NATIONAL QUALITY FORUM

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MEDICAID AND CHIP SCORECARD COMMITTEE IN-PERSON MEETING

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FRIDAY, JANUARY 11, 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 9:30 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
JULIE BERSHADSKY, PhD, Human Services Research Institute
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

ORGANIZATIONAL MEMBERS (Voting) (cont.)
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
SUE KENDIG, Center for Patient Safety *
VIRGINIA RANEY, Centers for Medicare and Medicaid Services
ROBERT SAUNDERS, National Committee for Quality Alliance *
KYLE STOCK, Community Catalyst
JANICE TUFTE, Patient Advocate

*** present by teleconference**

C O N T E N T S

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

9:31 a.m.

MS. MUKHERJEE: Hi, everybody. Welcome back today to our day two of the Medicaid and CHIP MAC Scorecard Committee in-person meeting.

My name is Debjani, and I'm going to turn it over to our Chairs for some welcoming words and then get started.

CHAIR PINCUS: So we had an extremely busy day yesterday, making our way through all of the removals and all but one of the additions. We also had the opportunity to practice on -- more than practice, actually -- implement the new voting, which seemed to work out quite well. And hopefully, we had enough discussion so that CMS is well-informed about our thoughts about each of the measures.

So this morning, just to give an overview, we have one more measure to discuss with regard to addition, the all-cause readmission, and then, we are actually going to

be voting on each of the motions from yesterday afternoon's discussion and whatever discussion comes out of that all-cause readmission discussion.

After that, we are going to be going with the little dots to prioritize. We still work with the little dots. We have little stickies. And so we'll give them out to everybody and we'll go through that process.

And then, after that, we're going to have a very broad discussion about, No. 1, what do we see as sort of, basically, how to maximize the utility of the Scorecard, to think about how states can get involved, the impact on providers and plans, and things like that, to help advise CMS on this.

And then, to talk about what do we foresee for the future in terms of how it can evolve over time. So we'll have an opportunity to have that discussion. And then, we're done.

I don't know if you want to say something about the lunch.

CHAIR ANTONELLI: And I just also want to welcome everybody back to the second day of this.

And I want to make one observation. Marissa, in particular, sort of started this with her comment yesterday. CMS reinforced that. And I really want to make sure we're all starting from the same place.

I think for those of us that have been in this room for other reasons multiple times, the modus operandi often is you come in, you evaluate measures, you promote measures, and if you were successful, that's a great thing because they got promoted to move forward. And if it didn't, that's somehow there wasn't a measure of success.

That's not really the calculus for what we're about today. With all deepest respect -- and, Karen, it was so helpful for you yesterday to acknowledge a lot of the questions we have about what next, what next, what next -- CMS needs to figure that out. And so therefore,

we're dealing with a fairly uncertain ecosystem. Because of that, none of us should be feeling that, if we were promoting a measure and it, quote, didn't make it into the Pillar 1 Scorecard, that someone we didn't value that domain or the measure itself. So be mindful of that.

Success, I would actually argue, especially in an environment where there are as many questions as there are solid answers about what next, success may actually be holding back a little bit before we put something into a situation where we don't know what the implications of that are. So that should be our collective perspective on what defines success.

And because this is an ongoing process, this is not a one-and-done, CMS has to figure out the implications. The capital A, small a, accountability conversation yesterday was powerfully compelling for my thinking.

So we will continue to have some fun today, do really, really good work. The staff,

as usual, you guys are amazing.

So I'm going to hand it over to Miranda.

MS. KUWAHARA: Thanks, Rich.

As Shaconna mentioned yesterday, after we adjourn today's meeting, we'll be walking about two blocks over to P.J. Clarke's for lunch. And I just wanted to get a quick head count for folks who would like to join us for that lunch. So if you're interested, please raise your hand.

All right. Thank you very much. We're excited to dine with everyone this afternoon.

MEMBER ANDERSON: I really appreciate what both of you have said as our leaders. And I'd just like to also underscore something that Marissa said yesterday that is part of that frame. And that is that the core sets exist, and this is the next step in terms of the Scorecard. But I think, as I went back last night and reflected about a couple of the things that we didn't add, it's not that they're not there.

MS. GORHAM: Okay. We'll jump back into our measure review with our last measure, 1768.

Before I start that, I just want to remind you to open your Discussion Guide.

All right. So 1768, Plan All-Cause Readmissions. The description of this measure: for patients 18 years of age and older, the number of acute inpatient stays based on the measurement year that was followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. The measure type is a process, and the data source is instrument-based data.

Twenty-five states reported this measure in 2017. It aligns with the QRS program, as well as Health Home Core Set.

A little history of this measure: during the 2014 review, MAP conditionally supported the continual use of NQF 1768. At the time the Committee was considering this measure,

as well as 1789, which is another all-cause hospital readmission measure. So during the review in 2014, MAP urged CMS to consider the potential uses of the measure, feasibility of data collection, and issues of alignment with other programs. MAP remained concern at the time about the lack of risk adjustment methodology available for the Medicaid adult population, and public comments shared that view as well. So that's just some history on the measure.

And then, the lead discussants for this measure are Jill and Kim.

MEMBER MORROW-GORTON: So I looked at this measure as filling a gap in the Scorecard, giving us a measure of more acute inpatient care as opposed to preventive outpatient office-based care.

I also looked at this measure as it's not just a measure of quality of what happens in the hospital, but it's a measure of transitions between hospital and home or hospital and nursing facility, or whatever, or hospital and rehab, or

whatever those transitions are. And I think that those handoffs are where there are significant risks for patients, and especially patients that are Medicaid patients because many of them have low health literacy rates.

I think that this can potentially promote assuring readiness for discharge and assuring that everything is in place for follow-up after discharge, and is somewhat more a measure of care coordination and the effectiveness of that, or as much a measure of that as it is of the quality of the hospital care.

MEMBER ELLIOTT: I had several of the things that Jill talked about, but a few other things.

First, this is a very complicated measure from a specification standpoint. So it is a little bit more challenging. It does fit into the making care affordable domain. I also know that this is not one of the favorite measures of a lot of the facilities and hospital

systems because it does sometimes impact their pay.

But it is a very actionable measure, which is why I think it's a really good choice for the Scorecard. And the rate really tells us not only about the care and services in the hospital system, but a lot of what happens before and after.

It does align with a lot of Medicaid requirements that we really want to focus on, such as assessing care needs prior to being admitted, making sure that we have everything in place to prevent admissions and readmissions, transitions of care, the discharge planning process.

It really does, in my mind, align a lot with best practices, such as medication reconciliation when people are discharged from the facilities, follow-up visits within 7 and 30 days. There's also the things that you would put in place in order to ensure that people don't get readmitted.

There are significant opportunities for care coordination, which is really why we do Medicaid managed care, to make sure that we're looking at the person from a whole-person perspective, including all the physical and behavioral health that may result in a person being readmitted.

Also looking at all of the long-term services and supports to make sure those are in place upon discharge, to make sure we don't have readmissions. It's an opportunity to look at all of the social determinants of health to prevent those readmissions, and the management of the chronic health conditions.

It's an opportunity to also involve community, which is also a big focus on the Medicaid side. So looking at all of the community health workers, assistance from them and others, family, caregivers, and scheduling follow-up appointments, ensuring prescriptions are refilled to prevent readmissions, and transportation for follow-up visits.

So to me, it's much broader than just looking at the readmission, but all of the things that are going to really prevent it. It's really an indicator of how successful the Medicaid programs and the health plans are with preventing those readmissions from occurring.

CHAIR ANTONELLI: So we'll open it up for discussion. Harold, Amy. And remember if you're way out in the bleachers, turn the card so I can see the name, please. Harold, Amy, Jeff.

CHAIR PINCUS: So I think this is an additional measure that's definitely worthy of consideration. But I just want to make sure that we also have some discussion about some of the recent health services research that's come out about the potential that this measure may be incentivizing some practices that actually have -- there's some evidence, and one could argue about the strength of the evidence, about increasing mortality because people are actually avoiding readmissions when they're needed. So it's just worth having some discussion about

that.

MEMBER HOUTROW: Yes, as someone on the receiving end of transfers from acute care hospitals to rehabilitation, I can say that our department, you know, one of the reasons that we are able to encourage primary services to hold onto their patients in the hospital to maintain medical stability prior to transfer is measures like this, because bounce-backs negatively impact the service that's discharging the individual to rehab.

And we have over the years had a major problem with high-acuity patients needing a higher level of care than can be provided in the inpatient rehab setting. This has been very helpful in terms of making sure that the referring services assure that the patient is actually medically stable to transfer.

To Harold's point, I think thinking about how these types of measures incentivize behaviors kind of across the spectrum is really important when we consider adding it. And so the

concern that people are just not being allowed to be readmitted, and that might actually be increasing morbidity and mortality, is also incredibly concerning.

CHAIR ANTONELLI: Jeff?

MEMBER SCHIFF: I have a question that I'm not sure David or Judy would know. But we did, the Medicaid Medical Directors did a review of readmissions, and many or most of these were for mental health conditions. And I just wanted to learn more about that from somebody who had more expertise, if they knew.

And then, just one other quick comment is, in the Scorecard, I wonder if this would fail because of some of the comments that were made by the lead discussants under promote effective communication and coordination of care versus the chronic care domain. I think that this seems to be appropriately in that category.

CHAIR ANTONELLI: Ken, and then, Steve. And then, Sue Kendig, you're third in line.

MS. KENDIG: Okay. Thank you.

MEMBER SCHELLHASE: So to answer Jeff's question, at least in little ol' Wisconsin, in our corner, the mental health diagnoses are clearly the largest cause of readmissions. So that's certainly true for us.

I have a couple of things. One is a question. And that is, for this measure, I was just looking at the specifications. I can't tell. Does the index admission have to be a truly inpatient status admission or can it be an observation admission? Is that something we know?

MEMBER MORROW-GORTON: I believe it has to be an actual inpatient admission, not a --

MEMBER SCHELLHASE: Not obs?

MEMBER MORROW-GORTON: -- you're going to stay in the ED forever and try and figure out what do you call that.

MEMBER SCHELLHASE: Well, an observation, actually, is people sitting in the hospital on a regular floor.

MEMBER MORROW-GORTON: Right.

MEMBER SCHELLHASE: And just, you know, it's the whole idea of lower-acuity care.

MEMBER MORROW-GORTON: But that's an outpatient --

MEMBER SCHELLHASE: It is. So you're following that dichotomy. I just wanted to make sure that that was clear.

CHAIR ANTONELLI: We'll get the specific case. So the measure developer, we're not going to ask you for comment, but if you would like to just specifically answer that question?

MEMBER SCHELLHASE: From a clinician's perspective, that doesn't usually look very different.

CHAIR ANTONELLI: Right.

MEMBER SCHELLHASE: Right? I mean, that's really an insurance industry distinction. And so that's why I'm asking. From a clinician's perspective, they look awfully similar.

CHAIR ANTONELLI: Okay.

MEMBER SCHELLHASE: The last thing is getting to the risk adjustment concerns that I'm well aware of. And this is probably a dumb question. The Scorecard is really intended to stay at the state level. So we're looking at a score that an entire state's Medicaid program gets. Is that really how this will get pushed out?

MS. LLANOS: So the measures submitted by states are at a state level, and that's what we would use for the Scorecards, yes.

MEMBER SCHELLHASE: Okay. So I think certainly, again in our little corner of the world, there are real differences in risk. Our State pays us differently because we have a higher-risk population using their own risk adjustment methodology. So it's a real thing.

But if you equalize that on a state level, certainly the health plans probably won't be in a kerfuffle about that. The states might feel like they look bad if we think that Wisconsin has got a lot of sicker people than

Illinois, whatever. But I think that that addresses some of that risk adjustment issue if this remains at a state-level score.

So thank you.

CHAIR ANTONELLI: Stephen?

MEMBER LAWLESS: Yes, actually, ditto on both. So I'm not going to repeat both the comments he made here.

The one comment I have here is, is the readmission, multiple readmissions within 30 days counted as a one or is multiple counted as the number of readmissions?

MEMBER MORROW-GORTON: I believe it's counted as one. I mean, we can ask the developers. But it's an index stay and it is one admission, even though there might be multiple admissions within that 30-day period. It's just one.

MEMBER LAWLESS: I think that counts, if you do it that way, to the person who is the frequent flyer, the bouncing and bouncing around gets missed.

