

NATIONAL QUALITY FORUM

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MEASURE APPLICATION PARTNERSHIP
JOINT MEDICAID ADULT AND CHILD TASK FORCE

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WEDNESDAY
MAY 24, 2017

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

MEMBERS PRESENT:

RICHARD ANTONELLI, MD, Co-Chair
HAROLD PINCUS, MD, Co-Chair
TERRY ADIRIM, MD, MPH, FAAP, Office of the
Assistant Secretary of Defense for Health
Affairs
KATHRYN BEATTIE, MD, St. Luke's Children's
Hospital
ANDREA BENIN, MD, Children's Hospital
Association*
DIANE CALMUS, JD, National Rural Health
Association
ANN GREINER, MUP, Patient-Centered Primary Care
Collaborative
MARY KAY JONES, Centene Corporation
SUE KENDIG, JD, MSN, WHNP-BC, FAANP, National
Association of Nurse Practitioners in
Women's Health
DEBORAH KILSTEIN, RN, MBA, JD, Association for
Community Affiliated Plans
RACHEL LA CROIX, PhD, PMP, Florida Agency for
Health Care Administration

MEMBERS PRESENT:

ROANNE OSBORNE-GASKIN, MD, MBA, FAAFP, MDwise,
Inc.
AMY POOLE-YAEGER, MD, Centene Corporation
AMY RICHARDSON, MD, MBA, Aetna Medical
CLARKE ROSS, DPA, American Association on Health
and Disability
CAROL SAKALA, PhD, MSPH, National Partnership
for Women & Families
MARISSA SCHLAIFER, RPh, MS, Independent
Consultant, Academy of Managed Care Pharmacy
GREGORY CRAIG, American Nurses Association

SUBJECT MATTER EXPERTS (VOTING):

KIM ELLIOTT, PhD, CPHQ, Health Services Advisory
Group

FEDERAL GOVERNMENT MEMBERS PRESENT (NON-VOTING):

SUMA NAIR, MS, RD, Office of Quality Improvement
LISA PATTON, PhD, Substance Abuse and Mental
Health Services Administration
MARSHA SMITH, MD, MPH, FAAP, Centers for
Medicare & Medicaid Services

NQF STAFF:

SHANTANU AGRAWAL, MD, MPhil, President and Chief
Executive Officer
HELEN BURSTIN, MD, Chief Scientific Officer
SHACONNA GORHAM, MS, PMP, Senior Project Manager
MIRANDA KUWAHARA, Policy Analyst
DEBJANI MUKHERJEE, MPH, Senior Director
MAY NACION, MPH, Project Manager
SUZANNE THEBERGE, Senior Project Manager*

ALSO PRESENT:

MARY APPLGATE, MD, FAAP, FACP, Ohio Department
of Medicaid

LINDSAY COGAN, Bureau of Quality Measurement and
Evaluation, New York State Department of
Health

LEKISHA DANIEL-ROBINSON, MSPH, Maternal-
Infant Health Technical Director, Centers
for Medicare and Medicaid Services

KAREN MATSUOKA, PhD, Division of Quality and
Health Outcomes, Centers for Medicare and
Medicaid Services

GIGI RANEY, LCSW, Centers for Medicare and
Medicaid Services

* present by teleconference

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

2 9:03 a.m.

3 MS. MUKHERJEE: Hi, welcome everybody.

4 My name's Debjani Mukherjee. I'm the senior
5 director for the Medicaid Adult and Child Core
6 Set Project here, and this morning we are -- I'm
7 glad and happy to have our CEO Shantanu Agarwal
8 here to say some welcoming remarks, and then
9 we'll get started with our day two for Medicaid
10 Combined Adult and Child Program. Shantanu.

11 DR. AGRAWAL: Thank you very much. I
12 was sitting here talking to Helen, telling her I
13 had to go get my BLS refresher today, because you
14 have to do that, and then I almost choked on my
15 melon and luckily she's certified, yes. Could
16 have saved my life.

17 Thanks everybody for attending. So
18 this is actually my first time going through the
19 Medicaid MAP process. I've been here about four
20 months now, so learning as I go. I really want
21 to thank Harold and Rich, our co-chairs today. I
22 know that you guys are, this is sort of a three-

1 day process. So I'll be interested to see what
2 all the results are. But thank you again for
3 your leadership.

4 You know MAP is, as you all well know,
5 is an extremely important process for NQF. It's
6 an important process for CMS. Certainly
7 identifying core sets that states can adopt is a
8 vital mission for us. It's extremely important.
9 I know that my staff is really dedicated to this
10 because it's a good way to help lead to quality
11 improvement in the Medicaid program.

12 One thing that we have tried new this
13 year, and you've already seen on the Medicare MAP
14 work is identification of measures that could
15 potentially be removed from these programs or
16 removed from the core sets. I think that is a
17 great place.

18 So as we think about where the gaps in
19 measurement are, and certainly this committee is
20 dedicated to addressing those gaps, at the same
21 time being able to look across the portfolio and
22 identify areas where, you know, a measure might

1 actually be removed I think is an important
2 message to send for quality improvement in
3 measurement overall, that we are really focused
4 at NQF and through our committees on having the
5 right measures.

6 It's not about having the right number
7 of measures or any other criteria, and it's also
8 I think a really worthwhile message to send to
9 providers -- thank you -- that you know, we
10 understand that there's a certain amount of
11 burden related to measurement, and therefore
12 having the right measures that are actually going
13 to lead to improvement that haven't been topped
14 out, that are scientifically still rigorous and
15 valid, I think that is an absolutely great
16 message to send to them.

17 Too often, I think they get an
18 impression of the contrary. So I just want to
19 again thank you for all the work. I think taking
20 on this additional look at the portfolio is
21 absolutely great, and with that I will turn it
22 back.

1 MS. MUKHERJEE: Thank you. So as we
2 get started, what I will do is go over a quick
3 update of some of the break times, as well as our
4 housekeeping. So as you know, all know the
5 restrooms are straight down the hall to the
6 right, and then please keep your cell phones on
7 mute and if you need to take a call, you can step
8 outside right by the reception desk where you
9 signed in.

10 If you would like to speak, please use
11 your tent cards and stand them up. That way we
12 know to call on you, and our break times today
13 will be 11:00, 1:00 and 2:50, and we'll try to
14 keep to these because we have public comments
15 right before, and we would like to allow for the
16 public to have an opportunity to put their
17 comments in.

18 Even though public comment happens
19 after voting, we would like to let you know that
20 we do consider their comments and sort of discuss
21 them afterwards. You all have laptops and by now
22 you're probably logged in, but it's guest and

1 NQFguest, and with that I will turn it over to
2 Rich to say some welcoming remarks.

3 CO-CHAIR ANTONELLI: I blew the
4 introduction. No pressure. So I'm Rich
5 Antonelli. I'm a general pediatrician and
6 medical director of Integrated Care, Boston
7 Children's Hospital. I have the absolute
8 privilege of co-chairing this task force, the
9 joint task force with Harold Pincus who's a
10 friend and actually a long-standing mentor for me
11 and the NQF staff. So basically is Karen here?

12 CO-CHAIR PINCUS: I thought you were
13 my mentor.

14 CO-CHAIR ANTONELLI: Well, that's sign
15 of a healthy relationship I think. Okay. So
16 we're going to -- I wanted to introduce -- so if
17 she's running late, am I pivoting from my talking
18 points.

19 Okay. So Helen is pinch hitting for
20 Elisa to do the DOIs today, so we'll go through
21 that process first, so that will buy us some time
22 before we launch with our CMS colleagues.

1 DR. BURSTIN: Great. Good morning
2 everybody. Thank you again for coming back.
3 Those of you who spent yesterday with us on the
4 Adult Task Force, and welcome to our Child Task
5 Force members. Today we did disclosures
6 yesterday with the Adult Task Force members. I
7 don't know that we necessarily need to go around
8 again. Maybe just as we walk around, if you
9 could just indicate your name and your
10 organization, just for the sake of the Child
11 folks, so everybody knows who's who.

12 I believe we only have the chairs as
13 subject matter experts and Kim Elliott, so we'll
14 save you guys for the end because their
15 disclosures are slightly different. So as we go
16 around the room, if you're on the Child Task
17 Force, we specifically want you as an
18 organizational member to only disclose if you
19 have more than a \$10,000 interest in any entity
20 that you think would be affected by the
21 recommendations of this group.

22 We fully expect that as an

1 organizational member, you're going to bring your
2 organization's viewpoint, so that in and of
3 itself is not a conflict. It is simply a
4 disclosure of who you're representing at the
5 table. So let's just start with that, and we'll
6 come back to the feds at the end too, if that's
7 okay.

8 Go ahead, please. Just introduce
9 yourself and your organization if we did
10 disclosures with you yesterday, just so everybody
11 knows who everybody is.

12 MEMBER LA CROIX: I forgot about that,
13 sorry. I'm Rachel La Croix. I'm here on behalf
14 of the National Association of Medicaid
15 Directors, and I also work for Florida Medicaid
16 in Tallahassee, Florida.

17 MEMBER KILSTEIN: Good morning. I'm
18 Deborah Kilstein. I am Vice President for
19 Quality Management and Operational Support at the
20 Association of Community Affiliated Plans or
21 ACAP. We represent 60 non-profit safety net
22 health plans in 29 states.

1 MEMBER OSBORNE-GASKIN: Good morning.
2 Roanne Osborne-Gaskin, representing American
3 Academy of Family Physicians. I'm senior medical
4 director at MDwise, a Medicaid Managed Care Plan
5 in Indianapolis, Indiana.

6 MEMBER CALMUS: I'm Diane Calmus, and
7 I'm representing the National Rural Health
8 Association.

9 MEMBER JONES: Good morning. I'm Mary
10 Kay Jones. I'm vice president of Quality
11 Improvement for Centene Corporation, which you
12 may not know it as Centene, but we have 23
13 different health plans that are -- they all have
14 their own little name, but we're one of the -- I
15 think the largest Medicaid managed care plans.

16 MEMBER SCHLAIFER: Hi. I'm Marissa
17 Schlaifer. I'm an independent consultant, and
18 I'm here representing the Academy of Managed Care
19 Pharmacy.

20 MEMBER ROSS: Hi. I'm Clarke Ross.
21 I am employed by the American Association on
22 Health and Disability, but I'm here representing

1 the Consortium for Citizens With Disabilities,
2 which is a Washington, D.C. coalition of 113
3 national disability organizations, and I'm also
4 the father of a 26 year-old son with co-occurring
5 disabilities.

6 MEMBER KENDIG: Hi. I'm Sue Kendig.
7 I am representing the American Association of
8 Nurse Practitioners, and I am in integration
9 specialist in women's health at SSM-St. Mary's in
10 St. Louis, and serve as director of Policy for
11 the National Association of Nurse Practitioners
12 in Women's Health and do independent policy
13 consulting.

14 DR. PATTON: Well, that was pretty
15 good timing. Good morning everyone. Lisa
16 Patton. I'm the division director for Evaluation
17 Analysis and Quality in the Center for Behavioral
18 Health Statistics and Quality at SAMHSA within
19 HHS.

20 DR. SMITH: Good morning. I'm Marsha
21 Smith, I'm the medical officer in the Center for
22 Clinical Standards and Quality at the Centers for

1 Medicare and Medicaid Services. Our division is
2 responsible for the public reporting, clinical
3 quality and performance measures.

4 MS. NAIR: Good morning. Suma Nair.
5 I'm here representing the Health Resources and
6 Services Administration. I'm the director of
7 Quality Improvement at the Community Health
8 Center Program. Serve about 25 million patients
9 across the country, half of which are Medicaid
10 beneficiaries.

11 MEMBER BEATTIE: Good morning. I'm
12 Kathryn Beattie. I'm the executive medical
13 director and administrator for St. Luke's
14 Children's Hospital, which is in Boise, Idaho.
15 It's the most remote children's hospital in the
16 country, and I'm here representing America's
17 Essential Hospitals.

18 MEMBER RICHARDSON: Good morning. I'm
19 Amy Richardson, also a general pediatrician, and
20 I am the Aetna Medicaid Senior National Medical
21 Director for Pediatrics.

22 DR. BURSTIN: Again, if you have any

1 disclosures for the Child Task Force folks as we
2 go around please.

3 MEMBER BEATTIE: I have no
4 disclosures.

5 MEMBER RICHARDSON: I'm an Aetna
6 shareholder as well as employee.

7 MR. CRAIG: Good morning. I'm Gregory
8 Craig. I'm representing the American Nurses
9 Association. I have no disclosures.

10 MEMBER SAKALA: Good morning. I'm
11 Carol Sakala representing the National
12 Partnership for Women and Families, and I have no
13 disclosures.

14 MEMBER GREINER: Good morning. I'm
15 Ann Greiner, president and CEO of the Patient-
16 Centered Primary Care Collaborative, and we work
17 to make primary care more central, more vibrant
18 and more patient-centered. I have no
19 disclosures.

20 MEMBER POOLE-YAEGER: Hi. I'm Amy
21 Poole-Yaeger. I am SVP of Medical Affairs for
22 Centene Corporation, along with -- I work there

1 for Mary Kay. I have the disclosure of being an
2 employer and a shareholder of Centene, and I am
3 also a pediatrician and very excited to be here.

4 DR. APPLGATE: Good morning. I'm
5 Mary Applegate. I am also a pediatrician and an
6 internist, and I serve as the medical director
7 for Ohio's Medicaid Program. I have no
8 disclosures.

9 DR. BURSTIN: Great, thank you, and I
10 believe on the phone we have Andrea Benin. Good
11 morning, Andrea. Are you with us?

12 MEMBER BENIN: Yep, hi. It's Andrea
13 Benin. I have no disclosures. I am representing
14 the Children's Hospital Association. I'm a
15 pediatric infectious disease doctor, and I'm the
16 senior vice president for Quality and Patient
17 Safety at Connecticut Children's Medical Center.
18 Thanks.

19 DR. BURSTIN: Perfect, thanks. Now
20 we'll just move on to the couple of SME, subject
21 matter experts, as we like to refer to them. I
22 believe we have Kim and we'll also have Rich do

1 his introduction and disclosures as well. This
2 is slightly different. Subject matter experts
3 sit as individuals. You don't sit representing
4 any organization.

5 So we'll ask you a bit more detail,
6 rather than just disclosure of financial
7 interests. So any activities you believe in your
8 subject matter that might be related to the
9 Committee's deliberations, grants, consulting, et
10 cetera. We know who you are. We've looked at
11 your CV, so we don't need a recitation of these
12 very impressive CVs, Dr. Antonelli. So just
13 briefly. Thank you, Kim.

14 DR. ELLIOTT: Just have to get my
15 buttons right. Kim Elliott, and I work for
16 Health Services Advisory Group currently. I've
17 worked in the Medicaid program for about 15 years
18 overall, the clinical programs for all of the
19 different populations, and prior to that I worked
20 in health plans and quality and really every
21 area. I have no disclosures.

22 CO-CHAIR ANTONELLI: Rich Antonelli,

1 medical director of Integrated Care, Boston
2 Children's Hospital, and I also have no
3 disclosures.

4 CO-CHAIR PINCUS: I'm Harold Pincus.
5 I'm a professor and vice chair of Psychiatry at
6 Columbia. I also am director of Quality and
7 Outcomes Research at New York Presbyterian
8 Hospital. In terms of my disclosures, I have
9 consulted for Mathematica Policy Research and
10 also for the National Academy for State Health
11 Policy, and I'm on committees for the American
12 Psychiatric Association and the World Health
13 Organization. I have research that's been
14 supported by NIH and several private foundations.

15 DR. BURSTIN: Thank you, Harold. I
16 think that -- we'll just have Terry, as soon as
17 she settles in, introduce herself, and if you
18 have any disclosures.

19 MEMBER ADIRIM: Sure, yeah. Hi, I'm
20 Terry Adirim. I'm sorry I'm late. It took me
21 two hours to go 15 miles. I just thought I had
22 to say that. But I am representing the American

1 Academy of Pediatrics. I have no -- nothing to
2 disclose.

3 My current position is Deputy
4 Assistant Secretary for Health Services Policy
5 and Oversight for the Military Health System, but
6 that's not why I'm here so --

7 DR. BURSTIN: Okay, wonderful, and
8 Gigi, we skipped over you, if you'd like to
9 introduce yourself and use your mic.

10 MS. RANEY: Hi. My name is Gigi
11 Raney and I'm work in the Division of Quality and
12 Health Outcomes at the Center for Medicaid and
13 CHIP Services. I am filling in this morning for
14 Karen Matsuoka, who is the director of Quality
15 for Medicaid and CHIP, as well as our division
16 director and hopefully she'll get here soon.

17 DR. BURSTIN: Thank you everybody. So
18 just one last comment. Thank you for those
19 disclosures. Please at any point during the
20 course of the deliberations, if you have any
21 concern about a comment someone has made or
22 something that you think signifies any potential

1 bias, please come forward to the chairs or myself
2 or any other senior staff at NQF.

3 It's always better in our experience
4 to try to address those things in real time,
5 rather than hearing about them after the fact.
6 So with that, I'll turn it back over to the
7 chairs, Rich or whoever.

8 MS. MUKHERJEE: We'll just go around
9 quickly and introduce staff, and Elisa, do you
10 want to start?

11 MS. MUNTHALI: Good morning. Elisa
12 Munthali, Vice President for Quality Measurement.
13 Welcome.

14 MS. KUWAHARA: Good morning, everyone.
15 My name is Miranda Kuwahara. I'm the project
16 analyst for both Adult and Child.

17 MS. NACION: Hello. My name is May
18 Nacion. I'm the project manager for the Child
19 Task Force.

20 MS. GORHAM: Good morning. I'm
21 Shaconna Gorman. I'm the senior project manager
22 for both Child and Adult Task Forces.

1 MS. MUKHERJEE: And I'm still Debjani,
2 so with that, I will turn it over to Rich to get
3 us started with our objectives and sort of an
4 overview of our meeting.

5 CO-CHAIR ANTONELLI: Some of this will
6 be a little bit of a deja vu for our Adult
7 members, but I'm going to err on the side of
8 reviewing it all for the -- at least for the
9 Child side today.

10 So the meeting objective is
11 considering states' experiences implementing the
12 core sets; develop recommendations for
13 strengthening both child and adult core sets; and
14 formulating strategic guidance to CMS about
15 strengthening the measure set over time to meet
16 the program goals.

17 So it will be a combination of looking
18 at measures and thinking strategically as well.
19 In the morning, we'll have a presentation from
20 CMS as well as the state panelist, kind of give
21 us a view from the front lines, if you will. CMS
22 will provide an overall update on the Medicaid

1 core set related activities, and then we'll hear
2 from our state panelists today.

3 The rest of day we'll work through
4 issues of shared relevance between child and
5 adult. So including maternal and perinatal
6 health, asthma measures, and supporting states to
7 participate in reporting, and then you should
8 have received all the supporting documents for
9 today's work, as we go from slide to slide to
10 reference if you need some help identifying where
11 we're at, so please ask the staff.

12 Next slide. All right. There we go.
13 So the charge, basically we've gone through this,
14 so I just want to bring us down to that final
15 one. Basically, MAP members from the
16 Coordinating Committee, Harold and I there, and
17 then the network groups that share this
18 particular interest, we're going to get the view
19 from the states, view from CMS in particular,
20 look at some of the gap areas.

21 Harold is going to give us a review of
22 some of the adult work that was discussed

1 yesterday, and think about measures for removal
2 from the set as well. This notion of parsimony
3 is near and dear to my heart as we're promoting
4 new measures going forward.

5 The next slide. This is the structure
6 of our delivered process. The Adult Task Force
7 met yesterday, shared interest today. Tomorrow
8 is Child only.

9 The next slide. As I mentioned,
10 maternal and perinatal health measures, asthma
11 measures across the age spectrum, and supporting
12 state's ability to participate in reporting of
13 the measures in the core sets. Be mindful that
14 those are voluntary expectations, okay.

15 Harold is going to take us through a
16 recap of yesterday, and as you're listening to
17 this, especially the Child Health folks, I want
18 to sort of put you on alert. Today is
19 specifically a crossover today, so be thinking
20 about opportunities to build on gap areas from
21 yesterday that have relevance across the age
22 spectrum. Harold.

1 CO-CHAIR PINCUS: So yesterday, we had
2 quite a productive meeting. We heard from Judy
3 Zerzan, who's the Medicaid medical director for
4 Colorado, who presented to us about some of the
5 very innovative and interesting work in Colorado.
6 We also actually were fortunate to have Rachel La
7 Croix on our panel, who was able to also fill us
8 in on some of the activities in Florida on a
9 regular basis.

10 I think it's really important that we
11 hear from I guess, you know, the people in the
12 states that are responsible for actually
13 implementing and interacting and using the
14 information that's being provided through the
15 Medicaid core set.

16 And so there were a number of specific
17 things that we did. First is with regard to
18 specific measures related to the core set, there
19 was one measure that we recommended for removal
20 and two measures that we provided conditional
21 support for.

22 The measure recommended for removal

1 was Measure 0476, which is the Antenatal Steroids
2 Measure, and the reasons for that was that
3 there's a very high reporting rate for this.

4 Of course, all the states it's a
5 required reporting for the Joint Commission on
6 Accreditation. It's already being collected in a
7 number of ways. You know, it appears to have
8 been pretty much topped out, and so it was
9 recommended for removal to reduce the overall
10 reporting burden.

11 The two measures that received
12 conditional support that were sort of nominated
13 and received conditional support, one was a
14 concurrent use of opioids and benzodiazepines.
15 It was conditional support because the measure is
16 not currently NQF-endorsed and there was a
17 feeling that obviously we are facing a major
18 crisis in terms of opioid abuse, and this
19 specifically also addressed an issue in
20 polypharmacy that was considered one of the high
21 priority areas.

22 And also particularly we're

1 particularly focused on reducing deaths and
2 mortality from opioid use. And so that was being
3 recommended and it's currently in the endorsement
4 pipeline.

5 The second one that was conditionally
6 recommended was the use of the CAHPS for home and
7 community-based services experience, and the
8 sense was that there's a clear gap in terms of
9 home and community-based services measures, and a
10 desire to also increase the number of
11 beneficiary-reported experience measures, and to
12 sort of fill both of those roles. It's something
13 that's also in the pipeline for endorsement, and
14 so that was also recommended.

15 The other thing that we did that I
16 think was a major portion of the day's discussion
17 was go through a reexamination of the gaps and
18 priorities among the gaps. So we went through
19 kind of eliciting both people's thoughts about
20 gaps, looking at past recommendations around
21 gaps, and then went through the exercise of
22 adding little dots to different categories.

1 What came out at the end of this were
2 really sort of -- we also try to identify where
3 there is an overlap in some of the gaps that were
4 previously identified.

5 So we identified nine areas in sort of
6 descending order of priority in terms of the
7 number of little dots that they got, was number
8 one behavioral health and particularly
9 integration of behavioral health with primary
10 care and psychosocial care and social services,
11 as well as thinking about this concept of
12 integration across the continuum of care, both
13 outpatient and inpatient, and in long-term care
14 services, and also thinking about the potential
15 for getting measures that address outcomes in
16 this area.

17 Number two was assessing and
18 addressing social determinants of health was the
19 second highest priority. The third was long-term
20 services and support of home and community-based
21 services.

22 We learned that there was some

1 interesting, innovative stuff going on in terms
2 of some work that's being done with the
3 Innovation Accelerator Program that CMS has been
4 involved with, as well as some work that's been
5 supported by the University of Minnesota or that
6 has been conducted by the University of
7 Minnesota, supported by the Administration for
8 Community Living as well as NIDLRR.

9 So that's another area for -- in terms
10 of a high priority. Particularly relevant for
11 our joint day today was maternal and reproductive
12 health was identified sort of as a fourth
13 priority, and particularly focusing on well woman
14 care, postpartum complications and access to
15 obstetrics care, especially in rural areas as
16 major areas.

17 The fifth area was efficiency
18 measures. There's a relative lack of those. the
19 sixth and seventh areas were pretty close in
20 terms of their level of support. The sixth was
21 new or chronic opioid use, and the seventh was
22 beneficiary reported outcomes as an area for

1 further development of priorities.

2 The eighth was workforce issues, in
3 particular thinking about primary care provider
4 burnout as a particular focus, and finally again
5 polypharmacy made it to the list as well. So
6 that pretty much summarizes where we were by the
7 end of the day.

8 I think that, you know, it was a very
9 useful day both in terms of understanding some of
10 the issues that are -- and some of the
11 innovations that states are undertaking, as well
12 as sort of understanding some of the challenges
13 that CMS faces as well.

14 CO-CHAIR PINCUS: So go to the next
15 slide. So for, okay. So just sort of to remind
16 people what's the purpose of actually developing
17 these child and adult core sets, is that there's
18 really three goals that's been set out for that.
19 One is to increase the number of states reporting
20 core set measures, and to increase the number of
21 measures that were reported by each state.

22 So this is a kind of a crowd sourcing

1 sort of process that we're going through. But
2 the most important thing is that we want to
3 increase the number of states that are actually
4 using it for quality improvement, that ultimately
5 we don't want to just do measurement for
6 measurement's sake, but we actually want to drive
7 improvement at the state level through --

8 So part of our job is to select
9 measures that actually will help to achieve these
10 goals.

11 Next slide please. From the CMS point
12 of view and Gigi may want to sort of add to this,
13 the core set measures really are part of a
14 regular report that they put out in terms of the
15 Child Health Quality report and Adult Health
16 Quality report, and produce for both states and
17 for many other stakeholders various analyses
18 using that data, and also obviously to inform
19 policy and program decisions that they make. You
20 want to add to that Gigi at all?

21 MS. RANEY: I think we'll speak to
22 that when I do Karen's slides.

1 CO-CHAIR PINCUS: Okay.

2 MS. RANEY: Thanks.

3 CO-CHAIR PINCUS: Next slide, and I
4 guess we're there.

5 MS. RANEY: Well, as you can tell,
6 I'm Karen. So I'm going to attempt to fill in
7 for her shoes as best I can.

8 I think Harold and Rich both set us
9 off well and we are really glad to welcome them
10 back as well as the members of the panel who were
11 here yesterday, those who have been here in prior
12 years as well as our new members, because this is
13 really is our opportunity to hear from the field,
14 not only from the states and stakeholders who are
15 generally quite vocal in telling us what things
16 work and what don't, but also to learn a little
17 bit more about what's going on and where the
18 needs are for that.

19 So we really do appreciate you guys
20 taking so much time out of your day and your
21 schedules to come here and participate with us.
22 We do know that there is a tight schedule today

1 and that Harold and Rich are going to be cracking
2 the whip on sticking to that so we're not here
3 until six o'clock tonight. But we also do want
4 to make sure there's an opportunity for robust
5 discussion.

6 Next slide please. So in terms of
7 building a foundation for quality membership,
8 there are really three components that we have
9 been focusing on at CMS, and that is measurement
10 and analysis and quality improvement. Today
11 we're focused on that measurement section of
12 that.

13 Next slide please. The quality
14 measurement reporting program. Next slide. As
15 you've already heard about, is a voluntary
16 reporting by states. So we just want to make
17 sure that everyone understands that when we're
18 talking about quality measures here today and
19 tomorrow, we're talking about state level
20 reporting.

21 We're not talking about provider level
22 reporting or individual accountability, but

1 really understanding what's going on at a state
2 level. So every year the states voluntarily
3 provide CMS with data on the adult and child core
4 set measures, and these are measure sets, one for
5 children and one for adults that our stakeholders
6 have told us are the key indicators for health
7 care access for the beneficiaries we serve.

8 Now while quality measurement itself
9 is not new to the Medicaid populations, what
10 distinguishes our core sets is that the states
11 that participate in this program are measuring
12 these key indicators of quality in a consistent
13 way against a uniform set of measure
14 specifications, which really helps give us a
15 national picture of what's going on in Medicaid
16 and where issues and concerns might be.

17 This consistency allows us to compare
18 performance across the states in an apples to
19 apples fashion, which we haven't been able to do
20 before with this population.

21 So you'll see here that we currently
22 have 27 measures in the core set and 30 measures

1 in the adult set, and you're going to hear this
2 word quite a bit today. We heard it yesterday a
3 lot. We always laugh when we say it, but
4 parsimony is really the name of the game here.

5 It takes a lot of money, a lot of
6 training and a lot of effort for states every
7 time we make changes to our adult and child core
8 sets, because they have to invest in that.

9 So we really would like to encourage
10 people to be thoughtful and considerate about the
11 measure changes that they're recommending, not
12 only measures for addition but measures for
13 removal, and we'd also like you to consider, you
14 know, proposing measures for removal not only
15 that might be low reporting but those that might
16 be high reporting as well, that might not feel
17 like they are necessarily needed anymore, that we
18 might be doing well on or know what's going on.

19 So looking at both of those things
20 because we're kind of looking at -- I think Karen
21 said it yesterday, sort of a one-in, one-out kind
22 of thing generally. The MAP gives us a bunch of

1 great recommendations. I think we had
2 recommendations for six measures to be added last
3 year to the adult measure set, and we added
4 three.

5 Three was a really big number, and we
6 sweated a lot over whether we wanted to add three
7 measures or two measures. So you know, these are
8 recommendations and they are very valuable, and
9 then we take those recommendations and then we
10 take those recommendations and we do a lot of
11 stakeholder input and feedback about the
12 recommendations that the MAP gives us before we
13 make a decision.

14 But the big difference between the
15 Medicaid MAP and the Medicare MAP is that they
16 are recommendations and they are not
17 requirements. So I just want to make that part
18 of it a little bit clear.

19 Next slide, please. I think we
20 already went through this a little bit and Harold
21 just went over it. Our goal is to increase the
22 number of states reporting and to increase that,

1 and to improve the quality of data reported. In
2 order to do that, CMS actually does have a
3 contract with a technical analysis and analytics
4 contract with Mathematica, that does help us to
5 support the states in measure questions and
6 reporting.

7 So they do work really closely with us
8 on that and hand in hand. So we just want to
9 make sure that whether we do provide support as
10 much as we can to states for the reporting of
11 these measures, okay.

12 So the next slide please. So the
13 input that we're requesting from the MAP this
14 year in that slide looks really tiny from here,
15 and we just want to talk about what you guys
16 think makes a measure useful. So it's not only
17 is it evidence-based but also is there room for
18 improvements and that states can or will
19 implement something as well.

20 So when we're looking at measures, we
21 want you consider reviewing measures not only
22 with low reporting rates that should be

1 considered for removal, but also the measures
2 that high reporting rates, and that we are really
3 focused on trying to make some incremental
4 changes. Again, that word parsimony comes to
5 mind. Okay.

6 Next slide please. One of the things
7 that we've really been working on over the last
8 few years is alignment. As you guys are all
9 aware, more measures sets are coming out every
10 day it feels like. They're across the board.
11 When we're thinking about alignment, we're
12 looking at alignment not only within CMS and CMS
13 programs, but also with states programs.

14 We have the AHIP collaborative measure
15 sets that came out last year. There are the
16 certified community behavioral health clinic
17 measure sets that came out a couple of years ago
18 and, you know, dozens and dozens of reporting
19 systems, whether it's through Medicare or other
20 things.

21 So we're looking at alignment and we
22 think that that's really important. But we also

1 need to keep in mind the level of reporting in
2 populations, and that what we're looking at is
3 state level reporting.

4 Another thing that we are thinking
5 about in terms of alignment, and this is a fun
6 one to add into the mix is the age ranges for
7 reporting, because oftentimes the CMS age ranges
8 are a little bit different than the HEDIS age
9 ranges, based on our coverage and how that works
10 out.

11 So you know, it's just trying to keep
12 things consistent if at all possible, and we know
13 that that adds some confusion. But it's
14 definitely something that we're aware of and want
15 to bring forward to you for consideration when
16 you're looking at measures, is some of those
17 alignment things.

18 And then under statute that state
19 reporting on these measure sets is voluntary, so
20 we really do work with the states and appreciate
21 their work on that.

22 So with that, the next slide is about

1 resources, and these are all links that you guys
2 can click on for -- with lists of our adult and
3 child core set measures and the different kinds
4 of measures that are going on, and as you know,
5 I'm not Karen. But you can email her if you've
6 got any questions about this presentation. I
7 hope that if you guys have any questions also,
8 I'll be happy to answer them. Thank you.

9 CO-CHAIR ANTONELLI: So why don't I
10 open it up, any comments or questions for Karen's
11 surrogate today, and Gigi thank you. Thank you
12 for the prep that led up to the meeting today and
13 for pinch hitting so well. So comments or
14 questions. Harold.

15 CO-CHAIR PINCUS: So Gigi, just is
16 there -- something I've just been curious about.
17 Since the origins of the child and adult programs
18 are somewhat different, is there anything in
19 terms of how CMS approaches the child that
20 differs with how it approaches the adult
21 components of this? So the general sort of
22 policy level approach.

1 MS. RANEY: I think what we found,
2 and I think everyone here is probably aware is
3 that there are fewer measures for pediatrics. So
4 one of the ways that CMS has focused on that is
5 through our pediatric quality measures and
6 reporting program, the PQMP program, which either
7 Kamila Mistry from AHRQ or Renee Fox will speak a
8 little bit about either today or tomorrow.

