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 APPLEGATE, 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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P R O C E E D I N G S

9:03 a.m.

MS. MUKHERJEE: Hi, welcome everybody. My name's Debjani Mukherjee. I'm the senior director for the Medicaid Adult and Child Core Set Project here, and this morning we are -- I'm glad and happy to have our CEO Shantanu Agarwal here to say some welcoming remarks, and then we'll get started with our day two for Medicaid Combined Adult and Child Program. Shantanu.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

We fully expect that as an

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. BURSTIN: Again, if you have any

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

MEMBER BEATTIE: I have no disclosures.

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

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

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

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

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

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

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

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

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

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

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

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

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

CO-CHAIR ANTONELLI: Rich Antonelli,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The measure recommended for removal

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

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

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

And also particularly we're

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

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

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

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

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

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

We learned that there was some

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

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

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

further development of priorities.

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

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

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

So this is a kind of a crowd sourcing

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

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

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

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

CO-CHAIR PINCUS: Okay.

MS. RANEY: Thanks.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

So with that, the next slide is about

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

better.

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

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

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

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

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

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

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

Next, and this is what has happened to

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

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

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

There's been massive reform in Ohio to try to contain costs, and that's actually one of the reasons that we're supporting managed care, so you can manage the budget better, and then you can put all the requirements into a structure. So here's the maternity core set, and of the three core sets that we're talking about, this is the one that I actually have least issues with, because it actually is most closely aligned with what clinicians need to do and what patients actually need.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

plan level as well.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

So go ahead. So this is a measure of

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

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

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

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

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

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

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

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

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

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

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

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

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

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

and behavioral health issues.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

to it as well.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

not appreciate that.

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

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

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

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

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

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

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

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

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

DR. APPLEGATE: Yeah, sorry about that.

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

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

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

FEMALE PARTICIPANT: Yes, yes.

CO-CHAIR ANTONELLI: Okay, Clark.

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

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

MEMBER ROSS: Okay, and then the

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

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

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

In our CPC and primary care

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

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

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

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

and decisions that go around that?

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

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

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

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

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

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

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

the list.

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

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

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

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

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

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

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

DR. APPLEGATE: So we have looked at

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

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

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

for example.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

So we have to figure out ways to get

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

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

We have had a contraceptive access

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

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

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

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

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

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

So I'd like to look at the core set

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

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

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

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

Next slide. So I just wanted to share

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

brief highlight. It's available on our website.

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

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

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

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

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

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

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

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

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

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

CO-CHAIR ANTONELLI: Mary, and then

Sue.

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

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

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

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

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

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

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

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

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

So that reminder is actually really

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

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

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

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

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

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

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

compare it back to a prior year.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

So we have the chlamydia screening

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

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

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

and maternity care across the child and adult core set.

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

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

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

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

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

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

So if you'd take a minute and pull out

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

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

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

(Off microphone comments.)

MS. GORHAM: Also if you look on the

web page.

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

(Off microphone comments.)

MS. NACION: MAP Medicaid Discussion Guide.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Next slide. Okay. We can go to the

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

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

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

MEMBER SAKALA: I just want to add one

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

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

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

making the measure selection decisions.

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

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

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

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

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

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

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

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

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

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

(Off microphone comment.)

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

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

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

CO-CHAIR PINCUS: Other thoughts? Deborah.

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

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

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

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

CO-CHAIR PINCUS: Yeah.

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

So that was the first kind of big red

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

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

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

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

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

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

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

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

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

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

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

(Off microphone comment.)

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

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

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

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

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

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

(Off microphone comment.)

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

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

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

CO-CHAIR PINCUS: Deborah, and then Marissa.

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

an option.

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

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

CO-CHAIR PINCUS: Marissa.

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

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

to answer that that's fine.

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

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

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

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

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

CO-CHAIR PINCUS: Sue.

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

CO-CHAIR PINCUS: Is there a second?

MEMBER SCHLAIFER: I'll second.

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

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

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

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

(Off microphone comment.)

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

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

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

Sue?

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

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

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

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

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

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

(Off microphone comments.)

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

(Voting.)

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

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

MS. KUWAHARA: There we go.

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

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

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

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

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

things that I think we really want to be learning.

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

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

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

CO-CHAIR PINCUS: All right, Terry.

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

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

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

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

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

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

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

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

CO-CHAIR ANTONELLI: Yes Andrea, go ahead.

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

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

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

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

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

CO-CHAIR PINCUS: Deborah.

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

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

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

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

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

CO-CHAIR PINCUS: Mary.

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

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

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

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

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

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

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

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

(Off microphone comment.)

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

CO-CHAIR ANTONELLI: Any seconds?

Kim.

DR. ELLIOTT: I second that motion.

CO-CHAIR ANTONELLI: Okay. Discussion? So there was a pretty robust discussion about conditions. We don't have to have that, but I feel for the sake of some degree of continuity, we at least need to have it raised in the context of 1391.

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

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

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

(No audible response.)

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

mute.

MEMBER BENIN: Correct.

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

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

MEMBER BENIN: Thank you.

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

(Voting.)

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

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

(Voting.)

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

(Voting.)

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

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

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

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

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

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

MS. KUWAHARA: Sure.

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

(Voting.)

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

CO-CHAIR ANTONELLI: We're good?

MS. KUWAHARA: Yes.

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

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

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

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

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

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

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

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

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

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

MEMBER BENIN: I see.

CO-CHAIR ANTONELLI: Okay, Carol.

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

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

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

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

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

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

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

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

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

MEMBER BENIN: Except it's measuring

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

DR. APPLEGATE: Correct, correct, correct.

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

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

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

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

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

CO-CHAIR ANTONELLI: So hold on --

MEMBER BENIN: I can imagine --

CO-CHAIR ANTONELLI: Andrea, just --

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

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

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

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

ahead.

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

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

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

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

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

measuring is not what Dr. Applegate wants.

CO-CHAIR ANTONELLI: Other comments? You guys count, too.

(No audible response.)

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

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

CO-CHAIR ANTONELLI: Sure. Please articulate it.

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

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

know.

(Off microphone comments.)

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

CO-CHAIR ANTONELLI: So the adults --

MEMBER POOLE-YAEGER: Conditional removal.

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

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

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

MEMBER ADIRIM: I second.

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

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

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

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

MEMBER BEATTIE: Kathryn.

CO-CHAIR ANTONELLI: Kathryn.

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

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

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

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

I'm very happy to entertain that.

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

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

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

MEMBER POOLE-YAEGER: Okay.

CO-CHAIR ANTONELLI: 1517.

MEMBER POOLE-YAEGER: Yes.

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

saying down there?

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

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

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

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

(No audible response.)

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

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

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

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

(Voting.)

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

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

MEMBER BENIN: Thank you.

(Voting.)

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

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

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

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

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

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

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

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

CO-CHAIR PINCUS: We already did that

yesterday.

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

MEMBER BENIN: No, I'm all set.

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

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

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

CO-CHAIR ANTONELLI: Okay, good.

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

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

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

CO-CHAIR ANTONELLI: Thank you.

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

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

CO-CHAIR ANTONELLI: Thank you, thank you.

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

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

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

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

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

Those are the specs as they stood in

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

PARTICIPANT: Nope.

DR. BURSTIN: Is anyone using them?

(Off microphone comment.)

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

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

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

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

CO-CHAIR ANTONELLI: Okay, Kim.