MEMBER ROMNEY: So it says in the measure description the numerator is the count of 30-day readmissions. So that would imply each admission is counted.

MEMBER LAWLESS: But if you go to description, it's one or more.

CHAIR ANTONELLI: Yes, NCQA is here. So let's pause for a second. Why don't you jump in, please?

MS. BYRON: Thanks. This is Sepheen from NCQA.

So each admission can be an index stay. This is looking at observed over expected. So I have colleagues on the phone who can speak more deeply about the technical specifications.

Robert Saunders should be on. So if you want to unmute? Robert, do you want to go into more detail?

MR. SAUNDERS: Hi. Yes. So there may be some element of confusion about the history of the measure. Once upon a time, we would only count, we would count the readmission within 30

days of its own index of that. And so that limited the pool.

But the way the measure is set up now, every readmission can itself be an index of that. And so if you were readmitted within 15 days, that new admission becomes a new opportunity to prevent another 30-day readmission.

MEMBER COGAN: I think the question is what is the count of the numerator? So the way I interpret this is it's the count of index stays that resulted in a readmission. I think that's the part that we're stuck on, is, what is the numerator actually counting?

MR. SAUNDERS: Right. So it is saying, how many of the index stays had a readmission that occurred within 30 days?

MEMBER COGAN: And if there were multiple admissions, it would be at least one?

MR. SAUNDERS: So if you had a readmission 15 days later and a readmission 20 days later, it is you're just counting one. One, this index readmission had a readmission. It,

therefore, failed the quality measure. We don't pile on that you had two or three or four readmissions for the same index of that.

CHAIR PINCUS: But I think what you're saying is that there would be two index events. So there actually would be two readmissions?

MR. SAUNDERS: Right. So for any index stay, there can only be one readmission within 30 days. And you start a new calendar for -- so if you're admitted on January 1st and get readmitted on January 15th, that closes out the books on that first index stay. So now, we're looking at the January 15th stay. Did that have a readmission within 30 days? And that one might not have a readmission for 30 days.

So this person would contribute two index events. They would have one readmission that is within 30 days. And that would be their count, and that would contribute to the total number of index stays and the total number of index stays that had a readmission within 30 days.

CHAIR ANTONELLI: Stephen, were you done?

MEMBER LAWLESS: That's good, I mean the clarity. So thank you for that.

Where it hurts, then, is if you are trying to do a benchmarking and seeing how many patients who have more than one disease have been multiply admitted. So it captures the data on an aggregate level, but just limits the benchmarking capability on looking at individual patients, I think. Maybe I'm missing it, but I think it does. So it hurts with the drilldown after that.

CHAIR ANTONELLI: Sue, on the phone.

MS. KENDIG: Hi. First of all, it's really hard not to be there. I miss being with you all. It's hard to participate over the phone.

But I want to kind of bring us back to something that was said when this was introduced. And that was the importance of integration with community supports for this. I think that's why I think this is such an important measure because

it's not just about what's happening in the hospital and the clinical care, which seems to be what we tend to focus on, but really provides the opportunity to look at those root causes of why there are disruptions and discontinuities in care once a patient is discharged into the community.

So I think it really incentivizes providers to better integrate with community resources and also provides us with the opportunity to look at why these readmissions are occurring and why people may not be accessing the care they need during those 30 days. So for example, are there transportation failures, even though services may be provided by the payers, and so forth?

So I like the idea that this actually helps to incentivize us in getting where I think we want to go, which is aligning both the community and clinical resources to improve outcomes.

Thanks.

CHAIR ANTONELLI: Sally, David, Jill,

Josh.

MEMBER TURBYVILLE: Good morning.

This is just a comment because in child health measurement -- and I just want to make sure it's kind of accounted for -- we're often put in a position where measures that work and are really important in adult health systems probably apply to child health systems. And there is a very similar measure not on the core set yet, I believe, that has a lot of value, and that's looking also at readmissions for pediatrics, all cause. I just want to note that we do not see the same high rates -- usually, average 5 to 6 percent readmissions -- with that standardized measure. There are some subpopulations where we might see higher, like 10 percent.

So just as a note, whatever happens to this measure, that a re-deliberation on any kind of similar measure being applied to children would be really critical in order to mesh out whether or not it's worth the juice to squeeze

with other quality issues being present in pediatrics.

CHAIR ANTONELLI: David?

MEMBER KELLEY: So I would support adding this measure. We've looked at this extensively. Our Medical Directors Network published an article on multiple states. There were a significant number of mental health admissions, but they were not the majority.

In our State what we do, we've actually been reporting this and it's been part of our MCO pay-for-performance for, I'm going to say, many years, probably five or six or maybe even seven years. We have not established a benchmark because NCQA did not have a benchmark established. So we incent our plans on incremental improvement year over year.

We also use this measure specifically at both physical and behavioral health readmissions for individuals with serious mental illness. We have our EQRO create a specific measure to hold both our physical and behavioral

health plans accountable. And that model, the majority of admissions clearly on the physical health side.

So this is a metric that at the state level we're fine with reporting it. And even though it's not perfect, it's a good indicator for care coordination, especially between physical health and behavioral health, to make sure that they're working together.

And from my standpoint, our managed care plans do pay attention to this measure. We also have an upside-only positive incentive for hospitals for both preventable and readmissions. So we're only rewarding the hospitals in our model. Our MCOs do not have a penalty as well. This is all upside-only.

MEMBER ZERZAN: Although part of that study that I think Jeff was getting at, if you drill down into the physical things -- I think Pennsylvania did this and Colorado did, too, at the time -- a lot of the GI readmissions are related to alcohol abuse. A lot of the

cardiovascular readmissions were related to IV drug use. So even though the behavioral health alone wasn't it, if you drilled into a lot of the physical health, they had that behavioral health overlay.

CHAIR ANTONELLI: Jill?

MEMBER MORROW-GORTON: So I just want to speak real quickly to the Health Affairs article that Harold was talking about that I actually happened to read like two days before I came. And I thought, oh, no, because I was supposed to be, you know, really positive for this measure, and I really am.

(Laughter.)

But when I thought more about that article, the population is a very different population. This was the over-65 population. It was a Medicare population.

They looked at three conditions, and the results were really mixed. One of the conditions, the mortality was higher. The other two, it was not.

So I think the sort of answer to that is still not clear. It's clearly a risk. I think if you look at it from an upside payment, rather than looking at downside, you may avoid that perverse incentive.

And I think from a statewide vantage point, we've started benchmarking this measure, at least to get a sense of where everybody is. So I think it's doable, even without a defined benchmark. You know, you can use some of the benchmarking frameworks and principles.

CHAIR PINCUS: Yes, I wasn't necessarily endorsing the study, but I wanted to make sure we had a discussion about it.

CHAIR ANTONELLI: Josh?

MEMBER ROMNEY: I just think, as we transition to a world of value-based care and population health management, transition of care is maybe the top one, two, or three things we need to do better at, and to have that on the Scorecard is important, as there's always measures, other measures you can do. But this is

something that people are familiar with; they've been working on. And it's something that does drive coordination between hospitals, post-acute settings, and clinics. And everyone needs to do a better job of coordinating.

CHAIR ANTONELLI: Josh, I want to ask you a follow-up question. What I heard you say was that it's an important concept, but I didn't necessarily hear you say and this is the measure. So could you say a little bit more concept and specific to this measure versus --

MEMBER ROMNEY: To me, the concept is transition of care.

CHAIR ANTONELLI: Correct.

MEMBER ROMNEY: Transitions of care need to be improved. And you can look at people looking at this as, oh, I need to not readmit people. But what we really send the message with using this measure is improve your transitions of care. And this is the best measure that I know of to facilitate that vital behavior.

CHAIR ANTONELLI: Okay. So you are

talking about the concept and specifically 1768? Okay. Thank you.

Harold?

CHAIR PINCUS: Just one point about the discussion raised earlier about behavioral health admissions. Yes, behavioral health readmissions represent a significant proportion, but, interestingly, a not insignificant proportion of those readmissions are not for behavioral health reasons, but are for general medical reasons.

CHAIR ANTONELLI: And Jordan, no hands online?

MR. HIRSCH: No hands.

CHAIR ANTONELLI: Okay. Is there a motion?

MEMBER ANDERSON: I move that we add 1768, All-Cause Readmissions, to the Scorecard.

CHAIR ANTONELLI: Second?

MEMBER KELLEY: I'll second.

CHAIR ANTONELLI: Okay. So what's going to happen now is we'll open for public

comments. And then, we have the measures from yesterday and the one from this morning. We'll actually go through that voting process.

So let's open for public comment, please.

MS. KUWAHARA: Sure. So everyone's lines are open.

And just to recap the measures that we put forth to vote on, there's Adherence to Anti-Psychotic Medications for Individuals with Schizophrenia; NQF No. 0105, Antidepressant Medication Management; NQF No. 0038, Childhood Immunization Status; 1448, Developmental Screening in the First Three Years of Life, and 1768, Plan All-Cause Readmissions.

If any member of the public would like to offer a comment, your lines are open.

And are there any members in the room with us today that would like to offer a comment?

CHAIR ANTONELLI: All set? Shall we vote?

MS. KUWAHARA: All right. We'll

proceed to voting.

CHAIR ANTONELLI: So it's the same link as yesterday.

MR. HIRSCH: So we are now voting on Adherence to Anti-Psychotic Medications for Individuals with Schizophrenia. And your options are, 1, to support recommendation for addition to the Scorecard, or, 2, do not support recommendation for addition to the Scorecard.

CHAIR PINCUS: Does everybody have it up on their computer? Okay.

CHAIR ANTONELLI: Miranda, it came from you? Or did it come from MAC?

MS. KUWAHARA: It came from the MAC Scorecard yesterday morning. And if it's helpful for folks in the room, I can forward that again, so it's at the top of your inboxes.

CHAIR ANTONELLI: Yes. Could you, please?

MS. KUWAHARA: Okay. I'll do that now.

CHAIR ANTONELLI: I've gotten a

thousand emails since yesterday.

I think we're waiting for one. Oh, there we go.

MR. HIRSCH: All right. For Adherence to Anti-Psychotic Medications for Individuals with Schizophrenia, 23 Committee members have voted in support; 7 Committee members have voted to not support. This amounts to 77-percent Committee members voting to recommend addition of Adherence to Anti-Psychotic Medications for Individuals with Schizophrenia to the Scorecard.

Committee members will now vote on NQF No. 0105, Antidepressant Medication Management.

For NQF 0105, Antidepressant Medication Management, 12 Committee members have voted in support and 19 Committee members have voted to not support this measure, which amounts to 39 percent in support and 61 percent of Committee members have voted to do not support. Therefore, Committee members have voted not to recommend the addition of NQF 0105, Antidepressant Medication Management, to the

Scorecard.

Committee members will now vote on NQF No. 0038, Childhood Immunization Status, with option 1, to support recommendation to the Scorecard and, option 2, do not support recommendation to the Scorecard.

Committee members have voted for 29 in support of NQF 0038, Childhood Immunization Status, while 2 Committee members have voted do not support. Ninety-four percent of Committee members have voted in support of recommending NQF 0038, Childhood Immunization Status, to the Scorecard.

Committee members will now vote on NQF No. 1448, Developmental Screening in the First Three Years of Life.

For NQF No. 1448, Developmental Screening in the First Three Years of Life, 28 Committee members have voted in support; 3 Committee members have voted do not support. Ninety percent of the Committee has voted in support of recommending NQF No. 1448,

Developmental Screening in the First Three Years of Life, to the Scorecard.

And now, Committee members will vote on NQF No. 1768, Plan All-Cause Readmissions.

For NQF No. 1768, Plan All-Cause Readmissions, 27 of the Committee members have voted in support; 3 Committee members have voted do not support. Ninety percent of the Committee has voted to recommend NQF 1768, Plan All-Cause Readmissions, to the Scorecard.

MS. KUWAHARA: So to summarize the votes today, the Committee recommended the addition of the four measures to the MAC scorecard, adherence to antipsychotic medications for individuals with schizophrenia, NQF Number 0038, childhood immunization status, NQF Number 1448, developmental screening in the first three years of life, and NQF Number 1768, plan all cause readmissions.

And for those of you in the room monitoring the voting screen, you'll notice that the denominator was 31 today. We've confirmed

with Julie Bershadsky, who is a member, she is casting her votes remotely. She was unable to join us yesterday, so.

CHAIR PINCUS: So I would add to that summary that not only have we made these, conducted these voting processes, but we've also had ample and active discussion across all of these that will hopefully inform some of the decision making at CMS.