9 But because there are fewer measures,
10 we have focused more energy and effort on issuing
11 grants, in partnership with AHRQ, to try and help
12 develop some measures in that area, to try and
13 help address some gap areas. With adults, it's
14 been a little different because Medicare has been
15 in this field for a long time, as well as all of
16 the other stakeholders that are here.

17 The number of measures is a lot
18 broader. So I think we've done a little bit more
19 measure development-focused work or supporting
20 measure development in that area than we have
21 done in adults. But otherwise, I think what
22 we're trying to do is have a good understanding

1 of the quality of care and what's going on in
2 those spaces, and really have measure sets
3 reflect those broadly.

4 CO-CHAIR ANTONELLI: May I presume
5 that if Andrea wants to weigh in, that she has a
6 way of jumping into the conversation?

7 Yeah. All right. So any other
8 comments or questions before we move on? So I
9 think Mary Applegate, we're moving you into the -
10 - from the dugout to the on deck circle straight
11 away. You ready?

12 DR. APPELEGATE: I am. First of all,
13 thank you so much for letting me come to speak to
14 you. I think I've met a few of you perhaps ten
15 years ago when I was -- before kindergarten I
16 suppose.

17 Yes. So I recognize many of you. I'm
18 so delighted to kind of come full circle and
19 bring kind of additional layers of experience and
20 insight into the whole measurement scene.

21 So just to give you some of the
22 perspective, you know, I'm there when the babies

1 are born. I resuscitate them. I was the coroner
2 in our county for a bunch of times, so I was
3 there when they did. I did hospice, and as I
4 looked at the care over this period of time, it
5 actually struck me that we're not measuring the
6 right things that are actually helping us take
7 better care of people.

8 So of course then, in an effort to try
9 to help more people I get to medicate, and then I
10 realize, oh, we have to report different things
11 that perhaps are even farther away from what
12 matters at the patient level, that the clinician
13 then can actually use a barometer or speedometer
14 of are they close to what they need to be doing
15 or not improve the health of the community they
16 serve.

17 So I've been in Medicaid full time for
18 five years and there's been a massive
19 transformation in just reporting for reporting's
20 sake, as I heard someone mention, to realizing
21 that the program was design to pay for services.
22 It was not necessarily designed to make people

1 better.

2 But now, in the days of value-based
3 purchasing, our job has shifted to managing the
4 health of populations. So what do we need in a
5 measure to actually manage the health of
6 populations, and that's actually what I'm going
7 to talk about.

8 So I'm here to talk about grown-ups,
9 pediatrics, but specifically the maternity sector
10 today. So -- how do I advance slides? Do I need
11 to come sit next to you? Okay. Go ahead and go
12 to the next slide. So just a snapshot of what
13 Ohio looks like. We're the seventh largest
14 Medicaid state. We cover over three million
15 people and close to 90 percent are in managed
16 care, with efforts underway to get everybody into
17 managed care.

18 We talk a little bit about why, but
19 essentially the idea is if you're going to have a
20 system of care, a basic tenet is get everybody
21 into the system. Then once they're in the
22 system, identify folks who have special needs and

1 then reliably apply evidence-based practice in a
2 way that's patient-centered, so not just patient-
3 centered medical home, but that honors personal
4 choice.

5 So to your comments about home and
6 community-based services. So that's actually
7 what we're trying to do. So here you have the
8 additional populations that we're going to be
9 moving in, all the foster and adopted kids,
10 breast and cervical cancer programs. We tried to
11 get the BCMH children in, and we're looking at
12 managed long-term supports and services as well.

13 We expanded the Medicaid benefit to
14 over 700,000 people in Ohio since 2014, and I'll
15 show you the cost implications of that, and we
16 have about 80 to 100,000 folks in long term care
17 and community supports.

18 So just a snapshot, if you want to
19 advance this slide. Here are the age ranges. So
20 you can see we cover long-term care, so we have
21 this large elderly population.

22 Next, and this is what has happened to

1 enrollment. So you'll actually see the family.
2 Since we have reproductive health folks here, the
3 family planning waiver folks with a very limited
4 Medicaid benefit is that top blue stripe, and you
5 can see that as the purple expansion population
6 gets bigger, that population pretty much melts
7 into it.

8 So more than 80 percent of the people
9 with that limited family planning waiver got the
10 full benefit with the expansion of the Medicaid
11 program. So you can actually see where CFC and
12 ABD is here. So those parts are not different
13 from any other states. Go ahead. This is what
14 has happened to expenditures. So I think what
15 may show at the most though is this next graph.

16 So we had a -- if you can advance to
17 the next one, or maybe did I take it out? What I
18 wanted to show is that we are capped by JMOC
19 actually, by our legislature, to a three percent
20 growth rate, and even though we expanded to that
21 700,000 extra population, we are still under that
22 three percent growth rate.

1 There's been massive reform in Ohio to
2 try to contain costs, and that's actually one of
3 the reasons that we're supporting managed care,
4 so you can manage the budget better, and then you
5 can put all the requirements into a structure.

6 So here's the maternity core set, and of the
7 three core sets that we're talking about, this is
8 the one that I actually have least issues with,
9 because it actually is most closely aligned with
10 what clinicians need to do and what patients
11 actually need.

12 We are very much looking forward to
13 getting the specs for the contraception measure.
14 What's important about measures too is not just
15 the measure itself but to my comments about what
16 do you need to manage the population, it directly
17 correlates to inter-pregnancy interval
18 measurement at a population level for a high risk
19 population level.

20 So that's a great example of
21 alignment. The adult quality grant was very
22 useful to us because it provided the resources to

1 get all of the coding and all of the work done.
2 So that's actually one of the enabling factors
3 for volunteer reporting, is providing the
4 resources to actually get the initial work and
5 then just maintaining the reporting is actually
6 not that difficult.

7 There were comments related to the
8 antenatal steroids earlier. We totally agree
9 with our Perinatal Quality Collaborative. We
10 actually looked to see what happened with
11 antenatal steroids and it turns out that patients
12 were actually getting it. It just wasn't being
13 documented or captured between inpatient and
14 outpatient and other settings. So we absolutely
15 agree.

16 We would suggest, however, that in our
17 population health management mission that all of
18 the measure sets actually tie in population
19 health measurement, even if it's more difficult.
20 So for example in this set, be very helpful to
21 have preterm birth rates. So what are we trying
22 to move in maternity care? We can probably

1 prevent half of all preterm births in the
2 country, half.

3 So if we can move agencies and
4 entities towards knowing what preterm birth rates
5 are, identifying women at risk for preterm birth
6 and then reliably getting them, you know,
7 progesterone antenatal steroids, delivering in
8 the right setting, you know, kind of a
9 standardized package of things that actually
10 helps outcomes, that is really, really helpful.

11 Okay, go ahead. So what I'd like to
12 point out here is what performance has been over
13 the last 20 years or so. So this is postpartum
14 care, and you can see the line there from 1998,
15 and then you can see the line here. I'm trying
16 to read the -- the dotted red line is actually
17 average. Now it's about five percentage points
18 difference.

19 So in 20 years, I would argue we
20 should be able to do better than just a five
21 percent difference. So we need measures that are
22 actually actionable and easily understood. So

1 one of the reasons for this is women lost their
2 coverage after the babies were born, and then our
3 highest risk women actually never show up for a
4 postpartum visit.

5 So the health system itself, in a fee-
6 for-service universe, does not know who's not
7 there. Does that make sense? So as systems have
8 transformed, we've gone to 100 percent
9 attribution model? So in Ohio, every single
10 person who's eligible for Medicaid will be
11 assigned to a primary care clinician and
12 practice, and somebody knows to be looking for
13 that.

14 So to my concept of get everybody in
15 the system and makes sure someone knows, it's
16 also a reason that managed care is helpful. So
17 that's actually one of the reasons for poor
18 performance. This also is a great measure
19 because it is marker for who -- which children
20 may die.

21 So in our state, the lack of
22 postpartum visit is correlated to infant

1 mortality. So again tying to a population health
2 measure is a really important piece. So the
3 postpartum visit is an opportunity, and then we
4 have to talk a little bit more about what really
5 happens and can it be at home and in other
6 settings as well. Okay, next.

7 What I would like to show is that
8 there is a difference between MACPRO and what we
9 do with HEDIS, which is Medicare managed care
10 only. So there's some duplication. So to the
11 extent to which we can eliminate duplication,
12 that's great. So if our state were 100 percent
13 managed care, then actually there would be no
14 usefulness in reporting something that has this
15 tiny little fee-for-service.

16 The trends often go the same
17 direction, but I'll show you that for some other
18 measures they don't correlate at all. What we
19 have done here is we've separated it by managed
20 care plans, because if we have managed care
21 plans, they have to know how they're doing as
22 well. So we want measures that matter at the

1 plan level as well.

2 The idea here would be if one plan is
3 doing a whole lot better, the other plans can
4 talk to them to figure out what did you end up
5 doing, especially if it's about preterm birth or
6 infant mortality. We are not competing on
7 safety. So if they have figured out mechanisms
8 or ways to work with communities, we actually
9 want them to work together.

10 In the current environment, there's
11 actually no good way for entities to work
12 together. So I'll show you some examples of what
13 we've done with this particular measure that gets
14 us there. Go ahead. So reporting challenges.
15 The administrative burden, duplication of effort.
16 Some measures with hybrid methodology simply
17 measure the amount of effort that the plans take
18 in pulling records to get their numbers to look
19 better.

20 They're not actually getting more
21 people to their postpartum visit, for example,
22 and I have a graph to show you the difference

1 between those. So if you really want a measure,
2 it needs to be the same across the board, so that
3 you're measuring something that's close to the
4 person.

5 So you can presume that the error in
6 documentation is, you know, the delta is about
7 the same. So just measuring administrative
8 effort is just not at all on target for what
9 people actually need, and it will never get you
10 to outreach efforts, for example. It just gets
11 to, you know, pulling charts.

12 Although I would say that if our EHR
13 vendors standardize certain things, that would
14 really help. So the measures have to be
15 meaningful at the practice or at the best
16 evidence level. So that's actually a litmus test
17 for us as well, and then managing the work load.
18 As I mentioned before, all the coding that goes
19 into it.

20 The other thing is I heard the note
21 that the measure needs to be useful for driving
22 improvement and some are and some aren't. You

1 don't really know what a good number is and what
2 you're supposed to be.

3 Go ahead. So here's an example of
4 timeliness of prenatal care matching. MACPRO
5 matches HEDIS in this particular one. But if you
6 go to postpartum visits, which is the next slide,
7 you'll see that it doesn't. So they don't
8 totally -- so what are we supposed to do with
9 that, right?

10 So since our leverage point is with
11 managed care, the only thing we can really manage
12 is the managed care number, unless we want to go
13 to 30,000 different providers and try to figure
14 out how to standardize what they're doing in fee-
15 for-service.

16 Next. This is the example of hybrid,
17 which are the straight lines on the top, versus
18 administrative only. So you'll notice
19 administrative only sort of line up. I just did
20 it for a year. But the other just measures the
21 effort that the plans did to make certain marks,
22 and what happens for us is by contract, if

1 they're less than a 25th percentile nationally,
2 we find them. So you'll notice they'll all be
3 clustered around the 25th percentile.

4 We have other things we can do to
5 drive measures like auto -- what we've done for
6 the maternity measures, is we have measures that
7 include the low birth weight CHIPRA measure, the
8 pre- and postpartum visits as well as we want to
9 do preterm birth weights, and that's how auto-
10 assignment happens. They don't get new families
11 unless they're doing a good job for that
12 population.

13 So the other method that you can use
14 is we've clustered pay-for-performance measures
15 around reproductive health, because essentially
16 managed care plans manage money. They actually
17 don't manage people. So for them to manage a
18 population, you know, they didn't get the memo,
19 we have a new job. They didn't get that.

20 So essentially they chose Medicare-
21 like patients, the diabetic hypertensive in the
22 hospital or SNF. We missed 100 percent of all

1 the \$3 million babies and of course the impact on
2 the life and life trajectory for those families
3 is incredible.

4 So those were the things that we did
5 within the program that can actually move a
6 measure, as examples of why measures could be
7 useful. But again, if we can stick to
8 administrative, we can get rid of kind of the
9 noise in the system.

10 Go ahead. So issues for
11 consideration. We want voluntary reporting, but
12 I think all the caveats about if it's actually
13 useful to the state, you won't have a single bit
14 of trouble getting voluntary reporting. So if
15 it's in line with what we have to do, absolutely
16 no problem, especially if there's some technical
17 assistance.

18 We have to transition from reporting
19 only to moving population health outcomes. So
20 that focus actually changes what our measure
21 does, and I mentioned the rest.

22 So go ahead. So this is a measure of

1 alignment. If you want to move the yellow box,
2 it has to matter at the patient and at the
3 community on the bottom. It has to matter at the
4 clinician and health system and the managed care
5 plan, and then it has to translate into the
6 population, which of course is what you want us
7 to report at the very top.

8 So unless you can follow the yellow
9 boxes, what we see is mutually harmful
10 activities, you know. One thing doesn't help
11 another. So I like this graph just because
12 people can kind of get it intuitively. Go ahead.
13 The other thing to take into consideration is
14 what levers do we have to actually move the
15 measure.

16 So this is in Ohio and in other
17 states. Many of them are SEM states. We have
18 two different ways we're doing that. One is
19 through episodes of care. So if we're moving the
20 measure a different way and the reporting doesn't
21 count the same, then we're just creating extra
22 work. So what we've shown here is a perinatal

1 episode of care in the red, and the four measures
2 that go with it, and you'll notice the postpartum
3 visit rate is right there, along with the
4 terrible status of 50 percent showing up is a
5 standard that's met by 75 percent of the
6 clinicians in Ohio.

7 Half are getting discharged into the
8 wilderness. I mean it's painful for me to look
9 at this. So that's a very powerful lever.

10 Next, and then what happens is at the
11 clinician level, so to my point about the
12 alignment, they get a map of where they are cost-
13 wise. But on that red grid there, they get a
14 checkmark or an X if they're actually passing
15 that 50 percent quality, pseudo-quality bar. So
16 we've tried to make the data transparent to the
17 alignment.

18 Go ahead. So issues for
19 consideration. You already mentioned the
20 difference in ages. So what we need to do is
21 follow populations longitudinally. So do our
22 measures actually do that, and I'll give you the

1 well child example. If we can see that
2 altogether, then we actually have a different
3 view of the gap.

4 And then the measures need to hang
5 together as indicators of the health of the
6 population. So do they do that. So that's
7 actually another question, and it's a good way to
8 actually look at gaps. And then I mentioned
9 here, even though I'm not part of the pediatric
10 set, I have just have to talk about school
11 performance as a massive, massive gap.

12 So as a pediatrician, the way I know
13 my kids are doing well is they're thriving in
14 school, and then we already referenced social
15 vulnerability measures and composite measures
16 that actually could be really helpful. So
17 there's been a bit written, and then population
18 health measures. Interpregnancy intervals
19 specifically and preterm birth dates are
20 important for the maternity core set.

21 Then just to mention what measures are
22 important in actually saving lives. So we have

1 two massive public health crises in the country,
2 infant mortality, particularly disparities in
3 infant mortality and the opioid and drug problem.
4 So you mentioned the opioid part. I'm just
5 wondering if we can add the infant mortality and
6 preterm birth part.

7 Go ahead. So we all want smart
8 measures that are aligned, and we should give
9 some consideration to composite measures too so
10 that there's a view. It's almost like writing a
11 term paper. You put everything on the table and
12 then you pull it together in a way so that
13 intuitively people can understand what you're
14 doing.

15 So I'll give you some examples. So
16 what we've done in Ohio is instead of laundry
17 list of all the good stuff, we have this
18 depiction, which I described to you before, of
19 who the people are in Medicaid. We have healthy
20 adults and kids along the first stripe. We have
21 women of reproductive age. You notice they get
22 their own stripe, those with chronic conditions

1 and behavioral health issues.

2 Then on the right side, you can see
3 the key measures we're actually going to move.
4 We're going to move preventive screens. We're
5 going to reduce preterm birth and infant
6 mortality. We're going to integrate behavioral
7 health to your earlier comments, and then if you
8 have a chronic condition, we're going to manage
9 it well.

10 At the very top of that, by design, we
11 are actually not going to tolerate a gap based on
12 race or place. So unless we design it for that,
13 we want to do each measure by that. We have
14 difficulties getting race data because minorities
15 are the ones who actually don't volunteer race,
16 and we're not allowed to require it now that
17 you're not going to the counties anymore. So we
18 lost our racial gap.

19 So what we've done is we've mapped the
20 state by disparate communities, and we're doing
21 the measure by those communities compared to the
22 rest of the state, as a way to get around it.

1 I'm going to show you some examples. So how to
2 make measures meaningful.

3 Go ahead. What we have is we're
4 holding the plans accountable. So what you have
5 in the three stripes are actually the three
6 population streams, and if you're a plan, pick
7 your color and then see how you're doing across
8 the entire thing, so that you have a view of your
9 population.

10 So what this has told us is our
11 managed care plans don't pay attention to women
12 of reproductive age, sadly. So this is a way to
13 actually drive improvement. So on the bottom
14 here we have prenatal care, postpartum care and I
15 can't quite read the last one. But you can pick
16 one of the plans, and this is all public, so you
17 can actually pick UHC or Centene, Buckeye. You
18 can pick your plan and see. Go ahead.

19 And what I want to show here is that
20 longitudinal view. So in the blue, we have well
21 checks and the black on top are the older
22 preschool kids and then the bottom line is

1 adolescents. So at one view, I have an idea of
2 what's happening to well care for children. But
3 unless they're clustered together, I don't have a
4 view to be able to tell the primary care docs
5 hey, you guys need to show up at school where the
6 teenagers are. You can't just rely on preschool
7 office visits, just as an example. Go ahead.

8 Then by plan, we actually show them
9 which measures are improving how much, and then
10 also what their patient satisfaction is along the
11 bottom. So we've seen, for example, that plans
12 pay patients \$20 for their A1C or something like
13 that could be drawn, and you know, to me as a
14 primary care doc that just makes me crazy. I'm
15 like you're just making your numbers better.

16 If you paid the cab ride or found
17 them, I would have taken care of their
18 depression, made sure they didn't run out of
19 medicine, made sure they're not alone, you know,
20 et cetera, et cetera. So this kind of feedback
21 to the plans is really, really important if
22 they're accountable, and you can imagine the next

1 thing is going to be feedback to the health
2 systems and the clinicians as well, and that's
3 what's coming.

4 Next. In primary care, we organized
5 it the same way, and you notice we have a number
6 of women's health measures. So in primary care,
7 we're saying you're responsible for low birth
8 weight babies. You're responsible for timely
9 prenatal care. Guess what happened? You can't
10 make us responsible. We don't know who they are.

11 I'm like you're taking care of the
12 preemie. Do you not know when the mother is
13 pregnant? Do you think you can help her get
14 progesterone, and every time we ask these kinds
15 of questions it's yes, yes, yes. So we are
16 totally investing in reorganizing the primary
17 care infrastructure, specifically with measures,
18 certain measures in mind that we're hoping
19 totally line up with all of our quality and
20 federal partners.

21 We totally revamped this when AHAB
22 came out with theirs. We had it kind of

1 solidified between Medicaid and the top five
2 payers in Ohio, and then we kind of revamped
3 trying to -- this is claims-based. We realized
4 we need to go to eQMs, although that year
5 requirement, 11 out of 12 months eligibility.
6 It's a huge problem. We have to tell people how
7 they're doing as they go. So it needs to -- what
8 we've done is we've done a rolling year of
9 eligibility. So even eQMs won't actually solve
10 this for us. Go ahead.

11 So then what I really want to show is
12 improvements are local. So you have to tell
13 communities how they're doing. This is preterm
14 birth rates by the three largest cities, so that
15 if one city is doing better than another, again
16 they can help each other, just like the plans
17 can.

18 And then to make it real, we have the
19 targets for improvements that would be real. How
20 many preterm babies do you have to save to
21 actually make that be a real difference and not
22 random. So we have to bring the math and science

1 to it as well.

2 Next. Community members don't do
3 graphs really. You have to make this information
4 intuitively obvious, and so we have color-coded
5 it so that you can compare the big three C's, you
6 know, Cleveland, Columbus, and Cincinnati, how
7 are they relative to each other. So I would
8 suggest that the first city, which is the
9 Columbus area, needs to go help Cincinnati, which
10 is on the right as it relates to this measure.

11 Then what you see on the bottom is
12 Franklin County, a trend over time, which is also
13 important. You have to tell communities are you
14 getting better or not. It turns out that in
15 Franklin County, we have a massively organized
16 effort with all the health systems. In 1-800
17 give me a prenatal visit today, taking
18 progesterone to scale and safe sleep. So this
19 would suggest that that's actually working.

20 Next. So then you have to tell the
21 plans how they're doing by population. Again,
22 this is not their main business or they didn't

1 think it was but it is. And then next, what I
2 want to show you is that even though we have an
3 infant mortality crisis in Ohio, prenatal care
4 and postpartum visits still are awful.

5 So we have everybody saying we want to
6 help but we can't do the very basics. So this is
7 actually news to them. So that's actually what
8 we need to do. I think I'm actually wrapping up
9 here. Is that it?

10 Then what we did for those top five
11 measures is we did for those top five measures is
12 we actually have this scorecard, and we have in
13 gray highlights demographically similar
14 communities, so that you can see relative
15 ranking. We actually give this to the
16 communities on a quarterly basis, in conjunction
17 with our public health partners.

18 So that's actually what we use your
19 measures for. This may really far away from what
20 you're thinking that we're talking about, but to
21 make it useful, that's actually what we've had to
22 do. So to the extent to which we can do this for

1 an entire population stream that's standardized,
2 so that you know where the gaps are and where
3 you're losing people, that's really, really
4 useful to us.

5 So that's it. That's actually the
6 Medicaid community measure view. Thank you.

7 CO-CHAIR ANTONELLI: Thank you very
8 much. We're going to take some time to get some
9 comments and questions now from the Task Force.
10 Thank you Mary for stepping in, and we have our
11 CMS presenter on deck. So I see your last -- is
12 it Sue Kendig? Yeah. Your cup was in the way.
13 So we'll go Sue and then Clark, and then over
14 here. Okay.

15 MEMBER KENDIG: That was great, thank
16 you. I have a couple of questions for you. I
17 have a lot of questions actually. So you talked
18 about -- first of all, you talked about
19 postpartum visits and how they correlate with
20 infant mortality, and then on Slide 163 I missed
21 your comment. You said something about they
22 missed all of the \$3 million babies.

1 So my first -- the first part of that
2 question, I guess is do you have a little more
3 background on how missing that postpartum visit,
4 how is that sort of the red flag around infant
5 mortality?

6 So that's a great question. So a
7 separate effort is actually doing predictive
8 modeling. So we took five years of infant
9 mortality in Medicaid and then got all of the
10 information we could about social determinants in
11 claims, to try to figure out what might be a
12 marker.

13 DR. APPELATE: So the analysis not
14 totally done, but there's a two to two and a half
15 times higher rate for infants dying for mothers
16 who don't show up at a postpartum visit. So it's
17 a marker for other things. Do you have
18 transportation? Does someone even care about you
19 to show up? Is it useful to you?

20 There's all that other stuff that goes
21 into it that I actually think is part of it,
22 which is part of my request to really look at

1 social vulnerability types of measures, which may
2 correlate more, but I don't have a claim for it.
3 So it's a proxy for other things.

4 MEMBER KENDIG: Yeah. That was what
5 I was wondering, because doing similar work in
6 Missouri, we're actually familiar with some of
7 the things that are going on in Ohio like Cradle
8 Cincinnati and I think Columbus has an effort,
9 Jay Iams's effort at Ohio State, and I'm
10 wondering when you're talking about all of these
11 markers and the social determinants and so forth,
12 because you commented on even though everybody
13 wants to work on this, we still have these
14 declines -- you know, we still have high rates of
15 no visits and so forth.

16 How are all of those community-based
17 efforts that one would think are addressing
18 social determinants that would then impact this?
19 Do you have a sense on how we can better capture
20 that, because that was a discussion yesterday.

21 DR. APPLGATE: Yes. So one thing I
22 didn't reference is that Ohio has invested over

1 \$26 million through managed care into the high
2 priority communities, specifically to end the
3 infant mortality disparities gap. What we did is
4 we asked the communities what do you think you
5 need. This was on the heels of City Match or the
6 Ohio Equity Institute.

7 That process was not necessarily
8 neighborhood friendly in that they had all this
9 science of picking upstream and downstream
10 measuring, what do you want to do and they landed
11 on something like progesterone and then realized
12 they didn't have what they needed to actually
13 move it.

14 So we developed a scorecard of
15 community-based efforts that started with how
16 many African-American women actually showed up to
17 community events, Every Day Democracy, racism
18 discussions.

19 We don't here in these circles
20 necessarily realize how hostile the health system
21 is and how dis and untrusted we may be in a lot
22 of the communities of color. We absolutely do

1 not appreciate that.

2 So we're simply measuring African-
3 American women show up to events, and then how
4 many get into evidence-based programs like
5 Centering, using community health workers or home
6 visiting, those three efforts, because the Safe
7 Sweep and general education is kind of canvassed
8 over all of them.

9 So the jury's still out on that. I
10 think our legislature wants results yesterday.
11 It's taken decades to get there. I asked them
12 please to give us three to five years to at least
13 figure out better indicators, and I do think the
14 big gap there is around the social vulnerability
15 pieces, and I also again acknowledge for women of
16 reproductive age, we will get absolutely nowhere
17 without the Department of Education.

18 We must get African-American women
19 educated out of high school, delaying their first
20 pregnancy as a direct link to poverty. So we've
21 learned this from third world countries and
22 Bangladesh is probably one of the best examples,

1 in which family size was seven to begin. They
2 undertook an effort like this. Family size went
3 down to two, and guess what happened? These were
4 the women we gave microloans to. They have their
5 own businesses and actually brought themselves
6 out of poverty.

7 So we must learn from the rest of the
8 world, but without education, you know, again
9 this alignment. We actually will never able to
10 meaningfully impact the health of our -- the
11 women in our program as much as we could.

12 Yes, so the postpartum visit. We also
13 have this adult-quality grant, where we try to
14 improve postpartum visits, and it was all about
15 connecting to the women. The women are very
16 isolated, interestingly enough. They're alone,
17 frightened, distrustful of everyone, often
18 traumatized, and so just accessing the system or
19 having it mean anything to them, you know, those
20 are the issues that we actually ran into.

21 So it's a marker for those other
22 things, but then you can have a plan for it. If

1 you have a way to identify who are the pool of
2 people to focus those efforts on, we can.
3 Totally separate for opioid-challenged mothers,
4 by the way. Yes.

5 CO-CHAIR ANTONELLI: So I want to make
6 sure that I focus this. I mean I'm glad that I
7 flew to Washington today just to hear you speak,
8 even though the Cavaliers beat the Celtics.

9 DR. APPELATE: Yeah, sorry about
10 that.

11 CO-CHAIR ANTONELLI: This is awesome,
12 but that said, I want to keep people, you know,
13 be mindful these -- as much as we'd like to
14 applaud this, think about this in the terms of
15 the themes that we need to do to promote
16 measurement, what some of the challenges are of
17 the state. So we -- and we can talk a little bit
18 about Ohio-specific challenges and opportunities
19 that engage.

20 So I want to go to Clarke and then I
21 think it was Terry, Ann and then over to Diane,
22 and then I think we probably only have until

1 about 10:00. Oh, and then Harold. We have only
2 until about 10:20, because our CMS colleague is
3 here next. Will you be here throughout the day
4 today?

5 FEMALE PARTICIPANT: Yes, yes.

6 CO-CHAIR ANTONELLI: Okay, Clark.

7 MEMBER ROSS: Thank you. I had two
8 questions on the Buckeye Dashboard, Slide 171.
9 You have four population groups on the right-hand
10 column. Are there other targeted population
11 groups, and specifically I'm thinking about
12 children with intellectual developmental
13 disabilities.

14 DR. APPLGATE: So we did not take out
15 children with special health care needs
16 separately, because this is the place we're
17 starting, and then I think that's actually a next
18 layer, as is the home and community-based
19 services population. So we have a whole bunch of
20 work around that, but it doesn't show up at a
21 dashboard that's at this high level.

22 MEMBER ROSS: Okay, and then the

1 second question is how you deal with co-occurring
2 folks. So 40 percent of individuals in the state
3 developmental disability systems across the
4 country also have a co-occurring mental illness,
5 and most everybody tends to separate behavioral
6 health out and children's special needs or
7 persons with disabilities. So how do you think
8 about and cross-walk this co-occurring dynamic?

9 DR. APPLGATE: So we put them in the
10 behavioral health bucket, if that was their
11 primary -- on a claim if that was in the primary
12 spot on the claim. So at least half of the
13 disabled population actually is in that
14 behavioral health condition.

15 So we have a map of what percent of
16 our population has which co-occurring conditions,
17 which -- I didn't include it here. But that was
18 specifically to give the plans a view of who we
19 are trying to take care of and what their needs
20 are, and we have more granular stakeholder and
21 other sorts of meetings.

22 In our CPC and primary care

1 initiative, all of the practices are required to
2 have a patient advisory council, and that has
3 directly resulted in, you know, structural
4 improvements, better access, different
5 communication, more focus on choice and self-
6 directed care. It's actually been pretty
7 amazing.

8 MEMBER ADIRIM: That was a really
9 great, very informative presentation. Thank you
10 very much. I have very simple two questions.
11 One, and you might have said it and I might have
12 missed it, but how many of the adult and the
13 child course, how many of those measures does
14 Ohio report out on?

15 DR. APPELEGATE: So I have the list.
16 We report on about three-quarters of them.

17 MEMBER ADIRIM: Okay, and then you did
18 have a slide on some of your reporting
19 challenges. How do you -- how does your state
20 determine which measures that you want -- is it
21 feasibility? Is it your state-specific
22 priorities? Like what are some of your thoughts

1 and decisions that go around that?

2 DR. APPLGATE: Right. So we pick the
3 ones that most closely align with actually
4 getting people better. So it's actually not any
5 more complicated than that.

6 We will be working really hard with
7 the contraception measure once we get the specs
8 for the reasons that I discussed. It rolls up
9 into a population level and is directly relevant
10 to what the clinician has to do at the point of
11 service.

12 So that test was actually the best
13 filter, and I used the postpartum example as an
14 example for why we report. We lined up the TA,
15 the adult quality measure grant with our TY
16 project. The measures at the clinician practice,
17 primary care specialist, episode level, plan
18 level. I mean it was an example of what you can
19 do with a measure that actually --

20 Now we moved to the community,
21 hopefully help move that postpartum visit to
22 actually help address the issues related to

1 infant mortality and disparities. So that's the
2 reason I used the postpartum measure. So it was
3 no more complicated than that.

4 MEMBER GREINER: Great presentation
5 and impressive what you're doing in Ohio. You
6 mentioned that you were reorganizing primary
7 care, and I had a little bit of an answer to my
8 question, which was how are you doing that
9 through CPC+ and maybe other ways as well. Do
10 you feel like the measures reflect what you're
11 trying to achieve with reorganized primary care?

12 DR. APPELEGATE: What's new in primary
13 care is bringing the sort of focus to the
14 populations they serve. So even patients that
15 are medical homes still largely were fee for
16 service. That's all about can the plans and
17 other payers, so not just public payers, but
18 private plans, can we get together and tell
19 practices these are the people who were in a
20 behavioral health institution five counties away.
21 These are the people who showed up with
22 admissions and ER visits, so that they can work

1 the list.

2 You do conduct yourself differently if
3 you're trying to take care of a population. So
4 the measures that are actually in there are a
5 start, but I think the real deal is can we feed
6 back information in a timely way. So again, you
7 know, maybe that rolling eligibility piece based
8 on an attribution model, that then allows for
9 financial gain if you do a better job.

10 So that's the other part with fee for
11 service, is the measures absolutely must be
12 amendable to value-based purchasing. So that's
13 the other thing that perhaps I didn't say quite
14 so plainly.

15 MEMBER JONES: Did you do any
16 breakout? I mean you focused kind of on the
17 urban areas. Did you look at y our rural areas?
18 I know access, especially in the obstetrics
19 space, is really a huge concern in rural areas
20 and one that's getting worse.

21 One of the concerns that we hear a lot
22 from providers is that their statistics look

1 horrible compared to these urban providers, for
2 reasons that are kind of outside of the controls.

3 I had -- one Colorado physician to me
4 said I'm not going to stop providing birth
5 services, but I keep getting dinged by the
6 insurance companies in her case, and was being
7 pestered by the state Medicaid agency because she
8 has a higher C-section rate during the winter.
9 Well, she says I have patients that live two
10 hours away and there's a snowstorm and there's
11 going to be no ability to even helicopter them
12 out.