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

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

CO-CHAIR ANTONELLI: Okay. Amy.

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

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

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

CO-CHAIR ANTONELLI: Thank you. Mary?

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

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

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

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

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

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

CO-CHAIR ANTONELLI: Deborah.

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

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

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

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

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

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

motion? Yes, go ahead please.

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

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

MEMBER LA CROIX: I will second.

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

(No audible response.)

CO-CHAIR ANTONELLI: Ready to vote.

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

(Voting.)

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

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

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

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

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

Operator, if you can open the line please?

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

(No audible response.)

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

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

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

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

LARC measure.

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

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

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

(No audible response.)

MS. GORHAM: Okay.

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

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

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

MS. GORHAM: All right. Let's go

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

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

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

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

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

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

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

Does the measure support efficient use

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

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

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

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

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

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

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

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

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

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

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

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

So we have the two PC05, the exclusive

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

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

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

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

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

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

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

We weren't quite sure the extent to

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

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

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

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

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

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

MEMBER KILSTEIN: That was the reason for my question.

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

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

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

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

CO-CHAIR PINCUS: Rachel.

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

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

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

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

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

MEMBER LA CROIX: Okay.

MS. DANIEL-ROBINSON: All right.

CO-CHAIR PINCUS: Sue.

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

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

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

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

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

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

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

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

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

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

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

MEMBER KENDIG: I'll second.

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

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

were not brought into the core sets should be reconsidered.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

So what is -- has never been answered

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

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

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

out a problematic messaging and problematic programming.

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

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

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

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

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

CO-CHAIR PINCUS: Mic.

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

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

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

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

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

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

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

of determination on that.

It's the rate of the women who received the services within the year. However, what you can do in terms of interpretation would be to take local level data or national level data, depending on how you're -- how you want to analyze the data.

But you take another instrument that provides the unintended risk, you know, the unintended pregnancy risk, and that is what you use to determine whether or not there is unmet need in terms of access.

So that interpretation guide that's on the maternal and infant health page actually goes into how you can look at that. But the raw rate in and of itself does not give you all of the information.

CO-CHAIR PINCUS: Kathryn and then Mary.

MEMBER BEATTIE: The answer to my question may be somewhere in this discussion but maybe someone can clarify it for me, which is how

do we know from claims data that a woman 15 to 44 is truly at risk for unintended pregnancy, and it's similar to what Andrea on the phone is saying, which is how are we getting to that population? I'm not understanding how we exclude those who are -- it would not be an unintended pregnancy.

And so are they just -- we're assuming oh, they're in the 15 percent if our goal is 85 percent, or are we looking at a gap in some data? That just seems like an advanced level of evaluation that most people aren't going to make in looking at state to state, right? And we're supposed to be respecting cultural components in these, and I do see practicing now in Idaho and Utah that this may have some real concerns for populations in our states. I just don't understand how we're getting to that definition in the denominator.

MS. DANIEL-ROBINSON: I think, again in terms of interpretation, using your example at the local level, the unintended risk there might

be different.

So one of the ways that we talk about in the interpretation guide is to look at the National Survey of Family Growth, that gives percentages. I mean you have to use something, right, to determine what's the percentage at risk and that survey is one of the ways to do it.

But I understand that there are also local, local instruments that provide that same kind of information. So it's -- again, I don't think that this measure is ever intended to be 100 percent of anything, or it's intended to be zero. But it's a -- it's a way to look at the range of services that are provided, and so --

MEMBER BEATTIE: I'm just not -- I'm sorry. I'm not understanding how we're getting at accurate data to even meet the measure. So how -- is there a code where I define --

MS. DANIEL-ROBINSON: Unintended pregnancy is not -- there isn't a code for unintended pregnancy in claims. I will say another thing about the measure.

It's being specified for electronic versions, and so in the future you actually will get the unintended piece more accurately because a question could be inserted into the electronic record that will ascertain the women's reproductive health plans.

But at this point with the claims data, no, you won't have the precise assessment about what her risk or intentions are.

MEMBER BEATTIE: So it might be premature to try and build this -- I absolutely agree with the intention of improving access to contraceptive care that's effective. But I'm just concerned as to whether we're able to today build a metric that actually measures what we're looking to measure.

CO-CHAIR PINCUS: Okay. Let's hear from a few other people. Mary and Roanne, do you have a question? Okay, and Kim, and then we also -- the senior project manager for the standing committee that reviewed the endorsement actually may have some comments. Available now or --

MS. GORHAM: Suzanne.

MS. THEBERGE: Yes, hi. The committee did discuss pretty extensively these questions around percentages and us getting at whether pregnancy is intended or unintended, and I think -- I don't know how much of the report from that project folks reviewed. Some of that discussion happened around some of the other two measures in the sets.

But you know, just wanted to re-echo that it was very clear that these are about access. It's never intended to be 100 percent. They're more looking to ensure that women who are interested in accessing contraceptive methods can do so and that it's not some kind of systemic blockage.

There was actually some discussion; I was just checking the notes, and there was some discussion about the fact that yes, there are particular religious denominations that don't want to use contraception, but -- or that may be counseled against, but they are -- many of them

actually are using contraception.

So I just want to flag that the committee did discuss these topics pretty intensively.

CO-CHAIR PINCUS: Mary.

DR. APPLEGATE: Okay. So just the practical piece of things. We have women at high risk for pre-term birth. Spacing pregnancies is a very effective strategy. The uterus has to recover. So the ultimate measure we're trying to get to is inter-pregnancy interval for high risk women.

Unless there's a measure for effective contraception, there would be maybe no way to do it. So for example Ohio did not participate because under DRGs, no one's going to do an $800 kit for the same cost of the entire delivery. So virtually our chances were zero, even if they were high risk -- high risk deliveries. So I just want to mention that.

And then in terms of intentionality, there have been tons of surveys. The PRAMS

survey is probably one of the more common ones. But the surveys actually indicate in some communities the unintentional pregnancies are 50 to 70 percent, and the use of the contraception might be less than ten percent.

So that just tells us we have an access problem. So the measure is intended to drive whatever you need to do in your state or your system to ensure that we provide the services that people, again the patient-centered piece, that people think will work for them.

So we know for teenagers, they can't think about a pill every single time. There may be people in their household who have opinions about whether or not that's a good thing. There's a respect for privacy and for dignity that actually results in youth and people with special chronic conditions, some of the disabled population, that actually prefer LARCs for example.

And there was virtually zero chance in Ohio postpartum. If you wanted one, you actually

could not get one. So the measure is actually in some ways a process measure, trying to get to inter-pregnancy intervals for high risk women. So I think it's very important though to make sure you understand that there is a gap, and essentially we're emotionally neutral.

But I can tell you if we eventually get to the point of doing our measures by disparate populations, we'll be able to make sure that everyone knows that we're keeping track of it. So this is about availability of very effective, you know, medication and intervention that actually can really help long-term outcomes.

CO-CHAIR PINCUS: So I have --

MEMBER BENIN: Can I ask -- could I ask a question about that comment? Would that be okay?

CO-CHAIR PINCUS: Okay. But I just want to say that I have Roanne, Amy, Kim, and Sue in line. Okay, Andrea?

MEMBER BENIN: You want me to ask? Okay. You want to me to ask? Okay.

CO-CHAIR PINCUS: Yeah.