CHAIR ANTONELLI: Rhonda.

MEMBER ANDERSON: During the discussion, the all cause readmissions was discussed as potentially care coordination. And when we look at it, it is not in that area of, or that domain right now.

Is it a recommendation that goes into the minutes or what happens in terms of where it might be moved?

Because it really, to me, and I think I heard kind of consensus from everyone, that it is care coordination or more of the care coordination principles.

CHAIR PINCUS: Let me ask Karen, just, you know, how important is it in terms of the categories that you have and how do you use the categories?

MS. LLANOS: So we use the categories to see how if there are, how we are aligning to our agency's meaningful measure of stream work, which is what comprises those categories.

So as I noted yesterday, they are subjective. There is a lot of overlap, as you can imagine. Several measures could fit into multiple domains.

So I think if there is a suggestion that you want to make we can certainly take that into consideration. And then I'll also say we also used it to see where some key gap areas are.

MS. GORHAM: And I just want to add that, when you all sent your measure recommendations in, the domains that we placed recommendations in were NQF Staff. So that was where we placed the domains. But we also noted, as Karen just said, that they could fall into

multiple domains.

CHAIR ANTONELLI: Lindsay and then Rich.

MEMBER COGAN: So, Karen, and this goes back to, again, either accountability or maybe further development of the scorecard, so you may not be able to answer this, but is there any plans to take these measures, roll up domains and then roll up across to give almost a composite, like in a quality rating system, but a quality rating system for a state Medicaid agency?

MS. LLANOS: So we haven't made those types of decisions. I think in terms of things that have been discussed, the display and how, if the measure would be rolled up or not, all of those things have come up in terms of feedback that we've actually gotten from a lot of our stakeholders.

So it's a common question. But we haven't made any decisions in terms of something like that.

MEMBER COGAN: Okay. That's where I think the issue of domain gets to be important, because we currently have a lot of measures in the one domain. And if we were to kind of roll those up, they would significantly have less weight, unless you were inherently weighting them. So just some further notes to think about.

CHAIR ANTONELLI: Yes. And so I'm actually going to step out of my co-chair roll and like to make a comment.

I am a member of the NQF Patient and Experience and Function Committee, which is about to get renamed, I think I can say that, Patient Experience and Function and Care Coordination Committee.

One of the issues that I have had, working with individual states and delivery systems when they are looking for measures, will often go to places like the readmission measure, which, on its face, is about utilization. And that there is a conflation that, well yeah, we can fix that by doing care coordination, whatever

that is.

And I want to caution us. There's no question that there are opportunities for improving care coordination across settings and sectors and disciplines, including patient self-management, et cetera, et cetera.

But I want to make sure, I for one don't feel comfortable just saying, yes, just drop it in a domain. Because I think that the opportunity to bring measures that are meaningful for care coordination and integration is also, for me, it's as important as selecting which measure that we use.

So, Rhonda, wherever you went, thank you for raising, raising that issue. But I think we need to have a conversation with appropriate minutes collected about what does that mean.

But on its face, I can tell you most entities that I have dealt with, especially on the payer side, think readmission is a utilization measure and that the care coordination will get, just, stuff will get

figured out. And that's not how systems are organically designed.

So I would appreciate it if that could get recorded in the minutes and NQF doing its internal reorganization with the PEF Committee, I think is really, really important. I think you're on that Committee with me aren't you, Carol? Aren't you on PEF? You're not.

That's the Page and Experience and Function Committee. And then care coordination is going to get folded into that. Jeff.

MEMBER SCHIFF: So, Rich, I'm a little confused by your comment. Are you advocating for this being in the care coordination domain or not?

CHAIR ANTONELLI: So what I'm advocating for, so now I'll sort of flip back to my Chair role, is I'd like to have a discussion with it. I didn't feel comfortable that somebody would make a suggestion, and that kind of makes sense.

And Lindsay sort of set the stage for

me to make that discussion. If you're looking at how many measures are in each bucket, and with the appropriate way things would be.

MEMBER SCHIFF: Right.

CHAIR ANTONELLI: So I'm making the observation as the Co-Chair, there hasn't been enough discussion, in my view --

MEMBER SCHIFF: Okay.

CHAIR ANTONELLI: -- to justify that, okay, yes, care coordination, this is a care coordination domain measure. We haven't discussed that.

So I would like, at some point, to bring that up for discussion, either in this group or, Karen, if allocating measures to each of those domains is something that CMS would prefer to do. So I'm calling it as an open question right now.

I'm willing to make a recommendation, but I'd like to hear other people's thoughts --

MEMBER SCHIFF: Right.

CHAIR ANTONELLI: -- if this Committee

is inclined to debate it.

MEMBER SCHIFF: I think that was my comment originally, was that I think it would serve the people we represent better to have it in the care coordination domain. It's not, like, all these measures, none of them are perfect, but putting it in that domain would have systems that just look at where they land and hence who is assigned the task of dealing with that as less of a utilization measure and merit of a system care coordination measure.

CHAIR ANTONELLI: That kind of language embedded in the recommendation is exactly what I want to capture. Lisa.

MEMBER PATTON: Yes, that's where I was going to go was that we have to be very clear in the accompanying language, that that's really sort of the impetus for this group in putting this forward.

Because I think that in many instances beyond a lot of the people in this room, people are going to look at that measure and look at it

strictly as a utilization measure. And they're going to be interested in hitting that mark and that's it.

And so I think to drive it and to have an expanded look at it, moving it to the care coordination domain and talking about it very clearly in that manner will help.

I'm the co-chair for the recently launched NQF Social Determinants of Health Data Integration Work Group. And so we're looking very carefully at the disparate data sources that would bring in a lot of those SDOH factors and those kinds of community collaborations.

And this is essentially a different tool and a different approach that would be supportive of that big picture thinking around these issues.

CHAIR ANTONELLI: Okay. So David, Carol, and Kamala. And Jill.

MEMBER KELLEY: So I would think of the readmission measure really being associated with care coordination. And in our programs, we

are incenting plans and -- or incenting in our patient-centered medical home, coordination of care to reduce readmissions.

So our patient-centered medical homes are focused on getting individuals with, enable to our care sensitive conditions, missions related to those, not all admissions, but to get them back in their, back to their primary home, medical home, within X number of days.

So we really look at this as a metric that tells us whether or not we're seeing better care coordination. It is a utilization measure and we hit our plans up on that. But we expect our plans, as well as our patient-centered medical homes, to really coordinate care looking at both preventable admissions but also readmissions.

So in my mind, it is a proxy for, hopefully better care coordination. I would also say that when you look at initiation and engagement, that measure, if that is done correctly, that is all about care coordination.

Because these are new individuals with a new diagnosis in what is actually happening to them. So are they initiating into treatment but are they staying engaged in treatment.

That is a coordination of care measure. And we handle that as such. It is in our combined integrated care program incentive for our MCOs.

And we just rolled out an incentive program to EDs in Pennsylvania.

CHAIR ANTONELLI: Yes.

MEMBER KELLEY: So it is, we really view this as a care coordination measure.

CHAIR ANTONELLI: Yes.

MEMBER KELLEY: It's access and availability of services, but it's also a care coordination measure.

CHAIR ANTONELLI: Yes.

MEMBER KELLEY: Thirdly I would probably argue that for Medicaid, the dental measure, it's an access to care measure. But if you really want to hold your plans accountable,

it's also a coordination of care measure.

It's getting that child, getting care management there so that child actually gets to that visit. Because in many instances, we have access to care and we have availability, but just not getting there.

CHAIR ANTONELLI: Yes.

MEMBER KELLEY: So, again, some of these measures could be bumped up into the coordination a little bit more.

CHAIR ANTONELLI: Yes. And if I could just make the observation. So you just gave an elegant rendering of all the reasons why an all cause readmission measure would be an indicator of appropriate care coordination, but it wasn't that, there was a period of magical thinking and that somehow this would happen.

I mean, you talked about access, you talked about the PCMH, you talked about the hand-offs, you talked about engagement, et cetera. So that's the kind of stuff that I want to capture back into this report. So thank you,

David.

Carol, Kamala and then Jill and then Shayna.

MEMBER SAKALA: So I'm going to also support this measure, plan all cause readmissions, as a care coordination measure. And I'd like to do it from the point of you, of a system that's moving toward alternative payment models.

I would include different types of healthcare homes, episode, population. What we want is everybody to be working together toward the same goals.

So from the point of view of where our system is heading, I think this is a good move as well.

MEMBER ALLEN: And my comment is really, as we think about the end user of the scorecard, that putting it in the care coordination domain makes it clear the intent of the measure.

Because I think, just as the

conversation was going on about the measure, not being a clinician, it was important for me to hear that that's how it was really being used on the ground. So I think without having that reflection, people would miss that.

CHAIR ANTONELLI: Jill, Shayna.

MEMBER MORROW-GORTON: I have some concern about that in the sense that people tend to associate care coordination with people with complex medical needs and disabilities. And not the person who needs help getting from A to B, who could use some assistance.

And I would worry that if we put it in that group without sort of using the broader meaning or broader definition of the word, that it would get interpreted in the more narrow way and we would lose the other pieces around it.

So I think it really is a utilization measure. I think it really belongs where the acute care hospital stuff is because I think it's got to get to the attention of those individuals and not to the attention of the disability

community, which is much smaller and already is all over care coordination.

It also is, I wouldn't want it to try to take the place of a real care coordination measure because I don't, you know, I think its way up in the stream. Yes, it can give you some sense of how well people are doing around the discharge planning and looking at transportation and those sorts of things.

But that would be my concern is that then people would say, well, we got a care coordination measure, it's perfectly good, we don't need to think beyond it. And, we don't have to think about that because it's care coordination, they're going to do it.

CHAIR ANTONELLI: Shayna.

MEMBER DAHAN: So I like this measure because it looks, it does seem pretty much care coordination to me, but I do think that these types of measures should get a little bit more specific because hospitals are now saying follow up with your PCP in two to three days.

So sometimes that does cause some unnecessary utilization, would be to come back to me to make an appointment with a pulmonologist that then I put you on a list for three months for that appointment. Where what I think really should happen within the hospital system is, they make the appointment with the specialist.

Because, if you've been inpatient, most of that stuff is not going to be probably best treated sometimes at the primary care so I think that, as far as when you look at readmissions, what would actually be the most useful data would be to see if after an inpatient stay that person was given an appointment with the appropriate specialist or follow-up in management and treatment for the reason that they were admitted.

CHAIR ANTONELLI: Thank you. Kamala, are you left over?

Good. So, Stephen, last word to you.

MEMBER LAWLESS: I'm actually fascinated in a lot of ways but also intrigued

that it's a process measure. So I think if it links with process it really is more about the process care coordination or part of the process of care coordination system versus an outcome measure. Which would be in results.

I think it was, I think it supports that it's a process measure, it's about care coordination. Rather than outcome, which would be something different.

CHAIR ANTONELLI: Yes. Okay, thank you. So what I'm hearing is, there's general consensus for this to be in the domain around coordination of care.

But if the report, the recommendation could have underlying it, and in fact, Dave Kelley's rendering I think is exquisite. And it's not just blue sky it's what they're doing, that's almost the play book that we could shamelessly steal and promote.

So I'm really comfortable with moving that forward. And I don't have the need to have a motion made. So I think we're going to close

this out now.

And then, Shaconna, over to you.

MS. GORHAM: So I'll actually turn it over the Miranda. She'll read all of our final decisions and recommendations that will be put forth to CMS, and then we will go into ranking of the measure additions.

And we have, on the wall behind you, the actual measures listed. And Jordan will pass out stickies. So we have four measures that you all voted on to recommend to CMS, so he will give you three stickies.

You can put all of your dots on the same measure. And when we say ranking, just as a reminder, we mean that you can put all three bullets on 1768, for example, and that could potentially be your signal to CMS to say this is the most important measure to add to the scorecard.

But we will see where the dots fall out and we will rank and we'll give you the listing after the ranking.

MS. KUWAHARA: Thanks, Shaconna. So ordinarily we would hold this exercise for both removals and additions, but because we only recommended removal of one measure, which was use of multiple concurrent antipsychotics, Pages 1 through 17, we're only holding this exercise for measure of additions.

And to recap again, there were four measures recommended for addition to the MAC scorecard. The first is 0038, childhood immunization status, NQF Number 1448, developmental screening in the first three years of life, 1768, plan all cause readmission, and adherence to antipsychotics medications for individuals with schizophrenia.

