

So I'd like to open the line, Operator, please, for public comment.

MS. KUWAHARA: So if any members of the public would like to offer comments, we are unmuting all lines. But first we'll take any comments in the room with us. Are there any individuals who would like to offer a public comment?

MS. HINES: Hi, this is Lisa Hines from the Pharmacy Quality Alliance.

MS. KUWAHARA: Sure, go ahead.

MS. HINES: Can you hear me?

MS. KUWAHARA: Yes.

MS. HINES: Hi, just one quick note. The antipsychotic use in children less than five is a PQA measure, and we'd be happy to discuss that for consideration in the future. It's not in the adult core set. Happy to provide more information, thank you.

MS. KUWAHARA: Are there any other comments? All right.

CHAIR ANTONELLI: And so for members of the public, we have not finished the removal consideration section. So you will have another opportunity to offer public comment as we proceed. We've had to move the agenda around a little bit for circumstances out of our control.

So with that, we will pause for 15 minutes, come back with your food, and we'll dig in. Thank you.

(Whereupon, the above-entitled matter went off the record at 12:41 p.m. and resumed at 1:05 p.m.)

CHAIR ANTONELLI: All right. Why don't we go ahead and put the first slide up, please?

And, Committee Members on the phone, you should have open lines.

We're going to continue the work of going measure by measure. I remind you we're not voting. We're making decisions about whether to

make a motion that gets seconded, and then the voting will occur after this process.

MS. GORHAM: Okay. Let's look at Measure 1392, the Well-Child Visit: First 15 Months. The measure is NQF-endorsed. The description of the measure is: the percentage of children 15 months old who had well-child visits with a primary care physician during the measurement year. This is a process measure. The data source is claims, electronic health data and paper medical records.

MAP members have continuously supported this measure, noting no significant implementation issues. This measure has not come up for discussion during our MAP reviews other than to say that you all continuously support the measure.

Forty-nine states reported the measure in 2017, and alignment for this measure is also, the measure is also implemented on the QRS program.

With that, I'm standing in Julia's

stead. So let me read her rationale for recommending this measure.

So she recommends removal only if NQF child immunization status is added to the CMS Scorecard, and that is a recommendation for addition. The measure serves as a worthwhile proxy for this measure, meaning, as a result, the childhood immunization status serves as a worthwhile proxy for this measure, well-child visits.

Additionally, California, which is where Julia is from, does not report well-child visits in the first 15 months, primarily because claims for a newborn can often be put on the mother's identification number in the months following birth, which makes reporting very difficult and potentially unreliable.

So her summary, the proposed addition of NQF 0038, the Childhood Immunization Status measure, would serve as a superior measure on a similar topic and priority area. And also, reporting is difficult in California.

With that, I will turn it over to Rich.

CHAIR ANTONELLI: Thank you.

All right. So, it looks like I've got Judy and Shayna. Good. Judy, go. No, I don't have Shayna; just Judy.

MEMBER ZERZAN: So, this is Medicaid's bread and butter, all of these well-child visits, and I feel strongly that this should stay on the measure set. Immunizations, I think there are more screenings and there's more interaction with the parents and other things, while immunizations might be a proxy. Both of them are very important, and I don't think one should supersede the other.

Even though there are potentially measurement visits and a lot of people get five instead of six visits, this is still a super, super, super important measure.

CHAIR ANTONELLI: I have Kim, Kamala, Ken.

MEMBER ELLIOTT: I really think this

is one of the more important measures to keep on the Scorecard because it is the lead-in for immunizations. It's the lead-in for developmental screenings, all of the things that you really need to pay attention to for children. So, I really do think that emphasis needs to be there in a Scorecard.

CHAIR ANTONELLI: Kamala?

MEMBER ALLEN: Thank you.

I would agree with what was just said. I think that the immunization measure, while an important measure, is not a proxy for well-child visit. The well-child visit is much more robust.

And contrary to our previous discussion around the antipsychotic measure, this is a measure that would be applicable to all children, as opposed to the antipsychotic measure, where we know that there's specific subpopulations of children for whom it may be much more particularly relevant, and those being relatively small in number.

CHAIR ANTONELLI: Okay.

MEMBER ALLEN: Thank you.

CHAIR ANTONELLI: Thank you.

Ken?

MEMBER SCHELLHASE: Agree with what's been stated so far. And I would add that, increasingly, immunizations may be moved to pharmacies. And I don't know that there are any states right now that would immunize or authorize immunizations of children this young, but that's probably in the not-too-distant future. And so, therefore, relying on an immunization metric alone as a proxy for well-child visits will really become very misleading.

CHAIR ANTONELLI: And I have a point of clarification. By pharmacy, do you mean pharmacy or do you mean retail-based clinic and you're conflating the two?

MEMBER SCHELLHASE: I mean pharmacies where drugs are dispensed.

CHAIR ANTONELLI: Pharmacies? Okay.

MEMBER SCHELLHASE: So, immunizations actually done by the pharmacist.

CHAIR ANTONELLI: Yes. Thank you.

I can't see -- that's it. Yes, Camille?

MEMBER DOBSON: Just not to belabor the point, but, you know, EPSDT is a requirement for Medicaid children, and this is the best proxy we have to assess whether the EPSDT visits are happening, presumably during the well-child. So, I agree.

CHAIR ANTONELLI: Okay. Steve and Amy.

MEMBER LAWLESS: Just to the flip side just for one second. If 49 states are already reporting and it's a requirement, what's the value going to be to adding it to the Scorecard?

CHAIR ANTONELLI: We're discussing removal.

MEMBER LAWLESS: Right. So, what's the value to -- sorry -- to maintaining it on it in terms of, unless there's a big enough gap already, what would doing this, keeping it on it, do more than just what is done now?

MEMBER DOBSON: This is one, at least from my perspective, that has quite a bit of variability and is an important thing to measure. And I think being on the Scorecard gives it a little more oomph. We still suck at that. And at least when I was in Colorado, and I think in Washington, too, our rates are not where CMS says our rates are going to be. I won't put Karen on the spot, but I don't know that any state's rates are where they should be. And so, I think there's plenty of room for improvement.

CHAIR ANTONELLI: Amy?

MEMBER HOUTROW: Just to play devil's advocate here, I'd like to make two points. One point is that we have acknowledged that this measure doesn't actually map to what the recommendations are, which are actually harder to achieve, so a higher threshold. And two, I think we're making an important point about the relationship between well-childcare and particular activities that should be happening there, immunizations and developmental screening,

which we do have measures that are about those two things. And so, if we're really thinking that the important aspect of the well-child visit is getting these other things done, then would be measuring those other things be the more appropriate choice?

CHAIR ANTONELLI: Shayna, are you back in the queue now?

MEMBER DAHAN: Oh, yes.

(Laughter.)

CHAIR ANTONELLI: I am paying attention.

And, Camille, if you could either take yours down or at least point it so I can see, please? All right. So, then, Kamala, you're next. Shayna? Then, Kamala.

MEMBER DAHAN: So, I think this measure is really important because of the fact that this continues to keep providers thinking about if these kids have well visits. And what happens is, when we get them in for a sick visit, we add the well visit to it. And if that's not

there, we're not stressing every visit as an opportunity to get vaccines and get screening and get the full well visit and monitor growth and lead. And there's a million things that happen there, and I think that this measure impacted practice by, you know, the kid with the strep getting the physical that day.

CHAIR ANTONELLI: Kamala?

MEMBER ALLEN: Two quick points. So one, I think to Amy's specific recommendations or thoughts or observations, I think the two things that she referenced, both immunizations and developmental screenings, may happen outside of a well visit in some instances. So I would not say that that would be necessarily the case.

And secondarily, we know we're thinking about other types of screenings and wanting those to happen. For example, substance use disorder screening, other types of preventive services. So, again, I don't think that taking this out is going to give us the benefit that we want in terms of a comprehensive view of

children.

CHAIR ANTONELLI: Thank you.

David, Liz. And, Amy, are you back in the queue? David?

MEMBER KELLEY: So as a Medicaid agency, this is on our pay for performance. I'd say there is still a huge gap where it's 66, 68 percent. Some of our plans do 72 percent. Our lower plans are under two-thirds. So there is still a quality gap there.

I think this age band is very, very important because of -- again, I'm an internist, so I may be a little dangerous here -- but, you know, all the things that need to happen in that first 15 months are vital; plus, it's an opportunity for the pediatrician to have an interaction with mom to make sure that mom is also doing okay.

I think that what's interesting, when chart review is done, it actually gives the state or health plans the opportunity to look at some of those things within the well-child visit that

may or may not be getting done that should be done. So even though it is kind of a global proxy for all the checkmarks, maybe not everything in EPSDT, it's a good proxy, and during chart review there's also an opportunity for MCOs, if they want to use it, to actually look at specific components within those requirements. So I would advocate that we keep this one as a measure.

MEMBER HOUTROW: Just to Shayna's point, to support, there is data in the literature that says, for infants and young children, children with special healthcare needs actually get better anticipatory guidance and health promotion screening because they're going to the doctor more frequently and have more opportunity. So getting them in is a meaningful thing.

CHAIR ANTONELLI: All right. So I've got Liz, Jill, and then I'm going to call the question, which David was being prescient about.

MEMBER MATNEY: I am not going to

advocate for removal or not removing; I'm not going to advocate either way. But I do, from an NAMD perspective with the state Medicaid agencies -- some of these children measures are problematic, just in the sense that some states use only administrative data, such as claims, and then, other states do chart reviews. We would definitely advocate for consistency across the states, but just understanding that it can lead to some false conclusions as to state performance.

Because if you're using administrative data only, you're going to miss out on well-child visits, immunizations, et cetera, that have occurred through maybe a primary insurance carrier that's not Medicaid. So we don't get that information today. So we do typically score low on these. I want to go back and advocate for doing chart reviews as well, but, you know, resources.

CHAIR ANTONELLI: Thank you.

So last word to Jill, and then I'm

going to call the question.

MEMBER MORROW-GORTON: So as a developmental and behavioral pediatrician -- and it may be heresy to say this -- but I think the 15-month visit is more important than the 12-month visit from a vantage point of language, even motor. You know, you see a kid not walking at 12 months; you're going to look later.

So I think that this particular measure gives us that window into picking up kids with developmental problems early, and sort of a good opportunity for anticipatory guidance in what's going to happen next, which is very different from what happened in the first year.

CHAIR ANTONELLI: Anybody want to make a motion? And if so, what is your motion? The question on the floor is, should this be recommended for removal from the Scorecard?

Ken?

MEMBER SCHELLHASE: I make a motion to not remove this from the Scorecard.

CHAIR ANTONELLI: So that's the null.

I'm looking for a motion to remove it.

MEMBER SCHELLHASE: Sorry. All right.

CHAIR ANTONELLI: Null is we stand pat. Does anybody want to make a motion to remove 1392 from the Scorecard?

Seeing none, we're going to the next measure.

MS. GORHAM: All right. The next measure is the Adolescent Well-Care Visit Ages 12 through 21. This measure is not NQF endorsed. The description of the measure: percentage of adolescents ages 12 to 21 who had at least one comprehensive well-care visit with a primary care practitioner or OB/GYN practitioner during the measurement year. The data source is administrative or a hybrid. MAP has continually supported this measure, noting no significant implementation issues. Forty-nine states reported on this measure in 2017. And as the measure before, this measure is also reported in QRS.

With that, oh, Julia again. Okay,

hold on.

So Julia recommended this measure for removal. With that, of course, she has discussed the issue and she has provided some notes.

Recommend removal of this process measure because the immunization for adolescence Measure 1407 is already on the CMS Scorecard, and NQF No. 1407 can serve as a proxy for the adolescent well care.

A key indicator of continuity of primary care is whether adolescents are up-to-date on their immunization. Because 1407 now includes the HPV series, reported rates are much lower than previous years and targeted quality improvement in education efforts are needed to improve very low HPV immunization rates. California, for example, reported a statewide managed care plan weighted average of 26.89 percent for the adolescent immunization measure in 2017.

So in summary, in the interest of Scorecard parsimony and needed QI efforts in a

related area, improving adolescent immunization rates, recommend removal in favor of the immunization of adolescent measures which is already on the Scorecard.

CHAIR ANTONELLI: Okay. We're open for comments. Shayna, then Judy, Ken. Wow. Let me just call on people that don't put their cards up.

(Laughter.)

So, Shayna, go ahead.

MEMBER DAHAN: So for adolescents, if they don't come in every year for their flu shot, you're going to miss a majority of these patients from 12 to 21 if you're only relying on vaccines. Because if they complete the two papillomas -- they'll all need two papillomas before 16 -- that could be six months apart. So technically, you could have a kid that comes in at 12 and, then, doesn't have to come in again until before college or 16 for meningitis vaccine, which isn't always required. So it would be like maybe one visit would happen secondary to that immunization

measure for this patient population.

CHAIR ANTONELLI: So here's the order: Judy, Ken, Rhonda, Lindsay, Elisabeth, Jeff, Marissa. And now, catch up from them.

MEMBER ZERZAN: Ditto to what I said the last time, only we really, really suck at this population and giving them access. Teenagers are hard, and this is a critical time in their life, and it is more than immunizations.

MEMBER SCHELLHASE: Also, ditto for me. I know in Wisconsin, by statute, pharmacists can do these immunizations, probably in many other states as well. And so, again, this would not be a good, immunizations would not be a good proxy for adolescent well visits, and, yes, we suck really bad at it.

CHAIR ANTONELLI: Yes. Thank you.

Rhonda, did you withdraw? Okay.

Lindsay?

MEMBER COGAN: So I have a bit of a different comment. So I think this measure overlaps with the Child Access to Care Measure.

So there is a Child Access to Care Measure on the Scorecard, right? Am I looking at the right -- is there not? Do I have that wrong? Okay.

So I was going to say we are measuring this already with Child Access to Care, but maybe that's not on the Scorecard. Okay. All right. Then, I rest.

But just a note: that measure is really high. So the Child Access to Care Measure for 12 to 19 is much higher than the Adolescent Well-Care Visit 12 to 21. So it begs the question, are they really not coming in or are they -- I mean, the Child Access to Care Measure is you have to see a primary care physician. So it just begs the question that this measure isn't really as bad as we think it is. Or is it that that upper age group is pulling it down? I mean, that was really my comment about it. I would think about this one for removal.

CHAIR ANTONELLI: Elisabeth, Jeff, Marissa.

MEMBER OKRANT: Yes, I just wanted to

bring up the transitional age youth group which doesn't get really measured for anything, and it's so critical for these appointments; and also, the importance of these appointments in substance use grading as well. So I think it should stay.

MEMBER SCHIFF: We this last year moved from Q2 year well-adolescent visits to Q1 year because we thought it was important, and included in the AAP recommendation on HIV screening and got a lot of blowback, which we've sort of stood firm against. And I think these visits are, if we really want our adolescents to have some exposure to a professional to discuss sexuality, drugs, mental health, we have to make sure we do this. So I'm thinking that we've got to leave it there.

CHAIR ANTONELLI: Thank you.

Marissa, then over to David.

MEMBER SCHLAIFER: Mine may not be, my question may not be that relevant, now that I've heard everything around the table. But I was

just curious, was it ever discussed for NQF endorsement? I was just curious about the non-NQF endorsement and whether it was discussed and shot down or whether it was never discussed or never submitted. Just curious. Because if it was shot down, I would kind of like to know why. But if not, we can move on.

MS. BYRON: I'm reaching way back in my memory bank right now. I believe that it was submitted at the same time as the Well-Child Visit ones, yet well-child went through and adolescence not.

There are some concerns, if I can recall correctly, about the evidence not being as strong. But, you know --

MEMBER SCHLAIFER: From what I'm hearing around the table, I'm kind of, you know --

MS. BYRON: Yes, I mean, I was thinking --

MEMBER SCHLAIFER: It's not as important, but I was kind of curious.

MS. BYRON: Yes. I mean, for us, similarly, it also is an access-to-care measure. So we see it as important. And I think some of it, I would echo the things -- the reason why we have it in HEDIS is because there aren't a lot of measures that target that age group.