13 So there's always that concern about
14 kind of the measurement in that rural space and
15 we kind of balance those competing criterion.
16 But I guess I'm just curious if that's something
17 you guys have looked at, if you've kind of looked
18 at those rural numbers, looked at kind of the
19 places where they're stopping providing obstetric
20 services, what the impact on prenatal care, all
21 of it, yes.

22 DR. APPELEGATE: So we have looked at

1 that, and you'll be surprised to note that some
2 of our rural counties actually do better. I
3 think there are less malpractice concerns because
4 their relationship with their patients is
5 actually better. I think the biggest issue we
6 have is not delivering a really high risk baby at
7 a Level 1 hospital. I think that's actually part
8 of it.

9 What we found with expansion is that
10 our advanced practice nurses really stepped up to
11 fill the gap, and as we've had a broader array of
12 workforce, we've actually done less inappropriate
13 intervention it appears. So for example, our
14 advanced practice nurses do the best in all of
15 our perinatal episodes, interestingly enough.

16 So to me this is fantastic, you know.
17 From the lowliest, you know, come the greatest
18 and interestingly enough even within Medicaid,
19 we're out-performing some of the commercial
20 payers in some areas. So we acknowledge that
21 transportation and communication -- we have areas
22 that don't even have cell service, in Appalachia,

1 for example.

2 So while we acknowledge that, I think
3 if we get to the social determinants measure ever
4 and put those two things together, that will give
5 us a better view.

6 CO-CHAIR PINCUS: Terrific
7 presentation, Mary. So a lot of what you
8 describe in terms of your efforts, I think some
9 of the undercurrent around it is really built
10 around the notion of what I term ruthless follow-
11 up, not letting people fall through the cracks.

12 To do that, you need to have sort of
13 the -- an appropriate sort of structural
14 infrastructure, at both the practice level and
15 also at the plan level. How are you trying to
16 make sure that that's there and that's booked?
17 What are some are using some -- and it follows up
18 on some of the stuff that Ann was talking about.

19 How are you making sure that that
20 infrastructure is actually there? To what extent
21 are you using some of these recognition programs
22 and other kinds of programs, both in terms of

1 sort of information system infrastructure but
2 also, you know, the practice care management
3 infrastructure to track these populations?

4 DR. APPLEGATE: Yes. That's actually
5 a great question. What I didn't include is
6 perhaps one of the points of biggest contention,
7 and that is whose job is what, right? There has
8 to be an assignment of roles and responsibilities
9 including hearing the patient voice, right. So
10 in our primary care model, we actually have
11 practice requirements, like 24-7 access to
12 someone who can diagnose and treat and actually
13 have the EHR.

14 That doesn't mean we're recreating
15 emergency rooms, because a lot of times you
16 simply need to talk to someone and try to
17 understand what's going on. There are
18 requirements around team-based care, risk
19 tiering, population management, the patient
20 experience, and then there are efficiency
21 measures about ED use, inpatient stays, generic
22 prescribing, for example.

1 On the plan side, this is the
2 controversy, what are they to do? They must be
3 responsive, even if the person has not agreed to
4 be in official care management that has all these
5 requirements around how fast you do the
6 assessment and if you have a delegate you find
7 them if they haven't done things.

8 That is not what practices need. They
9 need things like you know what? The VH provider
10 won't call me back. I have transportation
11 issues. They can't understand me accent-wise or
12 language-wise. Those are the things that the
13 plans can actually help with. But I would
14 suggest that as much as care management is a huge
15 part of our managed care plan program, there
16 could be other entities closer to the ground who
17 do it better.

18 So right now in primary care, they're
19 responsible -- the primary care clinicians are
20 getting this per member per month fee from one
21 dollar for a well child to \$22, I think, for the
22 third tier risk, and that's actually how they're

1 spending their money is on -- we thought it might
2 enhance primary care fees, so that we wouldn't
3 burn out the clinicians quite so much, because
4 they wouldn't have to see 30 people in a day.

5 But it turns out they simply have
6 different types of staff in their office. So the
7 plan requirements really are quite different.
8 They must communicate.

9 Initially, it's a fight over
10 attribution. They don't belong to me, you know.
11 How did you decide this? We are actually
12 structuring specifically quality improvement
13 efforts to get into the nitty-gritty with the
14 plans for how they're communicating this
15 information.

16 Practices still want faxes, and you
17 know what, the plans can't do 200,000 faxes in
18 one day. I mean it's just untenable. So we do
19 have a delineation of roles and responsibilities
20 that go with it.

21 CO-CHAIR PINCUS: One sort of related
22 question is how big are the incentives at the

1 practice level? We had some discussion yesterday
2 that surprisingly, some of the financial
3 incentives, even very easy ways of expanding
4 revenues such as reporting depression
5 assessments, are simply not being used at a
6 practice level. So I was curious about whether,
7 how large the financial incentives are that
8 you're putting in place.

9 DR. APPLGATE: Yeah. So it's -- so
10 if it's the whole population, it's \$1 per member
11 per month for someone who's totally healthy and
12 needs a well check. Fee for service works fine
13 if you don't need much, right. So there's not
14 much incentive there, although there may need to
15 be some outreach or you may need to have your
16 practitioner physically show up at the school.

17 Up to \$22, and what may happen is if
18 you have someone who has 12 different social risk
19 factors, that's actually not going to be enough.
20 So what has to happen is the health care dollar
21 cannot fix the entire social system, right.
22 That's not actually what we're trying to do here,

1 but we do need to prioritize which things need to
2 be addressed, that actually directly bear on the
3 health outcome.

4 CO-CHAIR PINCUS: Thank you very much.
5 We're going to pivot now. So Lekisha Daniel-
6 Robinson from CMS is there. So for those of you
7 tracking from a distance, we're going backwards a
8 little bit.

9 MS. DANIEL-ROBINSON: So good
10 morning everyone. Always a little bit of a
11 challenge to follow Dr. Applegate, because she
12 gives such an in-depth view of care within her
13 state. But she is also a part of the driving
14 force around the CMCS maternal and infant health
15 initiative. So if we can advance to the next
16 slide.

17 This initiative was based on an expert
18 panel, which Dr. Applegate co-chaired along with
19 a couple of other people in the room. So Deborah
20 Kilstein, Carol Sakala were a part of that expert
21 panel, that really worked over the course of a
22 year to identify a number of opportunities that

1 CMS and states could engage, to improve maternal
2 and infant health outcomes.

3 With that feedback, what we launched
4 the initiative in 2014, really as a way to
5 explore program and policy opportunities to
6 improve outcomes along with our state partners.
7 So the effort supports state to improve
8 measurement, obviously engage providers and
9 beneficiaries, identify quality improvement
10 opportunities and more recently to implement
11 value-based payment strategies.

12 Next slide. The activity -- well, I
13 should talk about the strategies very briefly.
14 We identify four key strategies that would be
15 needed to advance the effort. So one, engaging
16 state providers and beneficiaries, which you
17 know, has not typically -- when we talk about
18 providers and beneficiaries, has not typically
19 been the realm in which CMS works, but clearly as
20 Dr. Applegate referenced, that is where you're
21 going to see the movement.

22 So we have to figure out ways to get

1 down to those levels in partnership with our
2 states. Leveraging our federal partnerships. So
3 we've worked with the CDC, Centers for Disease
4 Control and Prevention, Office of Population
5 Affairs, HRSA and others as a part of this
6 effort, strengthening technical assistance to the
7 states and measuring quality and improving
8 performance.

9 Some of the key activities of the
10 initiative to date have been an improving
11 postpartum care learning series. I know Dr.
12 Applegate talked a bit about the importance of
13 the postpartum visit, and during the deliberation
14 of the expert panel, there was a lot of
15 discussion about using that visit as the
16 opportunity to address contraception care. So to
17 think about not just what happened in that
18 pregnancy, but preparing the women for health
19 throughout her life, but also thinking about
20 those things that may need to be addressed to
21 impact a subsequent pregnancy.

22 We have had a contraceptive access

1 grant. That grant provided funding, a small
2 amount of funding albeit, to 13 states, to
3 collect and report on two contraceptive care
4 measures. One is now currently in the child and
5 adult core set. So it's the postpartum
6 contraceptive care measure, and the other is a
7 contraceptive care measure for all women of
8 reproductive age.

9 So the grant has contributed to the
10 understanding behind, and even the specifications
11 in that measure. We've had a mobile messaging
12 piloting project, thinking about the beneficiary
13 level. Again, what are the ways we can begin to
14 impart the education that's needed to the
15 beneficiary, and connect them to their care.
16 Then finally as a mentioned, the value-based
17 payment strategy. I'll touch on that briefly a
18 little bit later.

19 Next slide, please. So at the heart
20 of all of our activities is the core set. As you
21 may know, the core set is made up of measures --
22 the maternity core set is made up of measures

1 from both the child and adult core set. However,
2 I don't like to look at it like that because it
3 really doesn't matter, right?

4 It's really, you know, it's clearly a
5 dyad relationship and the initial core set for
6 children, you know, the membership of the
7 committee that was looking at identifying that
8 core set was really thinking about what are some
9 of the prenatal aspects that would impact the
10 outcome of that pregnancy, and then the
11 discussion was picked up once we went -- moved to
12 identifying an adult core set, and that's where
13 we picked up the postpartum care measure.

14 Now at this point, I think people want
15 to make sure that measures related to improving
16 perinatal care are incorporated in the core set.
17 And so, you know, I think you'll find some in
18 either core set. So there's antenatal steroid
19 and the adult core set. However, that's really
20 about improving the function of the potentially
21 pre-term baby.

22 So I'd like to look at the core set

1 for maternity care as a whole, whichever side it
2 fits on, you know, it fits on based on your
3 deliberations. But it's really about impacting
4 those outcomes.

5 Next slide, please. So the measure is
6 related to maternity or perinatal care in the
7 child core set. So two are really well reported
8 on by our states. It's the well child visits
9 within the first 15 months of life, as well as
10 time limits of prenatal care.

11 Some of the others are a little bit
12 less frequently reported but still have a high
13 number of states reporting, and then I would say
14 the behavioral health risk assessment is probably
15 the lowest for a number of reasons in terms of
16 feasibility at the state level.

17 Next slide. The postpartum care rate,
18 as you can see, is one of the more frequently
19 reported measures by states, and then less so are
20 the antenatal steroids and the elective delivery
21 measure.

22 Next slide. So I just wanted to share

1 briefly some of the more recent -- the most
2 recent reporting of some of the key measures.
3 Timeliness of prenatal care is at about 82
4 percent. This is based on federal fiscal year
5 2015 reporting, you know, which is the most
6 recent data that we have available to us.

7 Next slide. The frequency of prenatal
8 reporting is at 64 percent.

9 Next slide. Low birth weight infants.
10 You know, I think we continue to see -- I think
11 there some consistency in this rate at 8.9
12 percent, and obviously if you were to look at a
13 map, there are some areas that -- where the
14 disparities are a lot greater, on probably all of
15 the measures related to prenatal care, but
16 certainly this one.

17 And then finally the postpartum care
18 rate at 58 percent. So one of the things we did
19 as a part of the maternal and infant health
20 initiative was to really focus on the postpartum
21 care rate. At 58 percent, there's certainly some
22 opportunity there. Clearly, Dr. Applegate talked

1 about what could happen during that visit if we
2 could get them there. So we took a little bit of
3 a look there.

4 Next slide. We worked with ten states
5 on the Postpartum Care Acting Learning Series,
6 which really was to think about ways that could
7 drive improvement in that visit rate within those
8 ten states. They partnered with their managed
9 care organizations, Healthy Start sites in their
10 states. They partnered with other local groups
11 to do some pilot tests of change.

12 Now we used the postpartum care
13 measure, and at the outset it's probably useful
14 to say that there are some challenges with it. A
15 few of them are listed here. There's probably --
16 well actually no. The last one sort of captures
17 it. But global billing has an impact on
18 assessing whether or not it happens. It also
19 creates sort of a slightly perverse incentive in
20 terms of ensuring that it occurs.

21 Therefore, there's also problems with
22 tracking. So there's the global bill piece,

1 which is unintended effects for occurrence and
2 there's the tracking of it, and then there's also
3 the fact that the measure only tracks whether or
4 not a visit occurred, and it really doesn't look
5 into some of the content pieces.

6 Nevertheless, we find that it's still
7 a very useful measure for the reason that we've
8 already discussed.

9 Next slide. So that out of the way,
10 we have used it and you know, I would say that
11 with those ten states our findings sort of
12 reflected a bit of your findings, in that
13 connecting women through community health workers
14 or other care coordinator type extenders was very
15 useful in the states that pilot, did some pilot
16 activities to improve the visit rates.

17 And then the other, which was, you
18 know, very low tech, very small but was found to
19 be very significant was just reminding women
20 about the postpartum visit. Like you know, very
21 basic. But these are some things that the states
22 found could be useful.

1 Next slide. So I talked a bit about
2 the content, you know, was missing from the
3 visit. So the other aspect that the states
4 focused on was how to get -- how to ensure that
5 women were getting what they needed from the
6 postpartum visit. In our ten states that we
7 worked with, I can tell you that the standard was
8 very different by state.

9 So some states followed like ACOG
10 standards. There were, you know, I would say
11 there are like of the ten states now, only ten,
12 there were six different -- six or seven
13 different sets of standards that they were
14 following. I mean so a standard is good, right,
15 but there isn't that consistency. So the content
16 piece, you know, I think is something that still
17 needs to be worked on the field.

18 Nevertheless, one of the things that
19 we found, which was very helpful, was tying
20 reimbursement to things like checklists was
21 useful. So one of the states incorporated --
22 they sort of unbundled their perinatal fee and

1 incorporated a separate payment structure to
2 allow for the postpartum visit and tied certain
3 elements to that visit, including completion of
4 the Edinburgh Postpartum Scale to screen for
5 maternal depression.

6 And then the other was looking at
7 reproductive life planning. So ensuring that
8 contraception counseling was occurring. Those
9 were some of the key aspects that the states
10 found to be helpful in the efforts.

11 Next slide. So you know, building on
12 the work that -- the pilot work that was done
13 with those ten states, and sort of moving forward
14 and thinking about some of the other activities
15 that are going on in this sphere.

16 So we've had activities such as the
17 major investment CMS made with strong start,
18 looking at approaches to delivering care such as
19 home visiting, birthing centers and others, in
20 addition to some of the QI work that we've been
21 doing, thinking about how we can use that, what
22 other reforms are necessary.

1 And so reimbursement is probably that
2 big missing piece, where Medicaid financing has
3 not necessarily always kept pace with the latest,
4 and perhaps in the case of maternity maybe not
5 even the latest. But the things that we've known
6 from the past 20 to 30 years about what actually
7 has an impact on care.

8 So we're working with the Innovation
9 Accelerator Program at CMS to -- of the support
10 states, and thinking about some of those local
11 practices. So whether it's CHW, whether it's
12 home visiting or some other things.

13 Thinking about your question related
14 to rural care, what are some of the care delivery
15 models that can help and assist a state with
16 improving their outcomes in all of these measures
17 with the reimbursement tied to it.

18 So this is clearly an area that we
19 will continue to use our core set measures to
20 assess the outcomes of. So I think I'll pause
21 there. So more information on the maternal-
22 infant health initiative. I just gave you a very

1 brief highlight. It's available on our website.

2 CO-CHAIR ANTONELLI: Thank you very
3 much. I'm open for comments or questions from
4 the Task Force. I can't see the -- yeah. By
5 tomorrow I'll know your face. Amy, and then
6 Harold.

7 MEMBER POOLE-YAEGER: Yeah, thank you.
8 I just wanted to comment that I completely agree
9 with your comment about the global billing being
10 a huge barrier in this. We have, you know,
11 managed care plans in 23 states. I can tell you
12 the number one correlating factor between
13 postpartum rates is whether there's a lot of
14 global billing in the state or not.

15 So somebody, you know, it does a lot
16 of times reflect the effort that it takes to try
17 to find out whether they had one or not, and I
18 always worry about do we really know how many
19 people are going in to get those prenatal visits
20 because of that sort of thing. So you know,
21 anything we can do to try to help, you know, move
22 people toward this does make sense. This is

1 something we should be tracking. We need to know
2 when they're going in order to be able to help
3 make sure they're getting there when they need to
4 so --

5 MS. DANIEL-ROBINSON: Yeah, and I
6 think we found another state that they -- if I'm
7 not mistaken, they still did the global bill, but
8 they found another mechanism to ensure that there
9 was tracking. So that at least a date was
10 submitted for the occurrence of that postpartum
11 visit.

12 CO-CHAIR PINCUS: I was wondering
13 whether you could expand upon your last goal up
14 there, in terms of informing value-based payment
15 opportunities and how you're thinking about that,
16 and what are the various alternatives you're
17 looking at.

18 MS. DANIEL-ROBINSON: So we're right
19 now in the process of identifying states that
20 we're going to support, and it's really focused
21 on the care delivery models of interest to them.
22 So if they are interested in thinking about how

1 to ensure that home visiting services are
2 appropriately financed within their state, then
3 that will be that particular state's focus.

4 And so we're really leaving it open to
5 the areas and the avenues that the states would
6 like to pursue, but ensuring that they are tying
7 the outcomes to, you know, the quality measures.
8 One of the key elements that was necessary for
9 those submitting expressions of interest was that
10 they needed to come with a care delivery
11 opportunity that had some data behind it.

12 So you know, it had to show within
13 their local community that this particular model
14 had an impact on outcomes in some way. You know,
15 we're not making it an extremely rigorous
16 exercise because, you know, there is -- we don't
17 want to create too much of a burden. But at the
18 same time I think we know enough already about in
19 general, you know, the kinds of models that have
20 an impact on outcomes. So that's how we're
21 thinking. Did that address your question? Okay.

22 CO-CHAIR ANTONELLI: Mary, and then

1 Sue.

2 DR. APPELATE: This will be quick,
3 thank you. I did want to mention that
4 independent of billing, like you shouldn't use
5 billing as a way to track your population. So
6 the way that we're solving for this, you know,
7 these are claims measures. So we're making this
8 assumption that that's how you track people. So
9 to my earlier comment about what do you need to
10 manage a population, essentially every patient
11 that you have come to your practice, after you've
12 done their H&P, their history and physical, you
13 have an idea. Like when a diabetic is there, I
14 know I need to get these five things one over the
15 course of the next year because it's part of
16 evidence-based care.

17 So if you're an OB, you need to know
18 everybody I deliver actually has to be seen. So
19 there has to be a flag in your EHR or your paper
20 record, if you still have paper, to ensure that
21 the person gets seen. So it's separate from
22 billing, and I think that's how we did it. We

1 have a 50 percent gain share. If the OB's cost
2 for OB care come in less than the state average,
3 they get to keep half.

4 So if you're a small town doc, do you
5 know how much money that is for you? That is so
6 much money compared to what is spent in the city,
7 realizing you have to pass a 50 percent C-section
8 mark and about 50 percent postpartum visit rates.
9 This is very, very doable. That link to the
10 finances is really important, but you have to
11 change your system at the point of service, so
12 that you know who needs what they show up.

13 MEMBER KENDIG: Just a quick question.
14 In both of the presentations, we talked about
15 measures and sort of impact on infant mortality.
16 I'm wondering if there has been any attention to
17 the measures and their link to maternal
18 mortality, particularly in light of data around
19 suicides, substance use disorder and so forth?

20 DR. APPELEGATE: So may I comment?
21 That's actually a great comment. Within
22 Medicaid, there's actually tension between

1 measures within the hospital, which we think
2 should be owned and done by the hospital versus
3 those in between systems and at a population
4 level.

5 There's still a lot of maternal
6 hemorrhage out there and for most hospitals for
7 licensure requirements, they actually have to
8 have processes and measurements in place, just
9 like they have to monitor catheter-related
10 infections and ventilator-associated ammonias and
11 that kind of thing.

12 So there are a couple of things. One
13 is kind of postpartum visit count. Anywhere
14 along the first like three months, officially the
15 measure is the end of the month in which the 60th
16 day occurred. In the old days, computers only
17 went to accuracy of a month. So can any visit
18 happen? The issue that we have with postpartum
19 visits also is that the, you know, you know what
20 you're going to be doing 51 days from now because
21 it has to be within 56 days.

22 So that reminder is actually really

1 important. These are people who often live day
2 to day. Life is chaotic and uncertain. So the
3 connectivity to maternal harm might be sensitive
4 also to the social vulnerability scores as well.
5 But many of them are within-hospital kinds of
6 measures.

7 MS. DANIEL-ROBINSON: So just to add
8 to that, you know certainly Dr. Applegate
9 addressed it, we are internally looking at
10 maternal mortality separately or thinking about
11 that. But at the same time we think that the
12 care delivered as assessed by the measures in a
13 core set are part of those factors that drive
14 maternal mortality. So we see the core set as
15 still this overarching mechanism to look at the
16 various outcomes of maternal care.

17 MEMBER POOLE-YAEGER: I just wanted to
18 add that, you know, I completely agree with Dr.
19 Applegate, that I don't think global billing --
20 you know, I don't think that claims is the way to
21 measure.

22 I'm just -- I'm just highlighting the

1 fact that if you're going to compare states and
2 you're going to look at rates and you're going to
3 say oh, the state is really terrible in a
4 particular rate and this state is really high, it
5 very much varies because there's different
6 billing patterns in every state.

7 So you know, we need more electronic
8 health record connectivity so that we can get a
9 standard playing field for -- it sounds like a
10 lot of what this, you know, Committee wants to do
11 is try to come up with things that we can do to
12 compare states. You're not comparing apples to
13 apples when you, you know, with some of these
14 measures so --

15 MS. DANIEL-ROBINSON: So I could
16 actually pile on, right, if you wanted to. So
17 just a little bit. So even in the data that we
18 have on postpartum care, it's looking at trends
19 is a challenge, because even within states there
20 has been a lot of changes from year to year. So
21 some states report on certain segments of the
22 population, which makes it a challenge to even

1 compare it back to a prior year.

2 Changes in methodologies, just slight
3 quirks in the data. So there's certainly that.
4 But then at the same time though, we hear I think
5 anecdotally but with some evidence that the
6 visits are not happening, you know. So you know
7 again, we put the challenges out there to show
8 that we recognize that there are -- they exist.
9 But at the same time, you know, there's still the
10 opportunity to use them to help drive change.

11 CO-CHAIR ANTONELLI: If this is too
12 long of a question, we can take it off line. But
13 I'm intrigued by something. I really love your
14 opening statement about that this is one
15 continuum, right. That appeals to me as a
16 pediatrician because, you know, my work doesn't
17 stop when they leave me. Hopefully I've
18 optimized the hand off to the adult side.

19 So this really integrative or broad
20 expectation from CMS, and then finding a partner
21 like Dr. Applegate in Ohio, who's saying give me
22 things that actually make an outcome. So I'm

1 sort of celebrating the positive synergy. It's
2 possible that there aren't 51 Dr. Applegates.

3 So for those states that are thinking
4 about value-based but in a very narrow way, that
5 potentially could even be somewhat destructive to
6 this broad, because you guys are laying the
7 groundwork for what the literature calls a life
8 course approach, and I'm celebrating that.

9 But as it -- so now I'm phrasing this
10 as somebody who embraces value-based outcomes and
11 life course. How can we collectively influence
12 the dynamic to grow more Medicaid state level
13 leaders, who then in negotiations with their
14 respective MCOs and/or ACOs actually say this is
15 great stuff?

16 MS. DANIEL-ROBINSON: That's a
17 really good question, and I think -- I don't know
18 if Karen has any thoughts on this, but one of the
19 ways I think I would perhaps start is thinking
20 about our projects in general, is that we're
21 really using the states that we're going to
22 support as part of that test case, and you know,

1 at the end it's not our hope that this just kind
2 of goes away and dies, you know, at or maybe I
3 shouldn't say die.

4 But that just sort of lives and
5 resides within those few states. I think along
6 the way, we would like to share some of the
7 outcomes of that effort, and really perhaps even
8 reconvene appropriate groups to move to think
9 about that integration a little bit more. So you
10 know, it's supporting the states. I think that's
11 perhaps the Step 1. But thinking about how then
12 we do something more expansive, not just within
13 our states but -- state Medicaid programs but to
14 think about some of the other partnerships that
15 can help support our state Medicaid agencies.

16 CO-CHAIR ANTONELLI: Thank you. So
17 actually I'm going to stop it here, because I'm
18 getting a little bit of a virtual hook. We will
19 reconvene at the top of the hour. That's 11:00
20 a.m. Eastern for people listening in. I want to
21 thank our colleagues from CMS. I thank Dr.
22 Applegate from the great state of Ohio, and thank

1 you to both of the Task Forces. See you at
2 11:00.

3 (Whereupon, the above-entitled matter
4 went off the record at 10:46 a.m. and resumed at
5 11:03 a.m.)

6 CO-CHAIR PINCUS: Okay. So now comes
7 the, I think sort of the -- in some ways the core
8 of our look at the core set, to really look at
9 the overlap between areas of importance between
10 the Adult and Child Task Forces. So we're going
11 to be looking at specific measures that are
12 cutting across maternal and perinatal health
13 measures, and then a little bit later we're going
14 to be looking at asthma measures, as these are
15 sort of crossover kinds of issues. So Shaconna.

16 MS. GORHAM: Okay, next slide. All
17 right. So as we talked about those shared
18 issues, we want to look at the actual measures
19 that are shared are aligned between both the
20 adult and the child core set and they -- some
21 were mentioned already.

22 So we have the chlamydia screening

1 measure, which is NQF 0033 on both core sets.
2 But we also have the contraceptive care
3 postpartum woman, NQF 2902 with different age
4 groups but -- age groups reported, but again on
5 both core sets.

6 Then we have the single measure with
7 the rate split across the measure set, and that
8 is the timeliness of prenatal care is on the
9 child set, and the postpartum care on the adult
10 set. Not listed on your slide but also shared
11 between the two core sets is Measure 0576, which
12 is the follow-up after hospitalization for mental
13 illness, and then we also have the BMI screening
14 on the adult core set. It is not endorsed, but
15 on the child core set the weight assessment is
16 Measure 0024.

17 Next slide. Okay. So our topic for
18 today at this moment, we're looking at the
19 maternal and perinatal care. So I would like to
20 again thank our presenters this morning, because
21 that is the perfect segue into our discussion.
22 There are 11 measures in the area of perinatal

1 and maternity care across the child and adult
2 core set.

3 So really highlighting the fact that
4 the mother's health and health care is extremely
5 influential on that of her child or her children.
6 The perinatal measures have a large presence in
7 the child core set, and a few are contained in
8 the adult core set, again reflecting the long-
9 standing importance of Medicaid in providing
10 health coverage to low income women and babies.

11 During this discussion, the Task Force
12 will review relevant perinatal and maternity
13 measures in both sets, to kind of see that full
14 picture of quality, acknowledging that there are
15 those 11 measures across the set which may seem
16 like a large number, but some still view a gap in
17 the core set in this area.

18 So we'll go to the next slide. So if
19 you look at your diagram, we kind of just broke
20 those measures up. You'll see that the child
21 core set measures are relevant again, the health
22 of the infant, the health of the infant and a

1 pregnant woman, and there are six measures
2 currently in the child core set and three of
3 those are shared. In the adult core set, we have
4 two maternity-related measures, and three which
5 are shared.

6 Next slide. So in preparation for
7 this year's review, staff compiled a list of
8 endorsed measures and PQMP measures that may not
9 be endorsed, that address the 2016 gap areas for
10 your consideration. In doing so, we gathered 32
11 total measures to be considered in the area, 22
12 endorsed and 10 PQMP measures that have not yet
13 been endorsed.

14 So this is a good time, I'm going to
15 stop for one minute, and just talk about the
16 measure universe. So in the little bit of pre-
17 work that we sent you all, you had the big Excel
18 sheet, which lists all of the gap areas and all
19 of the measures in those gap areas. So on that
20 maternity and perinatal tab were all of the
21 measures that I'm referring to.

22 So if you'd take a minute and pull out

1 your discussion guide, it was sent in an email.
2 So you can find it in the email attachment, and
3 it is also on your Committee SharePoint page. So
4 while you're doing that, I just want to kind of
5 walk through, and this is for really the benefit
6 of the Child Task Force. We did this yesterday
7 with the Adult Task Force.

8 The Adult Task Force have one
9 discussion guide, and the Child Task Force has
10 another. So for some of our returning members,
11 you will notice that the discussion guide is
12 different. We have walked into modern times now,
13 so we're using the discussion guide much like is
14 used with the other MAP work groups, as well as
15 the Coordinating Committee.

16 So I just want to walk you through it,
17 because it is arranged a little differently. If
18 you go down, we are now in Day 2. So if you go
19 down to Day 2 on your agenda -- it was also
20 emailed.

21 (Off microphone comments.)

22 MS. GORHAM: Also if you look on the

1 web page.

2 MS. NACION: So a quick reference
3 would be to look at the NQF Project web page
4 under MAP Medicaid. It's also listed there under
5 the Materials. Oh, it's called the --

6 (Off microphone comments.)

7 MS. NACION: MAP Medicaid Discussion
8 Guide.

9 MS. GORHAM: Yes. Okay, you all have
10 it? Okay. So if you'd move down to Day 2, I
11 just want to point you to the bottom of Day 2.
12 You have measures recommended by task force
13 numbers, and you have the gap area of maternal
14 and reproductive health. So if you would click
15 on that, and this is for the Child Task Force.
16 The Adult Task Force is a little different.

17 So let's look at the Child Task Force.
18 You will see the three measures listed under the
19 gap area of maternal and reproductive health is
20 what we called it. So let's use the first
21 measure as an example. If you click on the
22 Measure Specifications, it's not on yours -- if

1 you click on Measure Specifications, you will see
2 everything about that particular measure, all of
3 the specs.

4 Scroll down a little bit more, and you
5 will see the information we provided as a result
6 of the preliminary analysis, okay. Adult folks,
7 why you do not see measures recommended is
8 because there were no measures recommended by
9 Task Force members on the Adult side. So yours
10 is a little different. You don't have those
11 measures, no.

12 And just because we're here, Child
13 Task Force, if you look in the gray box to your
14 right in the upper right corner, if you click on
15 Measures, those are also all of the gap areas in
16 which task force members or your peers
17 recommended, measures to be discussed and voted
18 on today.

19 Then if you click on the tab that says
20 "Gap Areas," you have all of the gaps in which we
21 were able to identify measures for. So those
22 would be the measures that you saw on the Excel

1 spreadsheet. If you click on Measure Repository
2 that takes you out, and you can log in and
3 actually pull up the Excel spreadsheet if for
4 some reason you would like to do that.

5 All right. So I just wanted to start
6 the presentation so we can do that, so you'll
7 know as we're discussing some of these measures
8 where some of the information, you can find some
9 of the information. Okay, so let's go back to
10 slide 187.

11 And so I spoke about the list of the
12 32 measures, the total of 32. The list also
13 includes the two measures recommended in 2016 not
14 yet added. So that is the PC05 breast milk
15 feeding measure, which was also recommended by a
16 Child Task Force member.

17 I will share updates on endorsement
18 activities regarding the frequency of ongoing
19 prenatal care as well as the timeliness of
20 prenatal and postpartum care in just a minute.

21 So we can go to the next slide. So we
22 talked a lot about this a little earlier.

1 Lekisha presented some of CMS findings on these
2 two measures. These two measures have lost
3 endorsement. Endorsement was removed in 2016.

4 If we go to the next slide, I won't
5 stay on this slide at all, because Lekisha did an
6 excellent job of presenting. I will say that,
7 just to kind of repeat the reporting for 2015.
8 So in FY 2015, 29 states reported the frequency
9 of ongoing prenatal care, which is an increase
10 from 2012, which 25 states reported. 2013, 27
11 states reported and then in 2014 28 states
12 reported the measure.

13 Lekisha also discussed some of the
14 reasons why this measure was not reported. But
15 what I would like to do, if we go to the next
16 slide, and then one more slide, and look at some
17 of the reasons why this measure lost endorsement.
18 So again, this measure is found on the child core
19 set. It was recently reviewed for maintenance
20 endorsement.

21 The committee agreed that the measure
22 did not meet the evidence criteria, because this

1 measure is considered a proxy for access and
2 there is no empirical evidence for the visit
3 schedule or number of visits associated with
4 improvement in outcomes. Therefore, they did not
5 recommend the measure for continued endorsement.

6 After the NQF public comment period,
7 the developer withdrew this measure for
8 consideration of endorsement, so endorsement was
9 removed.

10 DR. BURSTIN: I'll just mention that
11 Carol Sakala, the co-chair, is sitting at our
12 table. So if there's any specific questions,
13 it's great to have her here. Thanks.

14 MS. GORHAM: Yes, okay. So if we go
15 to the next slide, timeliness of prenatal care.
16 Again, we saw this slide a little earlier, so I
17 won't go into details about this slide. I will
18 just remind you in 2015, 38 states reported this
19 measure, which is an increase from previous
20 years. 31 states reported in 2012, 33 states in
21 2013 and 36 states in 2014.

22 Next slide. Okay. We can go to the

1 next slide. So this -- okay. This is the
2 postpartum care rate and this is on the adult
3 core set. Again, we saw this and so in 2015, 35
4 states reported on this measure, which is an
5 increase from previous years.