And, again, this is a physical prioritization exercise, so for folks participating remotely, know that we're going to be offline for a few minutes and then we'll come back.

And, Julie and Sue, if you would like to place your prioritization ranking via the chat

function, we can record it. Put sticky notes here in the room.

MS. GORHAM: Don't all run up at once.

(Whereupon, the above-entitled matter went off the record at 10:34 a.m. and resumed at 10:52 a.m.)

MS. KUWAHARA: So staff took count of everyone's rankings, and I will read off the rankings in order of priority. The first was 1448, developmental screening in the first three years of life.

Next was 1768, plan all cause readmissions. And then adherence to antipsychotics medications for individuals with schizophrenia was tied with NQF Number 0038, childhood immunization status.

CHAIR ANTONELLI: Okay. So we are now moving into a different phase of the work today, around the scorecard measures to drive change and overall system performance.

Recall that there are three -- Kamala?

MEMBER ALLEN: Yes, Richard, I just

have one question about the ranking. The prioritization.

Is the goal that there not be a tie so is there like another round of ranking that you want us to do or it's sufficient to have --

CHAIR ANTONELLI: Very pragmatic question.

MEMBER ALLEN: Okay. Because I'm just wondering if you want everyone to now have one dot --

CHAIR ANTONELLI: Yes.

MEMBER ALLEN: -- and they just have to put them, you know.

CHAIR ANTONELLI: So who --

MEMBER ALLEN: I don't know what you need.

CHAIR ANTONELLI: Yes, ties are acceptable.

MEMBER ALLEN: Okay, thank you.

CHAIR ANTONELLI: Welcome to our democracy.

(Laughter.)

CHAIR ANTONELLI: All right, so talking a little bit about this I want to remind people that three pillars, our work is focused on the scorecard, which is pillar one. And these are the discussion questions. Now we're going to be opening this up.

So from the state Medicaid perspective, what are the health system performance changes you expect from the measures in the scorecard?

Aspects of the health system performance can be impacted, what aspects can be impacted with the scorecard, existing scorecard measures?

And remember you have the sheet from yesterday we tweaked to increase the impact of these measures in changing system performance.

And then what state level factors are important for maximizing the scorecard impact and overall health system performance?

So these are some of the questions for discussion today. We will open this up. And

then, Jordan, just assure our members on the phone have -- are they open to voice, or are they raising their hands?

They're un-muted, okay. All right. So a moment to reflect and then we can go ahead and get started. And, Marissa, you'll be our lead off and then Sally.

MEMBER SCHLAIFER: I just had a question. On the question, how can existing scorecard measures be tweaked, what do we mean by tweaked?

I mean, I know we can't change the measures, is it tweaking by prioritizing? What do we mean by tweaked?

CHAIR ANTONELLI: Karen, I'm inclined to maybe put that question out for you. Can you think of a way that --

MS. LLANOS: I mean, any changes would have to stem from the core set.

CHAIR ANTONELLI: Right.

MEMBER SCHLAIFER: Okay. So it's -- okay. So there may not be an answer to that

question.

CHAIR ANTONELLI: It may not be but I actually think that the experience we had yesterday with the perinatal measure as a placeholder and operationalizing that, and then quite honestly, I wouldn't mind, for the sake of the creating the public record, to talk a little bit about that developmental trajectory of, we are attached to whatever is in the core sets for recommending addition, or deletion, from the scorecard.

What would this group do in terms of prioritizing either gaps or modifications of existing measures to make that better, where does that system feed into each other?

Because I, I don't mind being open with everybody, what I've been struggling with, although yesterday's conversation for me was very helpful is, I didn't know how this group fit in with the rest of that ecosystem. I used to be on the group here that curated the core sets. And then this was an additional piece.

So there is some clarification coming from me, but I think that that's kind of what I'd like to hear in this conversation, okay. So I have Sally and then Clarke, and then is that Ken or Stephen, I, yes, okay.

MEMBER TURBYVILLE: So this is a question. And I don't know that it has to be answered today or maybe it's a call to action.

I'd love to better understand not, and learn from the conversation today, about how we can continue to tap into what are the health system performance changes that we might expect from the scorecard. For us it will be very helpful for us to, as we're working with our member organizations, which is pretty much all children's hospitals in the country, to help them prepare to be good partners in what the states need.

And so thinking about, in addition to the conversation in the record that goes, what role could CMS or other organizations that we and other like-minded organizations can tap into, not

just today but in the next year, again, so that we can do a better job in preparing our member organizations.

CHAIR ANTONELLI: Clarke.

MEMBER ROSS: Just an observation from a predominant sentiment and perspective and feeling within the consumer family movement and disability. And that is that our quality measures or our regulatory enforcement requirements, the most effective way of impacting change in the Medicaid program.

So is accessible mammography for women who use wheelchairs, is that an ADA regulatory requirement or is that a quality measurement?

Is re-balancing the system allocation between institutional settings and home and community-based service settings, a policy regulation or is it a quality measure?

And a lot of organizations and individuals in a consumer family movement and disability, they're happy that I'm here but their real focus is on using the regulatory mechanism

to enforce ADA and related kinds of modifications.

And, so we sit around focused on quality measures but a lot of folks who are impacted every day, don't focus on this. It's just, I don't know how to capture that in the discussion but it's a dynamic that I'm faced with every day.

CHAIR ANTONELLI: Yes. So I'm going to come back to you. Are you formulating a gap that has a potential solution or are you looking at a dichotomy and after the last day and a half you're not quite sure that you've heard anything here that would help you bridge that divide?

MEMBER ROSS: I, I'm not going to recite, re-answer that in the way you've asked it. In thinking about how to impact change, in my case, people with disabilities, particularly adults, we have to look at multiple factors.

Quality measures being one, domain of those factors, legal rights under the Americans with Disabilities Act being a second factor,

where we spend money in a policy sense is a third.

So I think that if adherence to medications and schizophrenia is actually an identifiable quality measure that state Medicaid agencies and others are working with, that will result in significant system change for people with schizophrenia. Our most disabling of mental illnesses, and probably the most disabling condition we face.

So I don't know if that's coherent enough to respond, but --

CHAIR ANTONELLI: So I'll move on but I just make the observation. I know when this roster was being formulated, there was a very specific focus to bring in enough sensibility and perspective of LTSS and this extra vulnerable populations.

And so I think that, what I'm hearing you say is, what's the added value of the quality measures of the promotion thereof and how do they relate to the regulatory environment. Because

the answer is clearly, it's a both, it's not an either or. Okay, thank you for that.

Stephen, Harold, Carol, Jill and then Amy.

MEMBER LAWLESS: To the answer about --

CHAIR ANTONELLI: After Amy, Kim.

MEMBER LAWLESS: -- the expectation of performance. A lot of work on developing the measures.

I hope that the plans will, the states will see this. They realize the power and comparison --- of comparing data but also opening up the discussion about whether system performance is there.

There was a hint about how hard it is to collect data. And people spend more of their emphasis on just collecting the data and saying, Ryan, we've finally got it in our EMRs, click, click, click, send it, leave it alone, we have no time for something else, than it's been a wasted exercise.

But if it's been more of a, all right, now let's have the discussion with the hospitals about system performance, that would be the trigger of the performance, that would be fantastic.

CHAIR ANTONELLI: Harold.

CHAIR PINCUS: So a couple of thoughts. One is, if you think about it, sort of the pyramid or triangle of having like a full range of measures up to the core set, up to the scorecards that allows, from the good side of focusing on particular issues that are deemed of high importance.

The potential negative of that, there is the ignoring of other things. And so that as things move forward, to keep some kind of surveillance so that you're not just looking at the scorecard but that you're looking at some breath of quality and, sort of across disorders, across different domains and so forth, so that it's not exclusively focused.

And that means, obviously, you're not

going to have full reporting on all of these things, but there may be other ways, both quantitatively and qualitatively.

The second piece of this is also to begin, as this moves forward, to think about, what are the mechanisms by which change occurs. So that as you're doing this, obviously there's going to be changes that are occurring both within states and across states.

And some efforts, and again, this is sort of research kind of thing, but it has very, very practical implications in terms of understand what accounts for some of the changes to understand both the mechanisms involved and what states, what plans, what providers have don't to sort of take action based upon what's being measured.

Because we know the power of measurement, and the question is, how was that power exerted and can we better understand that process and then apply sort of a more rational approach to measurement and how we, what are the

consequences of measurement.

CHAIR ANTONELLI: Carol, Jill, Amy.

MEMBER SAKALA: I just realized that, I think were, my comments are more suitable toward maybe the next section, so the future of the scorecard, they're kind of crosscutting, so if that's going to happen, I'll just wait.

CHAIR ANTONELLI: Yes, it will happen. Jill.

MEMBER MORROW-GORTON: So I think what we have to think about is, we can measure things and then we have to think about, can we fix them, can we improve them. And can we fix them and improve them in a meaningful way that's cost effective and that improves quality of life and improves quality of service as opposed to, can we just put it in the EHR and meet the number and be done with it.

And I think some of the, having a measure is great but the real work is underneath, figuring out what's the, sort of what are those things leading to that result, what are the ways

and the solutions to be able to improve that. That requires partnerships with research and the literature and other models that have been used in other places and that sort of thing.

So I think there's a, you know, it's great to have the measure and the number but there's a lot of work underneath that and I think that's where states and health systems will need assistance to make this successful.

CHAIR ANTONELLI: Amy.

MEMBER HOUTROW: Yes, I was just reflecting on what Clarke was saying and it seems like we, in the future, have some opportunities for measures that may address the population that's high cost and high need.

We know, at least for children with disabilities, the kind of issues around respite care and long-term services are the number one highest percentage of unmet needs. And that if there are some measure that we have, that then little a, big A accountability becomes more important.

I think in the disability space, the idea of using the ADA in a regulatory way to say we need access, it seems like the less hard hurdle to climb than it is, in some ways, to get services where you can wait on a wait list for years. And it doesn't seem feasible to climb that mountain.

And so I think I really appreciate what you said, Clarke, and wanted to challenge us in the measure development world and really be thinking about how we make measures and really get at some of these important issues.

CHAIR ANTONELLI: I totally agree with you guys that's why I'm grateful that you brought that up because we do have to connect these two universes. So I have Kim, Camille, Jeff.

MEMBER ELLIOTT: So I think of the scorecards really as quality. Everything that we're working in is focused on the quality of care and services that these are really representing.

But these measures that we're

including in the scorecard are really indicators of a lot of other things. So really, when I think about the measures that we're including in the scorecard, what that's going to drive down to the state level then down to the manage care level, down to the provider level.

And all of those things are going to keep trickling back up to really be that indicator of the quality of the care that we're providing. So that's why I think it's just important to include those measures that will have that kind of actionable opportunity on the provider, the health plan side in particular. Which will be driven by the state.

So Dave always talks about the metrics that they include in the paper performance and value-based purchasing and those sorts of things. And that's what's really going to start driving some of this.

CHAIR ANTONELLI: Camille. And then, Shayna, is that yours on edge?

MEMBER DAHAN: Yes.

CHAIR ANTONELLI: Okay.

MEMBER DAHAN: Yes.

CHAIR ANTONELLI: I can recognize your ponytail, but I can't see that unless I see the letters. So I got Camille, Jeff, Shayna.

MEMBER DOBSON: I wanted to piggyback on Clarke's comment. I think it's accurate that the scorecard, this pillar at least doesn't reflect really what a lot of people care about who get long-term services and support. It's not what the consumers really care about.

The challenge that we have representing the aging and disability agencies is that we don't have a HEDIS, we don't have, there isn't anything for the services that are non-medical, that people are getting in the community, outside of a nursing home. Because Medicaid is the only payer.

And so there hasn't been any push from the commercial sector, private insurance companies, to build measurements. So the states have been on their own in the wilderness,

building things as they go along, as best they know how.

And so one of the things we've been pushing with CMS, and Karen has been really receptive to it, is adding other aspects not in this pillar or context around this pillar, to explain the LTSS aspects of a state Medicaid program.

It is the highest spend, they are the highest risk individuals. Almost, not all, but very high number of them dual-eligibles.

So none of these data the state gets for those focus really, unless they're molding a Medicaid managed care plan, Medicare managed care plan in a lot of states. So it doesn't address that sector of our membership.

And so we're spending a lot of time asking CMS to put some more qualitative measures in, or at least explaining a little bit of the work that the states are doing to address the quality of care, to work on re-balancing, to get people, transition folks out of nursing homes,

the things that are important to our consumers.