To Lindsay's question about that child and access-to-care measure, that is in the core set. That one really just looks to see that you had a visit with a PCP. It doesn't have to be a well visit. It could be any visit. And that would probably explain why those rates are much higher. This one says it has to be a well-care visit.

CHAIR ANTONELLI: Okay. So, David, Lisa, then I'm calling the question.

MEMBER KELLEY: So in Pennsylvania, again, there's a huge performance gap. Our well-child visit in this age band is only 56 percent. And I can tell you, I've been there for 14 years. I'll say that over the last 10 years it was probably as low as like 35-36 percent when

we first started measuring it. So we've seen some improvement, but there's still a huge gap.

Our access to care in that 12-to-19 age band is actually 90 percent. So these kids are accessing a PCP, but they're not getting comprehensive access to care. And we do do chart review. So we differentiate, we can parse out what's just a quick sick visit versus an actual well-child visit.

So it's not just an access-to-care measure. It's really a more comprehensive access-to-care measure. And I would advocate we keep this.

CHAIR ANTONELLI: Lisa?

MEMBER PATTON: Yes, I was also going to just voice support for keeping this one. A few years ago, we had an NCQA measure that looked at risky behavior. A composite measure, it looked at risky sexual behavior, I think alcohol, tobacco, and drugs. And there was tremendous pushback. I mean, just the data collection burden, pulling it together, and physician

discomfort with some of it. So I think this at least gets us a little closer to addressing some of those issues, even without access to that measure.

MS. GORHAM: I just want to comment. Renee Fox from CMS just wrote in to comment that this measure was on the child core set before MAP started to review the measure. So I can't answer the question about whether or not the measure was submitted for endorsement because it's not in our repository. So I don't know that. But she did say the measure was on the core set before MAP reviewed it.

CHAIR ANTONELLI: Thank you, Dr. Fox.

All right. So, remember, null is we're not moving it. Does anybody want to make a motion to remove this measure from the Scorecard?

Going once, twice, thrice.

Next measure.

MS. GORHAM: All right. The next measure we are considering is NQF 2940, Use of Opioids at a High Dosage in Persons without

Cancer. This is a PQA measure. The proportion of individuals without cancer receiving prescriptions for opioids with a daily dosage greater than 120 milligrams morphine equivalent dose for 90 consecutive days or longer. This is a process measure. The data source for this measure is claims.

FY26 is the first year of reporting this measure. Fourteen states reported the measure in 2016, and 23 states reported the measure in 2017.

The history on this measure: this measure was conditionally supported for addition to the adult core set in 2015 after hearing from states that early intervention for people who are prescribed opioid medications is important to prevent addiction and a pathway to illegal heroin use. The MAP conditionally supported the measure pending endorsement. Subsequently, PQA submitted the measure for endorsement.

Lindsay Cogan is the lead discussant for this measure, and I will turn it over to Rich

and Lindsay.

CHAIR ANTONELLI: Lindsay, go ahead.

MEMBER COGAN: Great. And I think Julia also has some comments as well that she maybe submitted for this measure, too. I don't know if you want to take care of those.

CHAIR ANTONELLI: We'll look at her notes --

MEMBER COGAN: Great.

CHAIR ANTONELLI: -- but why don't you tee it up, please?

MEMBER COGAN: Perfect. So, Amy, I'm going to take your words because I had something else I was going to say, but you've summed up quite well with the use of multiple anti-psychotics.

So I don't see this as a quality measure. It is a measure of prescribing practices. It is, again, one of those utilization-based measures that are really tricky in understanding what is the right level. So lower is better, but what is the right level.

When you look to compare across states, our underlying Medicaid populations vary quite a bit, and we see this measure as being one that is particular sensitive to some of those different case mixes of the Medicaid populations being covered. Not to say that opioids is not an important issue; that is really not the point here.

And then, additionally, our New York State, we report this measure, and we are one of the highest; we have one of the highest rates. And I remember Mathematica coming back to us and really trying to dig in as to why. And it wasn't until we started tracking treatment, medication-assisted therapy for opioids, that it, then, popped up that this measure was actually measuring MAT.

So additionally, it's measuring buprenorphine-naloxone. Am I saying that right? Methadone is on the list as well. We haven't dug into the exact, but we have found a couple of formulas that are directly used by providers to

treat opioid treatment.

So our State really is not going to support a measure that disincentivizes the treatment, medication-assisted therapy treatment for opioids. That is an incredibly important area that we're directing a great deal of resources towards. So that's really the main concern I have with this measure, is any disincentivizes toward the treatment of opioid use disorder.

CHAIR PINCUS: Just a quick question. Isn't there a simple fix for that?

MEMBER COGAN: I mean, we can talk to the measure steward. So it's the last two years there's been this formula on there. I think they've taken it off in 2019, but I haven't gone back to confirm. I haven't dug into the issue of methadone, the methadone formulations that they do have and whether we're also picking up methadone treatment in our outpatient clinics.

But, again, it's an area of concern that we don't want to disincentivize treatment

for opioids.

CHAIR ANTONELLI: So, Marissa, yes, because I was going to say, unless you have that response, I'm going to put you into the queue. So, SreyRam, then I have Amy, then, Marissa, and then, Lisa.

Go ahead.

MEMBER KUY: I was just going to agree with many people in saying that this oversimplifies this measure, that there are plenty of people without cancer who may have terminal illnesses or sickle cell disease, or other conditions that do need opioid treatment.

And I am the biggest advocate for tackling the opioid crisis, but I think that this measure oversimplifies it and we can do better. We should throw it back that they need to come back with a measure that is much more refined.

MEMBER HOUTROW: We're actively seeing the pendulum swing, obviously, in prescribing practices. And I think one of the things that is happening now is a refusal to be the prescribing

physician for people who have conditions for which opioids are most certainly a justified treatment course.

And I am in agreement that this is too simplified and there is no appropriate threshold for what the level should be. So while you might be able to get at the issue of can we get out the methadone treatment for opioid abuse, we can't get out the underlying issue, as we don't know what the actual threshold is where we should be for a population of people.

CHAIR ANTONELLI: Okay. Marissa, Lisa, Stephen, then Josh.

MEMBER SCHLAIFER: I just want to make sure, first -- well, first, I want to mention that, during the MAP adult core set discussion about this, we had a lot of the discussion that's been around the table. I do think it's really important to point out on this measure that this measure is not saying that people should not be on opioids by any means. But the numerator is the number in the denominator with opioid claims

where the MED is greater than 120 milligrams for 90 consecutive days or longer. So this should not keep anyone from putting someone on an opioid medication or using opioids appropriately.

Knowing that there are patients that will need more than that, but those are the minority. We never measure assuming that we're going to get to 100 percent.

I think, as the adult core set task group, work group, whatever we were at the time, discussed this, it really is one of those things where we have to have a measure that can be used to address the opioid crisis right now. We have to have that, whether it's in the adult core set, or I would also think, my opinion, in the Scorecard.

We know this isn't the perfect measure. We know this doesn't address everything going on in the opioid world. PQA is currently focusing on those early 45-day starts, partly because the Adult Core Set Work Group focused on that as a gap. And hopefully, we will have some

measures there that we can talk about going forward.

But I think this has been accepted by many states. And it's early on in its use, and I believe we've gone from 14 to 23 states over the 2016-2017, and someone can correct me in a second on that.

So I think we are seeing a lot of uptake by state Medicaid programs. And we really do have to have a way to look at state Medicaid programs on the opioid use because that is one of the things that various government agencies are demanding, that PQA and other measurement organizations have found a way to address.

I don't know the question about MAT, and I think that was a really good comment. But Lisa Hines from PQA is on the phone. And so I would just ask that she get a chance somewhere in this queue to address that question.

CHAIR ANTONELLI: Yes, as long as she stays on -- I'm planning on playing this out a little bit -- and she absolutely will be asked to

weigh-in.

MEMBER SCHLAIFER: Okay.

CHAIR ANTONELLI: So, Lisa, Steve, and Josh, Jeff.

MEMBER PATTON: Sure. So much of what I was going to say aligns with Marissa's comments. I was going to add that we've done a lot of data analytics, good data analytics, coaching of the states, and worked with them on this metric as well as other opioid measures, and haven't experienced those same issues that New York seems to be experiencing. So I'm not sure where that misalignment is occurring, but, as Harold pointed out, I think there's probably a simple fix to that, or at least a fix.

And in addition, we've talked to a lot of states that have been working for quite a while to drive this prescribing rate down, the MED rate down. And whether or not the right number is 120, 100, 90, we've heard about a lot of efforts to drive down to 100. And with CDC putting out the guidelines, a number of those

states said, we're not going to 90; we're sticking at 100. So the right number is certainly up for debate. I do believe -- and Lisa can speak to this -- that PQA is working to respecify their measure to be in alignment with the CDC guidelines.

But I'll also mention that this was a part of a portfolio of opioid measures to also get at doctor shopping and multiple pharmacies, multiple prescribers. So there are those measures. And there's also a concurrent benzo and opioid measure that PQA developed that gets at some of the overdoses and deaths that we're experiencing as a country,

CHAIR ANTONELLI: Thank you.

Steve and Josh, Jeff.

MEMBER LAWLESS: So a little bit of what you're saying there; the state now prescription monitoring program is getting tighter and tighter and tighter. They're picking up a lot of these things anyway. And what they're asking for is the documentation of why

you're on.

Now I think a measure that says, are you documenting how well those systems are working, may be the better one that a patient who may -- you know, I think the opioid crisis is not these patients. It's the selling them from there. But I think having somewhere where it links up to the prescription monitoring program, how effective they are, I think would be a better indicator.

MEMBER COGAN: Did Julia put that in her comments, though? Because California is doing some work with their prescription monitoring program. Did she put that in there? So there's a new law in California that requires doctors to query the state system before they can prescribe. So there's efforts ongoing in exactly that area.

MS. GORHAM: So she actually rescinded her recommendation for removal.

CHAIR ANTONELLI: Josh?

MEMBER ROMNEY: Utah also has that

law. And as a prescribing provider, I'll tell you it's tough. Intermountain Healthcare is working really hard on this. We have strong opinions about it.

The first comment I have is that it's important to remember that this isn't about prescribing opioids; this is about prescribing more than 120 morphine equivalents every day. I don't know of any organization that recommends that the cutoff should be higher; 120 is conservative.

The other is the need to address the opioid crisis. Medication-assisted therapy is really important, but that's a small minority of the people that we're measuring here. And that feels like throwing the baby out with the bath water.

And we still need to drive physician behavior. Our experience at Intermountain is there are still, even though you wonder where they've been hiding for the last five years, there are still many providers who don't yet

understand that high-dose chronic opioids are not more effective or more beneficial than lower-dose chronic opioids.

CHAIR ANTONELLI: Dr. Schiff?

MEMBER SCHIFF: I think this is one of the measures that I would vote to keep in or not vote to remove, with the caveat that we need better measures. The better measures I think we need are a measure of new chronic use or risk of new chronic use, which is a measure that we helped develop with NCQA that looks at people who are new at 45 days -- who are naive and, then, have 45 days of use. And then, I think we still need in this measure set a measure of the quality of medication-assisted treatment, which is adherence at least. So I think we need to look at both of those.

With that in mind, I think this is one of the situations where I think having the measure as a placeholder, this measure as a placeholder is worth it.

CHAIR ANTONELLI: Thank you.

Are you back in the queue, Marissa?

MEMBER SCHLAIFER: Yes, I have a few comments, but --

CHAIR ANTONELLI: Well, so, no, I'm not calling on you. I just didn't know whether --

MEMBER SCHLAIFER: Yes.

CHAIR ANTONELLI: -- you have an artifactual sign.

So I've got Jill. Then, I've got SreyRam and, then, Marissa, back to you.

MEMBER MORROW-GORTON: So in Massachusetts we have used this level to actually identify providers who are prescribing these levels of drugs. We require prior authorization. We require them to justify it.

But we also have used it to pick up prescribers who are really doing a bad job at this. So while this measure is -- I agree with Josh -- not perfect, doesn't get to are we getting people in treatment, doesn't get to are we doing all the quality things, I think it's a

great start to kind of address the issue at multiple levels until we get to a point where we've gotten that under control and we have some more sort of pointed measures that will allow us to get to kind of that more refined quality.

CHAIR ANTONELLI: Srey?

MEMBER KUY: So I really liked what I think Jeff said earlier about looking at acute pain treatment. Because if you're going to go for the biggest bang for the buck, you should go for prevention. And if you're looking at someone who's getting 120 mil equivalence, those are the chronic users. If you prevent them from getting it in the first place, you won't have to deal with the chronic users.

So we're in Louisiana and we did Medicaid reform around payment reform. We put in payment reform where we would not pay for people getting more than 14 days for acute pain med. So those are people who hadn't had pain prescriptions in a year. And we saw a 40-percent drop in new opioid prescriptions.

So I absolutely agree that the opioid issue is huge. It needs to be on the Scorecard. But we shouldn't just pick a measure. We should pick the right measure, and that's what I think is really important. We need to pick the one that's giving us the biggest bang for the buck, that's going to give us the best outcome.

CHAIR ANTONELLI: So, Marissa, before I call on you, I'm actually inclined at this point, since I'm starting to see some repeat commenters, to bring PQA in. But I'm happy to temporize that if anybody here would like to make a statement before PQA weighs in.

Good. So go ahead, Shayna, and then, PQA, if you get ready to jump in?

MEMBER DAHAN: I just have a question. Does this measure collect the data through like an insurance claim? Does someone pay cash for the pills? Does it also collect that, or only people who actually had it prescribed and filled through insurance?

MEMBER SCHLAIFER: If you pay cash,

which you can do, unfortunately, we lose all tracking, and that is a big negative, but that's true of everything we can do in the opioid measure set.

CHAIR ANTONELLI: Okay. So, PQA, do they have an open line, Miranda? Okay. So if you can identify yourself?

MS. HINES: This is Lisa Hines.

CHAIR ANTONELLI: Feel free to make some comments and some additional detail.

MS. HINES: Sure. Can you hear me?

CHAIR ANTONELLI: Yes.

MS. HINES: Hi. This is Lisa Hines. I'm Vice President of Performance Measurement and Operations at PQA. And thank you for the opportunity to respond.

The measure uses prescription claims as the data source and evaluates at the health plan level, and does not capture claims, to answer that last question.

In terms of the methadone, prescription claims for methadone are not for

methadone-assisted treatment or methadone maintenance. They would be only the methadone for pain. And it is less than 1 percentage of the claims in our testing that were for methadone.

We have never included products that are FDA-approved for medication-assisted treatment. And then, recently, we removed all buprenorphine products because it is not a valid way of assessing morphine milligram equivalence.

So there are no medications included in the measure for a couple of years now -- actually, since the beginning -- for medication-assisted treatment, and with the removal of buprenorphine, we've even eliminated the unintended targeting of those patients. So I did want to clarify that misinformation in terms of the targeting. These are opioids used for pain.

And let's see, I'm trying to make sure I address all of the questions.

I appreciate all of the comments about

there being not a set threshold, and as we are aware of, there is really no established base dosage. We are aligning now with the CDC guidelines, and this is based on user feedback through our use in the CMS Quality Ratings Program for Medicare and, also, end-user feedback via our website.

We are also monitoring for any potential unintended consequences and exploring measures for initial opioid prescribing as well.

So we want to make sure, we want to ensure that this measure is only one tool that's used to address this crisis, and know that a comprehensive approach is needed and that patients need to be identified for opioid use disorder and treated appropriately and have access to that care. That pain management is very appropriate.

We acknowledge that this is one tool and this is for high chronic use, and it can be used as an indicator of those patients that are at increased risk for opioid overdose. That is

established in the evidence.

I'm happy to entertain any other specific questions that I did not address during this comment period and, also, look for any additional recommendations to refine the measure based on claims data.

CHAIR ANTONELLI: Thank you for that.

Rest assured, I have everybody whose sign is elevated in the queue.

MS. HINES: Okay.