MEMBER BENIN: So I just would -- it would be helpful for me to understand how having the feds indicate that this metric is on the list makes a difference for the state's, you know, desire to do what needs to be done around contraception. I think clarification of that.

I will also just comment that we do have the postpartum contraception metric on the list, which I understood that that was because of that interval issue. So a little clarification, because I think that comment was really important. I just want to make sure I understand it.

DR. APPLEGATE: Yeah. So from my perspective, this is Mary again -- from my perspective, the immediate postpartum one is super-important because you've already proven that the mother is super-high risk because she's got this baby in the NICU, right, although admittedly at that time, if you're worried your baby's going to survive or not, that might not be

a time that you're okay with waiting.

The message that we've had in Ohio, even for LARCs, is that we'll take them out whenever you want. It just -- the clinicians just don't care if they take them out. So that's the other piece of it is the messaging around no, you can't have it taken out, I mean there are a whole bunch of women. I think it was less than ten percent, but there was still a number of women who actually had them taken out in the three to nine month period or so.

The other measure gets to the front end, which is my comments about the disabled and young, very young mothers. So preventing or delaying the age of their first pregnancy is directly tied not just to outcomes, but also to poverty. So if that's something that they want, it's very, very difficult to actually try to be able to have that.

So in essence it really is a measure of access for this very specific part of reproductive health services.

CO-CHAIR PINCUS: So Roanne.

MS. GORHAM: Before Roanne, can you give me one minute? I just want to, we have a new face at the table. So if you will allow me to just introduce Dr. Lindsay Cogan from New York state. So please feel free to weigh into the conversation as we have it.

MEMBER OSBORNE-GASKIN: So I just wanted to echo Mary's point that unintended pregnancies may be -- so I was thinking specifically of the teens. So the teenagers who definitely -- that is a group that you definitely don't want an unintended pregnancy, and that the age group actually may have to go a little bit younger than 15 to address that.

And so I could understand them having problems with access to care across all, you know, ethnic groups or, you know, all women. So even if the measure was a little more focused, as you said you know, to disabled population or teen pregnancy or something like that, I think that would be definitely focusing the measure a little

bit better than just --

CO-CHAIR PINCUS: Kim.

DR. ELLIOTT: A lot of what I was going to say has already been said, but I don't think it's an access measure. I do think it's a process measure like Mary said. I also think that if we're going to get to the point of doing measurement on this across states that a lot of states are very competitive and want to have the highest rates in most of the measures.

My concern would be comparing like a Utah to a California or a New York, and how that may appear in a report that goes to Congress or something like that, like Utah would be failing when it's really a cultural or personal opinion on use of birth control or birth control methods. So I think we just need to be very cautious on that.

CO-CHAIR PINCUS: Amy.

MEMBER POOLE-YAEGER: Yeah. I think mainly what everybody's been saying. My, you know, my first reaction when I hear this is like

oh my gosh, somebody's going to tell me that I've got to get, you know, the rate up to whatever.

And so but I'm new to the Committee. So I don't, you know, when we approve it and it goes to CMS, I mean some of the words are oh, will it be even included in payment strategy and blah blah blah blah.

So I think that maybe some of the angst is around, you know, do we have any direction about, you know, with our approval, saying that it definitely would not be something that you -- I mean you said it's in a document, but I mean how does that make -- how do we make sure that it doesn't get used inappropriately when -- does that make sense, you know? That would make maybe me feel better too.

MS. DANIEL-ROBINSON: And I would probably say that that's a concern for many measures. You know, once it's out in that sphere, there is a loss of control from the owner.

So it's really on to -- on the user.

Again, our recommendation would not be to use certain measures in that way. It should not be like a pay for performance type approach to get to X, get level. Like that's -- that would never be our recommendation for this type of measure.

But again, I don't know how one would control that. I mean so whether or not it appears on the core set, it is in existence. It is NQF-endorsed and could very well be used incorrectly.

CO-CHAIR PINCUS: Sue and then Helen.

MEMBER KENDIG: You know, the coercion argument comes up each time, and I think it's important to remember also that having no evidence of offering a method is also -- could also be construed as a coercive behavior. So I think we also -- I think we need to balance that argument with the flip side.

With regards to the comment about having the postpartum measure, you know, this may be one way to get to appropriate content, as evidence of appropriate content in that

postpartum or maternal or well woman visit as well, because certainly for women's health care providers, all of these reproductive life planning is something that's included. In my view, this is capturing -- this is one method of capturing appropriateness of what is included in that care.

CO-CHAIR PINCUS: So Helen, and then hopefully we're ready to vote on both the child and the adult sides after this.

DR. BURSTIN: Great. Just one quick comment. Again, since you are MAP, consideration of payment and the way the measures are applied are completely within your purview. So there's nothing that says we couldn't capture some of this discussion, just to make you feel comfortable that this is about the measure and its potential appropriateness for inclusion in this program.

But we could certainly include and will certainly include some of the dialogue around how the measure could be used or would be

used around payment.

DR. MATSUOKA: And just to underscore I think what Helen just mentioned, but also Lekisha with regard to use, just a reminder that these core set measures -- and this MAP task force is somewhat unique and different from other MAP groups that you might be on, where you're talking about measures that are going to be done through rulemaking, that are going to be required and perhaps payment attached to it.

That's not this. These are state level measures that are used for quality improvement purposes only, not payment.

CO-CHAIR PINCUS: And is a voluntary program. Okay. I think we're ready to vote. So do you want to do the Adults first and then the child? Okay. So Miranda, you want to set that up?

MS. KUWAHARA: No problem. Let's see. So Andrea, we are asking the question should Measure No. 2903, Contraceptive Care, Most and Moderately Effective Methods, be added to the

adult core set. Your options are 1 support, 2 conditional support, or 3 do not support.

CO-CHAIR PINCUS: Okay, and so --

Okay. So just on the adult side, just to say, has anybody put forward any conditions for support? Because if we do vote for conditional support, we have to say what the conditions are. So nobody has put forward any conditions. Okay. So we're really voting for support or do not support. Okay.

MS. KUWAHARA: All right. Adult Task Force, feel free to submit your responses.

We're waiting on -- there we go. 63 percent of the eight members voted to support this measure for the adult core set.

CO-CHAIR PINCUS: Okay. 63 percent, so the measure --

MS. KUWAHARA: Yes.

CO-CHAIR PINCUS: So the measure gets support, okay. Rich, do you want to take it for the child?

CO-CHAIR ANTONELLI: Yeah. I guess I

want to ask the question about adding conditions, because the conversation up to now has included both the adult and the child. So we're focusing on the child task force. Does anybody want to put forth a condition for this measure? Yes. Lean into the microphone please.

MEMBER RICHARDSON: I apologize. I'm not entirely certain how to word this, but I do think some nuance could be created around the denominator, how you define it. Is it just all women of this age or could we be more accurate about the -- who are we measuring this for?

MEMBER POOLE-YAEGER: Can I have -- just I'm sorry I'm new, so I'm just asking details here. So is this just going to be conditions to the measure itself, or as you mentioned, you know, how the measure is used? Can we put a condition on how the measure is used? We could, yeah.

So I would propose that we, you know, that maybe we would have a motion to approve this with the condition that we very clearly state the

use cases where we think, you know, where they think this should be for quality improvement and not in a payment methodology or with no particular benchmark or goal in mind.

CO-CHAIR ANTONELLI: Okay. Does that meet what you were promoting, Amy?