So this isn't the only, I just wanted to let everyone know, this isn't the only piece that we're working on, others way that are not related to sort of NQF quality measures.

CHAIR ANTONELLI: Yes, thank you. Jeff.

MEMBER SCHIFF: So I just wanted to make a couple comments from the state point of view because I think all of us and states try to figure out how to leverage these measurements to be effective. And although we report them, what we do after we report them depends on the easiest, not the easiest, one of the things is from the managed care contracts, now we can put them in our ACO contracts.

But I think that, to Kim's point about what's an achievable opportunity, it's really about how much energy we can put into how many measures to really make a substantial difference.

Because every measure, if you really wanted to do something that involves an adaptive

change where people actual adopt a different kind of a behavior versus a technical change, let's calculate BMI in our medical records so we get the ding, the point, that is really the meat and the potatoes of this to me because those are the things that stick.

So I think that this scorecard will, I think that a lot of us will use this as the tool to go back and say, see, somebody said these are really important and you ought to do these so let's get on raising our rates around development of screening.

And that's how this gets to be useful so then we can do that. But this, in and of itself, is not that adapted change, it just gives you the selling point to be able to go out and do that.

And I also want to, I think to the point, to Clarke and Camille's points, there's other things we have to focus on as well. So we want to make sure this is in the proper context.

CHAIR ANTONELLI: Shayna.

MEMBER DAHAN: So my only, like, blanket concern sometimes, when I look at these scorecards and core sets, is that a lot of these measures that are being measured, come from or fall on the burden of PCPs who have high volume and low resources and low staff. Specifically if they're not affiliated with a hospital.

So sometimes I get concerned that when you keep pushing at primary care providers, that eventually it's just going to be about meeting your paid for performance and you're cutting out like the real quality of care because you're just worried about what you're numbers look like and you don't have the resources to actually do it all.

So one of the, like, for example, the developmental screening I think is really important. But I also think that there's a lot of kids that are screened through early intervention.

So if that's not going to get captured into the managed care plan that they had a full

early intervention screen, that there would be no reason at that point to do it in a primary care setting, that it's not going to look like these children actually got screened.

So there is things that, I think that when you pull data just from the EHR and claims, that these services are provided from other entities and that those things should be accounted for as well.

CHAIR ANTONELLI: So if I'm trying to extract the theme or themes from your comment, the implications for the scorecard are what?

MEMBER DAHAN: It's to show where we can improve, and hopefully that the states will provide ways in which those areas can be improved so that these processes can actually happen.

But I think that what falls into play is that when this data is collected, the pressure kind of immediately goes to one specific area of health care delivery, which tends to be primary care. And sometimes these services are actually being provided.

So I just caution like continuous pressure on one area without collecting the data from all the other community resources that are providing intervention. Such as school counseling. Some of those kids are getting screened for depression in the school, it's just not getting billed out, you know.

And so those things I think there's a lot of resources out there that primary care providers are referring out to but it's just not getting captured.

CHAIR ANTONELLI: Okay.

MEMBER DAHAN: So that's the thing. So to drive health care based on data that's just --

CHAIR ANTONELLI: So you would argue that measures in the scorecard need to reflect some aspect of integration?

MEMBER DAHAN: Exactly.

CHAIR ANTONELLI: Although the point of measurement could be at the primary care level. But I think that that's kind of the

spirit of the last day and a half anyway, and I think you're point is really, very well taken.

It also resonates with Stephen's challenge to the group about, so what if we're measuring, what are we going to do with the data, how do we feed that back into the system.

Okay, so I have Ken, David, Enrique and then Sue on the phone, you're in the queue as well. So, Ken.

MEMBER SCHELLHASE: And maybe somebody has already pointed this out and I missed it, if so, I apologize. But the way the scorecard is structured right now, it's really for the consumption of policy makers at a state level, right.

If those scores are aggregated and never disaggregated below the state level, then as a health plan medical director, I have no idea where my data sits in that little universe. I could be killing it or I could be the worst, don't know.

And even more so for consumers, for

patients, members of health plans, all they're going to see is, well, Wisconsin's state Medicaid is marginally better than average in newborn something or other. And it doesn't help them to decide, if they have a choice of I want to be in HMO, Medicaid HMO A, B, C or D, it doesn't give them that information.

So on the one hand we talked about the risks, or the risks, the lack of risk adjustment in some of these scores and that giving people heartburn, but that's okay if you've got aggregated state level data, but maybe it needs to be disaggregated for the purposes of people, individual members making decisions at a public level.

Or maybe not publicly disaggregated and feed back to health plans who are the ones that might be able to develop programs to improve their poor performance if when you disaggregate it you see that, okay, children's community health plan is really sucking wind on this measure, what are we going to do with it.

So if it stays at that state level, I think it's useful for state level policy makers. But I have a hard time envisioning how the data can be used to drive anything else.

CHAIR ANTONELLI: David.

MEMBER KELLEY: So in answer to the first bullet I'll say that, in the scorecard 1.0, nine of the measures that are on there are measures that we already use in one or several pay for performance programs. And the readmission measure is added to the scorecard that would make it ten.

So we're already paying attention to most of these. And what we do is, we take, it's two percent of the premium, to the managed care plans and say, here is your potential upside. Here's two percent.

And I think CMS allows up to five percent. But we actually put two percent of premium on the line with our MCOs.

So we expect our MCOs to be measuring these. We meet with them quarterly and we want

to know, we actually make them run some of these measures, not all, on a quarterly basis. Which they really love doing that.

But we want to know why they're not improving or why, what are they doing to move the needle. So as a state program you need to be able to measure, but measuring is fine, but you have to really be able to put some dollars on the table and you need to put infrastructure in place, so that you're actually doing quality improvement.

Working, we start by working with our MCOs, but that then goes down into the health systems. And they are, by contract this year, have to get the 30 percent of value-based contracting, which includes many of these quality measures.

So from a state Medicaid perspective, it's very important that CMS is looking at these. I feel good that your first round of scorecards was very similar to what we were, are we looking at.

So from our perspective, really, you can't just measure it, you really need to put some dollars on the table to incent improvement. And then you need to work with both the providers and health systems to make sure that there are positive incentives, not negative incentives, in place so that folks are focusing, hopefully for the right reasons, and really trying to get to true quality improvement.

So I would respect that any changes in the scorecard, final changes that CMS puts out there, we will certainly be paying attention to whatever those additional measures are. And probably taking steps in the future to tweak our programs that we have in place.

That takes time and contractually you can't do anything until 2020. As far as any contract changes, but that's how we would respond.

So whenever you guys come up with a final list, we might be thinking in terms of how we're going to be changing the contractual

arrangements for their MCOs.

As far as the LTSS, just a quick comment on that. Increasingly there are, will be LTSS measures, and hopefully CMS will pay attention to this. There are four LTSS measures that are now NCQA starting this year.

There is a transition of care measure that's actually now an NCQA measure. Not necessarily specific to LTSS but we are using it in one of our LTSS. We're making our plans to do it around transitions of care.

And then I think using leveraging the MDS, which is already there, to look at quality I think would be extremely helpful.

We are actually looking at and are developing the re-balancing measure that I think is important to look at, but it has to be interpreted very, very carefully.

So I'm going to repeat the concerns about not having LTSS here. Fortunately, those measures are still being newly implemented. I failed to mention that the home and community

based CAHPS as well.

So it was good, the horizon looks good for LTSS, but hopefully in the future you guys will be thinking in terms of maybe perhaps adding the future scorecards. At least something around LTSS.

CHAIR ANTONELLI: Thank you. And, Ken, are you back in the queue?

Okay. Enrique and then Sue.

MEMBER MARTINEZ-VIDAL: Thanks. So Ken's health plan is one of our members, so he said about two-thirds of what I was going to say.

And in my past life I worked with all the Medicaid medical directors and Medicaid agencies, so Dave said about the other third. But maybe just to add one more point.

I think it's really important to think about this, not in terms of both publicly, in terms of public reporting, which is important in and of itself, and it drives the policy makers, but at the state level and then down to the plan level, which is where I'm now working, I think it

really, it's great to have the P-for-P and contractual issues and all that.

And that can help drive dollars and all those things and focus, create focus on what the state wants the plans to focus on.

You know, all our plans, they care about all these things. It's not like they said, oh, we don't care about immunizations, they do. They care about all these things. They want to improve quality.

A lot of times it's like, but how do we do it. This is sort of Ken's point I guess but I'd like to push it a little further. It's like they do need help.

And we do this as an association, and I know other folks are out there doing as it as well. But it's like they need, and Jill referenced this as well, it's like, we need help understanding, what are best practices, how do we redesign our plans, how do we redesign our provider systems, how do we work on quality improvement strategies like Dave said.

So, again, from a plan perspective more broadly, I know that in my four months that I've been at ACHAP, that's a lot of what I hear is like, we get it, we want to do it, how do we do it, what are the things we need to do to make this happen.

So anything that can sort of push that down to the plan and provider level I think will be extremely valuable.

CHAIR ANTONELLI: Okay. Sue, you've got the mic now please.

MR. HIRSCH: I'll be reading a comment from Sue.

Quick comment to supplement Clarke's point. What I'm hearing is that the measure affects all populations. It may be of value to call out how particular populations may be affected or not adequately represented. For example, if a subset of women are not accessing mammography due to reduced access based on their disability, would it be important for systems and states to evaluate not only the metric, but also

root cause of decreased access among populations to drive improvements?

CHAIR ANTONELLI: Thank you. That's actually very helpful. So I've got Rhonda, then I think Marissa your card went up again. Rhonda, did you withdraw? Okay. So Marissa, Lindsay, Clarke.

MEMBER SCHLAIFER: I was just interested in learning and hearing the discussion and the concerns about how these measures will filter down or push down to the managed Medicaid plans. I think I felt a lot more comfortable today. And I think for those who are on the core set work groups, I was the one that constantly asked CMS, you know, when are we going to know what measures are in the managed Medicaid quality measures set? And are we influencing that in any way? And up to this point, during those meetings, it was well, we don't know.

And I think what I heard today that I took great comfort in and it sounds like people here have concerns, but I actually felt much

better when I heard that those measures that will go toward the scorecard -- and tell me if I didn't hear this correctly -- but the scorecard for the managed Medicaid set -- for the quality measures for managed Medicaid plans will come from the scorecard. Initially may come -- no.

MS. LLANOS: I didn't say that.

MEMBER SCHLAIFER: Okay. Okay, but this would be one source of potential?

MS. LLANOS: Potentially.

MEMBER SCHLAIFER: Okay. Okay.

MS. LLANOS: Potentially, but that's not something I said.

MEMBER SCHLAIFER: Okay, then I misunderstood. Because -- then I will say it again. But I do think, you know, as everyone said -- And I know, you know right now, it's great to hear what states are doing when states choose to do it. But speaking for -- speaking, having been influenced by my former employer, you know a PDM that works with many Medicaid plans. And also now working for a different PDM that now

works with many managed Medicaid plans, it will be so useful to have managed Medicaid quality measures that are similar across -- you know, the same across the country or at least put out there for states to hopefully pick up, that will be out there.

Because at least for the prescription benefit side, there are nationwide firms that are working with the different managed Medicaid plans. So if that wasn't, I obviously misunderstood. Because I think the more we can do to get the quality measures the same across the country would be helpful to allow prescription benefit management companies to really help push the -- at least the pharmacy, potentially the schizophrenia measure and really emphasize that.

MS. LLANOS: I'll just add, I think, certainly alignment is one of our biggest priorities at our agency. There is multiple reporting programs that states and providers are participating in. And certainly by leveraging

the core set, we're trying to not create yet another set of metrics. Right? So to the extent that the core sets influence measure selection across other programs. And we always start with what we already have states reporting. And certainly there's really an emphasis on trying to align.

CHAIR ANTONELLI: Lindsay, Clarke, Carol.

MEMBER COGAN: So a lot of my comments have been covered. The use of a scorecard at a state level, in New York, we then take that, apply it to each managed care organization. And then they in turn will push that down and do a similar scorecard to their provider network of practices.

But again, just to emphasize, because we've been doing a great deal of work with practice transformation and getting better insight into the practices and how they receive that information. Without technical assistance of what that scorecard actually means, it doesn't

go anywhere. In fact, it goes into the garbage can most -- I would say most of the time. So I just would emphasize that, that technical assistance of this is what it is, this is what it means, this is what you can do about it is probably the most important thing.