6 So if you go down one more slide, and
7 then the next slide, okay. So again, this is in
8 the adult core set. The previous was in the
9 child core set. The Prenatal and Reproductive
10 Health Committee did not reach consensus on
11 validity on this measure. They noted the limited
12 number of codes and the fact that the measure is
13 not addressed, addressing the content of the
14 visits.

15 Of course our CSAC made the final
16 recommendation and voted not to recommend this
17 measure, due to lack of empirical evidence and
18 validity issues. Endorsement was removed. So I
19 think I'll stop there and if there are any
20 questions about those measures, again Carol is
21 here.

22 MEMBER SAKALA: I just want to add one

1 more comment about the postpartum care measure,
2 and that is that it -- if you just have a visit
3 before 21 days, it doesn't count and there's a
4 lot of concern about that as disincenting, for
5 example, appropriate support for breast feeding,
6 wound care and other issues that would arise very
7 early on.

8 MS. GORHAM: All right. If no more
9 comments, we can move on. Okay. So we want to
10 talk about, as we kind of get in our process for
11 today, the measure selection criteria. We
12 reviewed for the adults yesterday, but I
13 definitely want to review for the Child Task
14 Force.

15 The measure selection criteria
16 developed to -- was developed to assist MAP with
17 identifying the characteristics that are
18 associated with an ideal measure set, either for
19 public reporting like the core sets or a payment
20 program, and are consistent across all of MAP.
21 They are not absolute rules; rather, they are
22 meant to just provide some general guidance on

1 making the measure selection decisions.

2 The central focus should be on the
3 selection of high quality measures that address
4 the NQS. Competing priorities often need to be
5 weighted against one another, and these measure
6 selection criteria can be used as a reference
7 when you are evaluating the strengths and
8 weaknesses of a program set.

9 In addition to the measure selection
10 criteria, some additional factors that influence
11 the choice of measures include we favor endorsed
12 measures when possible, because of the confidence
13 in the scientific properties; the ability to use
14 administrative data; whether the measure captures
15 a reasonably broad segment of the Medicaid
16 population and also could catalyze quality
17 improvement action in an area with low
18 performance or recognized disparity.

19 Whether the measure is designed for
20 use at a health plan or population level, or/and
21 whether the measure is aligned with other
22 programs. So some of the criteria listed on your

1 slide include, and I won't read them all, just
2 NQF endorsement. Program measure set is
3 responsive to specific program goals and
4 requirements; program measure set enables
5 measurement of person- and family-centered care
6 and services; program measure set includes a
7 consideration for health care disparities and
8 cultural competency, just to list a few of them.

9 Next slide. So potential reasons for
10 removal from the core set. When considering
11 measures for potential removal, please consider
12 some of the following. Some include multiple
13 years where the measure has multiple years of
14 very low reporting, whether the measure does not
15 provide actionable information for state Medicaid
16 programs; if there's a superior measure on the
17 same topic that has become available.

18 You have a voting decision handout at
19 your desk right in front of you. I named some of
20 those potential reasons for removal, not all.
21 Please read them all. But we wanted to look at
22 and I will turn it over to Harold and Rich for

1 discussion, if there are measures that we would
2 like remove. Let me just talk a little bit about
3 the process.

4 So we have both task forces here. We
5 encourage conversations together because these
6 are again measures and issues that are shared.
7 When we vote though, we will vote separately. So
8 you may have noticed that our set up or our
9 seating is very strategic. We have the Child
10 Task Force on the right and we have the Adult
11 Task Force on the left.

12 The first three members on the left
13 are joint members, so they are both the adult and
14 child task forces. So they will vote on
15 measures. Harold will begin facilitating the
16 voting process for the adults, since the Adult
17 folks landed first at NQF yesterday, and then
18 Rich will pick up with the voting process for the
19 child, since you all will be staying with us
20 another day. So we kind of did that
21 strategically and purposefully. So with that, I
22 will turn it over to Harold.

1 CO-CHAIR PINCUS: So obviously the
2 question at hand is are there measures that --
3 now are we asking only the adult side now, or are
4 we asking --

5 (Off microphone comment.)

6 CO-CHAIR PINCUS: So from the adult
7 side, are there any measures, at least in the
8 maternal and child component, that you would
9 consider removing? Obviously these two we just
10 kind of just discussed are potential options for
11 that. Anybody want to make a motion on that?
12 Remember the endorsement has been removed from
13 both of these measures, and one of them has been
14 withdrawn. So Rachel, yeah.

15 MEMBER LA CROIX: I do understand and
16 appreciate the concerns with these measures and
17 why they are no longer being endorsed. At the
18 same time from a state reporting perspective,
19 these are measures that plans and states I think
20 are pretty used to, since they have been part of
21 HEDIS for a long time and are relatively easy to
22 report on.

1 While I would very much like to see
2 measures that look more at the content of the
3 sets and making sure that certain things happen
4 that could directly lead to better outcomes,
5 until such measures are available I would be okay
6 with retaining these measures.

7 CO-CHAIR PINCUS: Other thoughts?
8 Deborah.

9 MEMBER KILSTEIN: Again, my only
10 concern with the postpartum visit rate is the
11 limitation on the days, and I think that we're
12 only seeing a slice of the answer to that
13 question about postpartum rates and we're not --
14 we're not seeing or encouraging. We may be
15 disincentivizing earlier visits in some cases.
16 So I do have concerns about that measure and what
17 it actually, you know, the information that it's
18 providing.

19 On the other hand, I see that, you
20 know, there's nothing else being put forward as a
21 replacement right now, which makes it -- makes it
22 difficult to make that decision.

1 CO-CHAIR PINCUS: I mean which is not
2 to say that we're -- after we have this
3 discussion about removal, we have discussions
4 about suggestions for adding measures. So think
5 of it also in terms of are there measures that
6 you might add that might be replacements. You
7 know, Carol, you might want to just talk a little
8 bit about the thinking of the -- through the
9 endorsement process or removing endorsement and
10 just --

11 MEMBER SAKALA: What the Perinatal and
12 Reproductive Health Committee went through?

13 CO-CHAIR PINCUS: Yeah.

14 MEMBER SAKALA: Yeah. So I think it
15 has been summarized pretty well, that first of
16 all going through the evidence part, which comes
17 early on in the flow of NQF consensus development
18 processes, both of those are sitting at expert
19 opinion and in that last few years, NQF has
20 really raised the bar to say we'd like to be
21 seeing a strong, systematic review there.

22 So that was the first kind of big red

1 flag in our deliberations, and also I think
2 there's a question about whether keeping
3 something sitting there allows complacency as
4 opposed to creating a tension that we'd better
5 get this filled. So that's, you know, I think
6 one thought.

7 I know NCQA is working on another
8 content measure, and there's also some potential
9 around the depression, a couple of depression
10 measures which are being specified for prenatal
11 and postpartum women. It's depression screening
12 and follow-up with the like Edinburgh measures,
13 the screening tools that are used.

14 So there are some potential things
15 that are kind of coming up pretty close in the
16 pipeline, and I think that's a possible
17 consideration. Also the postpartum contraceptive
18 care was a new postpartum content measure added
19 last time.

20 CO-CHAIR PINCUS: Other comments? I
21 wonder if Mary, you might just want to comment on
22 it as well?

1 DR. APPLGATE: So I want to make sure
2 I'm not hoarding the conversation. There's a lot
3 to say here. So I have to agree that the systems
4 are calibrated to the current measure, so
5 typically what we need in transition. So we
6 would be in favor of eliminating just that very
7 narrow window in which you need to be seen, and
8 then including that entire period.

9 The AMA/PCPI measure actually is quite
10 good, that has those four components.
11 Gestational diabetes, retesting the depression
12 screening, contraception attention and the one
13 that we can't get by claims is breast feeding
14 support. But I think as we get to the electronic
15 health record derived measures, I think all of
16 those are possible.

17 When we ran our measure for any visit,
18 not just during that period of time, the system
19 is calibrated to the six week follow-up. So 80
20 percent of the visits actually did happen there.
21 So we can't use that as, you know. We have to
22 recognize again, pushing down to the level of

1 patient what we need. So I think getting rid of
2 that restriction there is just as important as
3 the timeliness of prenatal care not being
4 measured from the time you're enrolled. But I
5 mean gestational agent for prenatal visit.

6 So I think we have to bridge the what
7 do you need life course wise, population health-
8 wise as it relates to the delivery of health
9 services actually in the measure, and I actually
10 think we can do it, you know. We can link vital
11 stats and claims together to actually be able to
12 get the measures that are meaningful on the
13 ground, and that's what clinicians and patients
14 both need.

15 That then lines up with not an expert
16 opinion, but with best practice.

17 CO-CHAIR PINCUS: So let me come back
18 to the Adult Task Force. Are there -- is there
19 anybody who wants to make a motion about removal?

20 (Off microphone comment.)

21 MEMBER CALMUS: Are both of those
22 measures a part of the adult?

1 MS. GORHAM: The postpartum rate is
2 the only measure that is a part of the Adult Task
3 Force.

4 MEMBER CALMUS: That was -- that was
5 what I was being confused by.

6 MS. GORHAM: The other two are the
7 prenatal care rate and the frequency of ongoing
8 prenatal care are on the Child Task Force.

9 CO-CHAIR PINCUS: But can the Adult
10 Task Force members make a recommendation for
11 removal of the ones that are on the Child Task
12 Force? Okay. So you can only make a
13 recommendation for the post -- for the prenatal.
14 Rachel.

15 MEMBER LA CROIX: Instead of proposing
16 to remove, could we -- I don't know if we can do
17 that through this venue, but propose that for the
18 adult core set the postpartum care measure would
19 tweak that day requirement? No, okay.

20 (Off microphone comment.)

21 MEMBER LA CROIX: Oh okay. Great
22 minds think alike.

1 DR. MATSUOKA: I think this is a theme
2 that we heard through both days so far. So I
3 think it's something that we might just think
4 about. It would -- of course, we would have to
5 know that it's deviating from specs of an
6 endorsed measure or in this case a non-endorsed
7 measure.

8 But you know, I think to address some
9 of these, we want meaningful measures. So if
10 it's a matter of a simple tweak, we can think
11 about, you know, asking our contractors to think
12 about that.

13 CO-CHAIR PINCUS: Deborah, and then
14 Marissa.

15 MEMBER KILSTEIN: Is it possible to --
16 right now, I mean it's a measure and it was
17 supported. Is it possible to have a vote to
18 change the support from full support from the
19 Committee to conditional support, which would
20 signal to CMS that it needs -- it's not NQF-
21 endorsed and it needs to be looked at and
22 potentially reconsidered? I don't know if that's

1 an option.

2 CO-CHAIR PINCUS: Yeah. I assume
3 that's an option.

4 MS. GORHAM: So I don't know what that
5 needs to be a formal recommendation of CMS,
6 because they know that it is not an endorsed
7 measure. But we certainly can include the note
8 in the report.

9 CO-CHAIR PINCUS: Marissa.

10 MEMBER SCHLAIFER: I don't know if
11 this is an appropriate question, and I realize
12 that we're voting separately. But it seems like
13 discussing together makes sense. So I was just
14 wondering Carol, and tell me if this is an
15 appropriate question, if you take off your --
16 since you've spent more time focusing on this
17 measure with the Committee discussion, if you
18 take off the endorsement hat and you put on this
19 committee hat, do you have it --

20 You know, I realize that wasn't what
21 the Committee discussed, but do you see a place
22 for this until something else? If you don't want

1 to answer that that's fine.

2 MEMBER SAKALA: Thank you for asking.
3 These measures have bugged me for a really long
4 time. I feel that you -- I mean you know that in
5 the pregnancy, you know that the woman has a
6 place to go. But other than that, I don't know
7 what they tell us and there's so much that we
8 need to get out of prenatal care and postpartum
9 care.

10 I feel these are so low bar at a time
11 when we're trying to ratchet up and also we're
12 hearing from the service provider community, you
13 know, please give us important measures. Give us
14 a few that matter. So my personal feeling is I
15 think these need to go. But thank you for
16 asking.

17 CO-CHAIR PINCUS: You want to say
18 anything else, Marissa?

19 MEMBER SCHLAIFER: No. Well, I feel
20 like this is far enough outside my expertise.
21 I'm not sure that I feel comfortable making the
22 motion to remove it, but based on that, I think

1 it sounds like we need a motion to remove it. So
2 if someone else won't make the motion, I will.
3 But I don't know that I'm the best person.

4 CO-CHAIR PINCUS: Sue.

5 MEMBER KENDIG: I'll make the motion
6 to remove it.

7 CO-CHAIR PINCUS: Is there a second?

8 MEMBER SCHLAIFER: I'll second.

9 CO-CHAIR PINCUS: Okay. So we can
10 have a formal vote on that. Kim?

11 DR. ELLIOTT: I was just going to say,
12 I think it's a really positive movement because
13 right now it really is looking at counts and it
14 really isn't focusing on content, and I think
15 that's the direction that we're all trying to
16 head, is to really effective and actionable sorts
17 of visits and measurement.

18 CO-CHAIR PINCUS: So we have a motion
19 on the table now and it's been seconded. Is
20 there any discussion, either for or against? And
21 to be clear, is the recommendation -- are we only
22 allowed to give, make a recommendation for

1 removal, or can it be a recommendation for
2 removal but with some specific sort of additional
3 comments attached to it? Yeah.

4 (Off microphone comment.)

5 CO-CHAIR PINCUS: So sort of a
6 conditional removal? Okay. Further discussion?
7 So let me just try to summarize what I think
8 people are not saying. So it sounds like people
9 are somewhat reluctant to fully remove any
10 examination of this issue from the core set.

11 On the other hand, they don't like
12 this measure, and so that there is a desire to
13 number one, think of a kind of transitional phase
14 of removing this measure as currently
15 constituted, or making adjustments to this
16 measure as currently constituted, but making a
17 very strong recommendation to CMS that they move
18 very quickly in replacing this measure with
19 something better. Does that capture? Does
20 anybody -- okay.

21 So do we need to vote on that? Okay.
22 So I guess we have to vote on what I just said.

1 Sue?

2 MEMBER KENDIG: So in going down that
3 path where we're saying quickly replace it with
4 something that is meaningful and actionable, is
5 that conditional support? I'm just trying to
6 clarify what button we're pushing to get where.

7 CO-CHAIR PINCUS: Yes, okay. So I'll
8 leave that to Miranda.

9 MS. GORHAM: So you're voting for
10 removal with the conditions that Harold stated,
11 and so the way the voting slide is set up
12 already, because we did this pre-meeting, it will
13 be yes or no. But the yes is saying that I'm
14 voting for removal, and we'll list the conditions
15 in the report, and no is, no you're not voting
16 for removal. And so right now only the Adult
17 Task Force members are voting.

18 CO-CHAIR PINCUS: So what button do we
19 push?

20 MS. KUWAHARA: All right. We're going
21 to take it to a vote. This is our test slide.
22 The adult has practice, though. I think we're

1 good to go with our clickers. So for Measure No.
2 1517, prenatal and postpartum care, timeliness of
3 prenatal care. I'm sorry. Here we go.

4 (Off microphone comments.)

5 MS. KUWAHARA: We're good. So for
6 Measure No. 1517, prenatal and postpartum care,
7 postpartum care rate, please cast your votes at
8 this time and you'll want to point your clickers
9 in this direction. We're waiting on one more
10 response. Great.

11 (Voting.)

12 MS. KUWAHARA: So 100 percent of our
13 eight voting members voted to -- what did we call
14 this?

15 CO-CHAIR PINCUS: Yeah, voted to sort
16 of conditional removal.

17 MS. KUWAHARA: There we go.

18 DR. BURSTIN: I think basically,
19 there's just yes/no. I mean the most important
20 role of MAP, as we've heard repeatedly from our
21 colleagues at CMS, is they just want to have the
22 comments. Harold did a great job summarizing it.

1 Essentially, there is an urging to move away from
2 this measure as specified, and I think they've
3 heard great conversations, I think.

4 CO-CHAIR PINCUS: Yeah. So
5 transitional steps of like at least temporarily
6 to fix this measure temporarily in terms of the
7 dates, and but a very strong recommendation to
8 move towards a more substantive measure. So now
9 the Child?

10 CO-CHAIR ANTONELLI: So we're going to
11 go through a similar process now for the one
12 that's in the Child core set. That's 1391,
13 ongoing prenatal. Open it up for questions or
14 comments, but Carol, I'd be happy to give you --
15 in your chairperson hat, do you want to give us
16 any background on this one that you may not have
17 already said on the prior?

18 MEMBER SAKALA: I think it's just
19 basically the same kind of issues, that we don't
20 know what happened, what the woman's experience
21 of care was, what the outcomes were, what the
22 resource use was. It just doesn't tell us the

1 things that I think we really want to be
2 learning.

3 CO-CHAIR ANTONELLI: And if I can just
4 probe once more, the approach to mitigation or
5 the conditionality that we just went through on
6 the adult side, from your perspective, applies to
7 this measure as well?

8 MEMBER SAKALA: Well, I think like
9 personally, I really want to move forward, create
10 attention with a gap, to get these filled with
11 better measures. However, I will share that I
12 had lunch yesterday with a vice president of
13 Maternal/Child Services for a very large health
14 plan and said what's your thought about this,
15 because she knows the issues.

16 She said I'd like to see a three-year
17 transition, because we are investing millions and
18 millions of dollars and have a lot of programs
19 set up around these measures. So when do we stem
20 the hemorrhage here of focus? It's -- I don't
21 have a good answer, but I just want to share that
22 conversation.

1 CO-CHAIR PINCUS: All right, Terry.

2 MEMBER ADIRIM: Hi, yeah. I just have
3 a quick question. Maybe it's not that quick,
4 about this measure. What was the evidence that
5 got it NQF-endorsed? Like what, you know, how is
6 this measure meant? You know, is it tied to any
7 kind of outcomes that have been demonstrated in
8 the literature? Like what, how did it get
9 endorsed?

10 MEMBER SAKALA: I'm sorry that I can't
11 remember. Two rounds back, I was staffing it at
12 that time. I wasn't a member of the Committee
13 and I don't remember the specifications. But I
14 think we've had a lot of emotionality around
15 prenatal care is a good thing and by getting
16 prenatal visits you save so many dollars or
17 whatever.

18 But the fact of the matter is, the
19 women who get prenatal care have better life
20 circumstances, more enabling, are more likely to
21 have wanted pregnancies, can get to the visits,
22 have work, jobs that are flexible or whatever.

1 So I think we really don't have that evidence in
2 the way that we would like to have it.

3 MS. GORHAM: We also have Suzanne on
4 the phone, who staffed the Committee, and so she
5 would like to add to your comment Carol.

6 MS. THEBERGE: Hi everyone. This is
7 Suzanne Theberge. I was the senior project
8 manager on the team. Actually, I think Carol
9 really covered it. I mean we know there is some
10 linkage between prenatal care and improved
11 outcomes, but we don't know what it is and we
12 don't know what exactly is the quality of care.

13 So the committee just really felt that
14 frequency does not equal quality, and I think
15 Carol stated it well.

16 MEMBER BENIN: Sorry. This is Andrea.
17 Can I ask a question?

18 CO-CHAIR ANTONELLI: Yes Andrea, go
19 ahead.

20 MEMBER BENIN: Do we have an alternate
21 measure of access?

22 MS. THEBERGE: I don't know if this is

1 a question to me. No. Now this measure, I mean
2 I think the Committee really discussed this as a
3 measure of a proxy to access to care, and it
4 does, I think, assess to some extent the
5 challenges that women face in accessing care.
6 But you know, in terms of getting, finding a
7 provider, getting to that provider,
8 transportation, et cetera.

9 But we don't -- we don't really have
10 anything, anything better and I think, Carol, you
11 may also remember that this was a real struggle
12 for the Perinatal and Reproductive Health
13 Committee, you know, again is something better
14 than nothing.

15 DR. BURSTIN: I'll just point out,
16 just to add to Suzanne's point, that the evidence
17 requirements changed significantly between 2012
18 and 2016. So our bar is higher. You have to
19 have quality, quantity and consistency of
20 evidence for the measure focus, and that wasn't
21 the case in the first round.

22 CO-CHAIR PINCUS: Deborah.

1 MEMBER KILSTEIN: I just want to
2 clarify. Are we voting or are we discussing both
3 the frequency and the timeliness measure?

4 MEMBER POOLE-YAEGER: Thanks. I just
5 wanted to, you know, we've been following these
6 measures for many, many years, and I would agree
7 with the statement about a lot of time and effort
8 has been put into trying to raise them. On the
9 other hand, you know, do I think that some of
10 these are really giving us a good idea of the
11 health of our population? You know, probably
12 not. I can give you an example on the timeliness
13 of prenatal care, since the measure looks for,
14 you know, first trimester if you're continuously
15 enrolled.

16 But 75 percent of our moms come in
17 just when they're pregnant and then disenroll.
18 It's that 42-day window which in the majority of
19 people are coming in in the second trimester,
20 which I don't know that anybody's going to think
21 that that's the first time you should get a
22 prenatal visit, you know.

1 So I'm interested in, you know, I like
2 -- there's a measure called WOEP, which is Weeks
3 of Enrollment in Pregnancy that NQF has, and I
4 think they may have actually retired it or
5 something. But it tells you -- it can tell you
6 at what gestational age did the mom get. That
7 seems like a much more -- at least for our first
8 access to care measure, that makes a lot of
9 sense. I don't know if there's -- and I'm not
10 recommending measures, but I do -- I do also
11 worry --

12 The other point was I heard somebody
13 at one point at some -- say oh, maybe we should
14 stop covering prenatal care because there's no
15 evidence to suggest that it makes a difference.
16 So we've just got to be really careful if we're
17 going to come out and say oh, we don't want to --
18 you know, we don't think there's evidence to
19 suggest that prenatal care is linked to outcomes,
20 and then somebody's going to take that down the
21 wrong path. So --

22 CO-CHAIR PINCUS: Mary.

1 DR. APPLGATE: So just a reality
2 check. I think it's a strong statement to say no
3 to a measure. We have to stop doing stuff that
4 actually doesn't work. So hats off to colleagues
5 around postpartum, realizing that the system will
6 have to transition hopefully to the better
7 measure.

8 These two measures are actually quite
9 different. Frequency has absolutely nothing to
10 do with outcome. You could show up in triage 20
11 times, and that just tells you perhaps that
12 you're not treating the person's anxiety. It has
13 nothing to do with the outcome of that delivery,
14 that timeliness may be a measure of a bunch of
15 other things including access, but what you --
16 what I need, you know, on the ground is
17 gestational age at first prenatal visit.

18 So the timing of the managed care plan
19 process for how long, 42 days to get them in, has
20 absolutely no bearing on it. So in the value-
21 based purchasing piece, let's measure actually
22 what we really need that actually may matters,

1 and that is we have to time and date the
2 pregnancies. They need to be seen between six
3 and eight weeks.

4 So in the days when we had expert
5 opinion, there was no -- the assumption was that
6 most people were healthy and you were just
7 looking for preeclampsia. So times have changed.
8 We have a burden of chronic disease in pregnant
9 women.

10 So I think if the answer is no, that's
11 a really strong statement and these two are
12 actually separate, frequency has absolutely
13 nothing to do with it. Timeliness actually is
14 important.

15 CO-CHAIR ANTONELLI: Would anybody
16 like to make a motion? Yes. Microphone, please.

17 MEMBER RICHARDSON: I'd like to move
18 that we remove this from the core set, 13 --

19 (Off microphone comment.)

20 MEMBER RICHARDSON: We're talking
21 about 1391, correct? 1391.

22 CO-CHAIR ANTONELLI: Any seconds?

1 Kim.

2 DR. ELLIOTT: I second that motion.

3 CO-CHAIR ANTONELLI: Okay.

4 Discussion? So there was a pretty robust
5 discussion about conditions. We don't have to
6 have that, but I feel for the sake of some degree
7 of continuity, we at least need to have it raised
8 in the context of 1391.

9 Carol, I don't want to put you on the
10 spot, but you bring a lot of experience to this.
11 So would you like to raise a comment with respect
12 to conditions in the report that will go to CMS?

13 MEMBER SAKALA: So for 1391, it's
14 sounding like maybe we can just recommend removal
15 straight up.

16 CO-CHAIR ANTONELLI: So I'm not going
17 to ask for a change in motion, because that's
18 consistent with the motion on the table. Are
19 there any comments?

20 (No audible response.)

21 CO-CHAIR ANTONELLI: Okay. So there
22 are no comments. Andrea, I assume you're not on

1 mute.

2 MEMBER BENIN: Correct.

3 CO-CHAIR ANTONELLI: Okay. So do you
4 want to see if we had coffee for breakfast this
5 morning and then proceed to the vote?

6 MS. GORHAM: And before we start to
7 vote, just so that for transparency for the
8 transcript, Andrea will be voting. She will be
9 chatting her vote, and we will actually use the
10 clicker here for her.

11 MEMBER BENIN: Thank you.

12 MS. KUWAHARA: All right. For the
13 Child Task Force only, we're going to do a test
14 run with your new clickers today. If you had
15 coffee with your breakfast this morning, please
16 press 1. If not press 2 and you'll want to
17 direct your votes in this direction.

18 (Voting.)

19 MS. KUWAHARA: All right. I think
20 everything seems to be working properly, so we'll
21 move on to Measure No. 1391. Measure No. 1391,
22 frequency of ongoing prenatal care. If you

1 choose to vote to remove this measure, please
2 press 1. If not, press 2.

3 (Voting.)

4 MS. KUWAHARA: I think we're still
5 waiting on one more vote. We're going to try
6 this one more time. Okay. Please cast your
7 votes one more time.

8 (Voting.)

9 MS. KUWAHARA: If anyone is seeing a
10 horizontal line on their clickers, that's
11 potentially problematic. So please let us know
12 if that's what you're seeing.

13 CO-CHAIR ANTONELLI: We're getting
14 Andrea's vote.

15 MS. KUWAHARA: Okay. Well, we do have
16 quorum, so we're going to view the results. 100
17 percent of the 12 members voted to remove -- I'm
18 sorry, 1391, 1391 from the core set.

19 CO-CHAIR ANTONELLI: So does that mean
20 that we didn't get everybody who's an eligible
21 voter to vote? Is it possible somebody
22 abstained?

1 MS. GORHAM: We have 13 members on the
2 Child core set, excluding the federal reps. For
3 some reason we're only getting 12 votes in. We
4 need nine for quorum, so we do have quorum. So
5 we can move on, but for some reason we're not
6 getting a vote.

7 CO-CHAIR ANTONELLI: Yeah, because I
8 guess I'm -- I would like to be convinced that
9 that's not because there's a technical problem,
10 because the vote is what it is. It doesn't
11 matter with respect to the quorum. But if we
12 start getting close, I don't want to go into a
13 vote where we're not sure if there's a glitch.
14 So can we maybe redo the coffee question?

15 MS. KUWAHARA: Sure.

16 CO-CHAIR ANTONELLI: So the goal is
17 all 12 voting members of the Child Task Force,
18 please vote whether you had coffee or not this
19 morning.

20 (Voting.)

21 MS. KUWAHARA: Here we go. We're
22 great.

1 CO-CHAIR ANTONELLI: We're good?

2 MS. KUWAHARA: Yes.

3 MS. GORHAM: So actually though, Ann
4 is not here in the room and she didn't vote. So
5 maybe it is her clicker that is not working,
6 because we have 12, yeah. If you can do hers.

7 MS. KUWAHARA: We're not capturing
8 that vote.

9 MS. GORHAM: Okay. So then it's that
10 clicker.

11 MS. KUWAHARA: Okay. Okay, all right.
12 Mystery solved.

13 CO-CHAIR ANTONELLI: So did we just
14 test Ann's clicker? So we're good to go. We
15 don't need to repeat the coffee question again,
16 okay. Whew. All right. Let's -- let us go on
17 next. So the Task Force has recommended removal
18 of 1391 from the core set.

19 Right, okay. So the -- we want to
20 open it up to find out if there are other
21 measures that the Task Force would like to
22 consider for removal, in addition to what we

1 discussed already. I'm sorry, 1517. So in
2 addition to -- okay, all right.

3 So let's do 1517, then we'll open it
4 up. So 1517, prenatal postpartum care. Open for
5 comments and Carol, I'll be happy to call on you.

6 MEMBER BENIN: I have a clarifying
7 question. It's Andrea. In the current child
8 core set, is it those prenatal and postpartum
9 care that are in there, or is it just part of the
10 measure? I cannot tell.

11 MS. GORHAM: It is just the prenatal
12 care portion of the measure. So the measure is
13 one measure, but the rate is split. So for the
14 child core set, the prenatal is on that core set.
15 So we -- you will still need to vote on 1517 as
16 it relates to the child core set.

17 MEMBER BENIN: I see.

18 CO-CHAIR ANTONELLI: Okay, Carol.

19 MEMBER SAKALA: Mary, I just wanted to
20 ask you to clarify what you said about needing
21 the gestational age. Are you saying that you
22 need a better measure than this for your

1 purposes? So even though you like documenting
2 the woman has a place to go, you -- this is not a
3 good measure for you?

4 DR. APPLEGATE: Yes. Let me clarify.
5 Right now, the specifications of the measure
6 relate to time from enrollment to time seen for a
7 prenatal visit. Well, your time from enrollment
8 in a plan is not a patient-centered view. It's
9 an enrollment process system kind of measure that
10 actually doesn't get to what you really need,
11 which is the women need to show up between six
12 and eight weeks.

13 So I need -- the patient version of
14 this is gestational age at first visit, which
15 then tells you access and real timeliness that
16 the entire system can focus on as being most
17 associated with being able to identify and
18 implement treatment for high-risk pregnancies.

19 MEMBER BENIN: Hi, this is Andrea.
20 Could we get clarification on that, because that
21 is not what I'm reading in the measure spec. The
22 measure spec reads the percentage that gets a

1 prenatal care visit in the first trimester, or
2 within 42 days. I mean obviously you have to be
3 enrolled in the first trimester.

4 DR. APPLEGATE: I think that's totally
5 true, but the majority of people are getting into
6 that denominator with the -- when you're
7 enrolled, you know, not in the first trimester.
8 So it's only the continuously enrolled. So
9 again, a lot of our Medicaid members are just
10 becoming enrolled because they're pregnant.

11 So they're getting -- they're getting
12 enrolled and of course they're going in for their
13 prenatal visit. That's why they got their
14 insurance so they could go to the doctor. So
15 it's really just measuring the people that have
16 access to their -- you know, that already know to
17 get into their care.

18 We have lower rates in the people that
19 are continuously enrolled than those that come
20 in. So I think it is totally not measuring what
21 we want to measure.

22 MEMBER BENIN: Except it's measuring

1 the effectiveness of once you're enrolled, being
2 able to get in. I mean it's measuring the
3 effectiveness of your program. It may not be
4 measuring the population health issue. But it is
5 measuring --

6 DR. APPELATE: Correct, correct,
7 correct.

8 MEMBER BENIN: Right. So it's
9 measuring how well the program works, which is
10 important.

11 DR. APPELATE: Yes. So this is Mary,
12 just to be clear about that, that's one of many
13 variables. So does the measure actually work if
14 our focus is really trying to get to a better
15 outcome and you're only measuring one of ten
16 pieces and it's not the most important piece?

17 MEMBER POOLE-YAEGER: I would also
18 add, you know, I think we may -- they may, and I
19 don't know the spec that well. They'd be able to
20 split it, you know, so because you can look at
21 the people that are continuously enrolled versus
22 the people that come in and still look at both of

1 them, you know, to sort of see, you know, what
2 weeks did get your first care and then also were
3 you getting your care within the first 42 days
4 after you've enrolled in the program.

5 You know, that might be a -- again,
6 just to -- if we want to put in a conditional
7 removal with the thought that we don't like this
8 measure but we know something important is there,
9 that we want to try to get that too.

10 CO-CHAIR ANTONELLI: So hold on --

11 MEMBER BENIN: I can imagine --

12 CO-CHAIR ANTONELLI: Andrea, just --

13 MEMBER BENIN: Yeah. I mean I can
14 imagine some -- I'm sorry.

15 CO-CHAIR ANTONELLI: Hold on please
16 for a second. So hold on to the thought about a
17 potential condition. I want to continue to
18 solicit comments. Okay Andrea, go ahead.

19 MEMBER BENIN: No, go ahead. I'll
20 come back.

21 CO-CHAIR ANTONELLI: No, no. You're
22 -- I'm holding a spot in the queue for you. Go

1 ahead.

2 MEMBER BENIN: I guess I would just
3 say then that while we may have a gap around this
4 other metric about what gestational age do people
5 actually get in, it does sound to me as though
6 this metric has some value in measuring something
7 different. So I would just -- that's what I'm
8 hearing, if I'm understanding correctly.

9 CO-CHAIR ANTONELLI: Okay. Other
10 comments? Amy.

11 MEMBER RICHARDSON: So exactly there
12 is something embedded in here that may be of
13 value, but you're in fact measuring, trying to
14 measure two things with one measure.