MEMBER POOLE-YAEGER: Yes.

CO-CHAIR ANTONELLI: Yes, okay. So should I take that as a motion for a condition attached to this vote?

MEMBER POOLE-YAEGER: Yes, I will make that motion.

CO-CHAIR ANTONELLI: Okay, and so Shaconna and team, do we vote on the condition before we vote on the measure, or do we --

CO-CHAIR PINCUS: You will vote 1, 2, 3.

CO-CHAIR ANTONELLI: So we're going to do all three?

CO-CHAIR PINCUS: Yes.

MS. GORHAM: And tell me what the condition is again one more time, just so I have

it clear for the record. Just so I have it clear. Rich, you can summarize for me if you want.

CO-CHAIR ANTONELLI: Yeah. So basically the -- your proposal is to accept the measure, but with specification of how the measure will be implemented, right? So it doesn't change the measure. It talks about the implementation or the use. I think you used the term "use cases."

MEMBER POOLE-YAEGER: Use cases, right.

CO-CHAIR ANTONELLI: So basically it involves how it gets implemented and potentially the data is interpreted, right?

MEMBER POOLE-YAEGER: Correct.

CO-CHAIR ANTONELLI: It doesn't change the measure.

MEMBER POOLE-YAEGER: Right, no. You know, I think we're probably stuck with the denominator as it is, so but if we don't use it for payment, we can kind of --

CO-CHAIR ANTONELLI: Yeah.

MEMBER POOLE-YAEGER: Does that make sense?

CO-CHAIR ANTONELLI: Okay. Staff, is that okay?

MS. GORHAM: Yes, we got it.

CO-CHAIR ANTONELLI: Okay. So child task force, we're going to be voting this, and there are three options. So Miranda, do you want to take us through this please?

MS. KUWAHARA: That's right. This is Measure No. 2903, Contraceptive Care Most and Moderately Effective Methods. We have three voting options. Number one, support for inclusion. Number 2, conditional support or number three, do not support. You may now cast your votes.

Correct.

CO-CHAIR PINCUS: With the condition. Support means no condition, yes. Carol.

MEMBER SAKALA: So what if the favorable votes are divided among the first two

categories? How does that -- does it roll up to something? Rolls up to conditional? Yeah down, okay. Thank you.

MS. KUWAHARA: And we are still waiting on one more vote. We have Andrea's. Okay, perfect. 15 percent of the 13 voting members voted to support the measure; 62 percent voted to conditionally support this measure; and 23 percent voted to not support this measure.

DR. BURSTIN: Conditionally support.

MS. GORHAM: So we actually have two more measures to discuss. BMI might take up more time, but we actually have two more recommendations for the child task force, and that is 0480 and 2830. Of course one again is the paper measure, the other e-measure, and that recommendation for the PC05 exclusive breast milk feeding was made by Carol.

MEMBER SAKALA: Just a point of clarification. Our spreadsheet actually had a third number suggesting that really those are both one in the same and should be considered

together; is that correct?

MS. GORHAM: That is, and Suzanne is still on the phone, so Suzanne correct me if I state this inappropriately. But the measure, the way we number here at NQF, you have the parent measure and those two metrics fall below, underneath that parent measure, and you're talking about 0341. It is just the number system, but Suzanne, weigh in please.

MS. THEBERGE: Yes. It has to do with the e-measure paired measure matching system.

MEMBER SAKALA: Can't we consider them together because we learned during our standing committee work that they were essentially the same measure, just different opportunities for collection?

MS. GORHAM: So then when -- after you all discuss, we can vote on that one measure number.

MEMBER SAKALA: Okay.

CO-CHAIR ANTONELLI: So open up.

MEMBER SAKALA: So I proposed this one

again, and it has been supported through three National Quality Forum consensus development process rounds, and last year, as Sean from ACOG said, it got 91 percent support by our Committee. I understand from NQF staff that that's kind of an outlier level of support, so it's very, very strong.

And then the e-measure, as we just discussed, is identical, but to facilitate more collection options. Last year the child task force recommended that this be added to the child core set, and CMS did not add this one, but we have the opportunity now to reconsider. I feel that this is really foundational.

I mean I would have expected this to go in the first year of the child core set personally because it's preventive, because it's relevant to a very large proportion of the maternal and infant population, because it has the potential to advance health equity and has been used to really take populations in certain facilities where they have fairly low historic

rates of breast feeding and support, provide the support and show significant improvement.

Also, constantly in my mind is what we're learning about the developmental origins of health and disease, the human microbiome. This is like really important for lifelong health and has benefits for both the child and the woman, and I have -- I think I have it here.

It's old and it's being updated, but the AHRQ AHIP evidence report from 2009, systematic review for children, reduces risk of otitis media, non-specific gastroenteritis, severe lower respiratory tract infection, atopic dermatitis, asthma, obesity, Type 1 and Type 2 diabetes, childhood leukemia and SIDS, and for women, reduced risk of Type 2 diabetes, breast and ovarian cancer, and I think they are looking now at some of the studies that have come out since then around cardiovascular health and other things.

This to me is such a big win measure, and helps us to not avoid problems that we might

otherwise deal with in this program. It is supported by ACOG, and the national average was 53 percent, and people have said it could be closer to 70 percent, 70 to 80 percent, in that range. Again, we don't have a benchmark but we do know that there's a wide variation and a lot of opportunity for improvement.

As far as federal and other national programs, it's used in the -- I wasn't quite clear on this, but read hospital inpatient quality reporting, the EHR incentive program. It's a measure in the CMS and AHIP core quality measures collaborative OB/GYN core set. It's in the Joint Commission Perinatal Care core set and collected by all hospitals with 300 or more births, and publicly reported in quality check and in CalHospitalCompare, which impacts about one birth in eight in the country.

So again, this was a topic where concerns with coercion were raised, but I would share with you that almost everybody around our very large standing committee table has

experienced at the point of care, and this was not a big concern, and nine in ten supported it.

So I think there's a certain kind of reassurance that we can take away from that, and again the fact of not ever expecting 100 percent is -- often allays concern.

We would have preferred a downstream measure later on. I personally like exclusive breast feeding at six months. That's standard. I'd like to really go for that. But we have difficulties with collection, and I can assure you that the provider community will be complaining because they would say there are so many things they don't have control over.

So that is a good reason to choose this tried and true, established measure that is a precursor to downstream success. So I propose that we shouldn't let the perfect get in the way of the good here, and address these powerful benefits to -- that could accrue to the Medicaid population. Thank you.

CO-CHAIR ANTONELLI: All right. Let's

open -- Carol, thank you, open this for comments. I want to remind people that we're considering the e-measure 2830, along with the paper measure for the sake of time efficiency. So open for comments, questions.

MEMBER POOLE-YAEGER: So I will just echo your passion for the benefits of breast feeding and how this is core to improving health, particularly breast feeding rates in Medicaid are lower than in commercial populations. So we know that there's a gap there. I think the -- this is sort of a hospital measure, right.

So the hospitals are going to have it. They're going to get it. I think it's important to say that it's important and again I'm sorry, I'm new, so I keep asking all these questions. But is putting it on the Medicaid core set, it's going to put the burden on the Medicaid agencies to report it, even though the hospitals are reporting it? I don't know.

I'm just trying to think about the burden for the states to try to get it, you know,

and is the value worth it if Joint Commission is already sort of pushing them?