CHAIR ANTONELLI: But I'd like to open it up for everybody, whether your sign is up or not. Specific questions for the measure developer and/or comments? Does anybody want to say anything to the woman on the phone? Lindsay?

MEMBER COGAN: So that's very helpful, Lisa. Is it Lisa?

MS. HINES: Yes.

MEMBER COGAN: Lisa, thank you. Lisa, that's very helpful.

MS. HINES: Yes.

MEMBER COGAN: I will send you some

numbers because that buprenorphine-naloxone formulary you had in there was not insignificant. It was pulling up our rate by -- the small population that got triggered in that manner, their rates were double. So if we remove that, our rate goes down quite a bit. So I can send you some numbers, just so that you have perspective.

MS. HINES: Yes.

MEMBER COGAN: That was not an insignificant removal.

MS. HINES: Absolutely.

MEMBER COGAN: And we appreciate that, yes.

MS. HINES: And it's been changed. Yes, I very much would appreciate that feedback and information. It's very helpful.

CHAIR ANTONELLI: Committee, anything else for the measure developer?

Okay. So David?

MEMBER KELLEY: Quick question. There was a comment about looking at cancer. Are there

any considerations about removing other conditions like sickle cell?

MS. HINES: You know, we've reevaluated sickle cell through our Measure Update Panel on numerous occasions, and we have numbers to be able to exclude it as needed. And we can reconsider it every time we've brought it to experts, external expert opinions. I would say, with the exception of the CDC, experts and through our expert panels, or TEPs, they have recommended to keep sickle cell in. But we can readdress that this cycle through the update process. We continually reevaluate how to refine the measure.

CHAIR ANTONELLI: Okay. So, Lisa, thank you. Please stand by. I'm going to come back into this.

MS. HINES: Yes. You bet.

CHAIR ANTONELLI: But, at this point, especially for you second-rounders, unless there's something new that you want to add, I would like to start preparing for the possibility

of a motion being made.

So, Marissa, I think that you were next. Then, I go to Lisa, David. Go ahead.

MEMBER SCHLAIFER: So, first, I thought the conversation about PDMP programs was very interesting. And the one thing I would not want to tie a Medicaid Scorecard to the PDMP programs because of the variation of the PDMP programs across the country. There are the states that are requiring doctors to check the PDMP program. There's other state programs that use PDMP only for law enforcement purposes. And then, there's the wonderful State -- and I hope I don't insult anyone in the room -- of Missouri that, after years of refusing to have a PDMP program, is getting close. So I would hate for their State Medicaid Program to be responsible for the fact that their State is behind the times on PDMP.

Because there are a lot of states where I'm sure the Medicaid program is great, but their ability to do a PDMP program is very poor.

For that reason, I feel like Medicaid directors would not necessarily want to be responsible for that, but I could be wrong.

On the use of this measure versus other measures, I think no one -- I can't imagine that there's anyone, either here or through PQA, or anywhere else, that things that, you know, 120 for 90 days, we shouldn't worry about people until we get there. I think what this measure does, and why it's the right measure for the Scorecard, is states should be doing things, and physicians should be doing things, and health systems should be doing things, that look at people in those first 45 days, that try and take action in those first 45 days. Everyone is correct that that's where we need to really take action. People shouldn't get to the 90 days.

But if our measure is at 90 days, it's going to capture all the good things that people can be doing, but it also captures the real problems and what states are just not performing in this area. And I think it's a really good

differentiation between states that are doing a good job and states that are doing a bad job, knowing that if you're doing a good job, you're catching people before the 45 days.

CHAIR ANTONELLI: Thank you.

Liz? And then, I'll go to David.

MEMBER MATNEY: Once again, I'm not going to advocate one way or the other, but the conversation that we've had at NAMD related to this specific measure is that there's belief over time that the efficacy of this measure is going to stall out because of different POS edits that are in play and things like that. The numbers are just naturally going to fall down.

And it doesn't also capture the diversion that is naturally occurring as these edits occur and legislation is enacted that limits the amount of prescribing power that doctors have. And so, then, they go to street drugs instead or street-buy prescription pills.

So what we have been advocating is a forward-looking perspective looking at measures

related to any type of emergency room visit related to overdoses, plus follow-up, as well as deaths.

CHAIR ANTONELLI: So let's go to Lisa next, and then, David. And then, Ken, you had your card. Is that still you? I can't see it.

MEMBER SCHELLHASE: Yes.

CHAIR ANTONELLI: It is? Okay.

Go ahead. Lisa?

MEMBER PATTON: Sure. So I think this question has sort of come up in the discussion. There is an NQF-endorsed continuity, retention of care, in MAP, measure now, 180 days, that we discussed for potential inclusion in the adult core set a few months ago. And that one didn't quite get there.

But just to share with you all that there is that NQF-endorsed measure available. For the purposes of the Scorecard, it seemed a bit narrow in focus perhaps for where we're trying to get with this. But, for the adult core set, we thought it was appropriate to nominate at

least.

And then, in terms of the data with the overdoses, with ER data, and with morbidity/mortality, one of the issues is just being able to adequately capture that data and to have a meaningful measure. And so people have looked at those possibilities, but, you know, at this point it's just not really, it's not something we're going to be able to adequately get at, except on a case-by-case. And some states are doing some really solid work around that, but we're just not there.

CHAIR ANTONELLI: Thank you.

So, David, Ken; call the question, in that order.

Microphone, please.

MEMBER KELLEY: There we go.

So in our State, 5 percent of our adults 19 to 64 are on these high doses. Any clinician who thinks that 125 milligram is not a high dose, we should have a discussion afterwards.

Regardless of what your diagnosis is, unfortunately, in the last decade or so, medical education has been perversely affected by the pharmaceutical industry to think that these drugs are safe. When I did my medical school, I had learned that these drugs are addictive and they're not safe, and they're really probably not all that effective for pain management.

I like this measure. There needs to be a front-door approach and a back-door approach. This is the back-door approach. This is looking at a population that has been inappropriately treated. They need more comprehensive treatment. Many of them do have complex conditions and need comprehensive pain management treatment, not just a pill to take a couple of times a day.

So from my standpoint, this is really a very important measure. I do have concerns always about tightening the reins during prior authorization, and we have made our managed care plans tighten the reins. I worry about

opioid-related deaths. Pennsylvania is one of the highest states. So I have concerns about being overzealous in looking at and interpreting our results, but it really comes down to, what are the interventions that you're going to put into place?

So I use this as a tool and as a gauge, but it's just one tool. It's not an intervention; it's a tool to tell me about the quality of care. So I would advocate that we maintain this on the dashboard.

CHAIR ANTONELLI: Thank you.

So, Ken, last word.

MEMBER SCHELLHASE: Yes. I would also agree we should maintain this. This is the low-lying fruit. And I would also point out that, increasingly, payers on the front end are limiting short-term opiate prescriptions. And that gets to SreyRam's comment that I think we ought to be looking at measures, because we would be riding the wave, as opposed to dragging everybody with us, and maybe standardizing that

some. So looking at ways to develop measures that appropriately limit the initial prescriptions to a certain number of days, based on whatever evidence we can garner.

CHAIR ANTONELLI: Thank you.

So is there a motion from anybody on the Committee? And actually, do we have any Committee members with their hands up? No? Okay. Is there a motion from anybody on the Committee for this measure to be removed from the Scorecard?

MEMBER HOUTROW: I make that motion.

CHAIR ANTONELLI: Is there a second?

Okay. All right. So noted.

And we're going to move on to the last measure in the panel for consideration of removal, 0018.

MS. GORHAM: All right. NQF 0018, Controlling High Blood Pressure, Ages 18 to 85. The description of this measure: the percentage of patients 18 to 85 years of age who had a diagnosis of hypertension and whose blood

pressure was adequately controlled during the measurement year based on the following criteria: patients 18 to 59 years of age whose blood pressure was less than 140 over 90; patients 60 to 85 years of age with a diagnosis of diabetes whose blood pressure was less than 140 over 90; patients 60 to 85 years of age without a diagnosis of diabetes whose blood pressure was less than 150 over 90. This is an outcome measure. The data sources are claims, electronic health records, payer medical records, and then, other.

Twenty-five states reported the measure in FY 2017. This measure aligns with a number of programs, including QRSP, QRS health home core set. It was also on the duals family of measures.

A little history about the measure: MAP supported the continued use of the measure, noting no significant implementation issues.

Judy is the lead discussant, and I'll turn it over to Richard.

CHAIR ANTONELLI: Yes. Thank you.

So, Judy?

MEMBER ZERZAN: Yes. I'll start with I don't feel as strongly about this as I do for other measures. But, that being said, this is a super-tough measure, and clinicians hate it because it's the most recent measure of blood pressure. And so depending on when you go, it doesn't reflect the average control. Often people with hypertension have lower blood pressure measures at home. And so, again, it doesn't capture that quite as well.

Also, the targets for blood pressure control have been moving around a lot without a lot of great evidence about tighter control versus what else you get. So this one, I just feel meh about. I don't think it's worth the sort of strong elevating of the Scorecard. I'm fine with it on the core set. I mean, it's not a terrible measure. But, like other measures, it's just not great. Meh.

CHAIR ANTONELLI: You've gotten so

mellow since you moved to the West Coast.

(Laughter.)

I actually do have a question about this. And then, actually, I thought I saw your card up, David. Did I talk you into lowering your card? Okay.

So I have a question. And just to make this declaration, I'm not raising this issue because I'm the Co-Chair, but, in fact, being a provider inside a standalone children's hospital that takes care of a lot of patients with congenital heart disease.

So the likelihood, if you're still followed at Boston Children's Hospital and are 18 to 25, that you've got garden-variety hypertension is close to zero. And, in fact, many of those patients, we would love for them to so-called transition into the adult world, and it doesn't happen.

And when I read the specifications, that's not on this exclusion list. And in Massachusetts, this is one of the things about

being a standalone tertiary/quaternary pediatric center that gives us agita, is there could be financial implications for this.

So I don't know, Sally, if you would add any color to that, but I just want to put that out there. Because, for those of us that take care of congenital heart disease, this is just really, really a scary measure.

So you don't have to add anything, but if CHA would like to put something on the table from Children's Hospital perspective? And if not, if I represented it, I'm good.

MEMBER TURBYVILLE: I think for this kind of measure we would defer to the clinical expertise of those caring for the patients. It is 18 to 85, but, as many of you may know, children's hospitals do often care for young adults into their early twenties and sometimes beyond, depending on how complex their condition is.

CHAIR ANTONELLI: Okay. So discussion is open. Dr. Kelley, then Lindsay.

MEMBER KELLEY: So I will start by saying that I think this should remain on the list. I think that we're looking really at a dashboard for a state Medicaid program and not at an ACO level. So your population is complex and different, but probably a tiny minutiae of the denominator, but very important. And that needs to be always considered.

When we look at high blood pressure, clinically, there are more than a few good medications that can be used. So there are therapeutic tools, even beyond medication, that can be used to control high blood pressure.

And I think it's important because the incidence and prevalence in the Medicaid population is very high. Here we are actually asking for blood pressure control, not just, oh, I took somebody's blood pressure. I do agree that maybe it's not fair, especially to look at high blood pressure at the end of the year, especially around the holidays if one goes into their physician -- I don't know -- between

Thanksgiving and Christmas.

But, from my standpoint, it's a very useful measure. We had held our health plans accountable. It does require chart audit. That's part of our pay for performance. And we have been able to move the needle. There's still a huge gap, though. I think our latest results, we were at, I think, 63 percent had their blood pressure controlled. So there's still a huge gap and a huge opportunity for improvement.

So high incidence, prevalence. The clinicians in the room know the kind of longer-term consequences of poor blood pressure control. And there's a huge ability to close an improvement gap in that larger denominator population.

CHAIR ANTONELLI: Lindsay, then Josh.

MEMBER COGAN: David, you hit most of what I was going to say. I will just sort of echo that this is a prevalent issue, and I would argue that not just diagnosed hypertension, but undiagnosed hypertension. When I hear from my

colleagues in chronic disease control, I think of the tip of the iceberg.

So although we're only measuring the tip of that iceberg, there's a huge population of undiagnosed hypertension out there. So I really would strongly advocate to keep this measure. It is one of the few outcome-based measures that we have. Like David said, we've worked so long, so hard on process, but our outcomes have not improved at the same pace. So it just feels like against where we want to move to remove an outcome measure.

I don't think that the structural issues with the measure rise to the occasion that I worry about, again, the applicability of this measure for an accountability level. So in some of the other measures, some of the structural changes that come up rise to that higher level of it raises those red flags for accountability. This one, while it has warts -- all quality measures have warts -- I don't think it rises to that level of I, then, now worry about its

applicability in the big A, accountability, arena. But, again, that's coming from a state perspective, not individual provider accountability.

CHAIR ANTONELLI: Josh?

MEMBER ROMNEY: I agree, every measure can be fine-tuned. We've actually been engaged with NCQA in the past week on this measure, and the fact we don't like, if I break my arm and go to urgent care, my blood pressure counts, but if I go to the emergency room, it doesn't.

But the fact of the matter is that hypertension is probably the most important risk factor for atherosclerotic cardiovascular disease and is a major, if not the No. 1, driver in healthcare costs. So it's important to address.

The other important thing to remember is that this is a quality measure in both the Stars and ACO programs, and it's valuable for Medicaid and CHIP to be aligned with those other CMS programs.

MEMBER ZERZAN: For the record,

Washington took it off of our payment because we had such low numbers on both our employer state retirees that qualified for the denominator of the measure and the Medicaid population was just super-low.

CHAIR ANTONELLI: Sally? Then, Shayna.

MEMBER TURBYVILLE: I just want to add an encouragement, and this applies to this measure and probably others. As very complex and chronically-ill children do live longer into adulthood, it warrants thinking about measures like this or others that perhaps before would not have required exclusions, but we're coming to a point in successfully moving children who previously would have died to adulthood. So just something as a note, and something that I think the Children's Hospital Association will continue to look at, along with our clinicians.

MEMBER DAHAN: I just have a question. So this would only look at the charts of people who they put in an ICD-10 for hypertension. So

if that patient never had an ICD-10 for hypertension, the people with high blood pressures within the chart won't be looked at? So an isolated high blood pressure wouldn't affect this measure. It would just be they'll be like flagged if they had a diagnosis in it? Yes?

CHAIR ANTONELLI: So it looks like everybody's blood sugar is bottoming out.

(Laughter.)

Does anybody want to make a motion about 0018? And remember the motion is to remove it from the Scorecard. The null is that it stays in.

Any hands, Jordan, from the Committee? No? Okay.

So we are done with the process of identifying and motioning for measures.

I think we will open this up momentarily for public comment. But if we could summarize? Whether that would be Miranda, Shaconna, if you guys could let us know what the measures that will be under consideration for the

voting process? We don't have to go into details about the voting process, but I think we'll open it up for public comment after we get the summary of the measures. Okay?

MS. KUWAHARA: Sure. So today we will be voting on three measures for removal from the MAC Scorecard 1.0.

The first is NQF No. 1517, Prenatal and Postpartum Care.

The next is Use of Multiple Concurrent Anti-Psychotics, Ages 1 through 17.

And the third is 2940, Use of Opioids at High Dosage in Persons without Cancer.

So we'll now take any comments from the public in the room first.

Okay, and I will open up the lines now.

MS. TUFTE: Hello. Can you hear me?

CHAIR ANTONELLI: Yes.

MS. KUWAHARA: Yes.

MS. TUFTE: Hi. This is Janice Tufte, and I just would like to thank you for this

continuing this. I'm sorry I'm not there today, and I was hoping to be part of the MAC Scorecard.

So regarding the 1517, I mentioned last time I do hope we are able to have some other perinatal measure that will be able to be in exchange for this, something with some outcomes or something. I don't know. I think it's very important.

And I just want to add, on the hypertension, I'm glad that this is possibly for removal because I think there's a lot of controversy with the 130 over 80. And I believe it's a possibility that people are not documenting it; you know, physicians or clinicians are not documenting that because of how they get docked, you know, for not being able to lower the blood pressure.