15 CO-CHAIR ANTONELLI: A little closer
16 to your mic, please.

17 MEMBER RICHARDSON: I'm sorry. You're
18 trying to measure two things with one measure,
19 and wouldn't it be cleaner if we recommended a
20 replacement that measures what we're after,
21 because I think Dr. Poole-Yaeger is correct, that
22 from a Medicaid perspective, mostly what we're

1 measuring is not what Dr. Applegate wants.

2 CO-CHAIR ANTONELLI: Other comments?

3 You guys count, too.

4 (No audible response.)

5 CO-CHAIR ANTONELLI: All right. Would
6 somebody like to make a motion? We're talking
7 about 1517.

8 MEMBER POOLE-YAEGER: Can I move for
9 that conditional, removal with the conditional
10 here?

11 CO-CHAIR ANTONELLI: Sure. Please
12 articulate it.

13 MEMBER POOLE-YAEGER: Again, I don't
14 -- I don't want to say that we -- I'm worried
15 we're removing the frequency of prenatal care.
16 If we remove the timeliness of prenatal care and
17 the postpartum care, somebody's going to think
18 that prenatal care doesn't matter anymore.

19 So I would move that we say that we
20 think there needs to be maybe a replacement to
21 this, make it conditional in asking for more work
22 on a transition to something that's more, you

1 know.

2 (Off microphone comments.)

3 MEMBER POOLE-YAEGER: Conditional move
4 to -- what did they do with that?

5 CO-CHAIR ANTONELLI: So the adults --

6 MEMBER POOLE-YAEGER: Conditional
7 removal.

8 CO-CHAIR ANTONELLI: Yeah. The adults
9 voted to remove with conditions that CMS should
10 consider for timely, i.e. rapid replacement.

11 MEMBER POOLE-YAEGER: Right, right.
12 I would say we should probably align with what
13 the adults said on this.

14 CO-CHAIR ANTONELLI: Yes, okay.
15 Second that motion anyone? If you could speak it
16 please, so we can --

17 MEMBER ADIRIM: I second.

18 CO-CHAIR ANTONELLI: Yes, okay. So
19 comments?

20 MEMBER BENIN: This is Andrea. I
21 would just comment that in the current situation
22 with so much uncertainty, it makes me really

1 anxious to remove metrics around access, and so I
2 just want us to be a little bit cautious about
3 how the conditional activity gets discussed.

4 CO-CHAIR ANTONELLI: Yes. I can't see
5 your name.

6 MEMBER BEATTIE: Kathryn.

7 CO-CHAIR ANTONELLI: Kathryn.

8 MEMBER BEATTIE: I'd just agree with
9 that, that I'm really uncomfortable with us
10 removing all of these measures around prenatal
11 access, and would be more comfortable with
12 recommending retaining it with a conditional of
13 an expectation of revision or recommendation for
14 revision.

15 CO-CHAIR ANTONELLI: So potentially
16 you would like to raise another motion? Yes?

17 MEMBER BEATTIE: You only asked for a
18 motion to remove it, so I did not --

19 CO-CHAIR ANTONELLI: Well no. I
20 didn't ask. I asked for a motion and what came
21 to the floor is what came out. So right now, the
22 point of discussion is what's on the floor. But

1 I'm very happy to entertain that.

2 But I think we're going to have to
3 vote with the one that's on the floor, and we can
4 come to that one. But I -- but the comment is
5 still -- the period for making comments on the
6 motion on the floor still exists.

7 MEMBER POOLE-YAEGER: And to clarify,
8 is this just postpartum one or is it postpartum
9 and prenatal, since we have -- this is timely,
10 just timeliness of prenatal. This is not
11 timeliness of postpartum. Only the prenatal
12 piece of the --

13 CO-CHAIR ANTONELLI: The prenatal
14 piece, yes, 1571.

15 MEMBER POOLE-YAEGER: Okay.

16 CO-CHAIR ANTONELLI: 1517.

17 MEMBER POOLE-YAEGER: Yes.

18 MEMBER ADIRIM: And maybe somebody
19 maybe from CMS can clarify, that if this were the
20 motion that, you know, for removal under the
21 condition that there's something suitable to
22 replace it, what that means to satisfy what she's

1 saying down there?

2 CO-CHAIR ANTONELLI: Will you weigh
3 in, Karen?

4 DR. MATSUOKA: Yeah. So to I think
5 Helen's point and I'm sure Rich made it this
6 morning, it's really the conversation that's
7 happening now that is instructive to us beyond
8 just the vote. So I wouldn't worry so much about
9 is it conditional removal, conditional keeping.
10 I think we hear the thrust of the policy
11 recommendation.

12 MS. GORHAM: We'll be sure, staff, to
13 include this in the report, so that it will be
14 public as well as CMS will have it. It will be a
15 livable document, if you will.

16 CO-CHAIR ANTONELLI: Any other
17 comments? Otherwise, I'm going to open for the
18 vote of the motion on the floor.

19 (No audible response.)

20 CO-CHAIR ANTONELLI: Okay. So we have
21 -- is your card an artifact? Yes, okay, okay.
22 All right. So let's get ready for the vote and

1 the motion on the floor, and it is essentially to
2 vote for removal of the 1517, the portion that is
3 in the child set, but essentially with the robust
4 language about the transition and the timeliness
5 of that.

6 So essentially it mirrors exactly what
7 came out of the Adult Task Force. Okay, tee us
8 up, please.

9 MS. KUWAHARA: Polling is open. You
10 may now cast your votes.

11 (Voting.)

12 MEMBER BENIN: What are the choices?
13 I can't see them.

14 MS. KUWAHARA: Andrea, we're asking
15 should this measure be removed -- well,
16 conditionally removed for rapid replacement.
17 This is Measure No. 1517, prenatal and postpartum
18 care, timeliness of prenatal care. One is yes,
19 you would like to remove this measure and two is
20 no.

21 MEMBER BENIN: Thank you.

22 (Voting.)

1 MS. KUWAHARA: Seventy-five percent of
2 our 12 voting members voted to conditionally
3 remove this measure from the core set.

4 CO-CHAIR ANTONELLI: All set? Okay.
5 So with respect to -- I guess I'm going to
6 address my opening of invitation for other
7 potential measures that the task force would like
8 to bring forward for consideration of removal?
9 Carol.

10 MEMBER SAKALA: So I'd like to raise
11 the issue of the behavioral health risk
12 assessment for pregnant women, which is not NQF-
13 endorsed. It's a PCPI -- it's in the PCPI core
14 set, but never really went through that testing
15 process, and was picked up some years ago.

16 It's -- for the Child set, it's the
17 least reported measure only for states. I feel
18 that Rebecca Gee was here two years ago with
19 wearing the hat of the Louisiana State Medicaid
20 medical director, saying basically that this just
21 didn't have feasibility of collection. I've
22 since heard that from Elliott Main, and then this

1 morning on Mary's slides, I saw data source
2 challenging.

3 So if we're looking to kind of weed
4 out measures that aren't really going places,
5 where we need them to go, maybe this is one of
6 them and it could be with -- it's a very
7 important concept, but we need a good measure to
8 be able to collect it.

9 CO-CHAIR ANTONELLI: Thank you. Any
10 other -- in fact, maybe why don't we do it this
11 way? If people want to make suggestions for
12 measures, and then we can discuss them, and in
13 the interim I don't know if it's possible to have
14 the staff pull up any measure so that if we're
15 being asked to evaluate, we can actually see them
16 in writing.

17 So can you do that? So hold on to
18 that. Let me open it up, and actually just so
19 that I'm clear, am I -- is Harold going to ask
20 the same line of questioning to the Adult side,
21 or should I just --

22 CO-CHAIR PINCUS: We already did that

1 yesterday.

2 CO-CHAIR ANTONELLI: Oh, you did this
3 yesterday. Okay. So this is just on the Child
4 side. So would anybody else like to suggest
5 measures for consideration for removal from the
6 Child core set? Andrea?

7 MEMBER BENIN: No, I'm all set.

8 CO-CHAIR ANTONELLI: You're good,
9 okay. So can we get a -- can we get the measure
10 up on the screens please?

11 For the sake of time management, Carol
12 as we're getting -- the staff is pulling this up,
13 would you like to add any more commentary? You
14 don't need to. I can open it up more broadly.
15 But I figure if you want to add something else.

16 MEMBER SAKALA: I'm sorry. I wish I
17 could even enumerate the components of it, but I
18 can't.

19 CO-CHAIR ANTONELLI: Okay, good.

20 MEMBER SAKALA: But maybe, you know,
21 maybe Mary can discuss what are the issues that
22 they've experienced in Ohio.

1 CO-CHAIR ANTONELLI: Yeah. Are you
2 okay with that?

3 DR. APPELATE: So I'm not a total
4 expert on this particular measure, but there's a
5 lot of manual work that's related to it. So it's
6 not a claims-based measure. So that's a whole,
7 you know, it's in magnitudes probably three- and
8 four-fold. It's not just double.

9 CO-CHAIR ANTONELLI: Thank you.

10 CO-CHAIR PINCUS: Rachel may also have
11 some comments.

12 MEMBER LA CROIX: Yeah. I was just
13 going to say due to how complex this measure has
14 looked and since it has looked like there would
15 be a high burden for data collection on it,
16 Florida Medicaid hasn't even pursued adding it to
17 our health plan reporting.

18 CO-CHAIR ANTONELLI: Thank you, thank
19 you.

20 MS. GORHAM: And this is not an NQF-
21 endorsed measure, so we don't have as much
22 information as you would -- as we would have for

1 other measures. We can -- I can share with you
2 some reporting information if that would all help
3 for this --

4 DR. BURSTIN: I could share the
5 components. I found it online if people want to
6 hear it. PCPI's list is probably --

7 CO-CHAIR ANTONELLI: So Helen, why
8 don't you give us the components and, Shaconna,
9 if you can give us some idea of the uptake, and
10 that will feed the conversation. Okay, Helen.

11 DR. BURSTIN: I don't know if Shaconna
12 has anything to add on this, but it is --
13 includes depression screening, alcohol use
14 screening, tobacco use screening, drug use,
15 illicit and prescription screening, intimate
16 partner violence screening and to satisfactorily
17 meet the numerator, all screening components must
18 be performed, and the denominator is all
19 patients, regardless of age who give birth during
20 a 12-month period, seen at least for prenatal
21 care.

22 Those are the specs as they stood in

1 2012. I don't know if they've been updated at
2 all. Shawn, do you know?

3 PARTICIPANT: Nope.

4 DR. BURSTIN: Is anyone using them?

5 (Off microphone comment.)

6 DR. BURSTIN: Okay. I was asking
7 Shawn from ACOG if anybody they knew was using
8 it. Okay.

9 CO-CHAIR ANTONELLI: And staff's going
10 to let us know a little bit about implementation
11 while we're -- go ahead.

12 MEMBER POOLE-YAEGER: We have a health
13 plan in Louisiana, so I -- and I know Rebecca Gee
14 is as passionate as anybody. So if anybody can
15 get this, you know, measure reported in the
16 OB/GYN community she probably could have. So
17 that's just I mean my comment on that. If she
18 couldn't get it done there in Louisiana, it's
19 going to be really hard for states to do that so
20 --

21 MEMBER SAKALA: And she had a grant to
22 make it work and couldn't do it with the grant.

1 CO-CHAIR ANTONELLI: Okay, Kim.

2 DR. ELLIOTT: I think some of the
3 challenges come into system design as well. If
4 you have carve-outs for behavioral health,
5 sometimes that creates some payment issues with
6 states and with health plans, and also some
7 states don't pay for the screenings and
8 assessments.

9 If it's not a paid for service, it's
10 much harder to, one, get providers to provide the
11 service, but also to have administrative data or
12 any claims data that would support it. So just
13 it's a very challenging measure from an
14 implementation standpoint, not that all of the
15 things that are included in it aren't critically
16 important. But it's just a challenging measure
17 as written.

18 CO-CHAIR ANTONELLI: Okay. Amy.

19 MEMBER RICHARDSON: So as you read the
20 specs, it seems to me that it's almost everything
21 but the kitchen sink in behavioral health, and
22 you could prioritize some of those. My only fear

1 with sort of saying no as a group to this is the
2 message that behavioral health issues,
3 particularly substance use disorder in pregnant
4 women is not important and it clearly is
5 important, and it's important to our babies in
6 particular.

7 But this is a not only technically
8 hard, but it's kind of another one of those we're
9 measuring everything but the kitchen sink in one
10 measure, and cleaner is better. So the message
11 being if we remove it, we remove it but we are
12 not downplaying the importance of behavioral
13 health screening and intervention during
14 pregnancy.

15 CO-CHAIR ANTONELLI: Thank you. Mary?

16 DR. APPLEGATE: Just one comment. I
17 totally agree. The best measures are the ones
18 that are tightly coupled with an action plan that
19 actually moves the measure.

20 So this has so many things in it that
21 it gets very complicated, depending on the
22 community that you might live in, and it's also

1 not clear that you can actually take it on in the
2 health system, because all the social
3 determinants of health actually weigh into this
4 as well. So I totally echo the sentiment.

5 The other thing, to the earlier
6 comments about what are the public health crises,
7 actually is around drug use, opioid and
8 polypharmacy use, which is tightly coupled,
9 actually close to 100 percent of our folks who
10 have that issue also smoke.

11 So one of the things that we need to
12 with measures is also bring focus to the fire,
13 you know. Where is the fire? This does
14 absolutely everything. So not only is there a
15 data collection issue, if I'm the doc and I have
16 -- or the nurse or whoever, and I have all of
17 these things, what do I actually do?

18 Generally what they do is they pick
19 one or they refer it out and there's no feedback
20 loop so nothing happens. So it's not actionable
21 or feasible.

22 CO-CHAIR ANTONELLI: Deborah.

1 MEMBER KILSTEIN: I've got a question
2 about the measure, and maybe I'm reading
3 something that's old. Is that from -- is the
4 data source expected to be electronic medical
5 records for this? Okay. So that's, you know.
6 So I would think that's part of what's making
7 this very difficult in terms of collection. Not
8 that the measure isn't important, but trying to
9 get the EMR data would be very difficult.

10 CO-CHAIR ANTONELLI: Okay. So a
11 motion? Yes, oh yeah. Actually, so the staff
12 has called this up. I don't know if I've ever
13 seen it, but Shaconna, just for the sake of due
14 diligence, why don't you share what you have
15 here. You've got utilization information?

16 MS. GORHAM: Right. So on the screen,
17 we have just the specs, but the actual reporting
18 for the information. So this measure was first
19 reported in 2013. At that time, two states
20 reported the measure and in 2014 and 2015 four
21 states reported that measure. 2015, 45 states
22 did not report the measure.

1 Reasons include some of what we heard
2 earlier. Data elements from electronic health
3 records are necessary for calculation, but are
4 unavailable; not reporting due to the need for
5 EHR access; chart review; resting this year, plan
6 to report next year; MCOs are not required to
7 submit this HEDIS measure; budget constraints are
8 just a few of some of the reasons shared.

9 I would like to just remind everyone
10 that in your supplementary material that we sent
11 out, you do have all of this information in what
12 was called the chart packs. That was sent as
13 well as CMS created a document called Background
14 Information for MAC Task Forces, and that
15 gathered all of the reasons why the states did
16 not report a certain measure. So I read a few,
17 but that those two documents are really
18 comprehensive.

19 CO-CHAIR ANTONELLI: Thank you, and
20 thanks to the NQF staff for being able to do this
21 so quickly. So Carol, do you have a comment or
22 are you going to respond to my request for a

1 motion? Yes, go ahead please.

2 MEMBER SAKALA: So I would like to
3 recommend that we remove this measure,
4 accompanied by a message that these are crucial
5 issues for this population and we would
6 recommend, as early as possible, prioritizing and
7 ensuring feasible collection and linking to
8 action that addresses identified problems.

9 CO-CHAIR ANTONELLI: Motion's been
10 made. Second?

11 MEMBER LA CROIX: I will second.

12 CO-CHAIR ANTONELLI: Okay. Comments
13 about the motion on the floor?

14 (No audible response.)

15 CO-CHAIR ANTONELLI: Ready to vote.

16 MS. KUWAHARA: All right. For Andrea
17 on the phone, we are looking at behavioral health
18 risk assessment for pregnant women. We are
19 asking if this measure should be removed. If you
20 would like to remove this measure, select 1, yes
21 or 2, no. You may now cast your votes.

22 (Voting.)

1 MS. KUWAHARA: Ninety-two percent of
2 our 12 voting members selected to remove this
3 measure.

4 CO-CHAIR ANTONELLI: All right. Thank
5 you very much to the Child Task Force and since
6 we've already asked for additional measures, we
7 can move beyond this point now to talk about
8 potential additions, so Shaconna.

9 MS. GORHAM: So give us one minute to
10 confer over here. We're trying to debate. We
11 have lunch scheduled for 12:30, I believe. So
12 I'm not quite sure if lunch is back there. It's
13 here, okay. So why don't we take a few -- before
14 we start a brand new discussion, why don't we
15 take a few minutes, grab lunch?

16 So we're a little bit behind, so let's
17 take about 15 minutes, grab lunch and then we'll
18 actually have a working lunch. Does that sound
19 okay?

20 MS. GORHAM: All right. So let's do
21 public comment actually before lunch. We can
22 grab public comments and then pick up lunch.

1 Operator, if you can open the line please?

2 OPERATOR: Okay. At this time, if you
3 would like to make a comment, please press star
4 and then the number one.

5 (No audible response.)

6 OPERATOR: And there are no public
7 comments at this time.

8 MS. GORHAM: In the room, do we have
9 any comments?

10 MR. CURRIGAN: Just to save time for
11 later discussion, I wanted to get you ahead of
12 talking about exclusive breast feeding and most
13 of moderately effective contraception.

14 The 27-member panel of the Perinatal
15 and Reproductive Health Panel that decided,
16 endorsed, made recommendations for endorsement
17 and then went to CSAC, had a 91 percent approval
18 for overall suitability for exclusive breast
19 feeding, breast milk feeding during the hospital
20 stay, and an 80 percent overall suitability and
21 recommendation for endorsement for both the most
22 to moderately contraceptive care measure, and the

1 LARC measure.

2 So I just want to have you save some
3 time and remember that the 27-member panel has
4 already recommended for endorsement and it has
5 been accepted for endorsement. They are endorsed
6 measures suitable for public reporting and
7 accountability at the health plan level. Thanks.

8 MS. GORHAM: Operator, can you open
9 the line just a little bit longer for public
10 comments for those on the phone please?

11 OPERATOR: Yes. Again, as a reminder
12 you may press star 1 to ask a question.

13 (No audible response.)

14 MS. GORHAM: Okay.

15 OPERATOR: And there are still no
16 public comments at this time.

17 MS. GORHAM: All right, thank you. So
18 we'll take a 15-minute break and grab some lunch
19 and come back.

20 (Whereupon, the above-entitled matter
21 went off the record at 12:23 p.m.)

22 MS. GORHAM: All right. Let's go

1 ahead and get started. We don't want to get too
2 far behind. If everyone can make their way back
3 to their seats. So we discussed measures for
4 potential removal.

5 Now we want to look at measures for
6 potential addition to the core set. So when
7 considering potential additions to the core set,
8 we definitely want to let the measure selection
9 criteria guide us in our decisions and I reviewed
10 those earlier.

11 Also feedback from state
12 implementation is very important. So Dr.
13 Applegate's presentation was very important, as
14 well as some of the information in your chart
15 packs and so forth. And then we also want to let
16 the gap areas guide us and those gap areas were
17 identified by you and your peers last year.
18 Yesterday, the adult task force went over gaps
19 again, and tomorrow the child task force will
20 discuss gaps.

21 This year, as we continually try to
22 improve the process, we have incorporated the

1 preliminary analysis in the discussion guide. So
2 we went over the discussion guide. We'll discuss
3 a little bit about the preliminary analysis. As
4 you know, MAP as a whole utilized the preliminary
5 analysis and we just started for the task force
6 this year.

7 So if we can go to the next slide. So
8 as we try to continually align this meeting with
9 other MAP meetings, we have adopted this
10 preliminary algorithm. So I'll review the seven
11 criteria used in the algorithm, and again we have
12 the answers to these questions in your decision,
13 in your discussion guide, I'm sorry.

14 So things to consider when completing
15 the preliminary analysis. Does the measure
16 address a critical quality objective not
17 currently addressed in the program set? Some
18 measures are outcome measures. So we know that
19 outcome measures are the decided preference for
20 the community. Does the measure address a
21 quality challenge?

22 Does the measure support efficient use

1 of resources and alignment? Does the measure --
2 can the measure be feasibly reported? Is the
3 measure NQF-endorsed? If a measure is in a
4 current set, are there implementation issues that
5 have been identified with the measure?

6 We also wanted to consider the
7 following Medicaid-specific subcriteria when
8 completing the algorithm for these meetings. So
9 we looked at the Medicaid adult and child
10 population, the high impact areas and the health
11 conditions associated, data collection and
12 measure implementation feasibility, the issues
13 related to resources needed for implementation,
14 and the threat of variation.

15 So the potential need for variable
16 measure prior to implementation at the state
17 level. We discussed voting earlier, and we
18 discussed kind of the quorum. We want to make
19 sure that 66 percent of task forces, the task
20 force members are available. So for the adult,
21 that means seven voting members, and for the
22 child, nine voting members.

1 We will ask you, or your chairs will
2 ask you again if you're supporting the measure,
3 if you're conditionally supporting the measure.
4 Again, we usually do not use the do not support
5 too much here in MAP in the Medicaid meetings,
6 but we do want -- if you elect to conditionally
7 support a measure for addition, that you state
8 what that condition is.

9 So again, you have your colorful
10 handout in front of you just as a reminder. So
11 as we move through the slides, you have that in
12 front of you. Some of the conditions that you
13 can specify for conditional support, excuse me,
14 are things such as pending endorsement, whether
15 or not the measure is NQF-endorsed. You can say
16 that, you know, you want that measure to go
17 through the process before CMS adds the measure
18 to the core set.

19 You can also specify if there is
20 something that needs to be changed or addressed
21 by the measure steward. I know there's just a
22 few reasons for conditional support.

1 Next slide. So last year we heard
2 from you all that wanted to know some of the
3 measures that were recommended from the previous
4 years, but not yet adopted from by CMS. This
5 contraceptive care measure 2903 was recommended
6 by the adult task force but not yet accepted by
7 CMS.

8 So now I will turn it over to Harold.
9 We did not have any task force members on the
10 adult side to recommend any maternal or perinatal
11 care measures. That does not mean that you can't
12 elect to do so now, but I will just say that as
13 we continue discussion, that the task force
14 members for the child core set that did
15 recommend, you will be asked to be the lead
16 discussant as you know, and you'll kick off the
17 discussion when we get there. But until then,
18 I'll turn it over to Harold.

19 CO-CHAIR PINCUS: So we have another
20 opportunity, if members of the adult task force
21 wish to recommend measures at this point.
22 Anybody wish to do that? Marissa.

1 MEMBER SCHLAIFER: I'm not
2 recommending a measure, but I just had a
3 question, maybe a process question. Is it worth
4 looking at what the? I guess are any of child
5 the things recommended by the child task force
6 members things that we should also consider? Is
7 that --

8 MS. GORHAM: So we can definitely do
9 that. I know, as you know Marissa, because you
10 have been on the task force for a while, that
11 some of the conversation in the previous years,
12 that some of the measures should be on both task
13 forces because we have moms becoming moms a lot
14 younger. And so maybe we should kind of share
15 all of the measures, so we can flip it for that
16 case.

17 Yes. That is totally fine. So us
18 advance to Slide 208, and we can look at the
19 recommendations made by the child task force in
20 2015 and 2016, and these measures were not
21 adopted by CMS.

22 So we have the two PC05, the exclusive

1 breast milk feeding, and it's the same measure.
2 One is the original measure, the paper measure
3 and then one is the e-measure. We also have
4 0477, and I believe that measure is not -- right.
5 It's no longer endorsed. So 0477, the under 1500
6 gram infant not delivered at appropriate levels
7 of care.

8 Just while we're right here, I'll just
9 make a note of why that is no longer endorsed.
10 The developer indicated that resubmission was too
11 much work for a measure that the steward itself
12 is no longer using. So uncertainty that others
13 were truly using it as a quality measure, and
14 that the best role seemed to be a population-
15 level measure, rather than a hospital-level
16 measure, which was the steward's main interest.

17 Then we have 2903, the contraceptive
18 care, most and moderately effective method was
19 also recommended but not added by CMS, and we can
20 go to the next slide. We can --

21 DR. MATSUOKA: So it's a couple of
22 different things. I think an overarching thing

1 that we aim for is parsimony. So that's an
2 overarching just principle. So for adding some
3 things in, what can come out. We ask that
4 particular question to all the groups that we
5 then take your recommendations to and get further
6 input from.

7 So we bring it to our various
8 different work groups that we have with our state
9 partners to get their input, our grantees and
10 internally within CMCS as well. And so when we
11 run those kinds of considerations, global
12 considerations through, we get that input in and
13 then out pops what ends up becoming the things
14 that we either decide to take out or put in. So
15 that's sort of a global comment.

16 In particular though, for the PC05
17 issue, I think here, not unlike the behavioral
18 health risk measure, I think unanimously everyone
19 recognized that breast feeding in general was an
20 incredibly important part of good maternal/infant
21 health that we start to monitor.

22 We weren't quite sure the extent to

1 which we wanted to give, you know, if you want to
2 think about a spot on our core set list is like
3 valuable real estate. Like do we want the breast
4 feeding measure that we picked to be something
5 exclusively in the hospital setting? We would
6 ideally have liked to see something that either
7 bridges those settings of care or maybe even has
8 something that's more ambulatory focused, as
9 opposed to hospital focused.

10 2903, contraceptive care. I think
11 that the reasoning there was that, as Lekisha
12 mentioned earlier this morning, we have a whole
13 maternal health initiative grant, looking to help
14 support states in being able to report this
15 measure. It's a brand new measure that was
16 developed at the Office of Population Affairs.

17 So I think part of our reasoning here
18 was that we wanted to gain a little bit more
19 experience working with the states on that
20 measure before we made a decision one way or the
21 other to put it on set. Infants not delivered at
22 appropriate level of care. It's not ringing any

1 bells for me. I don't know if Lekisha, you
2 recall the thinking around that.

3 MS. DANIEL-ROBINSON: I don't, but
4 again if that is a hospital-specific measure,
5 there could be -- that could be part of the
6 rationale. So measures that are specified, like
7 the early elective delivery measure, it's not
8 among the measures that are most reported. So
9 anyway, that's all I recall on that one.

10 DR. MATSUOKA: 2903, and I jumped
11 ahead a little bit to the next slide, is going to
12 be considered by the child group again, and it's
13 a measure that is for ages 15 to 44. Should that
14 also be discussed in terms of the adult group,
15 and kind of discussed together and voted on by
16 both groups, because otherwise you'd be
17 collecting it for just a subset of populations.

18 MEMBER KILSTEIN: That was the reason
19 for my question.

20 MS. GORHAM: So the purpose again, for
21 you all being here together, is so that we can
22 have that joint discussion. Just the purposes of

1 voting will be separate. But remember that
2 conversation is still considered a joint
3 conversation.

4 CO-CHAIR PINCUS: So maybe, I mean as
5 a process point, since this is an overlap area,
6 both sides of the room should engage in a
7 discussion but vote separately.

8 MEMBER ADIRIM: Yeah. I just wanted
9 to say the reason why I asked about 2903 and
10 about what the decision-making that went around
11 it is that I don't know if it was last year or
12 the year before, but we had a pretty robust
13 discussion around LARCs and how critical that
14 whole piece was. So I didn't want that to get
15 lost, how important that is to us on the child
16 core set so --

17 CO-CHAIR PINCUS: Rachel.

18 MEMBER LA CROIX: I know that the
19 other contraceptive care measures were picked up
20 last year in the adult and child core set. Is
21 the difference between those and this one that
22 the other ones are specifically about postpartum

1 women, and so that's almost a subset of this
2 measure? Is that correct?

3 MS. DANIEL-ROBINSON: So the
4 denominator's actually different, because this
5 one is only --

6 MEMBER LA CROIX: This one's an all,
7 okay.

8 MS. DANIEL-ROBINSON: Right. This
9 one is all excluding the postpartum women, so it
10 got separated out.

11 MEMBER LA CROIX: Okay.

12 MS. DANIEL-ROBINSON: All right.

13 CO-CHAIR PINCUS: Sue.

14 MEMBER KENDIG: Yeah. I was trying to
15 remember, because I remember that discussion from
16 a few years ago and as I recall, the child side
17 said yes and the adult said no, and I think I'm
18 remembering that CMS has implemented tracking on
19 both.

20 But you know, I'm wondering if we
21 don't need to revisit this contraceptive care
22 measure for all women because we have focused on

1 the maternal child piece and that's -- obviously
2 that's important.

3 But equally important is the pre-
4 pregnancy and the inter-pregnancy component that
5 contraception supports. So it's almost a
6 surrogate for do women even have access to care,
7 to maintain optimal health pre-pregnancy and
8 inter-pregnancy. So I would invite us to
9 consider that from the adult perspective as well.

10 CO-CHAIR PINCUS: So do you want to
11 make that a motion?

12 MEMBER KENDIG: Sure, yes. I think we
13 need to revisit the contraceptive care and
14 reinforce that recommendation as a measure of --
15 because it does promote well women care. I don't
16 know if that's worded correctly for a motion.

17 MS. GORHAM: Okay. So we can do that.
18 Do we want to -- so just for the purposes of this
19 is the second day of meetings for me, so just
20 really to be really clear. So can we -- does it
21 make sense, one, let's pull up these specs for
22 the 2903. If we want to engage in that

1 conversation. But I want to kind of keep the
2 process clean if we can. So Carol actually
3 recommended that measure, so she can be our lead
4 discussant, and then we can continue the
5 conversation and vote that way, if that is okay.

6 CO-CHAIR PINCUS: Actually so I
7 pushed, knowing that Carol had already made that
8 recommendation, I pushed you to make it an
9 official motion, so that we can now have a joint
10 discussion and then vote separately, okay.

11 MEMBER SAKALA: I'm fine to make that
12 motion if that's what we need to carry the
13 process forward.

14 CO-CHAIR PINCUS: Is there a second
15 from the adult side?

16 MEMBER KENDIG: I'll second.

17 CO-CHAIR PINCUS: So and it's already
18 been proposed from the child side. So Carol, do
19 you want to sort of lead discussion about it?

20 MEMBER SAKALA: Sure. So during our
21 last webinar, we were invited to consider whether
22 measures that we had recommended in the past but

1 were not brought into the core sets should be
2 reconsidered.

3 So I'm taking you all up on that and
4 raising two of them today for reconsideration,
5 because when I think of just the concept of core
6 fundamental population health issues, I think
7 these measures really speak to that, and
8 certainly for the Medicaid population.

9 A large, have a really important role
10 in health equity as well in my view. Just as a
11 reminder, two years ago in 2015 both groups voted
12 to support this conditionally upon NQF
13 endorsement, which happened late last year. So
14 the different years are kind of tripping over
15 each other.

16 And I feel that the arguments include
17 that, as Lekisha just said, this measure is
18 complementary to the crucial piece that we put in
19 place last year for postpartum women. I feel it
20 is relevant to both of the core sets and could be
21 age-stratified in the way we've done with other
22 measures.

1 I feel that it fits well with the
2 adult priority gap of inter-conception care, and
3 also the really quick results that Karen reviewed
4 on our webinar about the Medicaid medical
5 director priorities of reproductive health and
6 then yesterday the adult group identified
7 reproductive health as a gap.

8 So I think it's fitting in really well
9 with all of these, and I would say that there's
10 also growing evidence of a tie between access to
11 reproductive health services and some of the
12 maternal outcomes that we are experiencing a real
13 crisis about in this country. So I think that's
14 a broader contextual factor.

15 Just to say that this is a new
16 measure. It just got endorsed formally a few
17 months ago, but to let you know that there is an
18 impressive record already, favorable record of
19 implementation. Lekisha mentioned CMCS' maternal
20 and infant health initiative that funded 13
21 states to look at best practices around this
22 measure and how it's working out.

1 ASTHO has a contraceptive access
2 learning community supported by CMCS, Office of
3 Population Affairs and CDC, with 27 states using
4 this. Title X is using an adapted version for
5 its family planning annual report data. Planned
6 Parenthood Federation of America has a continuous
7 quality improvement department which sponsored a
8 learning collaborative with 20 affiliates, with
9 the focus on how do we honor women's choice and
10 autonomy around these issues, and offer
11 contraceptive care.

12 I want to just hit it right on that
13 though we didn't recommend this -- did recommend
14 this measure, there were concerns about the
15 possibility of coercion. It's really important
16 in this discussion to recognize that there's no
17 intention that this goes to 100 percent, and some
18 people are a little uncomfortable with a
19 benchmark.

20 I don't think we have one in Healthy
21 People, but the developer says it would be
22 desirable to go above 85 percent. We're nowhere

1 near that. I think right now we can, you know,
2 head in that direction with confidence. It's
3 also important to recognize that in the present
4 environment, too much contraception is not the
5 problem. It's about access to contraception.