I would love to say that we would have more effort around how do we capture breast feeding outside of the hospital as well. Can we do something around it? So I don't think I have an answer, but that was just some comments.

MEMBER KILSTEIN: The question is how would the state collect it from the hospitals for just the Medicaid population? I mean if it's a population -- if it's a hospital-based measure and it's for all population, how are they going to collect it for just Medicaid? Just a question. I mean maybe somebody could answer that in terms of the collection.

DR. APPLEGATE: So this is Mary. Perhaps I can address that, you know. It's 2017. Pretty much every state should be linking Medicaid claims with vital stats.

CO-CHAIR ANTONELLI: Right.

DR. APPLEGATE: So we've got to get out of the dark ages. This is directly from

vital stats, and so if we're doing our linkage which is better than 90 percent, we actually will have the data. So that opens up all of those fields. We might also suggest that one reason it doesn't get coded now is we didn't have a code in ICD-9. But I believe in ten, in ICD-10 we actually do. I don't know if it's exclusive or not. I'd have to look it up.

But what gets coded is also what gets paid, right. So I think even though this is a hospital measure, you heard me comment about how in Medicaid I'm not as interested in in-hospital processes. However, the decision to breast feed is made before you deliver. So now we're back into the outpatient arena. It is supported or discouraged by hospital practices and policies.

So at our hospital, we're in a rural hospital. We have 80 percent breast feeding rates, which is actually pretty amazing. But I can tell you every single nurse is almost a lactation consultant in and of themselves, and the amount of time they spend to support the

women is amazing.

So the hospitals absolutely are present at a very critical time to provide that support, particularly if those services are also available after they leave the home, and then can continue to be supported in the pediatric or general practice.

CO-CHAIR ANTONELLI: Thank you. So Karen, should I move you ahead of Lisa, because you want to respond directly to this.

DR. MATSUOKA: Just a little bit of --

CO-CHAIR ANTONELLI: Okay. So Karen and then I want to go to Lisa, and then we'll come over to Lindsay.

DR. MATSUOKA: So my only comment is that yes, we're in 2017, but Mary, Ohio, you guys are way ahead of the curve on so many things, and this is one area where you definitely are, I think. So I just want to put that out there, and you know, Rachel, I don't know if you want to say what Florida would be able to report on this measure. I'm not sure.

But the other thing I just wanted to add is that to this issue of, you know, where data is being collected and maybe reported elsewhere, I think Marsha and I just had a conversation at one of our breaks to see, you know, what we might be able to do at the federal level to source that data, so it doesn't -- so that we can do some of the data feedback to the states and not have to have the data be coming from the state.

But I think, you know, that's just a conversation we started literally today. So hopefully this time next year we'll have more to report back. But my sense is that many states are not yet at where Mary is in Ohio.

CO-CHAIR ANTONELLI: Okay, Lisa.

DR. PATTON: Thank you. Yeah, so this is kind of more of an in the weeds measurement question, and in the interest of time we don't have to get into it if we don't have time.

But I was curious about with the

exclusions, if there was consideration of looking at the mom's health and so adverse outcomes during the delivery that might impede breast feeding. So I just didn't know whether there had been consideration of those kinds of exclusions as well, and probably a low rate event but --

MEMBER SAKALA: So I can say that exclusions that are listed on the -- I'm looking at them in both places. Newborns who are admitted to the NICU, newborns transferred to an acute care facility, and newborns who die during the hospitalization, and there's always -- with measure development, there's always a tension between all of the little things you can add on and the burden of doing that.

I think one of the trade-offs is we're going to decide nowhere are we going to go near 100 percent to make it a feasible measure to collect.

CO-CHAIR ANTONELLI: Lindsay.

MS. COGAN: Thank you, and I'm sorry I was a little bit late today.

CO-CHAIR ANTONELLI: Yeah. I was just going to say can you just take a moment to introduce yourself, and then you can go right to your comment.

MS. COGAN: Sure, yes. So my name is Lindsay Cogan. I am the division director for the Division of Quality Measurement of the New York State Department of Health, and I'm a quality measurement subject matter expert and in charge of most of our reporting on the adult and child core set that New York does to CMS.

So I was excited to hear both Deborah and Amy's question come up, because it's often one that percolates back at the state. You know, why are we being asked to look at a facility-based measure yet again in another way, and Mary, I appreciate your comments. We do link vital stats with our Medicaid claims data. Now our vital stats data is old, doesn't come to us for two years. It's not timely, you know.

You've got 19-1/2 million people in New York. It takes a while to process the

information. So it's not actionable at that point for us. So what we do is we do report it using vital stats.

Breast feeding exclusively in the hospital is so poorly reported when we validate that against the medical record that it's not an area that we've been pushing as we have other areas within the birth certificate that we really want to capture, like previous pre-term and other high risk markers of future or subsequent pre-term or low birth weight.

So I do -- I do kind of echo that sentiment, that if we're already collecting this at the facility level, where is our actionable piece. So is it really that we want to tease out Medicaid only and then go back to a facility and tell them where they need to work, or is that confusing when a facility is already working on a measure for us to intervene as a state agency, and give them yet another number that doesn't jibe with what they're already reporting to the Joint Commission.

CO-CHAIR ANTONELLI: Thank you. Amy, and then Mary, is your card up again? Okay, Amy.

MEMBER RICHARDSON: Yes, thank you. So as a pediatrician, I might get drummed out of the tribe for raising questions, but here's what came to my mind and please don't understand or misunderstand. Completely agree with the health benefits of breast feeding. I'm not sure this is the measure and let me see if I can articulate why.

Indeed, there is evidence that long-term breast feeding affects development and health. I'm not sure there's any evidence that two to four days, which is all this is measuring, somewhere between two and four days of breast feeding changes health outcomes.

I think that the measure we really have to figure out how to get to is two things: the actually actionable piece, which is what's going on with the OB/GYNs and nurse midwives during the prenatal phase, because that's what really influences what you do after the baby's

born, and then the long-term piece.

I say that because it went round and round in my immediately past job with hospitals, who wanted us to support all kinds of incentives and so forth for them meeting this, and had many a person tell me from the hospital perspective off the record that they had already figured out how to game the data. So we can do it, but our -- be sure we're getting what we think we want.

CO-CHAIR ANTONELLI: Uh-huh. Terry.

MEMBER ADIRIM: Well, I am speaking on behalf of the American Academy of Pediatrics and I agree with you, and I'm a pediatrician. It is a very important measure concept.

I think we need to be working towards promoting long-term breast feeding, but to Karen's point earlier about real estate on the core set, I think if it's not a measure that's going to get us to that longer-term breast feeding, that it may not be worth that precious real estate because if you look at the data, women who breast feed in the hospital, not that

many continue breast feeding.

So I would advocate for -- I hate saying it, but not putting this particular measure on the core set, and look for better measures.

And again, we grappled with this in the military health system, because we really wanted to put this on our pediatric dashboard. But for the reasons that you cite and for all kinds of others, we really wanted to look at measures that are longer-term and the problem with that is that the data's not reliable by documentation. So that's my opinion.

CO-CHAIR ANTONELLI: Rachel.

MEMBER LA CROIX: I would just like to echo a couple of the other comments mentioned and Florida to our vital statistics data, and the certificate data is sometimes delayed by about two years also and has a lag. So there are delays in our being able to report on some maternal and child health status indicator measures.