So I appreciate everything you're doing. Thank you. I'm sorry I'm not there.

MS. KUWAHARA: Great. Thank you, Janice.

MS. TUFTE: Thank you.

MS. KUWAHARA: Are there any other members of the public who would like to offer comments?

Okay. I'll turn it back over to Shaconna.

MS. GORHAM: So if you all can bear with us for just one minute, we're going to vote before we go to break.

So just as a reminder of your decision categories, each decision that you make, you either will support the measure or you will support it conditionally.

So for this, because we just discussed measure removals from the Scorecard, you are supporting the removal of the measure from the Scorecard. Each vote that you take will be accompanied with a rationale. So we want to make sure that we are very clear about why we're recommending removal from the Scorecard to CMS, and we want to make sure that we document that in the report.

So, again, you have support. You

might have support with a condition, and greater than or equal to 60 percent of the Committee will have to vote in order for the vote to be approved.

Amy has a question.

MEMBER HOUTROW: When I would vote support, that would mean I am voting support of removal?

CHAIR ANTONELLI: Yes.

MEMBER HOUTROW: How could there be a support with conditions for removal?

MS. MUKHERJEE: Yes. So that would have been one of the measures that we had a rich discussion about, but didn't sort of decide to vote on removal. If we had moved forward, you could have said that, okay, I'm voting on this for removal with the caveat that you want another measure substituted in its iterations down the road. We have done that before on the core set side, which is why I think it's coming up now. But it's not an up-and-down, and it's to keep sort of consistent voting on both sides. Because

even when you vote for addition, you can say, based on these conditions.

CHAIR PINCUS: Just I think that we do need to clarify because the notion that when we were discussing, for example, the first one, yes, the question was having kind of a measure that would be a stand-in for something that could be better. So it's unclear. If that's what you want, do you vote for support, do you vote to support with conditions or do you vote for do not support? We need some clarity about the nature of that.

MEMBER HOUTROW: And further, if we really had those three categories, we should be doing the vote on all of the measures we just talked about. And I might have changed my decision to not raise my hand on a measure to put it to a vote for possible removal if I had known we were going to have these caveat options.

MS. GORHAM: All right. So let's make it simple because I just introduced some confusion. Because the decision categories --

and you'll see this when we bring up our voting slides -- the decision categories for support, support with conditions, and do not support are for the addition side. We're talking about removals now.

And so the way that it is phrased on our voting slide is: removal from the MAC Scorecard or retain on the MAC Scorecard. That is what you will see as voting decisions. So those are your two options.

I apologize. Strike what I just said. This is for the addition side. And you will have two options: to either retain or remove.

CHAIR PINCUS: In either case, there would be a summary of the discussion that preceded the voting.

MS. GORHAM: Yes.

CHAIR ANTONELLI: And for the sake of managing the discussion, sort of stick with that first one, where the notion of placeholder with suggestions for coming next. Do we need to recount those or does staff have them

sufficiently, so that if the vote is to retain, for example, those will find their way into the meeting summary? Okay. So that will be that we don't have to repeat all of those.

So vote to retain, we'll have the discussion already around the reason for retaining, but not quite being the optimal measure. And if you don't feel that your point was sufficiently heard, please bring that up, especially if we're voting to retain. Okay?

What I'm saying, using the first measure that we're about to discuss, if you vote to retain, but feel strongly that something else needs to happen as a caveat, if it's been brought up, that's already in the record. Okay? If you think of something new, bring it up, but, otherwise, we are sure that those caveats that make something a placeholder will find their way into the record already. Okay.

MS. GORHAM: I was taking a pulse on the faces in the room. So we're all on the same page. Okay.

So with that, I will hand it over to Rich, who will help us through the voting process. But Jordan will also help to lead us through the slides.

So you want to pay attention to the screens in the back of the room.

MR. HIRSCH: So we are currently voting on NQF No. 1517, Prenatal and Postpartum Care. Option 1, to remove from the MAC Scorecard, or, Option 2, retain on the MAC Scorecard.

MS. KUWAHARA: So an email went out this morning with a link to poll everywhere. You will be prompted to provide a screen name before voting. And then, once you enter that information, you'll be brought to this voting option. It came from the MAC Scorecard inbox.

So we have 30 voting members with us in the room today and online. Our magic number is 23 to achieve a quorum.

CHAIR ANTONELLI: So just a show of hands, does everybody have what they need in

order to vote?

Okay. Is there anyone in the room or on the phone that doesn't have what they need to vote?

MR. HIRSCH: All right. With all 30 members having voted, 23 members have voted to retain 1517, Prenatal/Postpartum Care, on the MAC Scorecard; 7 members have voted to remove. This amounts to a 77-percent retain score and a 23-percent remove score of 1517.

MEMBER HOUTROW: I'm sorry to interrupt. What is the percentage threshold by which something is removed? Is it 50 percent, 60 percent? Sixty-six? Thank you.

MR. HIRSCH: Because the measure is over the 60-percent threshold, this measure of 1517, Prenatal and Postpartum Care, will remain on the MAC Scorecard. The Committee is recommending to retain on the MAC Scorecard.

CHAIR ANTONELLI: Mic, please.

MEMBER SAKALA: It was about the additions to the qualifications. I just wanted

to ask to be put in the record that the magnitude of what I think is error is so large, we're coming up with this measure of 40-some percent not having a postpartum visit, when studies that ask women consistently get in the range of 10 percent.

So I voted to keep it because I think it's purely symbolic. But it's a real problem and I think that that should go in the record.

Thank you.

CHAIR ANTONELLI: Thank you, Carol.

I think there were many caveats about this, and I think all -- I don't think there was anybody in the room that didn't think that serving as a placeholder is for, what my granddaughter would say, a more better measure -- -- and hopefully, that is imminently coming. Thank you.

All right. Next?

MR. HIRSCH: All right. Now the Committee is asked to vote on Use of Multiple Concurrent Anti-Psychotics, Ages 1 to 17.

With all Committee members having voted, 29 Committee members have voted to remove from the MAC Scorecard the Use of Multiple Concurrent Anti-Psychotics, Ages 1 to 17, and 1 Committee member has voted to retain on the MAC Scorecard. Percentagewise, this comes out to 97 percent of the Committee has voted to remove Use of Multiple Concurrent Anti-Psychotics, Ages 1 to 17, from the MAC Scorecard; 3 percent of the Committee has voted to retain. Therefore, the Committee has voted to remove from the Scorecard. Recommend removal from the Scorecard.

You'll now be voting on NQF No. 2940, Use of Opioids at High Dosage in Persons without Cancer. No. 1, to remove from the MAC Scorecard, and, No. 2, to retain on the MAC Scorecard.

All right. With all Committee members having voted on 2940, Use of Opioids at High Dosage in Persons without Cancer, 11 Committee members have voted to remove from the MAC Scorecard, and 19 members have voted to retain on the MAC Scorecard. Sixty-three percent of

members have voted to retain on the MAC Scorecard. Therefore, this passes the 60-percent threshold, and the Committee has voted to recommend retaining 2940, Use of Opioids in High Dosage in Persons without Cancer, on the Scorecard.

CHAIR ANTONELLI: Use your mic, please.

MEMBER ROMNEY: I think you should only have to carry 60 percent. You should only have to clear 60 percent to carry the motion to remove, correct? Fifty-two percent would still retain.

MR. HIRSCH: Okay. Thank you.

MEMBER ROMNEY: The motion is to remove the measure. You have to have more than 60-percent people vote to remove the measure for the motion to carry. That's what we're looking for.

MEMBER HOUTROW: Are you recommending that the way that we phrase it is that we do it by that instead of how it was just phrased?

Okay. So it was just phrased that 63 percent voted to retain, above the 60-percent threshold, but, really, it's 37 percent voted to remove, which does not meet the 60-percent threshold. Is that accurate?

MEMBER ROMNEY: That is correct, yes.

CHAIR ANTONELLI: The outcome is the same. The description to get there is different. It's the mirror image.

MEMBER ROMNEY: That's not my recommendation. I'm not recommending that we change the rules.

CHAIR ANTONELLI: Right.

MEMBER ROMNEY: I'm clarifying that I think that's what the rules really are.

CHAIR ANTONELLI: Yes. Yes.

MEMBER HOUTROW: I think, given that that's what the rules are, we should say it in the way the rules are.

CHAIR ANTONELLI: The outcome is the same.

Good job.

Okay. Time for a break. Fifteen minutes? Fifteen minutes.

Thank you.

And then, the next phase is to vote for potential additions to the Scorecard.

(Whereupon, the above-entitled matter went off the record at 2:31 p.m. and resumed at 2:49 p.m.)

CHAIR ANTONELLI: Welcome back, everybody.

Now we get to transition from removal to consideration for addition.

MS. GORHAM: So I'll go through the next set of slides rather quickly because we have reviewed this next slide -- we can go to the next slide -- before.

And this is definitely just the process that we reviewed earlier. Recommendations will be gathered by the measure selection criteria as well as feedback from state implementers. We have many at the table.

And then, we look at the algorithm to

go through those measures to see how they applied as far as feasibility and usability to the measures.

So we'll skip past that slide and go to the next slide.

And in order for measures to be added to the Scorecard, all measures, at a minimum, will satisfy the State Health systems' Performance Pillar and Domains, and that is Pillar 1: be publicly reported, reported by at least 25 or more states, and fill a gap on the Scorecard.

Next.

The measure recommendations represent measures in three of the six domains. Please note that the recommended measures can and do fall in multiple domains. The domains are listed on the next slide with the measure recommendations.

And we can move to the next slide.

So those are the first three measures to be recommended for addition. And the next

slide shows the last three.

But, as we did before, we will go through each measure, discuss individually. I will give you some brief measure specifications as well as some history with this group. And then, we will turn to the lead discussant, in which we'll facilitate discussion.

So the first measure to be considered is Adherence to Anti-Psychotic Medications for Individuals with Schizophrenia. The adult core set includes this NCQA version of the measure which is adapted from the CMS measure that is NQF-endorsed. The NCQA measure that is currently on the core set is not endorsed.

The description for this measure is: the percentage of beneficiaries age 19 to 64 with schizophrenia who were dispensed or remained on an anti-psychotic medication for at least 80 percent of their treatment period during the measurement year. It is administrative data. Thirty-two states reported the measure in 2017, and it is aligned with the Medicare Shared

Savings Program, the Physician Value-Based Payment Modifier, Physician Feedback Program and Quality Resource Use Report.

A little history on the measure: there was some discussion during the 2014 review of this measure. The measure requires medical record review and/or data linkage. As a result, it is burdensome for states and others to report. MAP recommends the steward consider refining this measure to simplify the data collection methodology. That was the discussion in 2014.

Mary Applegate is the lead discussant, and I know that we have Mark standing in for Mary.

So I'll turn it over to Rich.

CHAIR ANTONELLI: Okay. So, Mark, are you prepared to fill Dr. Applegate's huge shoes?

MEMBER RIZZUTTI: Yes.

CHAIR ANTONELLI: No pressure.

MEMBER RIZZUTTI: I have some comments from Dr. Applegate supporting additional measure to the Scorecard.

Non-adherence is a major problem in treatment for schizophrenia. So non-adherence is a major problem, and it's linked to poor clinical outcomes for schizophrenics, increased hospitalizations, and ED visits; non-compliance with outpatient psychosocial treatment, violent behavior, higher risk for alcohol and other drug abuse dependence, increased cognitive and functional impairment.

The measure targets very high-risk individuals. Non-adherence is a cost driver.

Evidence-based studies have shown that adherence is closely tied to improvement at school, work performance, symptom alleviation, and prevention of relapse, and strongly linked to improved outcomes, mental health as well as general physical health outcomes.

There are some negative side effects. Those are outweighed by the benefit of long-term adherence, maintenance of pharmacological treatment. Specifically for schizophrenia, adherence to medications is singularly the most

important optimizing outcomes. It's a critical program objective for state Medicaid populations.

Due to the prevalence of behavioral health mental illnesses in the Medicaid population, the Scorecard should include another behavioral health measure for the adult population.

CHAIR PINCUS: I was just going to say, just looking at this slide in front of us, the denominator just says the eligible population. How is the denominator actually defined?

MEMBER COGAN: We should probably have NCQA speak to that because it is a little bit more complicated, or there's probably just something we didn't add in here. But maybe have NCQA address that? This is their measure, right? Yes.

CHAIR ANTONELLI: If you could just constrain to your comments to explaining the measure, and then, we'll come back to you after some discussion. Okay?

MS. BYRON: Yes. My colleague, Junqing Liu, should be on the line. She's the expert in this particular measure. She raised her hand. Can you see her?

MS. LIU: Hi. This is Junqing Liu of NCQA. Could you hear me?

CHAIR ANTONELLI: Yes.

MS. LIU: Great.

So the question about what the definition is for the denominator of this measure, the denominator for this measure is patients who have a diagnosis of schizophrenia and who are prescribed anti-psychotic medication.

CHAIR PINCUS: Does it require a single prescription?

MS. LIU: There are two. They need to have two prescription events to confirm that you are on this medication for schizophrenia.

CHAIR PINCUS: Okay. Thank you.

MS. LIU: Sure.

CHAIR ANTONELLI: So we are open for discussion. Lindsay?

MEMBER COGAN: This is one of those measures that hits a high-cost, high-need population. A lot of research we've done that's focused around adherence to this measure has led to the decrease of hospitalizations, the decrease of ER utilization, and high-cost hospitalizations for things not necessarily related just to schizophrenia, either. We've found a lot of association between those who maintained adherence and less hospitalizations for their diabetes. And so it is a high-value measure that addresses a very high-cost, high-need population across many of our Medicaid programs.

CHAIR ANTONELLI: I, then, had Ken, Jill, and then, Harold.

MEMBER SCHELLHASE: I agree that this is a high-cost, high-need population. This is more of a question, just looking at the balance of Scorecards, that we try to represent an entire plan at a state level. Is this a large enough population that we want to have some real estate taken up on the Scorecard to account for that?

I'm truly asking the question.

CHAIR ANTONELLI: Kim, and then, Harold.

MEMBER ELLIOTT: I agree, but, also, because it impacts so many other aspects of care for these individuals, that I think it's a really good thing to be monitoring and reporting on.

CHAIR ANTONELLI: Okay. Harold, Lisa.

CHAIR PINCUS: So I basically agree with this, that it's a very cost-high, tiny population that is a chronic population. And there are many different choices one could make about what's the best thing to measure for this population. But it seems to me this thing is probably, if we had to choose one measure, this probably makes the most sense because I agree with Lindsay that it cuts across.

It's not a perfect measure, you know, because it's not clear what is the optimal percentage that you would want to have that that has 80-percent PDC, but that it's a way of just really tracking that these people don't fall

through the cracks. I think that's really the core in terms of my support of it.

CHAIR ANTONELLI: Lisa?

MEMBER PATTON: Yes, I like this measure for the reasons everyone is describing, the number of areas it hits. But, in terms of the real estate available to us for behavioral health measures, I know a bit later we're going to be discussing antidepressant med management. And so I don't know whether kind of the overall picture of what we get on here, you know, we want to take that into consideration as well, as the discussion moves forward.

CHAIR ANTONELLI: I have David, Clarke -- excuse me -- David, Jill, Clarke, Dave.

MEMBER MORROW-GORTON: From my experience working in a long-term services and supports area, which sounds like how is that related to behavioral health, this population is a huge user of LTSS services. I think this measure is not just do they adhere to their medication, but what are all of those service

systems around them doing in terms of coordination and being able to help them adhere to that?

As well, I think, you know, there's not a lot else to offer, unlike depression where there's behavioral cognitive therapy, all that kind of stuff, for schizophrenia it's medication. So I think that this is a high-need, high Medicaid population, and I think this is a valuable measure.

MEMBER KELLEY: So in Pennsylvania, I think we're at -- our adherence rate for this measure is at 69 percent with huge plan variation between 58 percent and 77 percent. We are a carve out state. So we have physical health and behavioral health plans. This is actually a measure that we use where we measure both sets of plans. It's a combined incentive program. It's something that the plans are very focused on. We have our Patient-Centered Medical Home Program focused on this population as well.