6 So that's really the overwhelming
7 issue that we're facing, and I feel that the low
8 income women served by Medicaid are paying a
9 steep price, and this is intended to address care
10 by primary care providers, reproductive health
11 providers, and others who would be offering this
12 kind of care. I think if we make a difference,
13 we could help them make a difference.

14 And Lekisha, you may have some things
15 to say about the work that your initiative and
16 program has been doing in this.

17 MS. DANIEL-ROBINSON: Sure. So I
18 would just like to echo the fact that access is
19 still a real issue. So we have 13 states that
20 are funded to report on the measures, you know,
21 and to provide that best practice information.
22 But in addition, there were a couple of other

1 states that have also contributed in terms of
2 reporting on the measures.

3 There is a gap, you know. There is
4 certainly opportunity for improvement in access.
5 The other thing, in terms of the coercion piece,
6 we do include, with the posting of the
7 specifications for the initiative, an
8 interpretation guide. So in that guide, it talks
9 about how you should look at these measures.

10 So you know, as you mentioned, there
11 is not a benchmark goal that you're looking for.
12 But you can use these measures to determine what
13 level of access. So particularly if you want to
14 look at a state or go below that level and look
15 at whether health plans, there are challenges
16 within certain health plans, or within certain
17 geographic areas, those sorts of things, are ways
18 that we recommend use of the measures,
19 particularly when you're looking at like the LARC
20 pieces specifically.

21 So we do put that guidance out with
22 it, and you know, as you mentioned, the 13 states

1 that we're supporting are also part of the ASTHO
2 learning community and are really using the
3 measure to drive the change, to look at what
4 areas they need to focus on, whether it's, you
5 know, some of the provider education pieces or
6 the outreach.

7 I just heard about Delaware just the
8 other day. They're doing -- they're about to
9 launch a campaign in the next couple of days or
10 so that will last for the rest of the year, that
11 will, you know, where we will actually
12 potentially see some changes in the measure,
13 where they've worked with partners to get rides
14 for people to get to the visits and things like
15 that.

16 So it's a way to measure the access,
17 it's a way to look at it and that's one of the
18 ways it's being used currently.

19 MEMBER SAKALA: So I guess I just have
20 a little bit of a question about the most to
21 moderately effective methods as opposed to other
22 methods. So I understand and thank you for

1 explaining that this has to do with access to
2 contraception, and it doesn't look like it may be
3 much of a burden for the states to report because
4 they're administrative claims.

5 I'm just -- I'm not sure -- the list
6 of contraceptive methods that are listed here
7 look pretty comprehensive to me versus another,
8 and maybe I'm not framing the question the right
9 way. But I'm just struggling a little with the
10 most to moderately effective. If you just want
11 to, you know, that piece of it, I'm not sure what
12 that means exactly.

13 The other interesting thing that I
14 just noticed was there -- one of the exclusions
15 to those who are indicated for non-contraceptive
16 reasons, and I'm just trying to figure out how,
17 you know, how that necessarily would be excluded.

18 I mean suppose just -- and maybe I'm
19 just looking at it from the provider's side.
20 Somebody may decide that they don't want to have
21 a family or something like that. You know, would
22 that be considered a non-contraceptive reason.

1 I may be getting too much in the weeds
2 of, you know, exactly how it's going to play out
3 on the state level, but those were just little
4 pieces that I was -- I just had questions about.

5 MEMBER OSBORNE-GASKIN: So if you had
6 your tubes tied, you wouldn't be expected to be
7 provided, for example. That's, I think, what
8 number one is all about, and I wasn't quite sure
9 if I heard, but it's the people who are at risk
10 for an unintended pregnancy, so that's another
11 piece of it. So just to take one example, a
12 condom would be a relatively ineffective method
13 or unreliable method.

14 So it's sorting out -- the list is
15 actually, you know, I don't know how many are
16 there, but it's -- there are about, I have seen
17 13 or a lot of them. So eight are the -- is
18 pulling out the ones that are really going to
19 help women with fertility control.

20 MEMBER GREINER: I really don't have
21 a lot more to add, because that was beautifully
22 by both, discussed the pros and the cons. I

1 think one of the things, because I don't know if
2 Karen had mentioned that this may be, that there
3 was thoughts about it being implementable. But
4 it's administrative data.

5 So I would guess that if this were
6 added to the core set, that we would have a good
7 number of states that would be reporting on it,
8 because I just can't imagine that this isn't a
9 priority for a good number of Medicaid programs
10 so --

11 CO-CHAIR PINCUS: Marsha and then
12 Mary, and then I don't know. Andrea, do you want
13 to say something?

14 MEMBER BENIN: Sure. This is Andrea.
15 I think, as some of you may remember, I am the
16 one who is strongly concerned about how this
17 metric is written and risk for coercion. I could
18 not possibly agree more with the comments that
19 were made about the need for access to
20 contraception for all women, and certainly for
21 women in this group who -- but women who want it.

22 So what is -- has never been answered

1 for me is how does this denominator exclude
2 people who don't want contraception, don't want
3 to be on artificial hormones, you know, have
4 health risks for being on artificial hormones,
5 etcetera, etcetera. I think the coercion issues
6 are potentially real.

7 What I would like to see happen here
8 is the development of a metric that, you know,
9 that we list as a gap, that there's a real need
10 for a development of a metric that gets at truly
11 women who are at risk for unintended pregnancy,
12 which I don't know how you do that with claims
13 data in the way that this is written right now.

14 Maybe I don't understand that claims
15 data well enough, but you know, I'm not believing
16 that that is truly what the measure, you know,
17 what this metric measures. And so there, I just
18 think that we have to be a little bit balanced
19 about the, you know, this dire need that we have
20 to ensure people have access to contraception in
21 the current, you know, in the current environment
22 with the potential for, you know, really sending

1 out a problematic messaging and problematic
2 programming.

3 CO-CHAIR PINCUS: Thank you. I think
4 Lekisha and Marsha just want to comment, in terms
5 of sort of explaining stuff. So --

6 DR. SMITH: I had a question. When
7 you were presenting, you mentioned that this
8 measure was new, but it was modified? I think
9 the endorsement is new, but it was modified for
10 use in Title X programs? Could you explain how
11 that modification is? Because I used to work for
12 the state, and this was part of our performance
13 review.

14 We did have to offer contraceptives to
15 women, and it was the form that they accepted and
16 the rating was amongst, you know, the most
17 effective. So I just wanted to know how is it
18 modified for use in Title X?

19 MEMBER SAKALA: Thank you. I just
20 collected some information about how it's being
21 used right now, but I think Lekisha can answer
22 that.

1 MS. DANIEL-ROBINSON: So the steward
2 actually developed it for Title X. So it was
3 initially tested in Title X and has been
4 broadened to be collected and reported by a
5 larger body of -- a larger body, so using claims
6 data. So in terms of the modification, it was
7 actually perhaps modified for claims data as
8 opposed to, you know, modified for Title X. So
9 does that answer your question, Dr. Smith?

10 CO-CHAIR PINCUS: Mic.

11 DR. SMITH: We did not bill until
12 that's probably the modification for claims. But
13 I just wondered to the question about coercion,
14 you know, it has to be some counseling there that
15 is included and I don't know if that's one of the
16 codes that, you know, the woman was counseled and
17 she accepted the, or did not accept.

18 So the measure is just demonstrating
19 what forms, the rates of what forms of
20 contraception were accepted. So that's all. I
21 just wanted to know for sure. But I know that
22 our experience was that we generally did not bill

1 Medicaid, but we did encourage our grantees
2 through the health departments to bill, if they
3 have that capability.

4 CO-CHAIR PINCUS: Lekisha, was there
5 some other comment you wanted to make?

6 MS. DANIEL-ROBINSON: Yes, right.
7 So two things. One, currently in development as
8 a patient-reported outcomes measure, which would
9 be a complement to this.

10 So it would really assess the women's
11 experience with contraceptive counseling and
12 access to these services. So that's in
13 development, and I'm sure at which time it is
14 complete with the testing is complete and all of
15 that, it will be submitted for endorsement.
16 That's part of the process.

17 The other thing I wanted to say is
18 that I referenced the interpretation guide
19 earlier, and that really talks about how to look
20 at this measure. So you really don't want to
21 just take the measure and, you know, you get the
22 rate and that's the rate and you make some kind

1 of determination on that.

2 It's the rate of the women who
3 received the services within the year. However,
4 what you can do in terms of interpretation would
5 be to take local level data or national level
6 data, depending on how you're -- how you want to
7 analyze the data.

8 But you take another instrument that
9 provides the unintended risk, you know, the
10 unintended pregnancy risk, and that is what you
11 use to determine whether or not there is unmet
12 need in terms of access.

13 So that interpretation guide that's on
14 the maternal and infant health page actually goes
15 into how you can look at that. But the raw rate
16 in and of itself does not give you all of the
17 information.

18 CO-CHAIR PINCUS: Kathryn and then
19 Mary.

20 MEMBER BEATTIE: The answer to my
21 question may be somewhere in this discussion but
22 maybe someone can clarify it for me, which is how

1 do we know from claims data that a woman 15 to 44
2 is truly at risk for unintended pregnancy, and
3 it's similar to what Andrea on the phone is
4 saying, which is how are we getting to that
5 population? I'm not understanding how we exclude
6 those who are -- it would not be an unintended
7 pregnancy.

8 And so are they just -- we're assuming
9 oh, they're in the 15 percent if our goal is 85
10 percent, or are we looking at a gap in some data?
11 That just seems like an advanced level of
12 evaluation that most people aren't going to make
13 in looking at state to state, right? And we're
14 supposed to be respecting cultural components in
15 these, and I do see practicing now in Idaho and
16 Utah that this may have some real concerns for
17 populations in our states. I just don't
18 understand how we're getting to that definition
19 in the denominator.

20 MS. DANIEL-ROBINSON: I think, again
21 in terms of interpretation, using your example at
22 the local level, the unintended risk there might

1 be different.

2 So one of the ways that we talk about
3 in the interpretation guide is to look at the
4 National Survey of Family Growth, that gives
5 percentages. I mean you have to use something,
6 right, to determine what's the percentage at risk
7 and that survey is one of the ways to do it.

8 But I understand that there are also
9 local, local instruments that provide that same
10 kind of information. So it's -- again, I don't
11 think that this measure is ever intended to be
12 100 percent of anything, or it's intended to be
13 zero. But it's a -- it's a way to look at the
14 range of services that are provided, and so --

15 MEMBER BEATTIE: I'm just not -- I'm
16 sorry. I'm not understanding how we're getting
17 at accurate data to even meet the measure. So
18 how -- is there a code where I define --

19 MS. DANIEL-ROBINSON: Unintended
20 pregnancy is not -- there isn't a code for
21 unintended pregnancy in claims. I will say
22 another thing about the measure.

1 It's being specified for electronic
2 versions, and so in the future you actually will
3 get the unintended piece more accurately because
4 a question could be inserted into the electronic
5 record that will ascertain the women's
6 reproductive health plans.

7 But at this point with the claims
8 data, no, you won't have the precise assessment
9 about what her risk or intentions are.

10 MEMBER BEATTIE: So it might be
11 premature to try and build this -- I absolutely
12 agree with the intention of improving access to
13 contraceptive care that's effective. But I'm
14 just concerned as to whether we're able to today
15 build a metric that actually measures what we're
16 looking to measure.

17 CO-CHAIR PINCUS: Okay. Let's hear
18 from a few other people. Mary and Roanne, do you
19 have a question? Okay, and Kim, and then we also
20 -- the senior project manager for the standing
21 committee that reviewed the endorsement actually
22 may have some comments. Available now or --

1 MS. GORHAM: Suzanne.

2 MS. THEBERGE: Yes, hi. The committee
3 did discuss pretty extensively these questions
4 around percentages and us getting at whether
5 pregnancy is intended or unintended, and I think
6 -- I don't know how much of the report from that
7 project folks reviewed. Some of that discussion
8 happened around some of the other two measures in
9 the sets.

10 But you know, just wanted to re-echo
11 that it was very clear that these are about
12 access. It's never intended to be 100 percent.
13 They're more looking to ensure that women who are
14 interested in accessing contraceptive methods can
15 do so and that it's not some kind of systemic
16 blockage.

17 There was actually some discussion; I
18 was just checking the notes, and there was some
19 discussion about the fact that yes, there are
20 particular religious denominations that don't
21 want to use contraception, but -- or that may be
22 counseled against, but they are -- many of them

1 actually are using contraception.

2 So I just want to flag that the
3 committee did discuss these topics pretty
4 intensively.

5 CO-CHAIR PINCUS: Mary.

6 DR. APPELEGATE: Okay. So just the
7 practical piece of things. We have women at high
8 risk for pre-term birth. Spacing pregnancies is
9 a very effective strategy. The uterus has to
10 recover. So the ultimate measure we're trying to
11 get to is inter-pregnancy interval for high risk
12 women.

13 Unless there's a measure for effective
14 contraception, there would be maybe no way to do
15 it. So for example Ohio did not participate
16 because under DRGs, no one's going to do an \$800
17 kit for the same cost of the entire delivery. So
18 virtually our chances were zero, even if they
19 were high risk -- high risk deliveries. So I
20 just want to mention that.

21 And then in terms of intentionality,
22 there have been tons of surveys. The PRAMS

1 survey is probably one of the more common ones.
2 But the surveys actually indicate in some
3 communities the unintentional pregnancies are 50
4 to 70 percent, and the use of the contraception
5 might be less than ten percent.

6 So that just tells us we have an
7 access problem. So the measure is intended to
8 drive whatever you need to do in your state or
9 your system to ensure that we provide the
10 services that people, again the patient-centered
11 piece, that people think will work for them.

12 So we know for teenagers, they can't
13 think about a pill every single time. There may
14 be people in their household who have opinions
15 about whether or not that's a good thing.
16 There's a respect for privacy and for dignity
17 that actually results in youth and people with
18 special chronic conditions, some of the disabled
19 population, that actually prefer LARCs for
20 example.

21 And there was virtually zero chance in
22 Ohio postpartum. If you wanted one, you actually

1 could not get one. So the measure is actually in
2 some ways a process measure, trying to get to
3 inter-pregnancy intervals for high risk women.
4 So I think it's very important though to make
5 sure you understand that there is a gap, and
6 essentially we're emotionally neutral.

7 But I can tell you if we eventually
8 get to the point of doing our measures by
9 disparate populations, we'll be able to make sure
10 that everyone knows that we're keeping track of
11 it. So this is about availability of very
12 effective, you know, medication and intervention
13 that actually can really help long-term outcomes.

14 CO-CHAIR PINCUS: So I have --

15 MEMBER BENIN: Can I ask -- could I
16 ask a question about that comment? Would that be
17 okay?

18 CO-CHAIR PINCUS: Okay. But I just
19 want to say that I have Roanne, Amy, Kim, and Sue
20 in line. Okay, Andrea?

21 MEMBER BENIN: You want me to ask?
22 Okay. You want to me to ask? Okay.

1 CO-CHAIR PINCUS: Yeah.

2 MEMBER BENIN: So I just would -- it
3 would be helpful for me to understand how having
4 the feds indicate that this metric is on the list
5 makes a difference for the state's, you know,
6 desire to do what needs to be done around
7 contraception. I think clarification of that.

8 I will also just comment that we do
9 have the postpartum contraception metric on the
10 list, which I understood that that was because of
11 that interval issue. So a little clarification,
12 because I think that comment was really
13 important. I just want to make sure I understand
14 it.

15 DR. APPELATE: Yeah. So from my
16 perspective, this is Mary again -- from my
17 perspective, the immediate postpartum one is
18 super-important because you've already proven
19 that the mother is super-high risk because she's
20 got this baby in the NICU, right, although
21 admittedly at that time, if you're worried your
22 baby's going to survive or not, that might not be

1 a time that you're okay with waiting.

2 The message that we've had in Ohio,
3 even for LARCs, is that we'll take them out
4 whenever you want. It just -- the clinicians
5 just don't care if they take them out. So that's
6 the other piece of it is the messaging around no,
7 you can't have it taken out, I mean there are a
8 whole bunch of women. I think it was less than
9 ten percent, but there was still a number of
10 women who actually had them taken out in the
11 three to nine month period or so.

12 The other measure gets to the front
13 end, which is my comments about the disabled and
14 young, very young mothers. So preventing or
15 delaying the age of their first pregnancy is
16 directly tied not just to outcomes, but also to
17 poverty. So if that's something that they want,
18 it's very, very difficult to actually try to be
19 able to have that.

20 So in essence it really is a measure
21 of access for this very specific part of
22 reproductive health services.

1 CO-CHAIR PINCUS: So Roanne.

2 MS. GORHAM: Before Roanne, can you
3 give me one minute? I just want to, we have a
4 new face at the table. So if you will allow me
5 to just introduce Dr. Lindsay Cogan from New York
6 state. So please feel free to weigh into the
7 conversation as we have it.

8 MEMBER OSBORNE-GASKIN: So I just
9 wanted to echo Mary's point that unintended
10 pregnancies may be -- so I was thinking
11 specifically of the teens. So the teenagers who
12 definitely -- that is a group that you definitely
13 don't want an unintended pregnancy, and that the
14 age group actually may have to go a little bit
15 younger than 15 to address that.

16 And so I could understand them having
17 problems with access to care across all, you
18 know, ethnic groups or, you know, all women. So
19 even if the measure was a little more focused, as
20 you said you know, to disabled population or teen
21 pregnancy or something like that, I think that
22 would be definitely focusing the measure a little

1 bit better than just --

2 CO-CHAIR PINCUS: Kim.

3 DR. ELLIOTT: A lot of what I was
4 going to say has already been said, but I don't
5 think it's an access measure. I do think it's a
6 process measure like Mary said. I also think
7 that if we're going to get to the point of doing
8 measurement on this across states that a lot of
9 states are very competitive and want to have the
10 highest rates in most of the measures.

11 My concern would be comparing like a
12 Utah to a California or a New York, and how that
13 may appear in a report that goes to Congress or
14 something like that, like Utah would be failing
15 when it's really a cultural or personal opinion
16 on use of birth control or birth control methods.
17 So I think we just need to be very cautious on
18 that.

19 CO-CHAIR PINCUS: Amy.

20 MEMBER POOLE-YAEGER: Yeah. I think
21 mainly what everybody's been saying. My, you
22 know, my first reaction when I hear this is like

1 oh my gosh, somebody's going to tell me that I've
2 got to get, you know, the rate up to whatever.

3 And so but I'm new to the Committee.
4 So I don't, you know, when we approve it and it
5 goes to CMS, I mean some of the words are oh,
6 will it be even included in payment strategy and
7 blah blah blah blah.

8 So I think that maybe some of the
9 angst is around, you know, do we have any
10 direction about, you know, with our approval,
11 saying that it definitely would not be something
12 that you -- I mean you said it's in a document,
13 but I mean how does that make -- how do we make
14 sure that it doesn't get used inappropriately
15 when -- does that make sense, you know? That
16 would make maybe me feel better too.

17 MS. DANIEL-ROBINSON: And I would
18 probably say that that's a concern for many
19 measures. You know, once it's out in that
20 sphere, there is a loss of control from the
21 owner.

22 So it's really on to -- on the user.

1 Again, our recommendation would not be to use
2 certain measures in that way. It should not be
3 like a pay for performance type approach to get
4 to X, get level. Like that's -- that would never
5 be our recommendation for this type of measure.

6 But again, I don't know how one would
7 control that. I mean so whether or not it
8 appears on the core set, it is in existence. It
9 is NQF-endorsed and could very well be used
10 incorrectly.

11 CO-CHAIR PINCUS: Sue and then Helen.

12 MEMBER KENDIG: You know, the coercion
13 argument comes up each time, and I think it's
14 important to remember also that having no
15 evidence of offering a method is also -- could
16 also be construed as a coercive behavior. So I
17 think we also -- I think we need to balance that
18 argument with the flip side.

19 With regards to the comment about
20 having the postpartum measure, you know, this may
21 be one way to get to appropriate content, as
22 evidence of appropriate content in that

1 postpartum or maternal or well woman visit as
2 well, because certainly for women's health care
3 providers, all of these reproductive life
4 planning is something that's included. In my
5 view, this is capturing -- this is one method of
6 capturing appropriateness of what is included in
7 that care.

8 CO-CHAIR PINCUS: So Helen, and then
9 hopefully we're ready to vote on both the child
10 and the adult sides after this.

11 DR. BURSTIN: Great. Just one quick
12 comment. Again, since you are MAP, consideration
13 of payment and the way the measures are applied
14 are completely within your purview. So there's
15 nothing that says we couldn't capture some of
16 this discussion, just to make you feel
17 comfortable that this is about the measure and
18 its potential appropriateness for inclusion in
19 this program.

20 But we could certainly include and
21 will certainly include some of the dialogue
22 around how the measure could be used or would be

1 used around payment.

2 DR. MATSUOKA: And just to underscore
3 I think what Helen just mentioned, but also
4 Lekisha with regard to use, just a reminder that
5 these core set measures -- and this MAP task
6 force is somewhat unique and different from other
7 MAP groups that you might be on, where you're
8 talking about measures that are going to be done
9 through rulemaking, that are going to be required
10 and perhaps payment attached to it.

11 That's not this. These are state
12 level measures that are used for quality
13 improvement purposes only, not payment.

14 CO-CHAIR PINCUS: And is a voluntary
15 program. Okay. I think we're ready to vote. So
16 do you want to do the Adults first and then the
17 child? Okay. So Miranda, you want to set that
18 up?

19 MS. KUWAHARA: No problem. Let's see.
20 So Andrea, we are asking the question should
21 Measure No. 2903, Contraceptive Care, Most and
22 Moderately Effective Methods, be added to the

1 adult core set. Your options are 1 support, 2
2 conditional support, or 3 do not support.

3 CO-CHAIR PINCUS: Okay, and so --

4 Okay. So just on the adult side, just
5 to say, has anybody put forward any conditions
6 for support? Because if we do vote for
7 conditional support, we have to say what the
8 conditions are. So nobody has put forward any
9 conditions. Okay. So we're really voting for
10 support or do not support. Okay.

11 MS. KUWAHARA: All right. Adult Task
12 Force, feel free to submit your responses.

13 We're waiting on -- there we go. 63
14 percent of the eight members voted to support
15 this measure for the adult core set.

16 CO-CHAIR PINCUS: Okay. 63 percent,
17 so the measure --

18 MS. KUWAHARA: Yes.

19 CO-CHAIR PINCUS: So the measure gets
20 support, okay. Rich, do you want to take it for
21 the child?

22 CO-CHAIR ANTONELLI: Yeah. I guess I

1 want to ask the question about adding conditions,
2 because the conversation up to now has included
3 both the adult and the child. So we're focusing
4 on the child task force. Does anybody want to
5 put forth a condition for this measure? Yes.
6 Lean into the microphone please.

7 MEMBER RICHARDSON: I apologize. I'm
8 not entirely certain how to word this, but I do
9 think some nuance could be created around the
10 denominator, how you define it. Is it just all
11 women of this age or could we be more accurate
12 about the -- who are we measuring this for?

13 MEMBER POOLE-YAEGER: Can I have --
14 just I'm sorry I'm new, so I'm just asking
15 details here. So is this just going to be
16 conditions to the measure itself, or as you
17 mentioned, you know, how the measure is used?
18 Can we put a condition on how the measure is
19 used? We could, yeah.

20 So I would propose that we, you know,
21 that maybe we would have a motion to approve this
22 with the condition that we very clearly state the

1 use cases where we think, you know, where they
2 think this should be for quality improvement and
3 not in a payment methodology or with no
4 particular benchmark or goal in mind.

5 CO-CHAIR ANTONELLI: Okay. Does that
6 meet what you were promoting, Amy?

7 MEMBER POOLE-YAEGER: Yes.

8 CO-CHAIR ANTONELLI: Yes, okay. So
9 should I take that as a motion for a condition
10 attached to this vote?

11 MEMBER POOLE-YAEGER: Yes, I will make
12 that motion.

13 CO-CHAIR ANTONELLI: Okay, and so
14 Shaconna and team, do we vote on the condition
15 before we vote on the measure, or do we --

16 CO-CHAIR PINCUS: You will vote 1, 2,
17 3.

18 CO-CHAIR ANTONELLI: So we're going to
19 do all three?

20 CO-CHAIR PINCUS: Yes.

21 MS. GORHAM: And tell me what the
22 condition is again one more time, just so I have

1 it clear for the record. Just so I have it
2 clear. Rich, you can summarize for me if you
3 want.

4 CO-CHAIR ANTONELLI: Yeah. So
5 basically the -- your proposal is to accept the
6 measure, but with specification of how the
7 measure will be implemented, right? So it
8 doesn't change the measure. It talks about the
9 implementation or the use. I think you used the
10 term "use cases."

11 MEMBER POOLE-YAEGER: Use cases,
12 right.

13 CO-CHAIR ANTONELLI: So basically it
14 involves how it gets implemented and potentially
15 the data is interpreted, right?

16 MEMBER POOLE-YAEGER: Correct.

17 CO-CHAIR ANTONELLI: It doesn't change
18 the measure.

19 MEMBER POOLE-YAEGER: Right, no. You
20 know, I think we're probably stuck with the
21 denominator as it is, so but if we don't use it
22 for payment, we can kind of --

1 CO-CHAIR ANTONELLI: Yeah.

2 MEMBER POOLE-YAEGER: Does that make
3 sense?

4 CO-CHAIR ANTONELLI: Okay. Staff, is
5 that okay?

6 MS. GORHAM: Yes, we got it.

7 CO-CHAIR ANTONELLI: Okay. So child
8 task force, we're going to be voting this, and
9 there are three options. So Miranda, do you want
10 to take us through this please?

11 MS. KUWAHARA: That's right. This is
12 Measure No. 2903, Contraceptive Care Most and
13 Moderately Effective Methods. We have three
14 voting options. Number one, support for
15 inclusion. Number 2, conditional support or
16 number three, do not support. You may now cast
17 your votes.

18 Correct.

19 CO-CHAIR PINCUS: With the condition.
20 Support means no condition, yes. Carol.

21 MEMBER SAKALA: So what if the
22 favorable votes are divided among the first two

1 categories? How does that -- does it roll up to
2 something? Rolls up to conditional? Yeah down,
3 okay. Thank you.

4 MS. KUWAHARA: And we are still
5 waiting on one more vote. We have Andrea's.
6 Okay, perfect. 15 percent of the 13 voting
7 members voted to support the measure; 62 percent
8 voted to conditionally support this measure; and
9 23 percent voted to not support this measure.

10 DR. BURSTIN: Conditionally support.

11 MS. GORHAM: So we actually have two
12 more measures to discuss. BMI might take up more
13 time, but we actually have two more
14 recommendations for the child task force, and
15 that is 0480 and 2830. Of course one again is
16 the paper measure, the other e-measure, and that
17 recommendation for the PC05 exclusive breast milk
18 feeding was made by Carol.

19 MEMBER SAKALA: Just a point of
20 clarification. Our spreadsheet actually had a
21 third number suggesting that really those are
22 both one in the same and should be considered

1 together; is that correct?

2 MS. GORHAM: That is, and Suzanne is
3 still on the phone, so Suzanne correct me if I
4 state this inappropriately. But the measure, the
5 way we number here at NQF, you have the parent
6 measure and those two metrics fall below,
7 underneath that parent measure, and you're
8 talking about 0341. It is just the number
9 system, but Suzanne, weigh in please.

10 MS. THEBERGE: Yes. It has to do with
11 the e-measure paired measure matching system.

12 MEMBER SAKALA: Can't we consider them
13 together because we learned during our standing
14 committee work that they were essentially the
15 same measure, just different opportunities for
16 collection?

17 MS. GORHAM: So then when -- after you
18 all discuss, we can vote on that one measure
19 number.

20 MEMBER SAKALA: Okay.

21 CO-CHAIR ANTONELLI: So open up.

22 MEMBER SAKALA: So I proposed this one

1 again, and it has been supported through three
2 National Quality Forum consensus development
3 process rounds, and last year, as Sean from ACOG
4 said, it got 91 percent support by our Committee.
5 I understand from NQF staff that that's kind of
6 an outlier level of support, so it's very, very
7 strong.

8 And then the e-measure, as we just
9 discussed, is identical, but to facilitate more
10 collection options. Last year the child task
11 force recommended that this be added to the child
12 core set, and CMS did not add this one, but we
13 have the opportunity now to reconsider. I feel
14 that this is really foundational.

15 I mean I would have expected this to
16 go in the first year of the child core set
17 personally because it's preventive, because it's
18 relevant to a very large proportion of the
19 maternal and infant population, because it has
20 the potential to advance health equity and has
21 been used to really take populations in certain
22 facilities where they have fairly low historic

1 rates of breast feeding and support, provide the
2 support and show significant improvement.

3 Also, constantly in my mind is what
4 we're learning about the developmental origins of
5 health and disease, the human microbiome. This
6 is like really important for lifelong health and
7 has benefits for both the child and the woman,
8 and I have -- I think I have it here.

9 It's old and it's being updated, but
10 the AHRQ AHIP evidence report from 2009,
11 systematic review for children, reduces risk of
12 otitis media, non-specific gastroenteritis,
13 severe lower respiratory tract infection, atopic
14 dermatitis, asthma, obesity, Type 1 and Type 2
15 diabetes, childhood leukemia and SIDS, and for
16 women, reduced risk of Type 2 diabetes, breast
17 and ovarian cancer, and I think they are looking
18 now at some of the studies that have come out
19 since then around cardiovascular health and other
20 things.

21 This to me is such a big win measure,
22 and helps us to not avoid problems that we might

1 otherwise deal with in this program. It is
2 supported by ACOG, and the national average was
3 53 percent, and people have said it could be
4 closer to 70 percent, 70 to 80 percent, in that
5 range. Again, we don't have a benchmark but we
6 do know that there's a wide variation and a lot
7 of opportunity for improvement.

8 As far as federal and other national
9 programs, it's used in the -- I wasn't quite
10 clear on this, but read hospital inpatient
11 quality reporting, the EHR incentive program.
12 It's a measure in the CMS and AHIP core quality
13 measures collaborative OB/GYN core set. It's in
14 the Joint Commission Perinatal Care core set and
15 collected by all hospitals with 300 or more
16 births, and publicly reported in quality check
17 and in CalHospitalCompare, which impacts about
18 one birth in eight in the country.

19 So again, this was a topic where
20 concerns with coercion were raised, but I would
21 share with you that almost everybody around our
22 very large standing committee table has

1 experienced at the point of care, and this was
2 not a big concern, and nine in ten supported it.

3 So I think there's a certain kind of
4 reassurance that we can take away from that, and
5 again the fact of not ever expecting 100 percent
6 is -- often allays concern.

7 We would have preferred a downstream
8 measure later on. I personally like exclusive
9 breast feeding at six months. That's standard.
10 I'd like to really go for that. But we have
11 difficulties with collection, and I can assure
12 you that the provider community will be
13 complaining because they would say there are so
14 many things they don't have control over.

15 So that is a good reason to choose
16 this tried and true, established measure that is
17 a precursor to downstream success. So I propose
18 that we shouldn't let the perfect get in the way
19 of the good here, and address these powerful
20 benefits to -- that could accrue to the Medicaid
21 population. Thank you.

22 CO-CHAIR ANTONELLI: All right. Let's

1 open -- Carol, thank you, open this for comments.
2 I want to remind people that we're considering
3 the e-measure 2830, along with the paper measure
4 for the sake of time efficiency. So open for
5 comments, questions.

6 MEMBER POOLE-YAEGER: So I will just
7 echo your passion for the benefits of breast
8 feeding and how this is core to improving health,
9 particularly breast feeding rates in Medicaid are
10 lower than in commercial populations. So we know
11 that there's a gap there. I think the -- this is
12 sort of a hospital measure, right.

13 So the hospitals are going to have it.
14 They're going to get it. I think it's important
15 to say that it's important and again I'm sorry,
16 I'm new, so I keep asking all these questions.
17 But is putting it on the Medicaid core set, it's
18 going to put the burden on the Medicaid agencies
19 to report it, even though the hospitals are
20 reporting it? I don't know.

21 I'm just trying to think about the
22 burden for the states to try to get it, you know,

1 and is the value worth it if Joint Commission is
2 already sort of pushing them?

3 I would love to say that we would have
4 more effort around how do we capture breast
5 feeding outside of the hospital as well. Can we
6 do something around it? So I don't think I have
7 an answer, but that was just some comments.

8 MEMBER KILSTEIN: The question is how
9 would the state collect it from the hospitals for
10 just the Medicaid population? I mean if it's a
11 population -- if it's a hospital-based measure
12 and it's for all population, how are they going
13 to collect it for just Medicaid? Just a
14 question. I mean maybe somebody could answer
15 that in terms of the collection.

16 DR. APPLEGATE: So this is Mary.
17 Perhaps I can address that, you know. It's 2017.
18 Pretty much every state should be linking
19 Medicaid claims with vital stats.