Also, our adult core set group yesterday discussed a lot of difficulties with the antenatal steroids measure, which I think was a similar hospital-based measure already being reported by the hospitals, but difficult to look at at a specifically Medicaid, and from our Florida Medicaid perspective, most of our population is on managed care. So we're also looking for measures that are valuable at a health plan level, not just at a state Medicaid level as well, and it's difficult to get to that with some of these hospital-based measures.

MEMBER BENIN: I have a comment. This is Andrea.

CO-CHAIR ANTONELLI: Andrea, go ahead.

MEMBER BENIN: I would just like to strongly agree with Amy and Terry. While, you know, breast feeding is one of the most important things we can do for children, this metric does not get us I think where we need to be as far as really understanding that.

In addition, there are lots of reasons

why exclusive breast feeding, you know, may not be feasible but yet successful breast feeding might ultimately be feasible.

I would rather have us acknowledge a gap in getting to a really good breast feeding metric. So I would agree with them. Thank you.

CO-CHAIR ANTONELLI: Okay. So I am going to raise the vote here. I'll start by asking if, because we have to first decide if we're going to include conditional support in this. So I'm not asking you to say you want to support, but do we want to put a condition on there so we're voting against three choices versus two.

MS. GORHAM: And before we do that, let me just be very clear. Because CMS has already told us that the addition of an e-measure is a different form of reporting, we don't need to vote on both of the measures, so we will only vote on one.

CO-CHAIR ANTONELLI: So would anybody like to propose a condition?

(No audible response.)

CO-CHAIR ANTONELLI: Okay. So that means Miranda, we're voting on two choices here, please.

(Pause.)

MS. KUWAHARA: So just to reiterate one last time, this is for Measure No. 0480, PC05, Exclusive Breast Milk Feeding. This also encompasses e-measure No. 2830 and it's all under the parent measure number 3041. This is all one vote. We are going to vote for two options. One is support and three is do not support. Child task force members, you can cast your votes.

85 percent of the 13 respondents voted not to support this measure.

CO-CHAIR ANTONELLI: We'll open up for public comment. Operator, why don't we open up to the lines first and then we'll give people a chance in the room here to come up to the microphone.

OPERATOR: At this time, if you would like to make a public comment. Please press star

then the number one.

(No audible response.)

OPERATOR: And there are no public comments from the phone line.

CO-CHAIR ANTONELLI: Thank you. Public comments from the folks in the room here?

(No audible response.)

CO-CHAIR ANTONELLI: Okay.

MS. GORHAM: All right. I think we're going to power through and not take a break, but definitely if you need to step out and take a break, please do so. But I want to be respectful of time. I know that we have some adult members who would like to make their plane and trains on time. So we're just going to keep on with our asthma conversation, and I want to go rather quickly but definitely stop me if I am moving a little too fast or there are questions.

This before you is the summary slide for the asthma measures. We did a search and were found 12 total measures in the asthma universe, five endorsed, seven not endorsed.

Five of those seven not endorsed measures are PQMP measures.

Next slide. So I'll give you an update on just some of the maintenance and loss of endorsement in the asthma arena, if you move to the next slide. 1799, which is currently on the child core set, lost endorsement in 2016. It was recommended by the adult task force members for a few years but never added.

Next slide. Here is again a slide that you can also find in your chart packs, to just kind of tell about the median percent of children ages 5 to 20 remain on asthma control medication for at least 75 percent of their treatment period. Sixteen states did not report this measure, and some of those reasons include, again, budget constraints. MCOs are not required to submit this HEDIS measure. State-collected information on this HEDIS measure for use of inappropriate medication for people with asthma, the states report on in all age bands in the combined rate.

Those are just a few of the reasons not reported. Again, you can find a comprehensive list in the material that was sent to you before the meeting.

Next slide, next slide. So to get to the reasons that endorsement was removed from this measure, the Pulmonary and Critical Care Standing Committee noted concerns over the evidence, especially with a study noting inaccuracy in the data analysis, as well as with the long list of allowable medications.

They pointed out that the measure does not address whether patients are getting the correct medications for their particular type of asthma. The Committee and the CSAC then reviewed the measure and could not reach consensus. We went to -- the CSAC 60 percent rate in order to approve the measure for endorsement was not achieved, and so the endorsement was removed.

So again, in 2014, 2015 and 2016, this measure was recommended by the adult task force. Because endorsement was removed, you can move to

the next slide, was removed from this measure, CMS asked the staff to do an analysis on alternative ambulatory setting asthma measures, and we did that, and we also sent that to you pre-meeting in your material.

In doing that analysis to address the gap, if in fact the task force votes to remove and CMS removes that measure, we found two measures, 0047 and also 1800. So 0047, the Pharmacological Therapy for Persistent Asthma, and then 1800, Asthma Medication Ratio. The similarities of both 0047 and 1800, they both address prescribing patterns and not medication adherence, while 1799 addressed patient adherence to prescribing asthma medication.

Both 0047 and 1800 have comparable target populations and promote the use of long-term asthma control or medications. There is widespread use in both public reporting and quality improvement programs, and if we move to the next slide.

So just to add a little bit more

information about the two measures, 0047, measure stratification captures information related to prescription type. 1800 focuses on a ratio, making it easier to identify patients who may have inappropriate prescription treatment plans, and then also 1800 is identical to 1799 in target population, data source, and level of analysis, making the reporting burden minimal for states that have experienced reporting on 1799.

So that was pretty quick, but that gives you a little summary of the analysis that we completed on those two measures in relation to 1799. I will turn it over to Harold. I will say if we want to kind of take the same strategy we took with the maternal and perinatal health, we do have a recommendation for 1800. So we can have that lead discussant talk about 1800, then have a joint discussion and then vote separately.

CO-CHAIR PINCUS: Yes. I would suggest that we do maintain the sort of -- maintain alignment, that's the word people have been using, that we actually have a joint

discussion about potential replacements for the asthma measure.

MS. GORHAM: Okay. So if we do that, we're going to pull up the specifications for 1800, and then I'm going to turn it over to Terry, because she is the lead discussant.

MEMBER ADIRIM: If I may add, you stole my thunder. I wrote everything down here. Obviously, asthma is a very important condition for the Medicaid population. It's highly prevalent in both children and in adults. This measure covers children and adults 5 to 64, which makes it a nice measure for both measure sets.

There's a lot of really good evidence for this particular measure, which is why it was endorsed versus 1799 being unendorsed. It's also a high cost condition. People with asthma have frequent office visits and patient visits, and controller medications reduce both emergency department and inpatient admissions. So I would imagine this would be very important to state Medicaid agencies.

So I'm not sure how much more I can add, but except that I'm very much for this particular measure. The only downside I saw with this particular measure is that as a communication tool, you have to explain it, what the numerator means and what the ratio means. So just by looking at the measure results, you don't necessarily have an idea unless you know the measure. But it does have a lot of evidence to back it up as a -- for the outcomes that we're looking for.

CO-CHAIR PINCUS: I was just wondering, could you say something about that measure as compared to -- 1800 versus 0047?

MEMBER ADIRIM: I don't know 0047. I recommended this one, so sorry. I mean I guess Shaconna maybe.