I think we have over 140,000 -- and we

have about a million adults -- we've got 140,000, I believe, that have the diagnosis. And in LTSS, I think we're around 60,000 individuals. So this is a high cost, but it's also a fairly highly frequent -- the incidence and the prevalence within our Medicaid population is fairly high. And so these are really individuals we want our managed care plans to be very focused on. As a State, this is something we should really be paying attention to.

So it's not a perfect measure, but I would advocate that this be added to the dashboard.

CHAIR ANTONELLI: Clarke?

MEMBER ROSS: So this morning Amy asked how do we balance -- she didn't use balance, because Harold answered with balance -- the generic population versus special needs populations. Fifteen years ago, the World Health Organization published a report on the most disabling conditions in the world, and schizophrenia was No. 1 as the most disabling

condition.

The average cost in a state mental health system that serves a person with schizophrenia is something like $120,000 a year. As I said this morning, there are no LTSS/HCBS measures in the Scorecard, and someone in the opiate discussion used the word back-door. Not a great measure, but a back-door way.

So I would argue that this is a back-door way to get to LTSS/HCBS, and that this is the most disabling and maybe the most expensive population we face, paid for by Medicaid.

CHAIR ANTONELLI: Thank you.

So I've got Dave, and then, I'm over to Marissa and Sally.

MEMBER EINZIG: So I agree with the process on the surface also. I think it's wonderful. But I'm curious, so we would be voting on something that did not go through the NQF evaluation process, whether it was -- because it's not endorsed by NQF. So I'm just curious if

it went through a rigorous process besides the NQF process. Do you want to answer?

MS. BYRON: So the measure that is in HEDIS is aligned to the CMS measure. And the CMS measure is NQF-endorsed. So it's just we took that measure and, then, put it into HEDIS, but I think that, of course, that uses the specs that HEDIS specified.

CHAIR PINCUS: Just to clarify, this is an NQF-endorsed measure?

MS. GORHAM: No, it's not.

CHAIR PINCUS: Oh, it's not?

MS. GORHAM: No.

CHAIR PINCUS: It's not.

MS. GORHAM: The measure that is in the core set is not NQF-endorsed. I'm trying to chat with Renee to see if this measure was on the core set before we even started to deliberate on the core set measures.

But as Sepheen said, this measure is aligned with the CMS measure, 1879, which is NQF-endorsed.

I will say -- and Karen definitely correct me if I'm wrong -- I know for the core set the measures do not have to be NQF-endorsed in order to be on the core set. That is not a requirement, CMS's requirement. They do take our input, but it is not a requirement that measures are NQF-endorsed. So I'm assuming that is the same for the Scorecard.

CHAIR ANTONELLI: Does the word aligned mean the same thing as identical?

(Laughter.)

MEMBER COGAN: So the CMS measure that is endorsed talks about eligible population, enrollees in Medicare Part whatever. So you can't translate the endorsed measure right now to populations outside of Medicare the way it's written. So those are the changes that I believe were made in adapting this measure to capture other populations outside of just a Medicare-only population.

CHAIR ANTONELLI: Did you want to weigh-in on something, Karen?

MS. LLANOS: I just wanted to emphasize what Shaconna said. So the reason why in the initial developments of the core set you'll see some measures that are not NQF-endorsed is because exactly what Lindsay said. We understand that there is a dearth of measures specific for Medicaid and CHIP populations, and the endorsement process as well as the measurement development process is catching up and we did not want to exclude any measures because of whether or not they had an endorsed status. That's the process for the core set. And because we're using the core set as the feeder to this, the same would hold true.

CHAIR ANTONELLI: Okay. So I have Marissa, Sally, Enrique.

MS. RANEY: Shaconna, this is Gigi. I just want to let you know about the timeline for this measure on the core set, if you are still interested.

CHAIR ANTONELLI: Yes, we would be interested, Gigi.

MS. RANEY: Okay. The use of multiple concurrent anti-psychotics in children was added to the child's core set in 2016. So it's been on there for a few years now. I do believe that we were already working with NQF at that time.

MS. GORHAM: So, Gigi, we're looking at Adherence to Anti-Psychotic Medications for Individuals with Schizophrenia.

MS. RANEY: Oh, I'm sorry, wrong one. Thank you. Let me get to that.

That measure has been on the core set, the adult core set, since the beginning. So when it first started in 2013. So pre-NQF network.

CHAIR ANTONELLI: Marissa? Then Sally, then Enrique.

MEMBER SCHLAIFER: My comment is general and not specific to this measure, but I think it's important that we keep it in mind across all the discussions for addition.

As we talk about it around the table, I hear people say, you know, this may not be perfect, but we need to make sure we measure in

this area. And I know I said this earlier, but I think it's really important when we talk about additions that we keep in mind that all of these are on the Scorecard. They're all being measured.

CHAIR ANTONELLI: Core set.

MEMBER SCHLAIFER: So it's core set. Core set. Sorry. Thank you.

The core set, they're all -- so we have already acknowledged that these are very important things and that there's only 20-some measures in the core set. We've given them the real estate. We know they're important. We know they need to be measured. The question today is not should they be measured, are they good enough to be measured; it's, should they be elevated from the core set to the Scorecard? And I think that's a very different question. I think we just need to keep that in mind. Because we have already acknowledged these are important; they need to be measured. We want to make sure states measure them. That's not the question today.

CHAIR ANTONELLI: Sally?

MEMBER TURBYVILLE: In listening to the discussions -- and I'm not advocating in my comments whether this measure should or should not be added to the core set -- but it strikes me that it is a particular population with a specific condition and what the criteria are for it to rise to the Scorecard. There are other populations like sickle cell anemia that get absolute abysmal quality of care delivered to them that is lifesaving, not that this isn't lifesaving, that get a lot less traction.

And the reason why that is important is not to push one out and one the other. It is, especially in pediatrics where we do have smaller and smaller numbers for even sometimes very high-cost conditions, I think it would be helpful to formulate a little bit further the criteria, not for the core set, but what rises, what helps rise a measure that is so narrowly-focused to be on the Scorecard. So that we can have a better understanding of how to balance things, I mean,

how to support CMS in those efforts.

Is it the aggregate economic cost and severity of the condition for Medicaid that helps? Is it X, Y, and Z? And I'm sure there's no right answer, and it doesn't have to be so specific that it kicks things out immediately, but some criteria to help with that, at least for me. I'm having a hard time thinking through whether I should or should not support this measure, not because I don't think it's an important quality issue, but how does it fit in the Scorecard, given its narrower scope, so to say?

CHAIR ANTONELLI: Enrique. And then, Marissa, are you -- okay. Enrique?

MEMBER MARTINEZ-VIDAL: Again, not speaking for or against the inclusion of this or the addition of this, but our plans are always really concerned about being held accountable for services that are carved out from their ability to either impact them or, also, the data measurement. So when, Dave, you brought that up,

it just made me wonder your experience with both the health plan, if that's who's being measured on these -- I mean, this is at the state level, but it's coming up from the plans -- their ability to either impact the actual services or the requirements of the measure, as well as sort of the actual sort of implementation, the operational aspects of the data, the measure itself, in collecting the data.

MEMBER KELLEY: So in our carve out -- and I'll be very brief -- we make both physical health and behavioral health plans accountable for this measure. The behavioral health plans do not pay for the meds, but twice a month they're given a pharmacy data run, so they know who's on what and who's adherent, or at least getting a prescription filled. So we actually hold them both accountable for this particular measure.

And I'll go back. You know, what should elevate something, a measure to the Scorecard? Again, I shared our prevalence of this disease. It's a very, very disabling

disease. And I will tell you, these individuals are very costly. So even though it's one diagnosis, the numbers of individuals living with schizophrenia are very large in the Medicaid population, both the Medicaid and LTSS populations, and they are very, very costly. So in my mind, that's why it's already on our Pennsylvania Scorecard list and why I would recommend we add it.

CHAIR ANTONELLI: Enrique, are you done?

MEMBER MARTINEZ-VIDAL: Yes. Thank you.

CHAIR ANTONELLI: Jill?

MEMBER MORROW-GORTON: I just wanted to add a quick thought about Scorecard. I think that sometimes you want to say, oh, well, the Scorecard should have just the good measures, or whatever. I think the Scorecard should be a way that a state can look at the various aspects of what the Medicaid and the CHIP programs provide as sort of those hallmark things to identify your

performance.

Does that mean you need six well-child measures? I think not. But I do think it means that you need to reflect the different populations of people served by the Medicaid programs, partly because it's very different from the commercial world and it's very different from Medicare. And that's sort of how I think about a Scorecard.

CHAIR ANTONELLI: So is that a generic use of the term scorecard or the specific capital S Scorecard under discussion here?

MEMBER MORROW-GORTON: I think both.

CHAIR ANTONELLI: So I'm going to probe on that a little bit. Are you suggesting some process of generic scorecard at the state level have some way of finding its way to this capital S Scorecard?

MEMBER MORROW-GORTON: So I hadn't thought about it that way. I mean, when I think about our scorecards at the state level, our scorecard at the state level is to tell the

providers how they are doing on the measures that we have chosen as important. For LTSS, we have four. I mean, parsimony to the nth degree.

CHAIR ANTONELLI: Right, right.

MEMBER MORROW-GORTON: Because we had to start somewhere.

And I almost see this as a parallel process that -- and not to tell CMS what to do -- but that CMS's role in kind of feeding back to the states quality is to kind of give them a more rounded picture of their performance, rather than sort of very specific ones. And part of what that has to be is to look at the various populations that are involved.

CHAIR ANTONELLI: Okay. Thank you.

Does anybody want to make a motion?

CHAIR PINCUS: Yes, I would. Am I allowed?

CHAIR ANTONELLI: Yes. Yes, Harold, you are allowed to make a motion.

CHAIR PINCUS: Yes, I would make a motion to add this to the core set.

Okay. Next measure.

So with the hope of having an outcome of more time efficiency, we, the NQF staff, would like to propose that the motion at this junction not be a motion up or down, but if there is a motion up, which is what we heard, to think about it with conditions, so conditional support or support. We're not going to vote, but we want to tee it up, so that by the time the question gets to the vote, it's very, very clear.

So how would you guys like to frame that, so that when we get the voting protocol up, it's pretty clear to everybody?

MS. GORHAM: So when you're voting for an addition or recommendation for addition to the Scorecard, it would be a binary vote. So you're either saying support for a recommendation of addition or do not support, or you're saying we are supporting with a condition, and what that condition is, or do not support.

So right now, when we take the motion, we're asking that the person motioning, and

whoever is seconding, we want to say -- Harold would say, for example, I'm motioning for full support of addition. Or he might say, I'm motioning for support with a condition of X, Y, and Z. And then, that will be your second of that motion.

CHAIR PINCUS: In this case, I'm motioning for supporting it without condition.

CHAIR ANTONELLI: Okay.

MEMBER HOUTROW: Isn't, technically, the motion just moving us to the place where we have a vote? Okay. So why would we have to make a motion for one of the three options? Because what we're making a motion for is to move this forward for consideration for inclusion to be voted on. And then, within that vote, you're saying there's three options. There's inclusion, inclusion with conditions, and do not recommend inclusion, right?

MS. GORHAM: But it is a binary vote. So we want to make it clear of what you're voting on. So you're either voting for support or a

conditional support. And so we want it so that it's clear now while you all are still discussing and the discussion is fresh in your mind. Make that distinction now versus later on in the day.

MEMBER SCHLAIFER: I think it helps just to add -- we've often used we would support it if it was NQF0-endorsed and if the measure developer goes back. So I think, then, I would nominate it with that condition. So you could say, I really like it, but it's not NQF-endorsed. I'm not willing to support it.

MEMBER HOUTROW: The problem here is that, if I think I like it to be supported as is, I could make that motion. But, then, that doesn't allow your motion for it to be conditionally supported to go forward because you're now setting us up on a decision tree ahead of the time when we would need to do that.

CHAIR PINCUS: Okay. I'm getting a note. If you're going to talk, you need to have the mic on.

MEMBER ROSS: I just want to ask, if

anyone is going to consider voting for a condition, that in the motion it would be clear what the condition is.

CHAIR ANTONELLI: Yes. In fact, that's what I was going to say. The reason the staff made this suggestion -- and that's what we're trying to do, is to hear your preference -- is that, as proximate in time to the discussion of the merits of the measure, people can consider what those motions would be. Because, remember, anything that gets the motion, gets seconded, is going to wind up getting voted on later on. And so the suggestion was, as time proximate as possible to the conversation that is linked to that given measure, the more in-depth people may feel going with the conditions.

MEMBER HOUTROW: So the concern that I have is that I think, by setting us up for a binary vote, then, really, we might have to have two separate motions, one motion that is I fully support it and want to vote up or down, or I conditionally support and I want to vote

conditionally support or down, which means, then, we're going to have two separate votes. And is that really what we're intending?

MEMBER ROMNEY: Shaconna, I think a clarification is --

CHAIR ANTONELLI: Okay. So what we would like to do -- and again, this is to try to be time-efficient and to have the deep conversation as proximate as possible to the time you're making the motions -- then, we will proceed as we solicit the motion on these measures for addition to the Scorecard. People can weigh-in with what they would have as conditions and we'll include that in the time of the discussion with the measure. Okay?

I think that it's safe to say, although I will ask just because we've retro'ed this, but Harold made a motion that's been seconded. So as far as I'm concerned, this one is going through, period. But, just out of interest, is there anybody that said, if I had known that before, I would have suggested a

motion or a condition -- excuse me -- I would have suggested a condition?

Sally?

MEMBER TURBYVILLE: I really don't want to make the process trickier. But I think there was a distinction in voting with a caveat to recommend versus just including some of the considerations, right? I would only agree to recommend it if the measure developer or CMS do X, Y, and Z.

So I thought, initially, NQF's proposal was, right now, we could open it back up and see if there's a motion to support with condition, and my condition is XY, and look for a second. And then, what Amy said, then, later on, there would be a vote for full support, as Harold and someone else motioned. And then, if that didn't get its 60 percent -- because if you believe in the caveats, you should vote no on the full support, and then, you wait for the next round. Am I getting it correct?

CHAIR ANTONELLI: Yes. Yes, there's

no absolute truth here. I think we're just trying to formulate a process to get us there.

MEMBER TURBYVILLE: Yes.

CHAIR ANTONELLI: Right? Yes?

MEMBER HOUTROW: So I'm worried that there is a process of adherence that we need, that there is some absolute truth to this.

So this issue of how many conditions we can place on it, and how they get voted on, I think matters. Because if I were conditionally thinking about a measure, and I said, oh, yeah, I like this measure. I think it should be included with these conditions, I might later on still vote for full inclusion because of how much I thought it was a good idea.

And so I'm worried that the series in which we take these votes makes a difference, and how we gather the conditions and how many conditions we're going to allow, all are going to influence the outcome and the number of votes we have to take.

CHAIR ANTONELLI: I think owe fidelity

to the process to try it, right? So the first one is almost a moot point, unless somebody says, okay, I would have proposed a condition. And then, we would talk about that.

But I think going forward for the subsequent measures, maybe it would go like this: is there a motion on the floor, yes/no? And if the answer is yes, then we could take a follow-up and say, are there any conditions? And that would rise organically from the conversation.

So my observation, my suggestion that there is no absolute truth is predicated on the content of the outcome. I'm actually trying to have as relatively meticulous, rigorous, robust approach to the process that gets us to whatever that outcome is.

So I think are we okay, Shaconna, with that? We're okay with that? Okay.

So if people don't feel strongly about revisiting the first one, the first measure has gone through with a motion and seconded.

So now, we're ready to go on to the

next measure, please. 0105.

MS. GORHAM: All right. Measure 0105, Antidepressant Medication Management. The description of this measure: the percentage of members 18 years of age or older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment. Two rates are reported, and I won't read all of that because you have it in front of you.

But the measure type is a process, and data source for this measure is claims. Thirty-four states reported the measure in FY 2017, and this measure is also in the QRS program and MIPS.