And the other area that we struggle with in a state level, not even bringing it to a national or federal level is well we push similar measures down, health plans will then choose which measures they are wanting to work on because of you know, maybe one lacks -- or has an issue with child immunization. Another doesn't, but they have some the provider network. And then that provider is being asked to work on as many as eight different measures based on -- I mean they could have 14 different contracts.

I mean this is how complicated it gets. And then there's no cohesion at the practice level. They're being asked to work on, you know, this panel. We have to worry about child immunization. This panel we need to work

about anti-depressant medication management. And then at the end of the day, we're not really moving the dial on any one of those things because resources are spread way too thin.

So if we could think about -- and I don't have the answer, but if we could think about again, that cohesion, alignment. And I don't know -- I don't know what the answer is, but you know, it goes back to that issue of resources and you know, not being able to work on everything. So I'm seeing the scorecard get bigger and bigger and I'm having some angst. And you know, it's important to address these issues, but I feel like it we don't just pick just one thing to work on, then no one's going to be able to do everything. So that's just my thoughts.

CHAIR ANTONELLI: Clarke, then Carol.

MEMBER ROSS: I just wanted to build upon Amy and Shayna's and Karen's observation about other agencies. So there's the universe of all these other agencies dealing with special populations. But maybe there's a couple more

natural starting points. So the first thing that the Commonwealth of Pennsylvania and the state of Virginia did after the American Revolution was establish a state mental health authority. Every state has a state mental health authority. The first thing most states did after World War II domestically was pull out ID/DD population from the state mental health authority and create a state ID/DD authority.

So every state has a state mental health authority and a state ID/DD authority. And Camille might want to comment on aging and disability. These are large consumers of Medicaid dollars, particularly LTSS and HCBS, but also acute on the mental health side. And some of those state agencies are actually granted by the state legislature, the administrating authority for targeted population and target service. So they actually are quasi Medicaid authorities in selected states.

So this might be a way to start the dialogue about the potential of the scorecard and

what the state initiatives and ID/DD and Mental Health are doing as a pilot to try to see how we can get early intervention and maternal and child health and special education and developmental screening related too. But you need to start somewhere other than the abstract. And so I would state the state mental health authority and the state ID/DD authority.

CHAIR ANTONELLI: Carol?

MEMBER SAKALA: So picking up on a different set of comments in the room. I just wanted to reiterate what I said yesterday that the notice of proposed rulemaking comments due on Monday are for the Medicaid managed care organizations include the quality rating system that they will have. And the proposal is there to align with the scorecard among other proposals. So if you want to weigh in on that quickly you can do that.

And secondly on the how do we do it? How do we get help? I don't know about other fields but there's a pretty good national network

of perinatal quality collaboratives now. And I know for that field at least, you can contact your state folks and that they identify priority projects and work on them. And you can get technical assistance that way.

CHAIR ANTONELLI: Karen, would you like to make any comments? And I'll give the last word to you and then we'll move on to the next agenda item.

MS. LLANOS: So Lindsay made a lot of my comments, so I won't -- I think that I was just going to react to the earlier comment about whether or not the scorecard would ever provide other levels of data than states. And that is something that because these are data from states, that there is an expectation that states are -- and let me just step back -- I don't think CMS thinks that the scorecard is the only public reporting tool ever established or that we just came up with this idea. So I think we are -- we acknowledge that states are using their own data to do a variety of different things; monitoring

behavior performance or public reporting. And have done so with their providers and health plans for many, many years.

This is an opportunity for us to provide or highlight on a more national level, the data that everyone's been submitting to us on quality. Which has also been available previously, but this is probably going to give it a little bit more emphasis than before, in addition to administrative level data that we and our state partners have been collecting for many years. So this is a compilation of data in terms of how states work with their providers and health plans. And certainly we want them to continue the great work that they've been doing on provider profiling and best practices and QI.

So I think we see the scorecard as one of many steps that we are taking to help our state partners and to help ourselves get on this path to quality improvement. And to better understanding how to use data. And it is the natural next step based on all of our collective

efforts to start eight years ago on doing standardized reporting. So I think we see this as a continual evolution. And know that public reporting on the national level is just one piece. And that it has to be tied to better understanding how to -- what does this -- what do these data represent in helping our state partners and ourselves understand how to move the ball forward for everybody.

CHAIR ANTONELLI: Thanks a lot. All right, so we're going to transition now to the next and I think final agenda item. And you get to listen to Harold now.

CHAIR HAROLD PINCUS: Rich has been sort of doing the heavy lifting of this meeting. And I really appreciate his leadership there.

So this is -- actually there is a lot of overlap with these discussion questions and the ones we just had. This is taking it more from a future perspective to get us to begin to think and assist CMS to think about how we foresee or how we would like to see the scorecard

move in the future and you know, in the discussion questions before. But actually Karen, I was wondering if you could remind us about the timeframe because I think that would be helpful in sort of setting some stage for how we think about -- what do we mean by the future.

MS. LLANOS: Yes.

CHAIR PINCUS: And what's your timeframe in sort of thinking about the next steps?

MS. LLANOS: Yes, so our -- so we've got kind of short and long-term horizons. The shortest horizon is finalizing the measures that's across all three pillars for the fall release. And that will happen in the next several months. So this is certainly a vital conversation to have now.

In terms of the longer term horizon, there are, as you mentioned many, many factors currently at play including a lot of what we discussed. And having also just had our NAMD meeting with our state partners, a lot of the

same similar themes came up in terms of what needs to be defined at a CMS level? How will the scorecard look like in the future? So we think of this as kind of multiple next steps.

The first one is how to get to the finish line for the fall release because we know that has -- is already set in motion. While we're doing that, we have the ability to take a bit of a step back. So we'll have almost two releases under our belt. We'll have enhanced functionality, which is one of the biggest pieces of feedback. We'll have a process or a timeframe for having more recent data, because that was the other piece? Right? So because of the fall change, we'll now have the ability to leverage the latest core set data that would be available publically.

But we're also taking a step back at this time in trying to understand what do we need to define from the CMS perspective in order to give the scorecard a tighter shape than it has before? And a lot of the questions that we're

struggling with are ones that certainly we've posed and we've heard here. Do we include -- continue to be a small parsimonious set? Or do we include all of the core measures and highlight keys areas of focus? Right? There's pros and cons to all of this. How do we better or best create efficient ways of connecting the scorecard and the core set initiatives so that it is a more seamless process, particularly for Pillar 1?

And certainly as we think about all of the collective feedback, because we've used many, many approaches this year, how do we ensure that we're getting the broadest set of feedback across all the pillars? So we've got a lot of questions to define in the next, I would say six months, that would impact releases that go past this next Fall release.

CHAIR PINCUS: Just to follow up on that. So we have -- So in six months, roughly somewhere in October, November, September, you're going to be actually formally releasing--

MS. LLANOS: Yes, so --

CHAIR PINCUS: -- with the expectation --

MS. LLANOS: -- November is our tentative release timing for the next scorecard release. And that would reflect changes to -- or potential modifications to all three pillars, as well as enhanced functionality. And then we would go on an annual release thereafter. So as you can imagine, we're almost always in the cycle of development.

So a lot of what we would be discussing in the weeks to come are what is -- based on everything that we've heard so far and all our collective conversations in terms of the content changes that we've already shared with you guys in terms of additional measures, what is most viable for this next release? What needs to be phased in for a future one based on data availability or data accuracy. As well as taking into consideration, kind of this big versus small and all these other changes that we're defining.

CHAIR PINCUS: So two other just

questions again in terms of thinking a timeline. So do you see this kind of annual release going on sort of until 2024, which is sort of the -- we see these sort of qualitative changes in how you would do things once you get to that point?

MS. LLANOS: Yes, I think 2024 signifies -- Well I would say I think any changes that's tied to the mandatory reporting would probably need to happen before 2024, right, in terms of that. I think we have initially thought of the scorecard as an annual release. Because we are not tied to statutes, certainly I think we're flexible of terms of what that would mean. So we don't necessarily have to do an annual update or change statutorily. So for now, that is the plan, is to go into an annual cycle. And that could go well beyond 2024.

CHAIR PINCUS: And I guess the other thing is the, you know, the continued discussion we've had about the relationship between the core set and the scorecard. And I just sent you like actually literally last night -- I don't know if

some of you got an email, I guess from Mathematica about today being the deadline for making suggestions for the core set.

MS. LLANOS: Well so it's nominations for --

CHAIR PINCUS: Yes, nominations --

MS. LLANOS: -- the CMCS core set update process. So that's the process that we have talked about that is set in statute. And our center has the ability to choose whoever they want to, to lead that process. And Mathematica is the folks that are leading that process this year.

CHAIR PINCUS: So that will be a continual process also on an annual basis and that's in statute?

MS. LLANOS: That isn't -- there is a requirement that our agency releases annual updates on the adult and child core set. So that is base and statute. I would not want to go into detail because I'm not the one leading this.

CHAIR PINCUS: Okay.

MS. LLANOS: I certainly encourage my co-workers if they're on the line and want to make a comment -- but that is -- that is the statute. And I will say I think certainly from a historical perspective, we have used various different entities from the beginning. I don't know if any of you were part of the AHRQ process back in -- So we've tried different iterations of how to get to this annual update cycle. And this is the latest one.

CHAIR ANTONELLI: Okay. Does anybody else from CMS want to make a comment about the future schedule and their perspectives that are on the line?

MS. RANEY: So this is Gigi Raney. Hi.

CHAIR ANTONELLI: Hi, Gigi.

MS. RANEY: Can you hear me? Hi. I think Karen got it exactly right. We continue our annual review of the adult and child core sets as required by statute. The information that you got yesterday is about our core set

review process that we're going to be doing, which will be updating the core set for 2020. So nominations are due by the close of business today. And we'd like to encourage you guys to think about applying or sending it on to someone that you think might be appropriate.

But we are required by statute to review the core sets annually. We are not required to update them, but we are required to review them and take a look at them, which is what we've been doing under previous years through an NQF contract vehicle. And now it is, as you stated, a new contractor is working with us on that process.

CHAIR PINCUS: Okay. Thank you, Gigi. So comments from around the table with regard to the future? How you would -- suggestions you would have with regard to -- you know, particularly from let's say Medicaid perspective, what do you see the scorecard involving in the future? How one can maximize the functionality of the scorecard? How can we sort of think about

the development of the scorecard and ways that maximizes its impact? And also to maximize the input from not only states, but also various stakeholders in that process.

MS. LLANOS: Can I put a little bullet on that? I would -- Because we are having lots of conversations on the size, it would be really helpful if folks wanted to share their feedback in terms of keep it small, it would so much easier if you'd just all of the core sets. I mean if there's any initial reactions, I think that would be super helpful for us.

CHAIR PINCUS: So Carol, David, Rhonda, Jill, and I can't see which -- okay, I couldn't see the depth perception of who -- okay, and Judy and Lindsay.

MEMBER SAKALA: Great, so I have some proposals for building out the framework moving forward. I think that the domains are great. And I'm proposing -- this can be literal, but also figuratively, thinking of a grid. So you've got your domains and the measures that fall under

them. And then across the core populations that you're serving. So LTSS, children, child-bearing women and newborns, women of reproductive age. I think these are all large key groups in there. And I'm sure I'm missing some.

But anyway, I think that this would be a kind of a check on what is in the core set and what would be available that would apply to those various populations. I really liked what Jeff said about a kind of signal -- sending a signal. That I think this is really important to the people in the field about that.

And some thoughts about possibly changing the rules and the parameters. One would be to have maybe -- if it hasn't reached 25, to have a developmental category saying in two years we'll be, you know, going in this place in terms of filling gaps. And I think this is going to be a little harder to move forward. But I just want to suggest that it's possible to say if it's not in the core sets, we should look at this.

And the reason I think of that is

because we, on the core set groups, have made recommendations that we support. But CMS, because of the pressure to go incrementally, has not taken those up. So there are other measures that we have supported that potentially could fill glaring gaps in this grid that would be out there. And I think we can also look at that in the core set work or whoever's involved with that moving forward.

And lastly, I would think that the North Star -- I mean I love what I've heard from the Secretary, states should be leading transformation. We're going to drive outcomes. We're going to drive value. I mean I think that should be the North Star here of whether the items that populate that grid, conceivably can do that.

CHAIR PINCUS: Rhonda?