CO-CHAIR PINCUS: Yeah. Helen, could you maybe discuss the distinctions, because I think this would be ---

DR. BURSTIN: Sure, as the resident internist. So -- yes, so 0047 went by drug

class. So it for example looked at the percentage of patients age 5 and older who are prescribed long term control medications, and first it was inhaled corticosteroids. Second was other alternative, long-term control medications and then total patients prescribed long-term.

One of the issues that the Committee had when they reviewed this was a long list of meds, some of which are recommended, some of which really are not anymore. So I think these later two measures and the numbers are actually helpful here. 0047 was a very early measure submitted to NQF -- literally the 47th measure -- and 1799 and 1800 represent newer measures NCQA has recently adopted.

The advantage of these obviously is that they do specifically give you a sense of are patients getting the controller medications they need, but also in comparison to the emergency inhalers that they tend to use, which don't actually control asthma.

So both of these did very well, just

different approaches. And 1800 I think is probably the simpler of the two, since 1799 has two different rates.

CO-CHAIR PINCUS: So Marissa I see and Lindsay.

MEMBER SCHLAIFER: So I don't know if there's too much more that needs to be said, although I'll add a couple of things. So I can also count this as making a motion, if that will help move things along.

CO-CHAIR PINCUS: Okay.

MEMBER SCHLAIFER: Yeah, and so I think when we talk about the two different measures, I can also say I am not familiar with -- I mean I read up on it last night, but the 0047 measure, it's not one that I've seen used anywhere. This measure is used commonly across all types of programs. I think when -- just to follow up on that comment, if this one is a little more -- takes a little more thought because it's the ratio of controller medications to rescue medications.

That's what we think about though when we think about treating asthma. The other measure, 0047, is just what percent of asthmatic patients get a controller. But I think really when we look at quality, we're looking at -- looking at people who may have problems with their asthma, and not just any patient with asthma.

So I would say for all reasons, this is the better of the two. And I'd like to make a motion too.

CO-CHAIR PINCUS: While you're at it, make a motion.

MEMBER SCHLAIFER: I make a motion to include this to the adult core measure set.

CO-CHAIR PINCUS: Okay. So now we have a parallel set of motions, so that's good. Lindsay.

MS. COGAN: I just kind of want to echo New York State support for this particular measure, and when we look at the medication needed from the asthma across commercial and

Medicaid, we see little to no variation. When we look at the asthma ratio measure across commercial and Medicaid, we see 20 percentage point differences. We're at 80 percent in the commercial and 60 percent among our Medicaid managed care with children.

So we have identified this is a key area of the rescue to controller. So as a state, we would definitely support the inclusion of this.

CO-CHAIR PINCUS: Other comments? Anybody speaking against this measure?

(No audible response.)

CO-CHAIR PINCUS: Anybody speaking to recommend conditions for supporting this measure?

(No audible response.)

CO-CHAIR PINCUS: So I guess we're ready to vote. I guess first the Adult and then the Child?

MS. KUWAHARA: Yes. Bear with me for just a moment. I have to do some on the fly PowerPoint creation here.

(Pause.)

MS. KUWAHARA: Okay. We'll begin with the Adult Task Force. This is for including Measure No. 1800, Asthma Medication Ratio. Your options are 1 support, 2 conditional support and 3 do not support. But because we didn't identify any conditions, your only options are 1 support and 3 do not support.

(Voting.)

MS. KUWAHARA: One hundred percent of the eight voting members voted to support this measure.

CO-CHAIR ANTONELLI: And I'm presuming that the Child folks are going to weigh in on the conditions, so unless somebody feels that they didn't hear that, I'd like to proceed with the Child folks to vote. Do we want to -- on the Child side -- vote before we do the 1799 vote?

MS. GORHAM: So the Child Task Force actually has two decisions to make. One, you all will be voting for removal of 1799 and you will also be voting for the addition of 1800.

CO-CHAIR ANTONELLI: So is it okay to proceed with this vote and then we'll do 1799? Okay, all right. So Child folks, we're going to be voting options number 1, support, or 3, do not support. Miranda, there's no conditions on this one.

MS. KUWAHARA: That's right.

CO-CHAIR PINCUS: Once again, this is 1800, Measure 1800 we're talking about.

(Voting.)

MS. KUWAHARA: And 100 percent of the 13 voting members voted to support this measure.

MS. GORHAM: Before we move on, we would like to take public comment because this concludes the voting for the asthma section, but we do want to entertain public comment.

OPERATOR: And at this time if you would like to make a public comment, please press star then the number 1.

(No audible response.)

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

MS. GORHAM: Okay, I'm sorry. I'm jumping ahead of myself actually because we didn't vote on the removal for 1799 for the Child Task Force. So let's do that.

CO-CHAIR ANTONELLI: Okay. So Child Task Force 1799. Can you put that on the screen for consideration? So be mindful that we just voted for support of 1800. So the vote before us would be to recommend removal of 1799. Comments or questions before we proceed to a vote?

(No audible response.)

CO-CHAIR ANTONELLI: Okay. Hearing and seeing none, Miranda.

MS. KUWAHARA: So we're voting to remove Measure No. 1799, Medication Management for People with Asthma. This is for the Child Task Force. Your first option is yes, you would like this measure to be removed -- that's number one -- or number two, you would not like to see this measure removed.

(Voting.)

MS. KUWAHARA: One hundred percent of

the 13 voting members voted to remove 1799 from the child core set.

MS. GORHAM: Give us one minute. We are teeing up for the discussion for the Adult Task Force. We need to prioritize and rank our measures. Before we do that, we just want to make sure that we have all of the conversation for the asthma measures. So give us one minute.

(Pause.)

MS. GORHAM: It is going to take us about three minutes, so if you want to step out real fast and take a break, then we can do that. What we are going to do -- so I can just explain to you, so each year when we make recommendations to CMS, we also like to rank those recommendations. And so what we are doing now, we're going to do the old-fashioned way of ranking. We're going to use our dots like we did yesterday.

And so the measures, you're going to rank by importance, and so we will give you -- we are going to pass out dots momentarily and you

have -- we have two -- three measures for conditional support and one for support. You can put your dot wherever you want. You will have three dots because we have four measures.

Again, you can put them wherever you want and then however they fall out is what we will rank and send to CMS. So give us one minute while we do that.

CO-CHAIR PINCUS: And just to point out that the conditions differ among the three conditionally supported ones. For the contraceptive care one, the conditional issue was to be used for quality improvement not payment, for the CAHPS home and community-based services, it was -- the concern about looking into making it more readily actionable.

Actually, it was not conditional for the adults. It was conditional for the child, yes. So just to point that out. The contraceptive care was not conditional for the adults. Right, yeah. So one -- the home community-based was conditional to look into

making the results more actionable, and for the concurrent use of opioids and benzodiazepines, that was a weighty endorsement.

MS. MUKHERJEE: And you can put all of your three dots on one measure if you really feel strongly about sort of promoting or sort of ranking and sort of moving a measure up in the ranks.

CO-CHAIR PINCUS: And the Child group won't do this until tomorrow afternoon obviously.

(Whereupon, the above-entitled matter went off the record at 2:26 p.m. and resumed at 2:33 p.m.)

CO-CHAIR PINCUS: Okay. So just to announce the results of the prioritization, it looks like the -- yeah, that 1800 -- the asthma medication ratio -- got eight votes. The CAHPS home and community-based services got seven, as well as the concurrent use of opioids and benzodiazepines also got seven, and the contraceptive care one got five.