A little history: support for continued use of this measure, and the discussant is Julia Logan. So I have her notes. All right. She actually did not include notes for that one.

MS. KUWAHARA: It says on the notes Sarah Brooks.

MS. GORHAM: Yes, that's what

happened. Okay. Sarah, she again apologizes for not being here, but Sarah is organizational rep for NAMD, and Elizabeth is also an organizational rep for NAMD. So Sarah will speak.

MEMBER MATNEY: Liz will speak.

CHAIR ANTONELLI: Liz will speak.

MS. GORHAM: All right. Liz will be the lead discussant.

MEMBER MATNEY: So from our perspective, this is a high-priority measure because we want to ensure that there is appropriate care coordination being measured at the different layers of the system. It could be at the provider level. It could be at the managed care level. It could be at the fee-for-service care coordination level. Whatever it might be, we want to ensure that there are appropriate interventions in place to assist with keeping our recipients on their medication for a long enough time to stabilize at minimum, which would be through that continuation phase.

CHAIR ANTONELLI: Okay. So let's do Elisabeth, then Lindsay, Josh.

MEMBER OKRANT: I like this measure because it's more of an iteration measure. A lot of primary care physicians actually prescribe antidepressants. So I think it actually is good in terms of enhancing coordination of care and communication.

I do have a concern about having multiple measures that are looking at adherence to medication regimens because it's really not adherence; it's prescription fill. So I just wanted to express that.

CHAIR ANTONELLI: Lindsay?

MEMBER COGAN: Those were kind of similar to my comments as well. I think, Jill, you said it; when we talk about medication adherence to schizophrenia, that is really the gold standard. For antidepressant, for depression, there's multiple modalities of treatment. And so this is really just hitting one of them.

And so I think real-estate-wise and how much behavioral health measures are currently on the Scorecard, we've just suggested adding another one. I would set this one out for now. I think we've covered the aspects of care, looking at the aspects of care. Whether we want to have those aspects of care for every single condition, that's where we always come back to, how do we do this in a way that we don't have to have the same measure over and over and over again?

CHAIR ANTONELLI: Josh?

MEMBER ROMNEY: I don't support adding this measure for two reasons. The first is treating depression is multimodal, and the speed at which people achieve remission and no longer need treatment is variable. So you run a risk that you are looking for people to be adherent to medication that they no longer need.

The second is that there are better ways to measure care coordination for treatment of depression. You can measure whether people

are getting a PHQ-9. If they still have depression, you can also measure depression remission rates. That would be better.

CHAIR ANTONELLI: Judy?

MEMBER ZERZAN: So this measure really looks at 12 weeks and six months after starting. So it's not a forever medication use kind of measure. And I would say that depression is way more common in the Medicaid population in both Colorado and Washington, the two states that I know quite well.

I'll also say that use of antidepressants and continuation fills of medications is quite low, and this is an effective treatment. So I would advocate for keeping this on because it's quite common and there is a large quality gap.

CHAIR ANTONELLI: Dave?

MEMBER EINZIG: I'd be opposed to it because it has nothing to do with response or remission. And so just because a person is on medication or off medication, this does not

correlate with outcome per se.

CHAIR ANTONELLI: Jill, did you withdraw your --

MEMBER MORROW-GORTON: I just wanted to sort of talk a little bit about the heterogeneity of depression. And there's major depression and there's adjustment disorder depression, and there are all of these variations, I mean, sort of unlike schizophrenia, which is, by and large, a usually terrible sort of thing.

And that heterogeneity, in addition to what Josh was talking about in terms of the heterogeneity of response and the differences in modalities of treatment, I think make rising this to the level of putting it on a Scorecard difficult.

CHAIR ANTONELLI: So Ken. Judy, so you're back in? Okay. So then, Ken, Judy, Shayna.

MEMBER SCHELLHASE: I'd echo Judy's sentiments. I support including this in the

Scorecard. And to address some of the concerns, certainly, in our State there's no expectation that these rates are 100 percent. This is a heterogeneous condition. Not everybody needs to be on a medication. Not everybody needs to be on a medication for a given period of time.

What I do think, though, is that this puts pressure on a system, such as a health plan, to facilitate access to care. I believe, despite its imperfections, and acknowledging that we don't want or expect 100 percent of people with a major depression diagnosis to be on meds for six months, that this is an important measure to keep.

MEMBER ZERZAN: So my secondary comments, I would love PHQ-9 scores, but we are a long way from collecting those. So while I wish that was the measure, we're not to an outcome measure here yet, and there are plenty of other so-so measures.

I'd also say that this really measures if a clinician has decided to start medication.

So it's not the whole spectrum. But, once you've got a prescription, do you stay on it for a period of time? And I think that's an important population. You know, not everyone needs this. It doesn't measure therapy. There are plenty of other things to add. But I think this is a good window at are people trying to treat depression and do something with it, which I think is quite important in the Medicaid population.

MEMBER DAHAN: So I am hesitant to support this recommendation. I think the concept is good, except for the fact that I'm kind of shy to support all these measures that will influence prescriber prescribing habits. And I think that you should keep in consideration the influence that measures like this may have on specifically primary care, telehealth, and other providers that may not be psychiatrists that are treating these patients, and to have those things somewhat drive perhaps our decision to continue medicine and push it.

CHAIR ANTONELLI: Ken and Dave, are

you guys back in the queue? No. Dave is, but let me do Camille since that's a new voice. And then, Dave, you follow behind Camille.

MEMBER DOBSON: Yes, we haven't talked a lot about people using LTSS, and this is one of the major diagnoses who are LTSS users.

I agree with Judy that I'm not a clinician, the measure specifications and whether the modalities and all that kind of stuff. I think it's important to focus on the behavioral health issues that are germane to our Medicaid, especially older adults and people with disabilities who may not be caught in some of these other kind of measures, not to let the perfect be the enemy of the good.

CHAIR ANTONELLI: Dave?

MEMBER EINZIG: Not to be negative, but I really don't think this is a good measure. This is we start a person on medication and it takes 6 to 12 weeks to know if it's going to be effective. If it's not effective, why would you stay on it? Or sometimes you have treatment

emergent side effects. Why would you stay on medication at four months if you're experiencing side effects and it isn't working?

And so without a measure or without a spec, you know, maybe if this measure had something with it to say they're on medication, they tolerate it well, and document the benefit, then continue on it. So maybe with that qualification, but that qualification isn't there. This is just saying that the person has to be on medication without knowing if it's helping or hurting, or what.

CHAIR ANTONELLI: Okay. Shayna, are you left over? Okay.

So would somebody like to make a motion?

MEMBER DOBSON: I move that we add this to the Scorecard.

CHAIR ANTONELLI: Okay.

MEMBER ZERZAN: And second.

MS. GORHAM: So I just want to make sure that everyone around the table is

comfortable with the voting process. And you all keep us on our toes. So we appreciate that.

We're going to use some of the processes for voting that our other NQF committees use. And Sally is familiar because she just mentioned it. But what we're going to do, so it is definitely the Chairs are listening, and staff, we're definitely listening to the conversation.

So you can have a motion. For example, I'll use Harold in the last measure. Harold motions to fully support the measure. Someone seconds that measure. But, because the Chairs are listening to the conversation, which can say, well, you know, he can sense that there's not consensus for that full recommendation for addition or full support for the recommendation for addition. So then, he can say, is there a recommendation of conditional support, and what that condition is. And then, someone can second that.

And what will happen is -- we'll have

to do it tomorrow. We have new voting software. So we'll tee up the slides. So you will vote on both. There will be a vote for the full support of the measure and, if there is not 60 percent or above, then we will vote for the conditional support and whatever that condition is.

That way, you will all have the option or the opportunity to vote on the full support and the condition, because it was sensed that there was not consensus. And, of course, we want to make sure that we have consensus of the group. Does that make sense?

MEMBER ZERZAN: It might be helpful -- I don't know if there's someone from NCQA on this measure -- my remembrance, but it's not in here, is that this measure doesn't require that you're on the same medication for six months, but a medication. So I don't know if that changes other people's -- so that if one doesn't work for you, one SSRI, for example, doesn't work for you, you can move to a different class of medication and it still counts.

CHAIR ANTONELLI: Actually, I don't want to get back to the measure yet. I want to make sure that what Shaconna just reviewed meets everybody's expectations and we have full clarity. No concerns? And any hands?

Jordan, are people listening in on the Committee? Somebody's got their hand up? So she's the NCQA person? Yes.

So Amy?

MEMBER HOUTROW: I am sorry to bring up this point of clarification. So my understanding of what we just talked about is that, if a motion is made to vote to approve, then we will do a voting process. If it doesn't reach the threshold for inclusion, we will, then, go to a potential vote for conditions. Is that right? Yes.

So do the votes for conditions need to occur at, the motion to make a vote for conditions, do those need to occur now or do they need to occur later? Because if they don't -- the one we just did, antidepressants, we got a

motion to approve it without condition. And if we do not have a motion to approve it with condition, then it's an up-and-down vote and there's no opportunity to go to condition.

Why would we not, if we are going to have an up-and-down vote to include without condition, not also make a motion to include with condition?

CHAIR ANTONELLI: So that's what Shaconna is suggesting the process is. At the Chair's prerogative, if I didn't have a sense that there was consensus in the room, I would actually open it up and say, we have a motion that's been seconded for consideration for approval without conditions. But, given the fact that there isn't broad consensus, I do want to raise that question. Would somebody like to add that? And that's why we want to do it proximal to the time of the vote.

And then, tomorrow, because they'll have to change the voting template, we would basically have those votes. So you would have a

secondary option, depending on where you are.

You're good with that? Is everybody else good with that?

Great. Now if the Congress and the White House could follow our lead, we would all be in a much better place.

Okay. So now, Judy, I apologize. I'm going to actually bring us back into technical discussion. And then, I think there was somebody on the left, and I forgot who, was going to do a follow-up. So, Judy, just rewind, please.

MEMBER ZERZAN: Yes. Some of the concern was that, what if there's side effects or you switch? I believe, and others across the table nodded, that this measure is not a specific drug, but is more are you on any kind of antidepressant once a prescription has been initiated.

CHAIR ANTONELLI: That's right. And you were looking for the NCQA person to weigh-in.

But, Liz, before I open the line to her -- you're withdrawing your comment? Okay.

So is it Lisa from the NCQA? If you're available, can you address the question, please?

MS. LIU: Hi. This is Junqing. Could you hear me?

CHAIR ANTONELLI: Yes, we can hear you.

MS. LIU: Yes, you are correct, the medication can be changed. A person doesn't have to be on the same medication.

CHAIR ANTONELLI: Okay. Now you have something to say?

MEMBER MATNEY: I will just also add, I believe that the specification for this measure is not for depression associated with an adjustment disorder or anything like that. It's major depression. And that's not really something for a lot of our Medicaid populations that we see -- I mean, we always want to get towards remission, but we acknowledge the fact that many times these are a population with serious and persistent mental illness where

remission is not the goal.

CHAIR ANTONELLI: Okay. So we have a motion to approve without conditions, and it's been seconded.

But I am going to invoke my prerogative and say, would anybody like to suggest condition or conditions, and if so, we will entertain a motion for that as well.

Dave?

MEMBER EINZIG: Motion for condition.

CHAIR ANTONELLI: Okay. Yes?

MEMBER EINZIG: The condition that there is documented, not necessarily remission, but documented response and medication is well-tolerated.

MEMBER COGAN: I don't think you can make a condition that changes the measure.

CHAIR ANTONELLI: Right. It would have to be about the implementation of the measure itself. So in other words, the motion on the table is that the condition you apply can't be we approve the measure, but you have to change

the measure. You've respecified the measure, is what you're saying.

MEMBER EINZIG: So then, I would just be opposed to the measure.

CHAIR ANTONELLI: Exactly. Exactly. You have the option of expressing that opinion, something else. Exactly. That's why I get all these big bucks, you guys.

(Laughter.)

Did I see a hand or a card or something on the right side? No.

Jeff, please.

MEMBER SCHIFF: I just want to follow up on what Dave was just asking, though. If some of these, like if we accept one as a placeholder, what's the difference between that and asking to respecify the measure? So I just want to be clear I understand. Because that's different than a condition for implementation, right? So can you help me understand the distinction?

CHAIR ANTONELLI: You guys want to handle that?

(Laughter.)

MEMBER SCHLAIFER: I think what we said, when we said it earlier, even though I didn't necessarily agree, is that we're not suggesting specific change to the measure. We're saying to CMS, we support this measure, but we think there should be something better out there, and when you have something better out there, this should go away. That's, to me, what that meant.

I mean, I didn't support that, but, to me, that's what it was saying. It's not saying, we are not recommending a different measure. We're recommending that, as soon as CMS has a different measure, they do something different. But, for now, in today's world, we want it to stay. Is that --

CHAIR PINCUS: Yes, when I introduced the notion to stakeholders, that's exactly the way Marsha framed it, is the idea that, at the present time, we're supporting this measure, but we hope that you will rapidly find a measure

that's better than this that gets at the same issue.

CHAIR ANTONELLI: So a placeholder for a measure that you feel fundamentally doesn't meet your needs, Dave, is --

MEMBER SCHLAIFER: Supporting it as is, but --

CHAIR ANTONELLI: If you feel that its current version is worthy of placeholder status. Dave is speaking much more fundamentally than that. He's making a very clear argument that says this is not a good measure.

CHAIR PINCUS: Yes, let me add to that because I think that it is a difference. Because with the notion that the reason why this stakeholder thing kind of works is that there's ample discussion about what the problems are and what would be the value of keeping it, and what would be the strategies, the ways of thinking about how to move ahead.

So one could, if anyone had -- I mean, just to take, Dave, you as an example -- if you

thought that this was basically a good idea to have something like this and it could stay in the meantime, but they ought to be working on something that's better, then I would vote in support of it. But, if you think it's really a messy thing and it's not really going to be of value, then I wouldn't support it.

CHAIR ANTONELLI: Okay. Oh, Karen?

MS. LLANOS: And I'll say this for the benefit of myself and, also, for my CMS colleagues who run the core set who are listening. This is all in the context of the Scorecard.

I want to just re-emphasize what Marissa said a couple of conversations ago, which is, when you're voting something no, that's not casting a vote for it to go away from the core sets. The child and adult core sets have its own process. This is, do you think it has a particular merit to emphasize as part of the Scorecard initiative or do you not? So I just wanted to emphasize that.

And there are different ways of slicing and dicing what goes into the Scorecard, but just flagging that, right? So technical issues with the measures that you're discussing, you know, we're obviously noting that as well. We've got the stewards listening as well. That's a kind of conversation that's happening parallel. I just wanted to note that it's all in the context of the Scorecard. There's no voting on and off the island of the core set as part of this conversation.

CHAIR ANTONELLI: Right. Thank you for that.

Okay. So I think that we're going to the next measure. Full support is the motion that's been seconded, and that's what we will vote on, no conditions.

Okay. The other thing that I get to do, besides reading the room, is to remind people of the clock. What the staff would like to do, and I would like to concur and make the recommendation, is that we plow through all of

the nominations today. The hope is, by 4:30, we'll be done, and then, NQF staff will revise the voting templates and we will vote tomorrow.

Is there anybody that couldn't go through until 4:30?

The votes are tomorrow, yes. Okay. All right. So let's zoom along.

MS. GORHAM: All right. So NQF 0139, the Pediatric Central Line-Associated Bloodstream Infection, which is the CLABSI measure. The description of that measure: standardized infection ratio and adjusted ranking metric of healthcare-associated, central line-associated bloodstream infections will be calculated among patients in patient care locations. This is an outcome measure, and the data sources include electronic health data, electronic health records, paper medical records, and others.

CMS excludes the CLABSI measure data in the chart packs, which is the resource that you all received. The data is obtained from CDC National Healthcare Safety Network. So you will

not see in your information the number of states reporting on this measure. The alignment for this measure is Hospital Compare and inpatient quality reporting. Historically, the MAP has supported continual use of this measure.