20 CO-CHAIR ANTONELLI: Right.

21 DR. APPLEGATE: So we've got to get
22 out of the dark ages. This is directly from

1 vital stats, and so if we're doing our linkage
2 which is better than 90 percent, we actually will
3 have the data. So that opens up all of those
4 fields. We might also suggest that one reason it
5 doesn't get coded now is we didn't have a code in
6 ICD-9. But I believe in ten, in ICD-10 we
7 actually do. I don't know if it's exclusive or
8 not. I'd have to look it up.

9 But what gets coded is also what gets
10 paid, right. So I think even though this is a
11 hospital measure, you heard me comment about how
12 in Medicaid I'm not as interested in in-hospital
13 processes. However, the decision to breast feed
14 is made before you deliver. So now we're back
15 into the outpatient arena. It is supported or
16 discouraged by hospital practices and policies.

17 So at our hospital, we're in a rural
18 hospital. We have 80 percent breast feeding
19 rates, which is actually pretty amazing. But I
20 can tell you every single nurse is almost a
21 lactation consultant in and of themselves, and
22 the amount of time they spend to support the

1 women is amazing.

2 So the hospitals absolutely are
3 present at a very critical time to provide that
4 support, particularly if those services are also
5 available after they leave the home, and then can
6 continue to be supported in the pediatric or
7 general practice.

8 CO-CHAIR ANTONELLI: Thank you. So
9 Karen, should I move you ahead of Lisa, because
10 you want to respond directly to this.

11 DR. MATSUOKA: Just a little bit of --

12 CO-CHAIR ANTONELLI: Okay. So Karen
13 and then I want to go to Lisa, and then we'll
14 come over to Lindsay.

15 DR. MATSUOKA: So my only comment is
16 that yes, we're in 2017, but Mary, Ohio, you guys
17 are way ahead of the curve on so many things, and
18 this is one area where you definitely are, I
19 think. So I just want to put that out there, and
20 you know, Rachel, I don't know if you want to say
21 what Florida would be able to report on this
22 measure. I'm not sure.

1 But the other thing I just wanted to
2 add is that to this issue of, you know, where
3 data is being collected and maybe reported
4 elsewhere, I think Marsha and I just had a
5 conversation at one of our breaks to see, you
6 know, what we might be able to do at the federal
7 level to source that data, so it doesn't -- so
8 that we can do some of the data feedback to the
9 states and not have to have the data be coming
10 from the state.

11 But I think, you know, that's just a
12 conversation we started literally today. So
13 hopefully this time next year we'll have more to
14 report back. But my sense is that many states
15 are not yet at where Mary is in Ohio.

16 CO-CHAIR ANTONELLI: Okay, Lisa.

17 DR. PATTON: Thank you. Yeah, so
18 this is kind of more of an in the weeds
19 measurement question, and in the interest of time
20 we don't have to get into it if we don't have
21 time.

22 But I was curious about with the

1 exclusions, if there was consideration of looking
2 at the mom's health and so adverse outcomes
3 during the delivery that might impede breast
4 feeding. So I just didn't know whether there had
5 been consideration of those kinds of exclusions
6 as well, and probably a low rate event but --

7 MEMBER SAKALA: So I can say that
8 exclusions that are listed on the -- I'm looking
9 at them in both places. Newborns who are
10 admitted to the NICU, newborns transferred to an
11 acute care facility, and newborns who die during
12 the hospitalization, and there's always -- with
13 measure development, there's always a tension
14 between all of the little things you can add on
15 and the burden of doing that.

16 I think one of the trade-offs is we're
17 going to decide nowhere are we going to go near
18 100 percent to make it a feasible measure to
19 collect.

20 CO-CHAIR ANTONELLI: Lindsay.

21 MS. COGAN: Thank you, and I'm sorry
22 I was a little bit late today.

1 CO-CHAIR ANTONELLI: Yeah. I was just
2 going to say can you just take a moment to
3 introduce yourself, and then you can go right to
4 your comment.

5 MS. COGAN: Sure, yes. So my name is
6 Lindsay Cogan. I am the division director for
7 the Division of Quality Measurement of the New
8 York State Department of Health, and I'm a
9 quality measurement subject matter expert and in
10 charge of most of our reporting on the adult and
11 child core set that New York does to CMS.

12 So I was excited to hear both Deborah
13 and Amy's question come up, because it's often
14 one that percolates back at the state. You know,
15 why are we being asked to look at a facility-
16 based measure yet again in another way, and Mary,
17 I appreciate your comments. We do link vital
18 stats with our Medicaid claims data. Now our
19 vital stats data is old, doesn't come to us for
20 two years. It's not timely, you know.

21 You've got 19-1/2 million people in
22 New York. It takes a while to process the

1 information. So it's not actionable at that
2 point for us. So what we do is we do report it
3 using vital stats.

4 Breast feeding exclusively in the
5 hospital is so poorly reported when we validate
6 that against the medical record that it's not an
7 area that we've been pushing as we have other
8 areas within the birth certificate that we really
9 want to capture, like previous pre-term and other
10 high risk markers of future or subsequent pre-
11 term or low birth weight.

12 So I do -- I do kind of echo that
13 sentiment, that if we're already collecting this
14 at the facility level, where is our actionable
15 piece. So is it really that we want to tease out
16 Medicaid only and then go back to a facility and
17 tell them where they need to work, or is that
18 confusing when a facility is already working on a
19 measure for us to intervene as a state agency,
20 and give them yet another number that doesn't
21 jibe with what they're already reporting to the
22 Joint Commission.

1 CO-CHAIR ANTONELLI: Thank you. Amy,
2 and then Mary, is your card up again? Okay, Amy.

3 MEMBER RICHARDSON: Yes, thank you.
4 So as a pediatrician, I might get drummed out of
5 the tribe for raising questions, but here's what
6 came to my mind and please don't understand or
7 misunderstand. Completely agree with the health
8 benefits of breast feeding. I'm not sure this is
9 the measure and let me see if I can articulate
10 why.

11 Indeed, there is evidence that long-
12 term breast feeding affects development and
13 health. I'm not sure there's any evidence that
14 two to four days, which is all this is measuring,
15 somewhere between two and four days of breast
16 feeding changes health outcomes.

17 I think that the measure we really
18 have to figure out how to get to is two things:
19 the actually actionable piece, which is what's
20 going on with the OB/GYNs and nurse midwives
21 during the prenatal phase, because that's what
22 really influences what you do after the baby's

1 born, and then the long-term piece.

2 I say that because it went round and
3 round in my immediately past job with hospitals,
4 who wanted us to support all kinds of incentives
5 and so forth for them meeting this, and had many
6 a person tell me from the hospital perspective
7 off the record that they had already figured out
8 how to game the data. So we can do it, but our
9 -- be sure we're getting what we think we want.

10 CO-CHAIR ANTONELLI: Uh-huh. Terry.

11 MEMBER ADIRIM: Well, I am speaking on
12 behalf of the American Academy of Pediatrics and
13 I agree with you, and I'm a pediatrician. It is
14 a very important measure concept.

15 I think we need to be working towards
16 promoting long-term breast feeding, but to
17 Karen's point earlier about real estate on the
18 core set, I think if it's not a measure that's
19 going to get us to that longer-term breast
20 feeding, that it may not be worth that precious
21 real estate because if you look at the data,
22 women who breast feed in the hospital, not that

1 many continue breast feeding.

2 So I would advocate for -- I hate
3 saying it, but not putting this particular
4 measure on the core set, and look for better
5 measures.

6 And again, we grappled with this in
7 the military health system, because we really
8 wanted to put this on our pediatric dashboard.
9 But for the reasons that you cite and for all
10 kinds of others, we really wanted to look at
11 measures that are longer-term and the problem
12 with that is that the data's not reliable by
13 documentation. So that's my opinion.

14 CO-CHAIR ANTONELLI: Rachel.

15 MEMBER LA CROIX: I would just like to
16 echo a couple of the other comments mentioned and
17 Florida to our vital statistics data, and the
18 certificate data is sometimes delayed by about
19 two years also and has a lag. So there are
20 delays in our being able to report on some
21 maternal and child health status indicator
22 measures.

1 Also, our adult core set group
2 yesterday discussed a lot of difficulties with
3 the antenatal steroids measure, which I think was
4 a similar hospital-based measure already being
5 reported by the hospitals, but difficult to look
6 at at a specifically Medicaid, and from our
7 Florida Medicaid perspective, most of our
8 population is on managed care. So we're also
9 looking for measures that are valuable at a
10 health plan level, not just at a state Medicaid
11 level as well, and it's difficult to get to that
12 with some of these hospital-based measures.

13 MEMBER BENIN: I have a comment. This
14 is Andrea.

15 CO-CHAIR ANTONELLI: Andrea, go ahead.

16 MEMBER BENIN: I would just like to
17 strongly agree with Amy and Terry. While, you
18 know, breast feeding is one of the most important
19 things we can do for children, this metric does
20 not get us I think where we need to be as far as
21 really understanding that.

22 In addition, there are lots of reasons

1 why exclusive breast feeding, you know, may not
2 be feasible but yet successful breast feeding
3 might ultimately be feasible.

4 I would rather have us acknowledge a
5 gap in getting to a really good breast feeding
6 metric. So I would agree with them. Thank you.

7 CO-CHAIR ANTONELLI: Okay. So I am
8 going to raise the vote here. I'll start by
9 asking if, because we have to first decide if
10 we're going to include conditional support in
11 this. So I'm not asking you to say you want to
12 support, but do we want to put a condition on
13 there so we're voting against three choices
14 versus two.

15 MS. GORHAM: And before we do that,
16 let me just be very clear. Because CMS has
17 already told us that the addition of an e-measure
18 is a different form of reporting, we don't need
19 to vote on both of the measures, so we will only
20 vote on one.

21 CO-CHAIR ANTONELLI: So would anybody
22 like to propose a condition?

1 (No audible response.)

2 CO-CHAIR ANTONELLI: Okay. So that
3 means Miranda, we're voting on two choices here,
4 please.

5 (Pause.)

6 MS. KUWAHARA: So just to reiterate
7 one last time, this is for Measure No. 0480,
8 PC05, Exclusive Breast Milk Feeding. This also
9 encompasses e-measure No. 2830 and it's all under
10 the parent measure number 3041. This is all one
11 vote. We are going to vote for two options. One
12 is support and three is do not support. Child
13 task force members, you can cast your votes.

14 85 percent of the 13 respondents
15 voted not to support this measure.

16 CO-CHAIR ANTONELLI: We'll open up for
17 public comment. Operator, why don't we open up
18 to the lines first and then we'll give people a
19 chance in the room here to come up to the
20 microphone.

21 OPERATOR: At this time, if you would
22 like to make a public comment. Please press star

1 then the number one.

2 (No audible response.)

3 OPERATOR: And there are no public
4 comments from the phone line.

5 CO-CHAIR ANTONELLI: Thank you.
6 Public comments from the folks in the room here?

7 (No audible response.)

8 CO-CHAIR ANTONELLI: Okay.

9 MS. GORHAM: All right. I think we're
10 going to power through and not take a break, but
11 definitely if you need to step out and take a
12 break, please do so. But I want to be respectful
13 of time. I know that we have some adult members
14 who would like to make their plane and trains on
15 time. So we're just going to keep on with our
16 asthma conversation, and I want to go rather
17 quickly but definitely stop me if I am moving a
18 little too fast or there are questions.

19 This before you is the summary slide
20 for the asthma measures. We did a search and
21 were found 12 total measures in the asthma
22 universe, five endorsed, seven not endorsed.

1 Five of those seven not endorsed measures are
2 PQMP measures.

3 Next slide. So I'll give you an
4 update on just some of the maintenance and loss
5 of endorsement in the asthma arena, if you move
6 to the next slide. 1799, which is currently on
7 the child core set, lost endorsement in 2016. It
8 was recommended by the adult task force members
9 for a few years but never added.

10 Next slide. Here is again a slide
11 that you can also find in your chart packs, to
12 just kind of tell about the median percent of
13 children ages 5 to 20 remain on asthma control
14 medication for at least 75 percent of their
15 treatment period. Sixteen states did not report
16 this measure, and some of those reasons include,
17 again, budget constraints. MCOs are not required
18 to submit this HEDIS measure. State-collected
19 information on this HEDIS measure for use of
20 inappropriate medication for people with asthma,
21 the states report on in all age bands in the
22 combined rate.

1 Those are just a few of the reasons
2 not reported. Again, you can find a
3 comprehensive list in the material that was sent
4 to you before the meeting.

5 Next slide, next slide. So to get to
6 the reasons that endorsement was removed from
7 this measure, the Pulmonary and Critical Care
8 Standing Committee noted concerns over the
9 evidence, especially with a study noting
10 inaccuracy in the data analysis, as well as with
11 the long list of allowable medications.

12 They pointed out that the measure does
13 not address whether patients are getting the
14 correct medications for their particular type of
15 asthma. The Committee and the CSAC then reviewed
16 the measure and could not reach consensus. We
17 went to -- the CSAC 60 percent rate in order to
18 approve the measure for endorsement was not
19 achieved, and so the endorsement was removed.

20 So again, in 2014, 2015 and 2016, this
21 measure was recommended by the adult task force.
22 Because endorsement was removed, you can move to

1 the next slide, was removed from this measure,
2 CMS asked the staff to do an analysis on
3 alternative ambulatory setting asthma measures,
4 and we did that, and we also sent that to you
5 pre-meeting in your material.

6 In doing that analysis to address the
7 gap, if in fact the task force votes to remove
8 and CMS removes that measure, we found two
9 measures, 0047 and also 1800. So 0047, the
10 Pharmacological Therapy for Persistent Asthma,
11 and then 1800, Asthma Medication Ratio. The
12 similarities of both 0047 and 1800, they both
13 address prescribing patterns and not medication
14 adherence, while 1799 addressed patient adherence
15 to prescribing asthma medication.

16 Both 0047 and 1800 have comparable
17 target populations and promote the use of long-
18 term asthma control or medications. There is
19 widespread use in both public reporting and
20 quality improvement programs, and if we move to
21 the next slide.

22 So just to add a little bit more

1 information about the two measures, 0047, measure
2 stratification captures information related to
3 prescription type. 1800 focuses on a ratio,
4 making it easier to identify patients who may
5 have inappropriate prescription treatment plans,
6 and then also 1800 is identical to 1799 in target
7 population, data source, and level of analysis,
8 making the reporting burden minimal for states
9 that have experienced reporting on 1799.

10 So that was pretty quick, but that
11 gives you a little summary of the analysis that
12 we completed on those two measures in relation to
13 1799. I will turn it over to Harold. I will say
14 if we want to kind of take the same strategy we
15 took with the maternal and perinatal health, we
16 do have a recommendation for 1800. So we can
17 have that lead discussant talk about 1800, then
18 have a joint discussion and then vote separately.

19 CO-CHAIR PINCUS: Yes. I would
20 suggest that we do maintain the sort of --
21 maintain alignment, that's the word people have
22 been using, that we actually have a joint

1 discussion about potential replacements for the
2 asthma measure.

3 MS. GORHAM: Okay. So if we do that,
4 we're going to pull up the specifications for
5 1800, and then I'm going to turn it over to
6 Terry, because she is the lead discussant.

7 MEMBER ADIRIM: If I may add, you
8 stole my thunder. I wrote everything down here.
9 Obviously, asthma is a very important condition
10 for the Medicaid population. It's highly
11 prevalent in both children and in adults. This
12 measure covers children and adults 5 to 64, which
13 makes it a nice measure for both measure sets.

14 There's a lot of really good evidence
15 for this particular measure, which is why it was
16 endorsed versus 1799 being unendorsed. It's also
17 a high cost condition. People with asthma have
18 frequent office visits and patient visits, and
19 controller medications reduce both emergency
20 department and inpatient admissions. So I would
21 imagine this would be very important to state
22 Medicaid agencies.

1 So I'm not sure how much more I can
2 add, but except that I'm very much for this
3 particular measure. The only downside I saw with
4 this particular measure is that as a
5 communication tool, you have to explain it, what
6 the numerator means and what the ratio means. So
7 just by looking at the measure results, you don't
8 necessarily have an idea unless you know the
9 measure. But it does have a lot of evidence to
10 back it up as a -- for the outcomes that we're
11 looking for.

12 CO-CHAIR PINCUS: I was just
13 wondering, could you say something about that
14 measure as compared to -- 1800 versus 0047?

15 MEMBER ADIRIM: I don't know 0047. I
16 recommended this one, so sorry. I mean I guess
17 Shaonna maybe.

18 CO-CHAIR PINCUS: Yeah. Helen, could
19 you maybe discuss the distinctions, because I
20 think this would be ---

21 DR. BURSTIN: Sure, as the resident
22 internist. So -- yes, so 0047 went by drug

1 class. So it for example looked at the
2 percentage of patients age 5 and older who are
3 prescribed long term control medications, and
4 first it was inhaled corticosteroids. Second was
5 other alternative, long-term control medications
6 and then total patients prescribed long-term.

7 One of the issues that the Committee
8 had when they reviewed this was a long list of
9 meds, some of which are recommended, some of
10 which really are not anymore. So I think these
11 later two measures and the numbers are actually
12 helpful here. 0047 was a very early measure
13 submitted to NQF -- literally the 47th measure --
14 and 1799 and 1800 represent newer measures NCQA
15 has recently adopted.

16 The advantage of these obviously is
17 that they do specifically give you a sense of are
18 patients getting the controller medications they
19 need, but also in comparison to the emergency
20 inhalers that they tend to use, which don't
21 actually control asthma.

22 So both of these did very well, just

1 different approaches. And 1800 I think is
2 probably the simpler of the two, since 1799 has
3 two different rates.

4 CO-CHAIR PINCUS: So Marissa I see and
5 Lindsay.

6 MEMBER SCHLAIFER: So I don't know if
7 there's too much more that needs to be said,
8 although I'll add a couple of things. So I can
9 also count this as making a motion, if that will
10 help move things along.

11 CO-CHAIR PINCUS: Okay.

12 MEMBER SCHLAIFER: Yeah, and so I
13 think when we talk about the two different
14 measures, I can also say I am not familiar with -
15 - I mean I read up on it last night, but the 0047
16 measure, it's not one that I've seen used
17 anywhere. This measure is used commonly across
18 all types of programs. I think when -- just to
19 follow up on that comment, if this one is a
20 little more -- takes a little more thought
21 because it's the ratio of controller medications
22 to rescue medications.

1 That's what we think about though when
2 we think about treating asthma. The other
3 measure, 0047, is just what percent of asthmatic
4 patients get a controller. But I think really
5 when we look at quality, we're looking at --
6 looking at people who may have problems with
7 their asthma, and not just any patient with
8 asthma.

9 So I would say for all reasons, this
10 is the better of the two. And I'd like to make a
11 motion too.

12 CO-CHAIR PINCUS: While you're at it,
13 make a motion.

14 MEMBER SCHLAIFER: I make a motion to
15 include this to the adult core measure set.

16 CO-CHAIR PINCUS: Okay. So now we
17 have a parallel set of motions, so that's good.
18 Lindsay.

19 MS. COGAN: I just kind of want to
20 echo New York State support for this particular
21 measure, and when we look at the medication
22 needed from the asthma across commercial and

1 Medicaid, we see little to no variation. When we
2 look at the asthma ratio measure across
3 commercial and Medicaid, we see 20 percentage
4 point differences. We're at 80 percent in the
5 commercial and 60 percent among our Medicaid
6 managed care with children.

7 So we have identified this is a key
8 area of the rescue to controller. So as a state,
9 we would definitely support the inclusion of
10 this.

11 CO-CHAIR PINCUS: Other comments?
12 Anybody speaking against this measure?

13 (No audible response.)

14 CO-CHAIR PINCUS: Anybody speaking to
15 recommend conditions for supporting this measure?

16 (No audible response.)

17 CO-CHAIR PINCUS: So I guess we're
18 ready to vote. I guess first the Adult and then
19 the Child?

20 MS. KUWAHARA: Yes. Bear with me for
21 just a moment. I have to do some on the fly
22 PowerPoint creation here.

1 (Pause.)

2 MS. KUWAHARA: Okay. We'll begin with
3 the Adult Task Force. This is for including
4 Measure No. 1800, Asthma Medication Ratio. Your
5 options are 1 support, 2 conditional support and
6 3 do not support. But because we didn't identify
7 any conditions, your only options are 1 support
8 and 3 do not support.

9 (Voting.)

10 MS. KUWAHARA: One hundred percent of
11 the eight voting members voted to support this
12 measure.

13 CO-CHAIR ANTONELLI: And I'm presuming
14 that the Child folks are going to weigh in on the
15 conditions, so unless somebody feels that they
16 didn't hear that, I'd like to proceed with the
17 Child folks to vote. Do we want to -- on the
18 Child side -- vote before we do the 1799 vote?

19 MS. GORHAM: So the Child Task Force
20 actually has two decisions to make. One, you all
21 will be voting for removal of 1799 and you will
22 also be voting for the addition of 1800.

1 CO-CHAIR ANTONELLI: So is it okay to
2 proceed with this vote and then we'll do 1799?
3 Okay, all right. So Child folks, we're going to
4 be voting options number 1, support, or 3, do not
5 support. Miranda, there's no conditions on this
6 one.

7 MS. KUWAHARA: That's right.

8 CO-CHAIR PINCUS: Once again, this is
9 1800, Measure 1800 we're talking about.

10 (Voting.)

11 MS. KUWAHARA: And 100 percent of the
12 13 voting members voted to support this measure.

13 MS. GORHAM: Before we move on, we
14 would like to take public comment because this
15 concludes the voting for the asthma section, but
16 we do want to entertain public comment.

17 OPERATOR: And at this time if you
18 would like to make a public comment, please press
19 star then the number 1.

20 (No audible response.)

21 OPERATOR: And there are no public
22 comments at this time.

1 MS. GORHAM: Okay, I'm sorry. I'm
2 jumping ahead of myself actually because we
3 didn't vote on the removal for 1799 for the Child
4 Task Force. So let's do that.

5 CO-CHAIR ANTONELLI: Okay. So Child
6 Task Force 1799. Can you put that on the screen
7 for consideration? So be mindful that we just
8 voted for support of 1800. So the vote before us
9 would be to recommend removal of 1799. Comments
10 or questions before we proceed to a vote?

11 (No audible response.)

12 CO-CHAIR ANTONELLI: Okay. Hearing
13 and seeing none, Miranda.

14 MS. KUWAHARA: So we're voting to
15 remove Measure No. 1799, Medication Management
16 for People with Asthma. This is for the Child
17 Task Force. Your first option is yes, you would
18 like this measure to be removed -- that's number
19 one -- or number two, you would not like to see
20 this measure removed.

21 (Voting.)

22 MS. KUWAHARA: One hundred percent of

1 the 13 voting members voted to remove 1799 from
2 the child core set.

3 MS. GORHAM: Give us one minute. We
4 are teeing up for the discussion for the Adult
5 Task Force. We need to prioritize and rank our
6 measures. Before we do that, we just want to
7 make sure that we have all of the conversation
8 for the asthma measures. So give us one minute.

9 (Pause.)

10 MS. GORHAM: It is going to take us
11 about three minutes, so if you want to step out
12 real fast and take a break, then we can do that.
13 What we are going to do -- so I can just explain
14 to you, so each year when we make recommendations
15 to CMS, we also like to rank those
16 recommendations. And so what we are doing now,
17 we're going to do the old-fashioned way of
18 ranking. We're going to use our dots like we did
19 yesterday.

20 And so the measures, you're going to
21 rank by importance, and so we will give you -- we
22 are going to pass out dots momentarily and you

1 have -- we have two -- three measures for
2 conditional support and one for support. You can
3 put your dot wherever you want. You will have
4 three dots because we have four measures.

5 Again, you can put them wherever you
6 want and then however they fall out is what we
7 will rank and send to CMS. So give us one minute
8 while we do that.

9 CO-CHAIR PINCUS: And just to point
10 out that the conditions differ among the three
11 conditionally supported ones. For the
12 contraceptive care one, the conditional issue was
13 to be used for quality improvement not payment,
14 for the CAHPS home and community-based services,
15 it was -- the concern about looking into making
16 it more readily actionable.

17 Actually, it was not conditional for
18 the adults. It was conditional for the child,
19 yes. So just to point that out. The
20 contraceptive care was not conditional for the
21 adults. Right, yeah. So one -- the home
22 community-based was conditional to look into

1 making the results more actionable, and for the
2 concurrent use of opioids and benzodiazepines,
3 that was a weighty endorsement.

4 MS. MUKHERJEE: And you can put all of
5 your three dots on one measure if you really feel
6 strongly about sort of promoting or sort of
7 ranking and sort of moving a measure up in the
8 ranks.

9 CO-CHAIR PINCUS: And the Child group
10 won't do this until tomorrow afternoon obviously.

11 (Whereupon, the above-entitled matter
12 went off the record at 2:26 p.m. and resumed at
13 2:33 p.m.)

14 CO-CHAIR PINCUS: Okay. So just to
15 announce the results of the prioritization, it
16 looks like the -- yeah, that 1800 -- the asthma
17 medication ratio -- got eight votes. The CAHPS
18 home and community-based services got seven, as
19 well as the concurrent use of opioids and
20 benzodiazepines also got seven, and the
21 contraceptive care one got five.

22 (Off microphone comments.)

1 CO-CHAIR PINCUS: No. Colors are
2 meaningless, yeah. It's yellow, so you can't see
3 it.

4 MS. GORHAM: So we had a question.
5 The colors mean nothing. It's really the number
6 of dots.

7 CO-CHAIR PINCUS: Yeah. So it was a
8 very close race.

9 MS. GORHAM: Okay. The contraceptive
10 care -- 2903 -- received five votes, okay. And
11 so just so that you will note, the Child Task
12 Force will do the same process after you all
13 discuss the rest of your measures tomorrow.

14 So with that, that concludes our
15 discussion on maternal and perinatal health, as
16 well as asthma, and we are going to move right
17 along. Actually, it puts us back on schedule, so
18 we are moving at a good pace. I'm going to turn
19 it over to Rich.

20 CO-CHAIR ANTONELLI: All right. So we
21 want to change the focus a bit, thinking about
22 supporting states' ability to report measures,

1 ways of strengthening the core sets. Sort of
2 reflecting on our presentation from our CMS
3 colleagues, not just in the morning but even the
4 commentary that you guys fed into the measure
5 discussion, thank you, and Mary from -- and now
6 actually Lindsay as well as from the front, from
7 -- whoops.

8 So thanking everybody from this --
9 from CMS and the commentary that flowed into the
10 measure discussions, the sense of reality from
11 the front lines from Mary and from Lindsay as
12 well.

13 So this portion of the conversations
14 this afternoon really is in this space, that's
15 thinking pretty strategically, but there's going
16 to be a tactical component around the ability to
17 report some of these measures. So I think
18 Debjani, you're going to take us forward a little
19 bit here.

20 MS. MUKHERJEE: Sure. So there are a
21 couple of issues that sort of the task force
22 members and our chairs brought up to be discussed

1 today during sort of this strategic reporting and
2 sort of increase in reporting discussion section,
3 and some are more methodological such as
4 stratification segmentation, and sort of looking
5 at it for QI across age groups.

6 I know this topic is very near and
7 dear to Harold, and so I'm going to ask him to
8 talk a little bit about it. The other thing that
9 we're going to also look at is alignment. Before
10 we get started, I just wanted to give you sort of
11 a brief overview of sort of the amount of
12 alignment we have right now.

13 So for the adult core set, there's
14 some alignment with the AHIP core sets and about
15 -- most of it around OB/GYN measures. So the
16 elected delivery, antenatal steroids, some of the
17 screening measures, cervical cancer screening,
18 breast cancer screening, as well as sort of acute
19 and chronic care condition, high blood pressure
20 control diabetes testing and diabetes poor
21 control, so those are the ones.

22 And then as far as alignment with

1 federal programs, for the adult side most of the
2 alignment is with PQRS and MIPS, and that's with
3 nine measures. And then on the child side,
4 there's also alignment mostly with MIPS. So I
5 just wanted to provide sort of a brief overview
6 of sort of the amount of alignment.

7 So considering that core sets are in
8 upwards of 20's and 30's, having nine to ten
9 measures aligned, it's still sort of on the lower
10 level, sort of -- the amount of alignment, the
11 potential for further alignment still lies there.
12 So I wanted to start with that, and after that
13 we're going to sort of go back to the
14 methodological.

15 But before we started this, I wanted
16 to give sort of an overview and understanding of
17 what is the level of alignment right now. We
18 know there is some between the two core sets and
19 then we have screen shared now sort of the
20 alignment of the child and also the adult. So I
21 just went over sort of an aggregate of the
22 results there. And -- we can go back to the

1 methodological slides now.

2 So as far as the methodology goes,
3 stratification is something that can happen in
4 many ways, and I just list out some of the
5 potential ways of stratifying condition groups by
6 risk, by age, by any other factor of interest, as
7 just sort of things to discuss and for you to
8 provide your input on what works and not works,
9 especially for the Medicaid population at the
10 state level, especially when we're looking across
11 adult and child and potentially trying to align
12 collection of data.

13 Then we have some questions that I'll
14 turn over to Rich for, but what we're trying to
15 get here -- especially for staff to synthesize
16 and write for the report -- is what are the
17 elements of stratification. What works? We
18 always hear about age. Is risk group something
19 that we want to sort of talk about. Maybe what's
20 the role of social determinants of health.

21 You know, we've heard a lot about that
22 today, and then also when we get to sort of the

1 issues of alignment and data collection, you
2 know, we've heard a lot of the challenges today.
3 EHR and sort of interoperability have come up and
4 sort of connecting different databases. Anything
5 else that we can sort of add to that list, as
6 well as what -- how are states getting around
7 that would be great.

8 With that, I'll turn it over to Rich
9 to start the conversation with stratification.

10 CO-CHAIR ANTONELLI: So thinking about
11 this idea about stratification within a
12 population -- in this case the population is
13 defined as recipients of Medicaid -- how do we
14 optimize it or maximize stratification based on
15 measurement, and how do we incorporate
16 stratification in the measure mechanics.

17 I think this -- I was actually pretty
18 interested to hear the narrative about an hour
19 and a half or so ago, where you were sort of
20 drawing in terms of defining how some of the
21 current data flows that you're looking at
22 actually get at a stratification, enabling you

1 and your team to identify disparities.

2 So I think that's the place that we're
3 -- that we'd like to bring the conversation right
4 now in terms of stratification, risk or other
5 types of factors that would be meaningful. So I
6 think why don't we -- well, for the sake of time,
7 can you just go to the next slide so you can see
8 what sort of some follow-on questions are going
9 to be, some of the -- some challenges.

10 So as we define some opportunities,
11 what are going to be some of the challenges going
12 forward, other types of alignments, issues that
13 states need in the near future. Life course, the
14 conversation this morning from CMS talking about
15 for a lot of maternal and infant health. They
16 see that really as a continuum, which just brings
17 joy to my heart.

18 And then how can CMS facilitate
19 alignment at the state level, getting at that
20 notion of can Karen build other connections the
21 way we have such robust performance in New York
22 and Ohio and move that forward.

1 So that pretty much frames a lot of
2 the strategic questions that we would like to
3 bring up right now. So opening this to the Adult
4 and the Child Task Force, if somebody would like
5 to start the conversation. Harold.

6 CO-CHAIR PINCUS: So it goes back to
7 something we talked about a little bit yesterday
8 in the Adult Task Force was sort of -- at least
9 my view is that there are sort of three buckets
10 of activities in a sense that quality measurement
11 gets applied to, and we tend to focus on the
12 quality improvement bucket and also on the
13 accountability bucket.

14 But there's also the sort of
15 understanding and sort of knowledge gained kind
16 of bucket, which is basically built around sort
17 of understanding variation, so that one can set
18 priorities and identify where there's problems.
19 And so I think that we kind of underplay that a
20 little bit, often in terms of -- and one way of
21 understanding variation is to look at different
22 segments of the population, whether it's urban-

1 rural or whether it's by age or whether it's by
2 certain characteristics of the population,
3 minority and ethnic status and other
4 demographics, and also by different
5 comorbidities, and also looking at it in terms of
6 the different silos of care in which people get
7 their primary attention.

8 So one thing that we've been thinking
9 a lot about lately has been around issues of
10 coordination and integration between behavioral
11 health -- between or within behavioral health and
12 general medical care, that interface there, and
13 thinking of ways by which one could address that
14 in a more effective way, looking at both -- you
15 know, from the point of view of understanding
16 what's going on but also thinking about quality
17 improvement and -- particularly around
18 coordination, but also in terms of accountability
19 types of issues.

20 So to think about people with severe
21 forms of mental illness as a kind of disparities
22 population that could be in some ways easily

1 segmented out because it's on the basis of
2 diagnosis, and in many cases you have claims data
3 that allowed you to fairly easily pull out a
4 segment of the population based upon diagnosis,
5 you know, without a lot of additional data-
6 gathering.

7 The reason for looking at it from the
8 point of view of severe and persistent mental
9 illness is because that -- those individuals,
10 that group suffers from a great deal of
11 comorbidities, as well as a number of other
12 health and social mediator-related issues that
13 result in a 10 to 20 year age gap in terms of
14 mortality, that they, you know, are more likely
15 to die 10 to 20 years earlier than the general
16 population.