MEMBER ANDERSON: I like Carol's comments here about how to develop a grid. But I want to go back to Lindsay's comment earlier about so many measures that it sometimes is

overwhelming. And I know we had this discussion on the map about what are the basic foundational measures that are going to begin to help us make the major changes that we need to make?

And so I just want to caution us that maybe it's not about the question, large numbers or small numbers, but it's more on the foundational side of what will make and bring major change to the improvement of health and well-being of individuals in the Medicaid space? And then build on those, almost like Maslow's Hierarchy if you will, cautioning us though to be sure that we're not adding measures to just add measures.

And I know we all believe that, that shouldn't happen. But we also sometimes get very excited about oh, this measure or that measure. And so I just want to be sure that we're looking at the scorecard side of this. That we really ask ourselves the question. Are these foundational measures as implemented going to really make a major difference in the health of

our population?

CHAIR PINCUS: Dave?

MEMBER KELLEY: A comment on the size of the scorecard. I think we're close to just about right. When we've developed our program, we try to keep it around ten or less. Because otherwise plans, providers either get burned out or lose focus.

So I'd like the size of where we're at, even with some of the additions, probably okay, like I'd say lump all the well-child visits into one measure when I look at it. Because providers should be focusing on the well-child visits across all of those age domains. So I think the size of where we're at is good to expand too far.

I think if you look at the entire core set, we do look at the entire core set, but it's easier to have our plans focus. We focus on the core measures -- the performance measures. We also look at other measures where our plans are let's say underperforming. So I think staying

focused on a smaller subset is very useful.

I would like to see, I think, in the future, some of the measures that we talked about are not perfect. I'd like to see the postpartum measure be updated down the road per where the direction that NCQA is headed.

I think similarly, I'd put a plug in for NCQA and/or others to maybe take up either stewardship or look at the developmental delay and help to work with that current steward to make it happen, so that it gets NQF endorsement and maybe gets tighter and better developed so that there is consistency.

And around readmissions again, I think NCQA finally got their Medicaid readmissions back up and running and functional, which I think should really help considerably in standardizing how that's measured across plans. So I think those are some specific things that hopefully will get better over time.

I also think that we need to think in terms of CAHPS survey and really looking at

consumer experience. And we have some measures there now. I did propose both smoking and immunization be looked at. I guess they just missed the threshold. But those two things, smoking kills, you know, almost a half a million people every year. And depending on the flu season, between 20,000 and 50,000 people die from influenza. So I think we need to think in terms of what are things that we should focus on that are simple things that hopefully prevent -- improve the population health and prevent mortality?

And then I'll reiterate my previous comments about the LTSS measure set to also include in terms of something from the community based CAHPS survey or the MDS. I like the population grid. In my grid, I would have kind of populations. But I would also be thinking in terms of what are some of the high cost issues within some of those populations to focus on?

And then I think certainly looking at -- being able to look at outcome measures. We're

always looking for that -- the holy grail but we haven't found it yet. Think in terms of mortality as an outcome. What are some of the quality measures that we need to look at that would reduce mortality within our population?

And then lastly I think being able to look at social determinants in health. And looking at how that may or may not impact any of these scorecard measures.

CHAIR PINCUS: Ken, Jill.

MEMBER SCHELLHASE: I'd echo a lot of what's been said already. I guess a couple additional thoughts. I've heard that, you know, if you've seen one Medicaid program, you've seen one Medicaid program. And so I recognize that what I'm going to suggest may take more bandwidth than exists in the programs that do this. But talking in as much detail as possible with state Medicaid leadership and as many states as you can possibly talk to, to find out what they think would make the scorecard more usable for them and for their constituencies. I think that, that

would be in an ideal world, a really helpful thing to do.

And at the same time, I think that would be help you to avoid -- I'm not sure exactly how to characterize, sort of measures that are very close, but not quite the same as what the states are already doing. Which can make people tear their hair out in trying to, you know, develop programs where it might work for one nuance of a certain measure, but doesn't work for another one. And that's just -- that's a head versus banging the wall experience that most of us want to avoid.

So it would potentially -- those detailed conversations might lead to discovering ways to tweak our measures or the states can tweak their measures. And not have sort of this close call duplication, which really isn't quite the same thing -- quite the same measure.

CHAIR PINCUS: Jill?

MEMBER MORROW-GORTON: So I agree with David around a number of things. I like to think

about a scorecard as a report card. But I also like to think about it from kind of the business world as a balanced scorecard. So I think it should include measurements from across your book of business -- sorry for the business world language -- that reflects how you're doing in various areas. You can't measure everything you're doing, but it should be a signal. It should be a sentinel number that will tell you, are you doing well? Are you not doing well?

In terms of evolution, I think that balancing what's there is important. I think that getting rid of measures when you've gotten close to them being pretty good across the board needs to happen. And that requires kind of regular evaluation of the measures. And I think that it might be worth -- you know, so David talked about lumping all of the well-child visit stuff. Well it might be interesting to think about is there a way to sort of make a composite? Because is there a difference between a visit for a 10-year-old and a visit for a 12-year-old?

Well, probably not that much. Right? Whether they get -- and sometimes they get put in different groups.

So I think -- I think that's one way to think about it. And I think the other thing to think about is -- NCQA goes through their improved -- measure improvement process, right, as measures get evaluated, get redone to improve them after people have learned. Then we can incorporate that improvement into the scorecard.

CHAIR PINCUS: Okay. Lindsay and then Judy and Jeff.

MEMBER COGAN: Yes, my comments relate back to the overall number of measures on the scorecard. So in New York State, we used to do -- We've done pay for performance and incentivizing plans for, you know, well over 20 years. And when we first started, we started with a very small set, five, ten. And what we found was a lot of sort of teaching to the test. And they only care about those ten measures.

So we tried something a little

different and we expanded it. So then we made it like 30, which if you -- We do have composites, so actually it's much more than 30 if you break out the individual components. And our infinite wisdom was, you know, to have that flexibility and not just have people teach to the test. And some plans maybe that would give them the flexibility to focus and hone in on those areas where they're not achieving a high performance. But now we're coming back the other way.

So what we found was again, everyone's spread too thin. They hated that, especially the providers. So now we're kind of coming back to a much smaller focused, tailored, you know, curated list. And so we're thinking about the Super Six to get, you know, fun with it. And we're thinking about aligning that Super Six across pairs. So in our multi-pair commercial, going to Medicare and taking more of a MIPS approach, you know, high priority measures. They can't all be outcomes because we don't have an outcome measure for everything at this point. So those

evidence-based process measures that are very closely tied to an outcome. But we've really -- you know, done through measure prioritization exercise over the last year. And that's where we think we're driving is to again.

So our recommendation would be with the scorecard, don't put them all in. Unless the scorecard is really just a way to help visualize or show some things that are different than the core set, I would say stay away from putting everything in. And again, like Jill mentioned, sort of those high level indicators for certain things and again to echo that the best or the most important things. And that's incredibly difficult to do. But that would be, I think in a forward -- looking forward, that would get us where I think we all want to get is to see that system level change. And if we don't narrow and focus, we're going to stay in this world of we're all looking at different things and not get a collective drive forward.

MEMBER ZERZAN: So yes, I think my

preference would be to keep the scorecard on what CMS really wants to focus on. As others have said, the core set of adult and child measures is great, but it's way too many to focus on. And some of them are hard for states to do. There's also quite a bit of state variability, having come from one state to another where Colorado didn't do any hybrid measures. We just did administrative measures. And I know that other states do that also. Versus hybrid measures, states have different eligibility things.

So the core set is a little hard to interpret. And I think there's some opportunity with the scorecard set to try and get around those or focus on some that perhaps might be a little more similar. That being said, I know there will be plenty of states that will say mmm, I don't really care about my performance or I'm just doing this because I have to. Other states will actively be in competition because Washington is way better than Minnesota or Pennsylvania.

MS. LLANOS: That's right. Bring it.

MEMBER ZERZAN: So I think that the value of the scorecard is that it more focused and can get people together. The larger set is helpful so that if you're going to pick measures, you can pick measures off of a set, so that you're not making up too many extra measures. And there may be some alignment. But I think if you really want to put a focus on something, having the scorecard at about the level that it's at now is enough measures to make an impact.

And then I'd also say that not changing it a lot, sort of slowly tweaking it over time is also very important because these are all very hard things to change. And practice transformation is very hard. So I'd say it takes two or three years to really start to see the impact of some of this change. And I think you need to allow for that. And showing some of the trends over time is going to be where some of the value is at.

CHAIR PINCUS: Actually I had myself

in line too. So let me step out of the chair role for a moment. There were three points I wanted to make. One specific to a particular domain and then two broader comments.

One is you know, we have fairly limited focus in terms of alcohol and other drug abuse problems. And the one that we have from the core set that's in the scorecard is initiation and engagement. And I came very close to recommending that being removed. But I didn't because I thought it would be sort of a useful place-saver.

But there is some clear problems with that measure based upon a project that we had done several years ago where we did a national evaluation of the VA mental health system. That you're actually penalizing providers that screen. Because if you're screening people, you're finding people who are less motivated and less likely to follow up.

And so it's -- and initially going back, you know, years ago, this was part of

Washington Circle measures that included identification, initiation, and engagement. The identification one was left out because it's not really a quality measure. But it does -- it's sort of a balancing measure. So I think it's good to have something for -- something other than opioids as a place-saver. But I think some work on getting something in there that incorporates some screening element to it, would be important.

Two broader issues, you know since we're looking at a timeline that at least extends to 2024, there's a couple of other things to think about as one moves along that timeline. Number one is we've talked a lot about having sort of the importance of different domains and different populations. But I think one thing we haven't talked a lot about is the actionability as a criteria in terms of what are the leavers that states and states through plans have? And to think about that in a very specific way in terms of learning from what has been done in

terms of the more actionable elements and mechanisms for that.

Number two is this is actually something that Shayna had brought up earlier on a side conversation is that you know, around here we have all, you know, different stakeholders. But one group of stakeholders we don't have are information system vendors and people with expertise in informatics. By the time, you know, we get to 2024, there's going to be a lot of changes in terms of the availability of technology. And that ought to be anticipated as things move forward.

You know, I came here from a meeting that I co-chaired with Bill Galley from Calgary. The Quality and Patient Safety Committee for WHOs ICD-11. So people, when I say ICD-11, people will say what are you talking about? We just put in ICD-10. Actually the rest of the world was using ICD-10 for over two decades before we got to it.

So ICD-11 is actually approved by the

World Health Assembly. And it's built on more of an informatics framework, so that quality and patient safety activities can be pulled in, you know, through the ICD-11 in a much more specific way than in the past. And I'm not saying that, that's a be-all and end-all, but we ought to be anticipating all of the different opportunities that might exist as technology evolves over the next, you know, five to ten years. And they should probably involve the stakeholders in the process.

CHAIR PINCUS: Jeff and then Pamela. And, Candy, is yours still up or is that residual?

MEMBER SCHIFF: I think I'm breaking into a cold sweat about ICD -- what was that number again, 12?

CHAIR PINCUS: Eleven.

MEMBER SCHIFF: I just had a -- I feel like this is a lumper and splitter conversation, you know about -- that we're having. But I wanted to -- And some of the work on social

determinants is about this, but I think that if I thought about where the set could evolve potentially, it may be around sub-segmenting some of the populations for some of the measures. Not creating new measures, but you know, the developmental screening is an issue, you know, for different kids with different race and ethnicity.

Same thing you could say for some of these measures around disability. So I think that's a place where the measures could evolve that would be helpful. And I know that some of the core set measures, there's a request to submit them by subpopulations, although I can't remember the details right now.

The other thing I was just going to say is that some of the work I presume in the other two pillars could relate to -- or inner-relate to the quality here. And I'm not sure what's going to be in the other two pillars, but I'm thinking about things like continuity of enrollment for example or things like that, that

may have a big impact on whether or not people get their vaccinations.

So I think that some interplay of the pillars may really be an important way to move state systems and quality forward. Because if every -- if systems specifically for example don't have continuity of enrollment for whatever reason are less so, they may have poor results on these. So I'm just suggesting that we look at that.

And then I just want to say one other comment about the -- every state Medicaid system is unique and perfect in its own way. But I just want to say that we use -- we use social proof a lot in our state systems to get our states to move. So I can look at Dave's measures and say look at all they're measuring and including it with programs in Pennsylvania to get Minnesota to think about whether we're using our withholds most effectively. So I want to -- I just want to be clear that that's part of the leverage we use is to go talk about what our other colleague

states are doing.