And the lead discussant for this measure is Stephen Lawless.

CHAIR ANTONELLI: You're on, Stephen.

MEMBER LAWLESS: I am. I'm supportive, actually, of this measure.

CHAIR ANTONELLI: But your mics need to be on, please.

MEMBER LAWLESS: It is. Sorry.

I'm supportive of the measure going on, and especially after hearing about the admission part. The admission was a piece of this.

I think the areas to consider, though, there's a growing number of CLABSI infections that are not classic central line infections. So you have central lines and you have PICC lines, and you have oncology patients who have what is

called coexisting conditions.

And a couple of years ago, the admission went to a change of including not just central lines you're putting a line to, also including oncology children with mucosal-acquired infections. They're included now. So the rates have gone up. And it's causing a little bit of angst about what we can do with that.

So I think in this, the clarification about are MBIs or those mucosal barrier infections included or not would have to be included or had to be clarified. And whether PICC lines, which have not been part of the initial admission, I think, dataset -- these are the small catheters that go into the line here, but, then, are threaded up. Those infection rates, I don't think the same data is robust. So I think just a clarification of what kind of lines and conditions included would be important here.

CHAIR ANTONELLI: So I need to ask for a clarification. As the lead discussant, your

role is to say here's why I want this measure to go into the Scorecard. But it seems like you've raised a couple of issues around clarification.

MEMBER LAWLESS: Clarification.

CHAIR ANTONELLI: Okay. So in fact, are you not really the lead discussant promoting it or are you sort of the lukewarm --

(Laughter.)

MEMBER LAWLESS: No, no, no.

CHAIR ANTONELLI: To paraphrase Judy, are you the MAP discussant?

MEMBER LAWLESS: I'm lukewarm, more towards warm.

(Laughter.)

CHAIR ANTONELLI: Okay.

MEMBER LAWLESS: I just need for my mind, if that's clarified, how we do that, then I'm in favor of it --

CHAIR ANTONELLI: Okay.

MEMBER LAWLESS: -- as an inclusion. I just had to, full disclosure, I just need those two clarifications.

CHAIR ANTONELLI: Okay. So I need to think about this for 30 seconds. If somebody is MAP, can they bring it forward? Yes? Okay. I suppose that is the case. Okay.

So I'm going to frame this as a way to create a glide path to a productive discussion after this. There is this measure. And Dr. Lawless has pointed out a couple of things that he thinks would be important clarifications to, then, make it ready to go into the Scorecard. Is that --

MEMBER LAWLESS: Correct.

CHAIR ANTONELLI: Okay. So I think what I'd like to do is to maybe open it up for one more step. And that next step is not so much do you agree with Stephen's suggestions for clarifications, but, just on the face of the measure itself, is there somebody that wants to talk about promoting this measure as it stands? And I'm not looking for a motion. I'm just looking for anybody that wants to be sort of an unadulterated lead discussant/advocate.

Rhonda?

MEMBER ANDERSON: Having been in roles in children's hospitals and seeing the pre and the post, if they've come from long-term care, rehab, et cetera, with lines, with central lines, I think this is really a key. Because many times they come into our acute care institution with those infections already. So I think the parameters here are important in terms of the long-term care and the other locations, as well as the acute care facilities. And I fully endorse us adding this.

CHAIR ANTONELLI: Okay. So that's a good starting point.

So, Stephen, we will work on what you're talking about. I just needed to get that.

So you're saying let's consider this on its face?

MEMBER ANDERSON: Yes.

CHAIR ANTONELLI: Good. Before I move to Amy, do you have anything else to say?

MEMBER ANDERSON: I have one other

question in relation to Stephen. And that is that it is already on the Scorecard. I mean, it's already on the core.

CHAIR ANTONELLI: Yes.

MEMBER ANDERSON: And these parameters are the parameters that they obviously looked at and people are using right now when they report. So do we know the answer to his question? Have they included like the ports, et cetera?

CHAIR ANTONELLI: So I don't want to go there yet. I want to talk about the measure and, then, we will come to that.

So I've got Amy, Sally, and then, I think Ken. Yes? Okay.

MEMBER HOUTROW: While I definitely appreciate the value of addressing this as an important topic for a very small subset of hospitalized patients, to me, this seems much more appropriate to be living in the space of hospital-based quality improvement which they are doing. It doesn't feel like this rises to the level of population-level Medicaid, for inclusion

beyond the core set into the Scorecard. So I would not support it as it's a very narrow population in a very narrow time window of when kids are hospitalized.

CHAIR ANTONELLI: Sally, then Ken, and then, Jill.

You withdraw your comment or temporize your comment? Okay.

So, Ken?

MEMBER SCHELLHASE: I would just echo some of the other comments. I think this is a really important thing. I think most pediatric hospitals are laser-focused on this already. I don't know that, because of the relatively narrow subset of the population, I'm not sure it should take up real estate on the Scorecard.

CHAIR ANTONELLI: Thank you.

Jill?

MEMBER MORROW-GORTON: So I want to look at it from a little bit different standpoint, from a state standpoint. The children's hospital or hospitals in our state

don't necessarily reflect the impact that the Medicaid program has on those institutions, right? Boston Children's has kids from Saudi Arabian and from New Hampshire and from Rhode Island, and commercial kids.

And the Medicaid -- this is supposed to be a Scorecard for state performance in Medicaid and CHIP, and this is a very different measure in terms of who it's measuring than all of the other measures that we have. And I think that may be confusing to people who are going to be looking at this Scorecard.

CHAIR ANTONELLI: Okay. So, Stephen, here's what I would like to do. Before I open up the discussion for the potential of modification, the desirability thereof, I think I'd like to call the question about the measure as it stands. Remember, it's the Scorecard; it's not the core set. So unless somebody has a tremendously burning reason to put their foot on the brake pedal, I'd like to reach out and just say, does anybody want to make a motion that this measure

should be considered initially without conditions before going to the Scorecard?

Dr. Fox from CMS would like to make a comment. So while my challenge to you is percolating, Renee, do you have an open line?

MR. HIRSCH: I will be reading Renee's comment. She says, this is a measure which we get the numbers from CDC, and it is from the nosocomial infections, and it is only in the NICU, and it's all payer, not specifically Medicaid.

CHAIR ANTONELLI: Thank you, Dr. Fox, and thank you, Mr. Hirsch.

So would anybody like to make a motion to move this measure forward into the Scorecard?

Okay. And just so I'm not -- because I know what NQF staff has just advised us, if the answer is no, I'm willing to come back with conditions, but I don't want to spend a lot of time thinking about how do we make a measure better. So from my view, this is sort of the gate to get us to the next place.

So I'm not seeing any hands that are willing to consider moving this forward into the Scorecard. Okay.

MS. GORHAM: All right. Let's move forward to the next measure. 0038, Childhood Immunization Status. So the percentage of children 2 years of age who have had a number of immunizations. The measure calculates a rate for each vaccine. This is a process measure, and the data sources are claims, electronic health records, paper medical records, and registry data.

Forty-four states reported this measure in 2017. The history: the MAP supported this measure for continuous use.

Alignment for this measure, it is in QRS; it is in MIPS, Physician Feedback Quality Resource Use Report, the Physician Value-Based Payment Modifier, as well as the AHIP pediatric core set.

With that, we have lead discussant Stephen Lawless.

CHAIR ANTONELLI: Okay. Sir?

MEMBER LAWLESS: Fairly common and straightforward. I mean, followed by lots of people and stuff. So I actually endorse the measure. It's nothing controversial. Well, it's controversial about immunizations somewhat, but I think in terms of the measure itself and what it's doing, it aligns with the American Academy of Pediatrics and it aligns pretty much with the standards we pick.

CHAIR ANTONELLI: I'll open it up for --

MS. GORHAM: Well, let me read because I looked at the wrong lead discussant. So we also have Julia Logan and Sally Turbyville and Jill.

So let me quickly read Julia Logan's, and then, I'll turn over to you, Sally.

CHAIR ANTONELLI: Okay. Good.

MS. GORHAM: So her rationale -- and this is Julia Logan -- vaccines are a critical aspect of preventive care for children and are a cost-effective way to foster both child health

and population health. By encouraging care providers to vaccinate children, the measure protects these most valuable individuals while building important immunity and reducing medical cost. Immunity is needed nationally and in California. Improvement of immunizations is a quality improvement priority for California Medicaid. And it's currently a measure that managed care plans are required to report.

In addition, this measure would allow for removal of the 1319. You talked about that earlier.

So her summary: addition of this measure addresses a critical quality objective and a quality improvement needed nationally and in California.

CHAIR ANTONELLI: Sally?

MEMBER TURBYVILLE: Agree with the previous discussants about this being a quality issue and something that we would like state Medicaid programs to both be monitoring, but very active in trying to improve.

I think, furthermore, from the perspective of the children that children's hospitals often care for, they are particularly vulnerable to getting their vaccinations, or those around them, if there does need to be a delay due to treatment that they need. In fact, even for children with medical complexity, our expert clinicians from our hospitals felt strongly that this measure, childhood immunization, would be appropriate even in looking at networks that care for children with medical complexity, realizing that the schedule part may be not always 100 percent, but that it's that important.

So we really think having it on the Scorecard, not just on the core set where we're happy it is, but to put it into this public reporting realm would be of real value to those who would use the report.

CHAIR ANTONELLI: Thank you.

MEMBER MORROW-GORTON: And I think I'm the last one. So to not repeat what other people

have said, I think this measure actually is better than just measuring a visit because the expectation of practitioners is not that you just do them at the visits that they're assigned to, but that at every visit, every time you see that child, and even outside of that, you're looking to see where kids' vaccination rates are and what they need.

So I think that this is a measure of how well your office functions/coordination of care. And I'd like to put a plug in for this is something that gets skipped very often in kids with disabilities, even those that don't have complex medical needs. So I think that this is something that there's a real gap for that population.

CHAIR ANTONELLI: Kim, then Shayna.

MEMBER ELLIOTT: I don't want to discount the importance of vaccines and the immunization process, but I don't really see it as a replacement for like the well-child visit, which covers a much broader spectrum of care and

services for the child.

But there's also some challenges with data sources. It's not just strictly in admin data. Lots of states get it from registries. There is a lot of private sector and pharmacies now providing immunizations. So not all of the data is always as collectible as it once had been when it was just strictly a chart or claims review sort of measure.

So I think it just should be thought in those concepts as well, in addition to just how valuable the immunizations themselves are.

CHAIR ANTONELLI: Shayna?

MEMBER DAHAN: I think that this is a great measure and data that would be important to be collected because of the fact that it is looking at vaccines before the second birthday. Usually, a lot of the patients that I see, the vaccines are driven by their entry into preschool or public school. So it would be really interesting to see if putting a measure like this helps primary care providers get those vaccines

done in time as opposed to letting like public programs to stress those vaccine administrations.

CHAIR ANTONELLI: Okay. So I'm going to call on Enrique, but, then, I just want to let everybody know, unless you have something substantial to move us away from making a motion to move this forward, which is sort of how I'm reading the comments so far, for the sake of time management, I'm going to give you the floor, Enrique, but I'm happy to let Sally and Ken push back, if you don't like my making an executive decision.

Go.

MEMBER MARTINEZ-VIDAL: This is a clarification on what we're voting on, to make sure -- I want to make sure that we are divorcing this decision from the well-child visit decision. Because this is saying that, if we vote yes for this, then the well-child comes off. And I think we decided not to do that this morning.

CHAIR ANTONELLI: That could come up if there was a sentiment that people wanted to

bring that out as a caveat. But, no, right now, the discussion on the floor is 0038, should it be recommended for addition to the Scorecard?

MEMBER ROMNEY: The Discussion Guide does mention that this would be a replacement. So it's good to clarify that.

CHAIR ANTONELLI: Okay.

MEMBER TURBYVILLE: Yes, and as someone who put it forth, I didn't put it forth in that context.

CHAIR ANTONELLI: Right.

MEMBER TURBYVILLE: So I put it forth on its own merit --

CHAIR ANTONELLI: Right.

MEMBER TURBYVILLE: -- not as a replacement.

And then, quickly, maybe as the lead discussant, realizing the challenges with data -- and that includes our hospitals and specialty care providers being able to get vaccination information, so that they can vaccinate some of these children that they're trying to make sure

they're up-to-speed -- and how long this measure has been around, and I am very empathetic and sympathetic to states, but I feel like it's so important from our perspective that pushing it forward and, then, maybe that will help drive resources to states and some of these various data-holders.

To me, I know it's a problem with data. I've audited these measures. Twenty years ago, it was a problem with the data. And I think, for us at Children's Hospital Association, we don't want that to be something to hold it back.

CHAIR ANTONELLI: Yes.

So, Josh, I want to thank you because it does state that specifically in the Discussion Guide.

But I'm going to not make a motion, but I'm going to frame the question. And then, people can, anybody interested can make a motion. For 0038, should it be recommended for addition to the Scorecard, initially with no conditions?

MEMBER HOUTROW: So moved.

CHAIR ANTONELLI: Okay.

A second. Okay.

Then, I'm not inclined to ask for conditions because I think the Discussion Guide is not where any of us feel we should be going with that, but I am willing to have people challenge me on that. No?

Marissa turns into a pumpkin in three minutes.

(Laughter.)

It's okay. It's okay.

Next one, please?

MS. GORHAM: All right. So the next measure is 1448, Developmental Screening in the First Three Years of Life. Endorsement was removed in May 2017. The developer withdrew the measure because they can no longer support the measure.

I'm going to, just for sake of time, not read the description. But it is a process measure. The data source is the claims,

electronic health records, and paper medical records.

Twenty-seven states reported the measure in 2017, and this measure is also in MIPS.

Just a little history on the measure: the measure was discussed, a very robust discussion, in 2017, and it was recommended for removal from the core set. The group voted to keep the measure because, while the specs need some work, the intent of the measure was good. So although the conversations led toward removal, the group ultimately decided that it should remain on the core set because it shouldn't be removed because the specs needed work, and the intention beyond the measure was good.

CHAIR PINCUS: The bottom line is that it's on the core set.

MS. GORHAM: Yes.

CHAIR PINCUS: And I'm going to moderate this --

MS. GORHAM: Yes.

CHAIR PINCUS: -- because Rich is going to make a motion.

MS. GORHAM: And David Kelley is our lead discussant.

CHAIR PINCUS: Yes. So, David, do you want to kick it off?

MEMBER KELLEY: Sure. I'll start by saying that, as a general internist, I actually see great value to this measure. From a Medicaid standpoint, this is really, I think, quite vital. Even though it may not be a perfect measure, we have the opportunity for pediatric-serving providers to evaluate and screen using validated tools, looking for developmental delays.

And so this involves a large population. So probably in Pennsylvania -- and I think it's the first three years of life -- probably over 150,000 kids in Pennsylvania would fall into they need this screening. It may actually be higher than that.

So high prevalence within Medicaid. And I think more importantly is really the

downstream. Even though this is a process measure, it is the downstream consequences of what will occur if developmental delays are not detected.

And I think there is a fair amount of robust literature that looks at getting children into early intervention, and that there's improvement in several domains, social relationships, use of knowledge and skills, taking action to meet needs, being able to better communicate, and reading and mathematics.

So I'll defer the literature to my pediatric colleague. But I really feel this is a very important measure because it's a high prevalence, but it's that downstream. If these kids aren't screened, you can't get them into early intervention. And I've heard the argument, well, we don't want to screen because we don't know if we have early intervention providers. You should be able to get them into those early intervention providers. It will really make a huge impact on these kids.

CHAIR PINCUS: Rich?

CHAIR ANTONELLI: Yes, and thank you, Dr. Kelley. And that's coming from an internist.

I think if you take nothing away from my promotion of this measure for consideration for the Scorecard, let me tell you why it lost NQF endorsement. One of the criteria by which measures maintain NQF endorsement -- this was NQF-endorsed, by the way. So it had it. It lost it because Oregon Health & Science University, OHSU, did not have sufficient funding to do ongoing measure maintenance.