17 They also represent a kind of -- sort
18 of a sentinel issue in terms of issues around
19 coordination between behavioral health and
20 general health care. It's also linked to issues
21 around accountability, because if one thinks of -
22 - you know, in terms of thinking about who is

1 accountable for the health care of individuals
2 with severe and persistent mental illness, it's
3 not clear, you know, who is responsible.

4 If I'm a psychiatrist and I have a
5 patient with schizophrenia and diabetes, am I
6 just responsible for the care of that
7 schizophrenia and the outcomes, or do I have some
8 responsibility for the outcomes for diabetes?
9 And on the other hand, what about their primary
10 care provider? To what extent did they share
11 accountability for both of those?

12 If you have an expectation of shared
13 accountability, it essentially requires that the
14 primary care provider and myself talk to each
15 other in order to coordinate care.

16 And then if one can then pull out that
17 population and look at, for example, the relative
18 degree of diabetic control or of control of
19 hypertension and so on, or the degree to which
20 they access preventive health care services as
21 compared to the general population, that gives
22 you kind of a hook to kind of look at number one,

1 setting a priority but also looking at how one
2 can improve in that, especially when there's a
3 disparity.

4 So I guess what I'm encouraging -- and
5 it's begun to do that because in fact there's an
6 earlier point in time where this came up. I
7 guess Helen stepped out. There was a question
8 about whether the -- if you're looking at a
9 segment of a denominator, does that have to be a
10 separate measure or not? And the ultimate
11 decision was that it is a separate measure.

12 And so there's actually now a number
13 of different measures that are actually pulling
14 out severe mental illness as a separate category,
15 and looking at that from the point of view of the
16 disparities population, and actually -- you know,
17 we actually have sort of an editorial under
18 review to -- with respect to that review about
19 sort of actually adding this to the National
20 Disparities Report as an example of that.

21 So I just wanted to sort of introduce
22 that notion. There's a couple of measures that

1 have been added to the adult core set that do
2 look at this, and there's a number of measures
3 that have been approved by the -- or have been
4 endorsed by the Standing Committee for Behavioral
5 Health in this area.

6 So I just wanted to sort of raise that
7 issue and to think about, you know, to what
8 extent -- and I know we had a little bit of
9 discussion about this the other day Karen, in
10 terms of like how much additional burden does it
11 add to do that, because it's not without any
12 burden, and to think about when's the best time
13 and under the best circumstances to do that.

14 DR. MATSUOKA: I would actually turn
15 it over to our state representatives here,
16 because it certainly has come from the context of
17 -- I forget which specific measures you were
18 talking about last time -- or yesterday, gosh,
19 yesterday. But certainly one of the --

20 CO-CHAIR PINCUS: Because there were
21 several of the measures that were not -- that we
22 had recommended that were not --

1 DR. MATSUOKA: That's right. Yes, and
2 among the reasons for why we didn't move forward
3 with them is because we heard from the state
4 perspective that in fact stratification is
5 essentially like having another new measure.
6 It's not as simple -- it's not as simple as it
7 may seem from the point of view of, you know,
8 typical data. You have a data set and you just
9 slice it in a different way.

10 So I would actually, you know, be
11 curious to hear from our state folks in the room
12 who would be best able to answer that particular
13 kind of question.

14 MS. COGAN: Sure, I can speak to that.
15 Harold, I know we had presented some data at a
16 behavioral health summit a couple of weeks ago,
17 where we showed some of our data stratified. So
18 we do stratify all of our quality measures by
19 things like serious mental illness. I'm going to
20 talk about this a little bit tomorrow. We're
21 going to start doing this more in the child space
22 with children with special health care needs, or

1 seriously emotionally disturbed children.

2 Stratification is one of the most
3 powerful tools that we have. It's a way of using
4 the data that you already have in the best
5 possible way, into trying to determine where the
6 needs are or where you may need to dig a little
7 deeper, or those alternative reasons why you may
8 see a lower rate in a certain population may
9 relate to something totally unrelated. But it
10 gives you that great starting point.

11 I was very strongly against having
12 separate measures that are pulling out sort of
13 the stratified population and standing them on
14 their own, because it kind of loses context. You
15 take it out of the framework of wow, this
16 population is doing so poor. You put it on its
17 own, it loses that power back to the health care
18 setting that really says hey, there's something
19 not right here.

20 So I was pretty vocal when CMS asked
21 for some of the adult Medicaid states to comment
22 on whether you should do poor control, for

1 instance, for just seriously mentally ill. We
2 were very against that. We felt it was
3 duplicative. We felt that looking through our
4 stratifications, that actually that population,
5 that wasn't where the issue was, that there were
6 other issues, and that we know that that
7 population is younger. Maybe they haven't gotten
8 there yet.

9 But we felt like having an additional
10 measure would have been -- it's just too much
11 burden. Doing the stratification would have been
12 much more powerful we felt.

13 DR. APPLEGATE: So perhaps it's no
14 surprise that states are already slicing and
15 dicing existing measures by populations and by
16 criteria to try to develop insight into what's
17 actually going on. So I think one of the
18 challenges is we actually may not be doing it the
19 same way you are, and your way might be better
20 than our way.

21 So perhaps there's some cooperation
22 that could be helpful. Once we figure out what's

1 meaningful, then that's actually when it should
2 become an official measure, particularly in the
3 context of transformation of the health care
4 delivery system. So for example, if we had
5 children, 50 percent of whom died because they
6 had a behavioral health condition, people would
7 be shrieking, absolutely shrieking. That is
8 exactly what we have with the SPMI population
9 related to cardiovascular disease and diabetes.

10 So as we're shifting and carving in
11 behavioral health services, as we're bringing our
12 behavioral health partners to value-based
13 purchasing and paying for six months of ADHD
14 care, and I'd like to do my first episode
15 psychosis -- I'm not a psychiatrist -- first
16 episode psychosis episode of care.

17 Now, we're using data and transparency
18 in this feedback loop that actually can drive
19 performance, but in order to figure out what's
20 meaningful, we actually have to do some testing
21 on the ground. So to come out first and say this
22 is the measure, you may be aiming for something

1 that's not right.

2 So a little one degree error here is
3 a 35 degree error, you know, down the road. So I
4 think we have to be super careful. We also have
5 to listen to our stakeholders. So you can slice
6 and dice your information, but when I get to the
7 community, then my numbers are so small I can't
8 do anything. In the end, what we're trying to
9 transform is care in that community.

10 So I think there are a few anxieties,
11 I suppose, about specifying exactly how
12 stratification happens when and in which context,
13 depending on what the objective is. I do think
14 the one stratification that would be helpful are
15 in areas where the measures are gargantuan and
16 the disparities are huge, and this is
17 specifically around racial disparities.

18 So we absolutely should measure the
19 most common first public health kinds of measures
20 -- infant mortality, pre-term birth -- by this
21 racial divide. Otherwise, we can't come up with a
22 plan to specifically close that gap. So since

1 that's so big, no matter what community I go to
2 in Ohio, there's a two and a half to threefold
3 difference. And until I put it in front of people
4 -- you know, even the communities that have, you
5 know, the worst issues, they actually don't quite
6 understand it until we line them up according to
7 everyone else.

8 So I do think that if there's a place
9 to start, we absolutely have to learn how to talk
10 about disparities around racial and ethnic and
11 those minority populations before we ever get
12 into diagnosis-based ones, realizing that the
13 diagnosis doesn't tell you severity.

14 CO-CHAIR ANTONELLI: Yes.

15 DR. PATTON: Yeah, so just a couple
16 of points I was going to mention. As part of the
17 group that led the development of the SMI and the
18 physical health comorbidity measures, you know,
19 the immediate driver for those was the sense of
20 health disparities around the SMI population, and
21 really trying to move the needle on diabetes and
22 cardiovascular screening and kind of get at some

1 of those mortality issues that Harold raised.

2 Sort the larger driver -- where I
3 think we have great news to report at this point
4 -- is that, you know, in looking at
5 accountability, we're also very aware of the
6 disconnect between primary care and specialty
7 care, between community mental health centers and
8 hospitals and so forth, and where that kind of
9 falls off. But we were -- we had lots of
10 conversations about the accountability issue.

11 And so CMS and SAMHSA are partnering
12 now -- along with others -- in the 223 program,
13 so the certified community behavioral health
14 clinics. So we now have a package of quality
15 measures that are being used by these clinics
16 that are involved in this program, and we're now
17 in the demonstration phase of that.

18 I think, you know, our hope is that
19 that will alleviate some of that disconnect and
20 some of the accountability around, you know, when
21 people are in the communities and some of the
22 ways to better track over time with those

1 outcomes.

2 CO-CHAIR ANTONELLI: Can I just ask
3 you to expound? When you use the word
4 accountability, are you using it in the capital
5 A, ACO sense, or small A, which means the
6 patient-family caregiver unit just wants to know
7 who the go-to entity is?

8 DR. PATTON: So our thinking, you
9 know, early on with the development of the
10 measures was the small A, and over time with the
11 context of health care and so forth it should --
12 yeah.

13 CO-CHAIR ANTONELLI: Yeah, that's
14 great. Okay. I had Clarke and then Rachel.

15 MEMBER ROSS: So I wanted to reinforce
16 Harold's observations but broaden them, and there
17 are three other entities here at the National
18 Quality Forum that demonstrate the broader
19 approach. So June 6th and 7th, the Medicaid
20 Innovation Committee meets, and who are the four
21 targeted populations?

22 People with serious mental illness,

1 people with substance use disorder, people who
2 need long-term services and supports,
3 particularly long-term -- home and community-
4 based services, and individuals with, quote,
5 complex medical needs. So that's one forum.

6 The second forum is the work group on
7 persons dually eligible for Medicare and
8 Medicaid. So we've had a committee here since
9 2011 on dually eligible people. We have a set
10 aside program in the ACA targeted to dually
11 eligible people.

12 We have demos, we have an office in
13 CMS, because a proxy for these challenges is the
14 severity and complexity of illness and poverty
15 reflected in the dually eligible population, and
16 we know who they are, or at least we can count --
17 we can identify them.

18 And then third is National Quality
19 Forum has a disparities committee, and an issue
20 that's been discussed in the last several months
21 -- I wish Helen was here -- Rich probably knows
22 Dr. Lisa Iezzoni from Harvard, who's a leading

1 disability researcher in the country, and she
2 makes the same arguments Harold just made, except
3 she uses severe disability, not severe mental
4 illness, although severe mental illness is part
5 of severe disability with paralysis, spina
6 bifida, MS, Parkinson's.

7 So the National Quality Forum is
8 obviously grappling with how to define and put
9 parameters around this complex issue. It is
10 broader than severe mental illness, but severe
11 mental illness is obviously a most unmet and
12 severe population.

13 The last point is who's responsible.
14 Like it or not, whatever the performance, every
15 state in this country has a state mental health
16 authority, and every state in this country has an
17 intellectual and developmental disability
18 authority, and that's created a lot of problems.
19 But it also is a historic recognition that those
20 two populations -- so that reinforces Harold's
21 point -- are unique and have -- require unique
22 responses, or they're so prejudiced and biased

1 against that we created these two silo state
2 systems for them.

3 But so just random thoughts about the
4 complexity in response to Harold's points.

5 CO-CHAIR ANTONELLI: Thank you. I
6 think Rachel, Diane, Deb and Karen, are you in
7 the queue? So I think you might have been. So
8 Rachel, Karen, Deb, then Diane.

9 MEMBER LA CROIX: For Florida
10 Medicaid, we primarily are often looking at our
11 performance measure data at plan level, and then
12 using our plan level data to then come up with
13 our statewide weighted rate, depending on plan
14 size for performance measures. We are not
15 running all of these measures in-house based on
16 claims and encounter data.

17 So the extent to which we could
18 stratify the data, we could do that using claims
19 and encounter data. But based on our plan-
20 reported data, we haven't really been at a point
21 where we could do that with the information
22 they're reporting. It's typically the aggregate

1 rates and it's been audited by an NCQA certified
2 auditor.

3 One new thing we are requiring plans
4 to do this year is to support that patient-level
5 data file that NCQA started having. So we will
6 be receiving that patient level data and could
7 then do some stratified analyses on our end. I
8 can't go ahead and commit resources to that. I'd
9 have to run that through my management first.

10 But that is something we'd be able to
11 do. One thing that we did take a look at, kind
12 of coming at it from the other direction -- and
13 it's interesting you brought up the SMI
14 population as an area of stratification. We do
15 have an SMI specialty managed care plan in our
16 Florida Medicaid program, and we found that they
17 actually have been performing less while on a
18 number of the mental and behavioral health
19 measures than our standard managed care plans.

20 So one thing that we have just started
21 exploring internally is looking at the
22 populations within those plans that they used for

1 those measures, and then seeing whether the
2 average risk scores for their populations are
3 markedly different, whether that's correlated at
4 all to the plan's rates for some of these
5 measures, looking at their rural versus urban
6 populations, looking at racial and ethnic make-
7 ups for those populations, specific to some of
8 those mental health measures, age breakouts.

9 We also -- since we do have an SMI
10 specialty plan, we have an SMI algorithm so we
11 can identify everyone who meets that algorithm,
12 whether they're in the specialty plan or not. So
13 also looking at within all of the plans what
14 percentage of their population for those mental
15 health measures -- meaning the eligible member
16 criteria -- what percentage meet that SMI
17 algorithm.

18 So we have been trying to drill down
19 and look at some of those things. But it hasn't
20 been looking at the varied, just a specific group
21 with a diagnosis and then how they have done on
22 different measures.

1 CO-CHAIR ANTONELLI: Karen.

2 DR. MATSUOKA: So this is just a
3 follow-up question, just to probe a little bit
4 more deeply into making -- turning the
5 recommendation into some concrete action. So
6 first I want to hear from the state folks in the
7 room, but then I also want to put it out to the
8 rest of the group too. So Lindsay if I hear you
9 right -- and maybe Mary you too -- rather than
10 calling out -- so in the adult core set we've got
11 not only the diabetes poor control measure, we've
12 got the diabetes poor control measure
13 specifically for those individuals who also are
14 SMI.

15 So if I hear you correctly, for you
16 guys it would have been preferable to just say we
17 should just have the diabetes A1c poor control
18 measure, and then maybe suggest to the states
19 that you think about stratifying by different
20 condition groups like SMI.

21 So one is I just want to make sure I'm
22 hearing that correctly. And if that's

1 preferable, I'm curious to know what that would
2 mean for you Rachel in Florida. Does it mean
3 that we would -- because you do, sounds like,
4 rely on NCQA having a spec at the plan level.
5 But you actually would want us to somewhere
6 indicate that another way to operationalize that
7 would be for you to pull NCQA 2607.

8 MEMBER LA CROIX: Yes.

9 DR. MATSUOKA: So if that's the
10 direction that we would go in, then I wonder if
11 we can throw out to the group, you know, what are
12 your all thoughts about that as an approach?

13 CO-CHAIR PINCUS: Let me just add sort
14 of an intermediate approach, which is to think of
15 it as a set of two nested measures, you know,
16 sort of the full population and then nestle it in
17 the specific population, segmented population.

18 CO-CHAIR ANTONELLI: Yes. Well I have
19 to pause for a second, because we've got other
20 comments and/or questions, and then we will be --
21 I can't wait to hear the conversation on that,
22 but I don't want to derail the people that have

1 gotten in the line. So if you can hold that
2 thought, and then our state folks and everybody
3 else get your responses ready.

4 But Deborah, then we're going to do
5 Diane, and then I actually want to get in the
6 queue, and then we'll open it up to Karen's
7 provocative thought-provoking questions. Okay.

8 MEMBER KILSTEIN: Well, my comment
9 relates to both what Rachel and Karen was asking,
10 which is stratification. A lot of it depends on
11 what is the reporting level. So for example, a
12 health plan that doesn't get race and ethnicity
13 data from their state, or has a behavioral health
14 carve-out can't report on some of these measures.
15 That has to be done at the state level. If at
16 all, it would have to be done at the state level.

17 So there are decisions that states
18 make that can, you know, decide whether or not it
19 can even be done at a plan level and rolled up,
20 or whether it can only be done at the state
21 level.

22 MEMBER CALMUS: So I think from a

1 policy perspective, this is actually really
2 desirable and something that we're seeing, you
3 know, talked about in Washington a lot, the
4 desire to kind of use this data to eliminate
5 silos and hopefully to kind of figure out what
6 non-health care, you know, social services can
7 improve health outcomes and kind of really have a
8 better way to judge and get to that data.

9 I think it's important that it's
10 really dependent on the measure, you know. For
11 some measures, looking at the rurality versus
12 urban might be very important. For others, it
13 might not be. We're seeing a lot of disturbing
14 data coming out looking at reduced life
15 expectancy in rural areas that I think, you know,
16 gets back to some of these issues.

17 It would be really helpful to have
18 some of this data separated out to be more
19 actionable, and we were talking yesterday a lot
20 about being actionable data. And so I think
21 that's a way that this could be used additionally
22 to really look at -- we talked about access to

1 maternity and OB services in rural. So you know,
2 looking at it as a way also to identify kind of
3 failures of access within the system.

4 Having this data can be really helpful
5 in making sure -- in sending information to
6 either the states or to Washington to say here's
7 where more resources are needed. So I think
8 that's another benefit for this sort of
9 stratification.

10 CO-CHAIR ANTONELLI: So I'm stepping
11 out of my role as the chair and wearing my
12 medical director hat of integrated care for
13 Boston Children's, and I want to -- this
14 perspective is coming from the delivery system
15 side, with the hope that I've got a payer that
16 basically is saying how can we do this together,
17 right. So from the delivery system side.

18 If you think about the vignette that
19 Harold articulated, a patient with schizophrenia
20 and with diabetes, we know there's fragmentation
21 there. And if that fragmentation occurs just when
22 there's multiple medical conditions, and then you

1 superimpose a behavioral health condition or two
2 and things explode.

3 So what we do on the delivery system
4 side is actually look at those -- look at the
5 data, look at the utilization and presume that
6 those patients -- the term that I use is they're
7 medically homeless. Everything is essentially
8 reactive. There's no single point of entry to
9 the system except the emergency department,
10 etcetera, but we're actually measuring in those
11 spaces.

12 So I want to bring this conversation
13 -- for me, the idea here -- and Harold teed this
14 up, QI versus accountability, capital A versus
15 small A. So how do you attack fragmentation?
16 You measure it. You can get data flows from
17 claims. We actually go to the families and
18 caregivers themselves, so we actually -- some of
19 our earliest data when we look at fragmentation
20 for these patients that have complex and multiple
21 chronic conditions actually comes from the
22 families themselves.

1 So to the degree that there's a
2 capital A opportunity, meaning that we can
3 meaningfully pull in, for example, housing, food
4 security, appropriate behavioral health capacity,
5 that is great. The slicing and dicing on the
6 quality side I also want to encourage that. I do
7 react a little bit to having a different set of
8 measures for the population, and I really like
9 the notion of let's just look at the measures
10 that we have, and then maybe decide that we need
11 to add some on top of that.

12 So that's what it feels like from the
13 delivery system side, and I do want to make the
14 final comment as -- these are not mutually
15 exclusive, right? So depending on the
16 receptivity of your Medicaid leadership, your
17 state, your region, you may start with a capital
18 A accountability and say figure it out.

19 Or you may start in the QI space, for
20 people who are sitting and scrambling like where
21 are we going to get appropriate housing
22 resources, etcetera. So I really like that

1 approach to thinking about stratification. Okay,
2 Harold had a comment. And then Karen, I'm going
3 to ask you to tee up the question that you did,
4 and then we're going to poll the group's thoughts
5 on that.

6 CO-CHAIR PINCUS: So I think there's
7 been a very productive conversation. I look
8 forward to hearing some of the responses. Just a
9 couple of responses back, I agree with Clarke
10 that, you know, part of the issue in terms --
11 especially the SMI and more broadly the disabled
12 population -- is that they do face
13 discrimination, both stigma as well as, you know
14 -- especially for people with physical
15 disabilities -- there's practical discrimination
16 in terms of accessing, you know, general medical
17 services.

18 Also for, you know, for behavioral
19 health populations, people don't want them in
20 their waiting rooms. They also have, you know,
21 poor health hygiene. The medications they take
22 can interfere with or in some ways exacerbate the

1 conditions they have. So it really requires some
2 kind of coordination.

3 The issue of carve-outs is kind of an
4 interesting issue because, you know, ultimately
5 to get adequate care for these populations, the
6 carve-outs have to talk to the med-surg plans,
7 and that's -- you know, either they have to be an
8 integrated plan or there has to be some way by
9 which they communicate about their populations so
10 there can be an overall population management.

11 That's some ways -- you know,
12 depending on how things are set up with the
13 state, that's partly something to build into
14 contracts, you know, with both the carve-outs and
15 the med-surg plans or, you know, within the so-
16 called integrated plans, because integrated plans
17 are not so integrated often, you know, as you see
18 those.

19 But I think one of the really
20 important things is the actionability. I think
21 that having this sort of segmentation really
22 enhances the actionability to be able to use that

1 to pinpoint where the problems are. You know,
2 both at a population level but also begin to
3 understand what actually are some potential ways
4 to fix things.

5 I mean is it -- and just -- to even
6 just put it down at a clinical level, I mean is
7 the problem with my sort of patient with
8 diabetes, is it the fact that I'm not at all
9 encouraging that individual to adjust their diet
10 or to inquire, from my point of view, about how
11 they've been sort of utilizing their -- you know,
12 utilizing their insulin levels, adjusting their
13 insulin levels, or for that matter maybe it's up
14 to me to adjust the anti-psychotic medication, so
15 that it's less likely to cause metabolic
16 disturbances, and to be in touch with their
17 primary care provider with regard to what I'm
18 doing, so that there is a kind of joint strategy.

19 But like I said, it also goes up in
20 terms of how my practice at an organizational or
21 clinical level, what kind of information am I
22 getting back. What kind of relationships exist

1 between the CMHCs and the FQHCs in order to share
2 information to grease referral pathways and
3 things like that. What kind of obligations are
4 put in place at the managed care plan level in
5 terms of that sharing of information, that
6 sharing of efforts around quality improvement?

7 So you know, it sort of forces a lot
8 of actions to respond by maintaining this kind of
9 sort of longitudinal follow-up on the data around
10 this segmentation.

11 CO-CHAIR ANTONELLI: Thank you. Okay,
12 Karen. You ask the question again and then
13 people, I'd love to have you riff on your
14 thoughts with that.

15 DR. MATSUOKA: So in a nutshell -- and
16 if we were to just use the Alc control measure as
17 an example, we have an Alc control measure for
18 anyone who has diabetes. But then to kind of be
19 a gauge for this behavioral health integration,
20 we also added in Measure 2607 for the 2017 core
21 set which specifically looked at Alc control for
22 those individuals with diabetes who also happen

1 to have a serious mental illness.

2 So the question becomes, you know, is
3 it better to just have the global A1c measure,
4 and then suggest -- encourage states to stratify
5 it by different kinds of, you know, condition
6 groups or population groups? Or do we call out a
7 separate measure, which seems to be the NQF way
8 as well, which also happens to be the method that
9 states who really depend on their health plans to
10 submit aggregated data to the state would most
11 likely be reporting these kinds of measures, or
12 is there some kind of hybrid approach?

13 MS. COGAN: I mean, I would agree with
14 the hybrid approach. So I think where we stand
15 is not having a separate measure to stratify the
16 existing measure. The way that we do our
17 stratification -- and Rachel we do the same thing
18 that you're thinking of doing -- we've been
19 collecting patient level data from our health
20 plans for years.

21 Taking that Medicaid ID and linking it
22 back to our enrollment and eligibility, and then

1 we know things like race, age, region. We can
2 look at their entire claims history, run a very
3 simple algorithm to pull out SMI diagnoses,
4 right, and we'd be happy to share that and spread
5 that and have everybody do that, if they have
6 those internal resources.

7 But it is resource intensive. So I
8 think a hybrid approach would probably be the
9 best. I just worry that going down this path of
10 having separate measures, when does it end,
11 right? So you put one out there for SMI. So IDD
12 is next. Medically fragile children are right
13 behind them, and then foster kids are here too.

14 So it just -- you're already at 27.
15 So let's use what we have to the fullest ability
16 before we start tacking on additional measures
17 would be our suggestion.

18 CO-CHAIR ANTONELLI: So what's the
19 piece, Lindsay, of the hybrid component that's
20 attractive?

21 MS. COGAN: Because if a state like
22 Florida cannot pull together internally to

1 stratify what comes in from the health plans,
2 you're essentially doing the same thing. So if
3 you have the leverage to gather that from the
4 health plans and pull in a separate measure for
5 individuals with SMI, you're essentially doing
6 the same thing.

7 At our state, we aren't going to add
8 another measure -- another hybrid Measure 411 on
9 top of the plans. We're just not going to do it.
10 So we're not going to report that measure. We're
11 going to stratify the one we have.

12 CO-CHAIR ANTONELLI: Yeah. But I
13 guess I'm just trying to figure out the hybrid
14 component from the state Medicaid perspective.
15 The status is you're going to use the measures
16 that you have and stratify?

17 MS. COGAN: Yes. I think the hybrid
18 approach I'm talking about is across other
19 states. It's not within my state.

20 CO-CHAIR ANTONELLI: Okay. Oh okay,
21 okay. You've brought that up.

22 (Simultaneous speaking.)

1 MS. COGAN: But so if I wanted to do
2 it my way and Florida wanted to do it their way,
3 we're still getting to the same -- I think we're
4 still getting to the same path, which is you want
5 to look at this measure by individuals, serious
6 mental illness.

7 CO-CHAIR ANTONELLI: Thank you.

8 MS. COGAN: Fair enough, yeah. Sorry.
9 It's doing hybrid.

10 CO-CHAIR ANTONELLI: Okay, Mary.

11 DR. APPELEGATE: So not to make things
12 more complicated, but your diagnosis by itself is
13 not necessarily the only variable that gets you
14 to a terrible outcome, for example. So one of
15 the things that we're doing in our stratification
16 process is we actually look at the -- we do the
17 linkage that you talked about, and then in the
18 claims history we actually have an algorithm for
19 what counts for uncoordinated care, and it's
20 those people with the diagnosis that actually we
21 need to target.

22 So the measure itself, stratified by

1 SPMI, is not enough. It's the people who
2 actually have no indication of coordination in
3 care. So if all of their claims only come from
4 the CMHC, we're in trouble. If they only come
5 from the physical health side of the world, we're
6 in trouble. If they have inpatient stays either
7 utilization, kind of five pharmacies and six
8 different prescribers, we're actually in trouble.

9 So our slicing and dicing also gets to
10 the context. So that's actually what we need to
11 develop a plan for how do you systematically get
12 people better is focus on the folks who are most
13 likely to do poorly, and in our system it ends up
14 being those who actually don't seem to be
15 connected in any kind of logical way.

16 CO-CHAIR ANTONELLI: Looking for
17 fragmentation. Yes.

18 DR. PATTON: Yeah. I was just going
19 to say, you know, the long view for the measures
20 -- for the SMI physical health comorbidity
21 measures was certainly not that they would be
22 needed, you know, forever. I mean the real hope

1 in developing those measures was that health care
2 would catch up, that that population -- the
3 health disparities would be reduced and that
4 would -- we wouldn't need it to be separated.

5 I'll give you just a quick example.
6 There's an NQF measure, depression with a suicide
7 screen. So it's a similar kind of issue in that,
8 you know, most of us working in mental health
9 would anticipate if you have a client with
10 depression, you'd screen for suicide. That
11 doesn't always happen.

12 So it's about driving the standard of
13 care, because over time what we would hope is
14 that any person presenting with a diagnosis of
15 depression would also have an accompanying
16 suicide screen. And so that it would just become
17 standard practice, and there would no longer be a
18 need to measure that because no one would ever
19 think about working with someone with depression
20 without assessing for suicidality.

21 CO-CHAIR PINCUS: Just one comment
22 actually to Mary. Lisa Kern from Weill Cornell

1 actually has a grant from the Commonwealth to
2 actually develop different ways of looking at
3 fragmentation in terms of care, and she's
4 actually sort of testing out different
5 alternative models. Actually Larry Costello and
6 I are both sort of on the grant as well.

7 (Pause.)

8 CO-CHAIR ANTONELLI: Okay. I think
9 we're good. Okay. I think we're about to get to
10 the slide that talks about a public comment.
11 Operator, could you see if anybody would like to
12 weigh in for public comment please?

13 OPERATOR: If you would like to make
14 a public comment, please press star 1 on your
15 telephone keypad.

16 (No audible response.)

17 OPERATOR: And we currently have no
18 public comments at this time.

19 CO-CHAIR ANTONELLI: Okay.

20 CO-CHAIR PINCUS: Wait. Can we have
21 that open for a few more seconds?

22 OPERATOR: Of course. Again, if you

1 would like to make a public comment, press star
2 1.

3 (Pause.)

4 (No audible response.)

5 CO-CHAIR ANTONELLI: Public comments
6 in the room?

7 (No audible response.)

8 OPERATOR: No public comments on the
9 phone.

10 CO-CHAIR ANTONELLI: Okay, Miranda.

11 MS. KUWAHARA: All right, everyone.

12 Here we have our next steps. Tonight, our Adult
13 Task Force will be leaving us and we'll continue
14 tomorrow with our Child Task Force. We have on
15 the screen a timeline of what's coming up. Some
16 highlights for you all.

17 We have public comment on our draft
18 report July 7th through August 6th, and then we
19 have our MAP Coordinating Committee. It's to be
20 determined. It will be some time in August, and
21 then final reports will be submitted to CMS
22 August 31. We will expect CMS to issue its

1 annual update to the Medicaid adult and child
2 core sets late 2017.

3 Here we have listed the NQF project
4 staff if you ever need to reach out to us. All
5 of you may contact us directly on the Committee
6 SharePoint site. Our contact information is
7 listed there, and then our project contact
8 information is listed on this slide. We have
9 separate email addresses for both adult and
10 child, and you can always visit our project page
11 for any meeting materials. All right.

12 CO-CHAIR PINCUS: So I just -- so I
13 just want to really thank actually the NQF staff
14 for their really sort of remarkable ability to
15 keep things organized and to provide us with the
16 information we need, and to sort of keep on
17 moving us ahead. I also want to thank the CMS
18 staff, in terms of it's really been I think an
19 excellent partnership in terms of moving this
20 agenda ahead, and certainly, you know, with
21 representatives from the states that are so well
22 informed and active. It's really good to have

1 that as part of this as well.

2 I want to thank the members of the
3 Adult Task Force. I mean, we did a lot of work
4 and got a lot done, and you know, we really had
5 very good discussions, and I think that helped
6 inform the process going forward. So thank you
7 all.

8 DR. MATSUOKA: And I just want to join
9 in and also thank the great NQF staff, all of
10 you, the Adult Task Force members before you
11 leave, you know. Thank you very much. But a
12 special shout out to Harold. Thank you so much
13 for chairing the Adult Committee very gracefully
14 and keeping us on time. So thank you Rich.

15 MS. MUKHERJEE: Staff definitely would
16 like to thank our Chairs.

17 (Applause.)

18 MS. MUKHERJEE: Because without our
19 Chairs, we would pretty much be a ship without a
20 captain. So thank you.

21 CO-CHAIR ANTONELLI: All right.

22 (Simultaneous speaking.)

1 CO-CHAIR ANTONELLI: And to remind the
2 Child Task Force here that we're only halfway
3 done actually in a journey that will last
4 decades, but that's why we do the work we do.
5 The Adult Task Force, it's really gratifying to
6 actually sit in a room and look for the
7 similarities rather than always looking for the
8 differences. So thanks to the Adult Task Force.

9 So I'm actually going to go in reverse
10 order, just because it's different and it feels
11 fresh. To CMS, thank you for the opportunity of
12 this partnership. I'm mindful of tremendous
13 pressures on Medicaid in general, and yet we're
14 sitting in this room pruning out measures that
15 don't really fit the bill.

16 Hearing from the front lines of
17 Medicaid leadership, we need better measures. I
18 didn't get a sense in today's entire conversation
19 that we should take our foot off the gas pedal.
20 I'm grateful for that, and I'm proud of the
21 leadership that we saw today and the vision of
22 CMS and our state leaders.

1 Then finally NQF, you guys are
2 absolutely phenomenal. So thanks for making this
3 really hard job actually easy enough for a simple
4 PCP to do.

5 MS. GORHAM: I want to echo all the
6 thanks, but I made the joke earlier that
7 yesterday, we ended at 4:03, and perhaps we would
8 end at 3:59. But actually you all were so
9 fantastic today that we're actually ending at
10 3:25. So if you don't mind, then, definitely you
11 are free for the day and again, thank you. We'll
12 see the Child Task Force tomorrow.

13 CO-CHAIR PINCUS: Thank you.

14 (Whereupon, the above-entitled matter
15 went off the record at 3:25 p.m.)
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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Measure Application Partnership
Medicaid Adult and Child Task Force

Before: NQF

Date: 05-24-17

Place: Washington, DC

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