CHAIR PINCUS: By the way, with regard to segmentation, we actually did a project with the Commonwealth Fund that came out of it a recommendation that there be -- that people with severe mental illnesses be considered a disparities category and that it would be relatively easy to sort of segment, sort of general health measures by that category to look at their disparity. And that's something -- a strategy that adds very little additional effort --

MEMBER SCHIFF: Right.

CHAIR PINCUS: -- that can identify areas where you can change things.

MEMBER SCHIFF: And like the health -- Similar to that, the health home measures, which a lot of our -- most states are related to behavioral health conditions are some segment of -- some of those measures overlap and they're reported specifically for the people in that population.

CHAIR PINCUS: Exactly. So Kamala and then Rich.

MEMBER KAMALA ALLEN: Thank you. And I apologize. I have a long list of comments. I'm making up for being somewhat less verbose yesterday.

So to Karen's question about core set measures or not, I think I would agree with what's been said now by several people, not in terms of pulling all of those into the scorecard. I think the -- at least what I understood yesterday about the intent and value of the scorecard was that we want to elevate certain levels for public reporting. And it's not just about what we're collecting and working on within our states and within our systems. But from a policymaker perspective, what do we want to put forward as a parsimonious set of measures to really provide a comprehensive picture of health of the population. And so from my perspective, that would not be consistent with the inclusion of all core set measures.

As I think has also been said, I think it would be really helpful to have a better sense of the CMS priority when we come into this discussion. Because I think as we saw today, there's several measures that could be related to a particular topic. Some already on the scorecard and some that are proposed for addition. How do we as a group make a decision about the -- you know, in the context of there being a tension between not including all core set measures and including those that we really want to elevate and focus on.

I think what was also said was -- I think Joe mentioned the fact that we want to -- when measures get to a certain level of performance, thinking about rotating those off. Hopefully we won't then kind of drop in performance once they are no longer on the scorecard as we then prioritize issues that are maybe at that particular point in time, more pressing. That there's more energy or concern around. And some guidelines and guiderails

around how to do that.

I want to actually say that there is kind of tension here as well because when we rotate off, then we lose the ability to continue to look at those trends. And so thinking about the value of trends and how we do that in that context.

And then the last point -- Actually Harold, you made some things -- made a point very similar. We talked about on the child core set discussion, the gap area of adolescent substance use being one that required attention. And so I just would like to kind of put that out there again that, you know, as NO CHCS, we are about to embark on a process to work on that. But that as we think about what the gaps are, having some discussion or feedback loop from the scorecard group.

And I know, as Karen said, that we're really looking at the core set as the feeder into the scorecard, but making sure that there is feedback from any discussion that might happen

here around gaps that then gets translated back to that process. And I know that, that process is no longer here in QI with Mathematica and just making sure that there is some mechanism for that connection. Thank you.

CHAIR PINCUS: Rich.

CHAIR ANTONELLI: So in the last six years in this room, I can count on one hand the number of comments that I've made that actually is coming as a pediatrician. So that's the frame for what I'm about to say.

CHAIR PINCUS: I thought everything you say comes from a pediatrician.

CHAIR ANTONELLI: It applies to frail elderly, as much as it does the NICU graduates. But this one is actually going to be as a pediatric observation that I want to make. And I would probably have asked Sally to make this comment representing CHA, but I am concerned about the results of yesterday's discussion.

I want to come to the discussion around the hypertension piece measure, just as an

example. So this is not about that measure, but that whole notion that many of these measures start at the age of majority without any biological underpinnings at all or even often times socioeconomic or psychological dynamics. And really there is a population that is very analogous to the population that Clarke and Amy and Camille have talked about as well. And these are youth and young adults and adults that have complex needs that aren't a big enough prevalence population that I can make a meaningful argument to get them onto any individual Medicaid director's radar screen.

And so in Massachusetts in the land of RomneyCare and I'm proud to be there, patients that are 18 plus, I call medical home refugees. They're attributed to ACOs. Getting them into any semblance of an adult care model is -- it's challenging. I'm a pediatrician and I take care of women up to the age of 50 that have significant neurodevelopmental disabilities. And it's not that Boston has a dearth of providers.

And so I really need to call out this notion that there are youth, young adults, and adults with pediatric or childhood onset conditions that don't fall under really any of these measures very well.

Now the collective wisdom might be the scorecard isn't the place to put them and that's okay. And maybe that would be the core set. But even that's a bit challenging. So in this room in May, we promoted to sickle cell measures, antibiotic prophylaxis at the time of diagnosis and cranial ultrasound. And if you're not clinical, trust me those are two very important ones. And the first one actually is a lifesaving one that costs about 19 cents a day.

But yesterday the comment was made on the opioid measure about, you know, gee patients with sickle cell, are they in or out? And I -- that put a bit of a stake in my heart because we don't have a way of getting measures into the discussion here if they don't find the way to the core set. So we don't have any quality measures.

In the case of antibiotic prophylaxis, potentially a lifesaving measure isn't in scope. But we can talk about patients with sickle cell disease and whether they're going to fall into the 120 equivalence of morphine per day, you know, opioid dependence measure.

There is a chasm there that I find deeply disconcerting. I think there are some administrative issues that we need to think about in terms of these sort of, we'll call them special populations -- it could be schizophrenia. I think about children, youth, and young adults with these complex needs. So it's really very much a plea.

So to bring this home to something positive, which is why when I was on the coordinating committee at the MAP, people used to think that I was a geriatrician. In the space of integration and measurements -- and performance measurements, what is a patient engagement around a co-created plan of care? What does the handoff look like from one provider to another one,

setting to another?

I'm very comfortable riding the coattails of predominantly adult-focused measures. I really am when it comes to care integration. But there will be times -- and I think that patients with schizophrenia is one population and neurodevelopmental disabilities in general. These are left-behind folks. They really are medical home refugees. And I just felt the need to share that.

CHAIR PINCUS: Thank you. So any other comments, questions? Oh, I didn't even see it. It's sideways.

MEMBER OKRANT: Elisabeth. Sorry.

CHAIR PINCUS: Okay, Elisabeth.

MEMBER OKRANT: I just wanted to also kind of make a plea also around substance use measures. I also almost put the IET measure up for removal, but because it's really the only measure in there, I didn't want to do that. So I think it's really important to start thinking about measures that measure substance use as a

chronic disease and getting those kinds of measures into the scorecard.

I also think that some of the information that can be extracted from IET in terms of actionability is really about stratifying that measure from OUD and AOD, and where that person was identified or indexed. So really the rich data in terms of IET comes from stratifying it. So it's really a shame to just have one rate or, you know, a numerator and denominator.

I also just also wanted to put out there that patient-reported outcomes, I hope are a way that we're moving toward as well on the scorecard developing performance measures around patient-reported outcomes as well.

CHAIR PINCUS: Any other last comments? So I want to turn it over to Miranda to tell us sort of what are the next steps but first there has to be -- I guess at first there has to be a public comment. Correct?

MS. KUWAHARA: That's right. So this

is our last opportunity for public comment. We'll begin with any participants in the room.

MS. STOCK: Hello. Oh, that's better. Hi, my name is Kyle Stock and I'm a senior policy analyst with Community Catalyst. We are a national health advocacy organization who works with individuals and communities throughout the country to make sure that their voices are heard about decisions affecting their health.

We work with children, families, and people with complex health needs, including behavioral health and long-term services and supports. And first of all, I'd like to thank you for your work on addressing quality of healthcare.

We would like to talk a little bit about a couple of the gaps and the future of the scorecard. We are interested in seeing measures related to the long-term care and services and supports, particularly because Medicaid is one of the largest payers for those services. We would ask you to consider adoption of some of the CAHPS

home and community services survey questions, which has been endorsed by NQF.

We are also concerned about the gaps and measures for mental health and substance use disorders. And would urge you to look to the CAHPS experience of care and health outcomes ECHO survey, which includes several critical outcome questions.

We would also ask you to consider the SAMHSA National Outcomes measures, which are currently being used in New York. These measures track improvements in critical life activities including education, employment, and stable housing. These are a couple of examples of measures that are truly meaningful to consumers. And we hope the committee will prioritize these types of measures.

As a final note, I would also say that we would support disaggregation of data by race, ethnicity, and disability. I appreciate the opportunity to speak with you all. Thank you so much.

MS. KUWAHARA: Thank you. And we will open up the lines for folks joining remotely in just a moment. Are there any members who would like to offer comments?

MS. TUFTE: Yes, this is Janice again. I really -- I just want to say hello and I really appreciate this discussion this morning. And I remember we had a similar discussion last May. And something I think that's very important that somebody had brought up about what is of interest to different states. And I think that -- I know that we have information on what states report what for the core set. But there might some easier graphics where I've recently been engaging more consumers with meaningful measures. Sort of teaching them from a peer level to engage them in one state in particular.

And if I was able to explain to them on a basic level like how -- what states are interested in what, it would really help. Like we have to go to different charts. So if we could click on the link like you know, for Pap

smear or whatever and it would show what states are reporting, rather than having to go to a different graph would help.

And I think what was mentioned about ICD-11 is actually very important because the infographics really are able to give opportunity to a lot of people to be able to understand a little more about their health, rather than just reading a measure. And I hope that we do take that sooner than later. And I just want to say I agree with other people that it's important to have placeholders like in the perinatal, I had mentioned.

And I appreciate Harold, what you had mentioned about as a mental health measure, then it's true -- it's important to be there. But I guess to look at the outcomes of it, why are we measuring some of those? So I hope to participate on some of the other calls. And thank you very much for your work.

MS. KUWAHARA: Thank you, Janice. Are there any other commenters? All right. I'll

turn it over to Jordan to review next steps.

MR. HIRSCH: Thanks a lot. Important upcoming dates next week, Wednesday, January 16th, we will have our post-meeting web meeting.

MS. KUWAHARA: Which will be cancelled because we have -- because we have covered all of our agenda items.

MR. HIRSCH: Okay, strike that then. February 25th to March 27th, we will have public comment period for the draft report. In the summer, we will have a series of strategic considerations web meetings. And finally, September 9th, the final report is due to CMCS and made available to the public.

In the meantime, please contact us with any questions or concerns that you have. Email us at maxscorecard@qualityforum.org or call NQF at 202-783-1300. As well as please view the project pages that we have posted here. And thank you for joining and participating.

CHAIR PINCUS: Well, it's been a pretty intense day and a half. And I really want

to thank all of you for sticking with us. I mean this is an enormous committee. And the range of contributions -- the full range of people have made contributions in important ways and we really appreciate that.

I think what we've come through is going to really helpful to CMS as they move ahead with this very ambitious process that they want to do. And of course, I can't go without, you know, thanking NQF staff who really have set this up so that we can be maximally productive.

So thank you all. And I especially want to thank my co-chair, Rich.

CHAIR ANTONELLI: Thank you. And I am thrilled that I've had limited media exposure in the last 36 hours. And the fact that so much positive energy could come out of this city. I am just thrilled and that's a lot to do with you guys. So thank you, thank you, and thank you.

I want to start by recognizing Karen and the CMS team. This is a challenging time. And I don't mind the fact that you said, we're

not quite sure what the stuff is with the TBD, but trust us. You have my trust. And you have my sweat equity. And I think you know that this committee, all 32 of us, we're here for you. And just thank you. Thank you for maintaining that energy and focus for us.

And then the NQF staff, as hard as it may appear for the co-chairs, these guys do all of the work. I don't -- I think they live here. And I just -- every single one of them -- Jordan is new to the team. I don't know if he left. I was about to say something complimentary to get him to blush. But I think he did a great job for, you know, just sort of coming on board. So again, NQF staff, thank you very much. CMS, thank you. And to each of you guys.

MS. MUKHERJEE: Of course from the staff perspective, we definitely want to thank our chairs. They help us, guide us, and sort of make this meeting a success. Committee members, thank you for agreeing to be part of the committee. And of course, CMS, thank you for

giving us the opportunity to do this work. And definitely my team members. Without them, and especially with people like Jordan who are very new and jumping into this, this would not be a successful meeting.

MEMBER MORROW-GORTON: And we would like to thank our rock-star co-chairs and all of the staff.

MS. GORHAM: So we changed the lunch reservation to one o'clock since we're ending a little early. So if you plan to join us for lunch, the reservation is at 1:00. And we can all walk over together. And you can leave your bags here.

(Whereupon, the above-entitled matter went off the record at 12:31 p.m.)

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: 01-11-19

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