I co-chaired -- at the time, I think we were a task force here. And I can remember the agonizing vote that said, okay, it lost its NQF endorsement, but I looked at the specifically at the CMS folks and said, but this thing has to keep going. And fortunately, it's still there.

So it didn't lose endorsement for any reason about lack of validity or importance. It is profoundly important. As David said, talking about setting the stage for downstream

consequences, those patients with remediable developmental delays that don't get picked up cost more, and as they move into adolescence, they find their way, unfortunately, into the criminal justice system. So there are all kinds of reasons to promote something as simple, elegant, and evidence-based as this measure.

CHAIR PINCUS: So I have Kim, Lindsay, Lisa, Kamala.

MEMBER ELLIOTT: In the interest of time, I'll keep this really short. I do agree with everything that is said. It is probably one of the most important things that we're looking at for the Medicaid population because it does impact the rest of the lives of these children and everyone that surrounds them, not only from a personal perspective, a financial perspective; it's across the board.

However, I am very concerned about it not having somebody to maintain the measure itself, a measure steward. Because, as we all know, the tools that are used for developmental

screening, the codes that are used to identify it, all of those do change over time. So from that perspective, I would probably make it more of a conditional recommendation, if I were the one nominating it, simply because we need to have somebody who's maintaining that measure, making sure it's accurate for reporting purposes.

MEMBER COGAN: So my comments go more towards the operational challenges of collecting and reporting this measure. I totally agree this is probably the most important measure on the child core set, and I've invested a great deal of resources in the last year figuring out a way to get this on a population level that does not involve sampling medical records.

And I am so disappointed that the recommendations that came out of sort of the AHRQ and CMS work on the electronic health record format went nowhere. I can't find anybody who has integrated this standardized screen in EHR that would allow us to capture it on population-based in New York. That's been my

experience. If it's happening elsewhere, please tell me.

Right now, the difference in the spread and scores that you're seeing between states is the difference between one state running it, administratively looking for CPT codes, and another state that's investing heavy resources in pulling medical charts. And that's why you're seeing a difference. To me, that's not meaningful. I want to know what the true prevalence of the screening is that is occurring.

And we're involved in a really large demonstration project in our State, and we're continuing to sort of fight uphill. But, with those data collection issues, I feel that at this time I wouldn't put it forward on a Scorecard yet. But I think if we can figure out some of those, then absolutely.

CHAIR PINCUS: Lisa?

MEMBER PATTON: Yes, I was going to raise the data collection issues as well and burden. I think we heard during those

conversations quite a bit about the concern around burden. And I might not be remembering correctly, but I think that was a huge concern. So I certainly support this as a placeholder and would hope that we could address some of those data collection issues, and so forth, going forward. But I think it's a very important area to be screening.

CHAIR PINCUS: Kamala? Oh, okay, Sally?

MEMBER TURBYVILLE: I actually have one question for CMS, and then, also, just want to note, for this measure, it's our understanding -- and we've also reviewed it -- it's not so much that the steward and developer is not maintaining the measure. It is that they could not afford to put the measure through the NQF endorsement process.

So the difference between maintaining a measure and NQF endorsement is something for CMS to consider a process to check how well a measure is being maintained. So it wouldn't even just apply to this measure. Again, because my

understanding, and in discussions -- and it would require a confirmation for something as high stakes as this, are you maintaining the measure to the point about codes and tools? -- because my understanding is they are and they're committed to that. They just didn't have the hundred thousand dollars or more that it takes to put it through an NQF endorsement process. That is a different step in a maintenance.

And given that you have said that non-NQF-endorsed measures can end up on the Scorecard, kind of thinking through how to check in with the steward or a developer that a measure is being appropriately maintained? Because NQF provides a wonderful door for that. So outside of NQF, how are we assured?

I think the next question is, again, the data collection issue for states being one. It would be really helpful to get some thoughts, if not directionally or definitive directionally, about, for the Scorecard, how is CMS is going to handle when there are no data issues? If there

are enough states reporting -- in this case it's at least over 25 -- move forward or?

So I'm having a hard time thinking, should I put on when I was a measure developer working for NCQA hat? You figure out the data collection issues here. It's too important. Let's get the resources to you, yes. Sympathetic, but by putting it on the Scorecard, hopefully, that will happen. Or do I want to be a little bit more thinking through let's keep it on the core set, get those data infrastructures set, because we're more interested in how accurate in terms of completeness of data it is on the Scorecard? And I think I'd really like to hear from the states and CMS on that.

CHAIR PINCUS: Sally, Sally, we actually have CMS on the phone right now to respond.

MEMBER TURBYVILLE: Okay. But I'm talking about the Scorecard, not the core set.

CHAIR PINCUS: Can we have Renee Fox to speak on the phone?

MEMBER TURBYVILLE: Yes. And you may not have the answer today.

MS. FOX: It would help if I took myself off mute.

(Laughter.)

So I don't have the answers. I think Sally said everything I would want to say. It does have a measure steward who does maintain it, and our contractor works with the measure steward to update the annual tech spec. So, yes, I think all of what Sally said was true.

That's all I have to say.

CHAIR PINCUS: Okay. So could we hear from Jill, and then, Jeff?

MEMBER MORROW-GORTON: So I think the question about numbers of tools, and whatnot, in reality, there are not that many tools that pediatricians are using. They can all be put into an electronic record, and then, you could pull it that, yes, it was done.

I just wanted to add to what Rich said about identifying kids with remediable delays.

Even if you identify kids who don't have remediable delays -- i.e., they're going to have an intellectual disability, or whatever -- they as well function better if you identify them earlier and get them into services earlier, as do their families.

CHAIR PINCUS: Okay. Jeff?

MEMBER SCHIFF: So I think I, like others -- including my pediatric colleague, David Kelley, over there --

MEMBER KELLEY: Honorary.

MEMBER SCHIFF: Honorary.

Well, I am supportive of this. I just have a process question because I feel like I could vote to unconditionally support this, but I'd like to make some recommendation that somebody pull together states. We have a pretty robust system in Minnesota about how we collect this data, and I'm sure other states do, too. And it seems like there should be some effort to standardize that. And I'm not sure who does that because the measure steward sounds like they

don't have the ability to do it. So I just want to put that in. I'm not sure if that's a condition for a vote, but I want to vote affirmatively, and then, suggest that.

CHAIR PINCUS: Okay. We have the measure steward online, I think.

Colleen, are you online?

MS. REULAND: This is Colleen. I'm on the line.

CHAIR PINCUS: Okay. Can you introduce yourself and tell us what the status of the measure is?

MS. REULAND: Sure. Hi. My name is Colleen Reuland. I'm the Director of -- (telephonic interference).

Can you guys hear me?

CHAIR PINCUS: Somebody is talking over you.

MS. REULAND: Okay. This is Colleen Reuland. I'm the Director of the Oregon Pediatric Improvement Partnership based in Oregon Health & Science University. I also was the

measurement expert that supported the ABCD effort, assuring that our child development effort was an effort that engaged over 26 states. So I was able to work with 26 states on the measurement.

The first question was whether I'm supporting, if I'm stewarding the measure. I would say at least once a week I handle questions and manage the measure. Every year I update the spec because it's part of the CHIP refer measurement specs and provides insight and input about whether there are additional schools that meet the criteria. And I reach out to Bright Futures because the measure is meant to be aligned with Bright Futures.

Where I didn't have funding was to meet the kind of ongoing maintenance of NQF. And frankly, given the funding that I had, I wanted to invest it in states using it. This is one of the only CHIP refer measurements. This is not an NCQA measure that had extensive use.

And I've worked with a number of

states on what it meant in terms of once they started to report. For example, Alaska was one of the bottom states. Once they started reporting it, according to the National Survey of Children's Health, they're one of the top five states. So it's had a really dramatic impact in terms of state-level activities, particularly because it's a Bright Futures recommended service, and state Medicaid agencies are accountable for ensuring their Bright Futures Medicaid services are covered.

In terms of the comment about the variation in the findings, I just confirmed with my Mathematica partners, who I coordinate with throughout the measure steward process, but I'm pretty positive all of the people that reported the metric reported the metric as an administrative measure. So the variation that you're seeing in the findings I don't believe is due to some using hybrid versus some using claims.

The reason we kind of wanted to create

options is we knew that if proceeded with a hybrid measure, a majority of states would be unwilling and unable to support on the metric. And we wanted to guide and inform the quality improvement effort.

In terms of it being inserted into the electronic medical record, I couldn't agree with you enough how frustrating it is that there wasn't alignment of the quality indicators. I will say in our State we've been measuring developmental screening and have now incentivized this and tied money to it since 2013. So I will tell you, all of our EMRs in our State have developmental screening.

So efforts in our State are supported through a couple of different mediums and a couple of different health systems. Every single one has developmental screening in it, which was driven by the measure and the reporting of the measure.

So I think we have great models that we could share with other states about how they

might be able to incorporate that into EHRs. In fact, we can offer practices in our State about how they might better use their EHR maintenance.

I think those were the four areas of questions that I heard.

CHAIR PINCUS: Okay. So, Marsha?

MEMBER SMITH: I was just going to add to what Renee was saying about the measure. There's a difference between having a measure steward and having measures endorsed. Because in some of our programs in CCSQ we have measures that are not NQF-endorsed, but they're used and they're maintained, and we ensure that they are appropriate for our program.

So I think that that's something that we should consider. Like the measures that are being used here for addition to the Scorecard are for measures of state health system performance. And that's what we're looking for, and we want to make sure that they're an appropriate measure for that purpose. And, then, assessment of how they're maintained with the measure steward is

important, not necessarily throwing them out just because they're not NQF-endorsed. They may be appropriately used for the appropriate setting.

CHAIR PINCUS: Is that residual or is that new?

Okay. Dave? Amy is on, too. So, Amy, then Dave. Okay?

MEMBER HOUTROW: One of the things about how this gets measured in EHRs can vary pretty substantially by practices who are having different insurers that will reimburse for a billing for screening. And I think that highlights kind of a lack of uniformity amongst payers to pay for developmental screening, which means that it's not showing up when you pull it out of the billing records.

To me, this is such an important measure, and it's such a key component of pediatric practice, that we have got to figure out a way past the variability issue that you brought up earlier. We know where some of this variability is coming from. It's not just how

people are collecting. It's how people are putting the information into the record that matters. But I can't imagine a world where this doesn't get put forward because it's the basics of pediatric care.

CHAIR PINCUS: Okay. Dave, and then, Rich. And then, we will entertain motions.

MEMBER KELLEY: I do want to go back to, again, it looks like all the states except for one reported administratively, and there's a huge variation. So being able to report administratively, there's less burden. It is inaccurate.

I think that we internally do also look at a hybrid methodology and our rates go up. But, with that being said, I think it's very important.

We also used a CHIPRA grant with some of our larger pediatric providers to actually embed the screening tools into the electronic health record, so that it was automatically scored. So the clinician would walk in the room,

have a discussion with parents. And I don't know if that's helped our rates go up, but I know that when we looked specifically at those providers -- and these were large providers, CHOP in Philly, Children's in Pittsburgh, and some of their clinical sites, and two other large pediatric-serving health systems in Pennsylvania -- it really helped move our rates up.

And that was because we automated it. We made it easier for clinicians, and then, we had also worked, though, with their billing folks to say, yeah, make sure that this is getting counted from a claims standpoint.

So it is possible, and maybe the medical directors, our network, maybe we need to think in terms of sharing best practices for this particular measure, so that we can get other states that are really struggling with the collection of this measure.

CHAIR PINCUS: Rich?

CHAIR ANTONELLI: So I feel that one of the advantages of the Scorecard, even with

those pieces of the Scorecard that are yet to be defined, the piece that I find most attractive is it really is getting ready for public reporting broadly.

Lindsay, I can tell you, I feel that pain. By one measure, you would think like, if this was that important, it should be built in the EMRs. But, remember, those of us that provide care for children are the flea at the end of the tail of the dog. The rest of the attention comes on the adult side because kids are not expensive. Now, if you're one of the top 1 percent of the kids, et cetera -- so I don't want to get on the soapbox here. But it doesn't surprise me at all that EMR vendors, whose three top priorities are Medicare, Medicare, and Medicare, are really devoting very little resources to this.

This screening tool is actually pretty simple. But the fact that you've got this many states reporting is a sign that people are willing to do this on paper.

So I talk about not letting perfect be the enemy of the good. Where we are right now is okay. But you put this thing somewhere that sends a message to states and EMR vendors; this will be a required public report that will do a favor for an entire generation of children and pediatricians.

You've got this kind of performance for pediatricians using a pencil and a piece of paper, and they're dropping codes. So please don't think about this is not a good measure because it's not being adopted. It has way more to do with the fact that this is pediatrics and a subset of pediatrics is developmental medicine. I mean, that's about as far down the feeding chain as you can get.

CHAIR PINCUS: So let's call the question. And is there a motion?

Second.

Okay. And the motion is for -- microphone.

MEMBER ANDERSON: 1448, Developmental

Screening to be added to the Scorecard.

CHAIR PINCUS: Okay. Any other comments/discussion on this measure?

MS. GORHAM: I'm sorry, did we have a second for full support?

CHAIR PINCUS: Yes, there were several people seconded.

MS. GORHAM: Okay.

MS. LLANOS: Can I just clarify one thing that I think Rich may have just said inadvertently? So the Scorecard, there's no requirements for reporting on that.

CHAIR ANTONELLI: Right. No, no, I get that.

MS. LLANOS: Okay.

CHAIR ANTONELLI: But we talked about before --

MS. LLANOS: It elevates it.

CHAIR ANTONELLI: Exactly.

MS. LLANOS: Yes.

CHAIR ANTONELLI: Exactly. And by 2024 --

MS. LLANOS: Yes.

CHAIR ANTONELLI: This is the way the Fed sends signals to Wall Street.

MS. LLANOS: Potentially.

CHAIR ANTONELLI: Yes.

CHAIR PINCUS: But we have to be careful about not going beyond what actually --

CHAIR ANTONELLI: Well-taken. It's signaling the intention.

MS. LLANOS: I mean, I'll say it. Let's use a concrete example. Irrespective of the Scorecard, there's legislation making the child core set mandatory, and this is one of them, right, potentially? So that would be the signal --

CHAIR ANTONELLI: Yes.

MS. LLANOS: -- versus the Scorecard.

CHAIR ANTONELLI: Yes. Point well-taken.

CHAIR PINCUS: Okay. So let's move on to, hopefully, the last -- or do you want to stop and do that tomorrow morning?

Do people want to do the last one or do they want to do it tomorrow? Amy?

MEMBER HOUTROW: So I have a question about process. There seemed to be some concern about feasibility of implementation of the measure in an accurate sort of way. So then, do we say, I want to conditionally support this measure with the idea that CMS determines the feasibility of an accurate reporting? And do we need to do that? Do we need to ask? Is anyone going to make a motion for that in order to have such a vote later?

MS. LLANOS: Can I just point something out? So there's reporting challenges with everything that we get, right, that we produce, that states produce for us. So obviously, NQF, you guys guide. I would suggest that you don't focus on the accuracy of the reporting because I feel like there's challenges and variations in how all of our state partners collect and report. So I would just steer away from that for the purposes of recommendations.

CHAIR PINCUS: Elizabeth?

MEMBER MATNEY: I would just echo what Karen had noted. I know that earlier I had recognized some of our data challenges, and we're working, NAMD is working with CMS on adding all the caveats and narrative around the Scorecard measures, where we want to relay accurately, where we are in the process of changing.

So agree, don't let that be the impetus for supporting or not supporting. Because a lot of us feel like this is a good opportunity for quality improvement and to get kind of our butts in gear to collect things in better ways.

CHAIR PINCUS: So we will adjourn now, and we will consider the last measure tomorrow, the All-Cause Readmission Measure tomorrow. And then we'll do all the voting on the additions tomorrow.

So everybody have a good evening.

(Whereupon, the above-entitled matter went off the record at 4:38 p.m.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Medicaid and Chip Scorecard Committee
In-Person Meeting

Before: National Quality Forum

Date: 01-10-19

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R Gross

Court Reporter