(Off microphone comments.)

CO-CHAIR PINCUS: No. Colors are meaningless, yeah. It's yellow, so you can't see it.

MS. GORHAM: So we had a question. The colors mean nothing. It's really the number of dots.

CO-CHAIR PINCUS: Yeah. So it was a very close race.

MS. GORHAM: Okay. The contraceptive care -- 2903 -- received five votes, okay. And so just so that you will note, the Child Task Force will do the same process after you all discuss the rest of your measures tomorrow.

So with that, that concludes our discussion on maternal and perinatal health, as well as asthma, and we are going to move right along. Actually, it puts us back on schedule, so we are moving at a good pace. I'm going to turn it over to Rich.

CO-CHAIR ANTONELLI: All right. So we want to change the focus a bit, thinking about supporting states' ability to report measures,

ways of strengthening the core sets. Sort of reflecting on our presentation from our CMS colleagues, not just in the morning but even the commentary that you guys fed into the measure discussion, thank you, and Mary from -- and now actually Lindsay as well as from the front, from -- whoops.

So thanking everybody from this -- from CMS and the commentary that flowed into the measure discussions, the sense of reality from the front lines from Mary and from Lindsay as well.

So this portion of the conversations this afternoon really is in this space, that's thinking pretty strategically, but there's going to be a tactical component around the ability to report some of these measures. So I think Debjani, you're going to take us forward a little bit here.

MS. MUKHERJEE: Sure. So there are a couple of issues that sort of the task force members and our chairs brought up to be discussed

today during sort of this strategic reporting and sort of increase in reporting discussion section, and some are more methodological such as stratification segmentation, and sort of looking at it for QI across age groups.

I know this topic is very near and dear to Harold, and so I'm going to ask him to talk a little bit about it. The other thing that we're going to also look at is alignment. Before we get started, I just wanted to give you sort of a brief overview of sort of the amount of alignment we have right now.

So for the adult core set, there's some alignment with the AHIP core sets and about -- most of it around OB/GYN measures. So the elected delivery, antenatal steroids, some of the screening measures, cervical cancer screening, breast cancer screening, as well as sort of acute and chronic care condition, high blood pressure control diabetes testing and diabetes poor control, so those are the ones.

And then as far as alignment with

federal programs, for the adult side most of the alignment is with PQRS and MIPS, and that's with nine measures. And then on the child side, there's also alignment mostly with MIPS. So I just wanted to provide sort of a brief overview of sort of the amount of alignment.

So considering that core sets are in upwards of 20's and 30's, having nine to ten measures aligned, it's still sort of on the lower level, sort of -- the amount of alignment, the potential for further alignment still lies there. So I wanted to start with that, and after that we're going to sort of go back to the methodological.

But before we started this, I wanted to give sort of an overview and understanding of what is the level of alignment right now. We know there is some between the two core sets and then we have screen shared now sort of the alignment of the child and also the adult. So I just went over sort of an aggregate of the results there. And -- we can go back to the

methodological slides now.

So as far as the methodology goes, stratification is something that can happen in many ways, and I just list out some of the potential ways of stratifying condition groups by risk, by age, by any other factor of interest, as just sort of things to discuss and for you to provide your input on what works and not works, especially for the Medicaid population at the state level, especially when we're looking across adult and child and potentially trying to align collection of data.

Then we have some questions that I'll turn over to Rich for, but what we're trying to get here -- especially for staff to synthesize and write for the report -- is what are the elements of stratification. What works? We always hear about age. Is risk group something that we want to sort of talk about. Maybe what's the role of social determinants of health.

You know, we've heard a lot about that today, and then also when we get to sort of the

issues of alignment and data collection, you know, we've heard a lot of the challenges today. EHR and sort of interoperability have come up and sort of connecting different databases. Anything else that we can sort of add to that list, as well as what -- how are states getting around that would be great.

With that, I'll turn it over to Rich to start the conversation with stratification.

CO-CHAIR ANTONELLI: So thinking about this idea about stratification within a population -- in this case the population is defined as recipients of Medicaid -- how do we optimize it or maximize stratification based on measurement, and how do we incorporate stratification in the measure mechanics.

I think this -- I was actually pretty interested to hear the narrative about an hour and a half or so ago, where you were sort of drawing in terms of defining how some of the current data flows that you're looking at actually get at a stratification, enabling you

and your team to identify disparities.

So I think that's the place that we're -- that we'd like to bring the conversation right now in terms of stratification, risk or other types of factors that would be meaningful. So I think why don't we -- well, for the sake of time, can you just go to the next slide so you can see what sort of some follow-on questions are going to be, some of the -- some challenges.

So as we define some opportunities, what are going to be some of the challenges going forward, other types of alignments, issues that states need in the near future. Life course, the conversation this morning from CMS talking about for a lot of maternal and infant health. They see that really as a continuum, which just brings joy to my heart.

And then how can CMS facilitate alignment at the state level, getting at that notion of can Karen build other connections the way we have such robust performance in New York and Ohio and move that forward.

So that pretty much frames a lot of the strategic questions that we would like to bring up right now. So opening this to the Adult and the Child Task Force, if somebody would like to start the conversation. Harold.

CO-CHAIR PINCUS: So it goes back to something we talked about a little bit yesterday in the Adult Task Force was sort of -- at least my view is that there are sort of three buckets of activities in a sense that quality measurement gets applied to, and we tend to focus on the quality improvement bucket and also on the accountability bucket.

But there's also the sort of understanding and sort of knowledge gained kind of bucket, which is basically built around sort of understanding variation, so that one can set priorities and identify where there's problems. And so I think that we kind of underplay that a little bit, often in terms of -- and one way of understanding variation is to look at different segments of the population, whether it's urban-

rural or whether it's by age or whether it's by certain characteristics of the population, minority and ethnic status and other demographics, and also by different comorbidities, and also looking at it in terms of the different silos of care in which people get their primary attention.

So one thing that we've been thinking a lot about lately has been around issues of coordination and integration between behavioral health -- between or within behavioral health and general medical care, that interface there, and thinking of ways by which one could address that in a more effective way, looking at both -- you know, from the point of view of understanding what's going on but also thinking about quality improvement and -- particularly around coordination, but also in terms of accountability types of issues.

So to think about people with severe forms of mental illness as a kind of disparities population that could be in some ways easily

segmented out because it's on the basis of diagnosis, and in many cases you have claims data that allowed you to fairly easily pull out a segment of the population based upon diagnosis, you know, without a lot of additional data-gathering.

The reason for looking at it from the point of view of severe and persistent mental illness is because that -- those individuals, that group suffers from a great deal of comorbidities, as well as a number of other health and social mediator-related issues that result in a 10 to 20 year age gap in terms of mortality, that they, you know, are more likely to die 10 to 20 years earlier than the general population.

They also represent a kind of -- sort of a sentinel issue in terms of issues around coordination between behavioral health and general health care. It's also linked to issues around accountability, because if one thinks of -- you know, in terms of thinking about who is

accountable for the health care of individuals with severe and persistent mental illness, it's not clear, you know, who is responsible.

If I'm a psychiatrist and I have a patient with schizophrenia and diabetes, am I just responsible for the care of that schizophrenia and the outcomes, or do I have some responsibility for the outcomes for diabetes? And on the other hand, what about their primary care provider? To what extent did they share accountability for both of those?

If you have an expectation of shared accountability, it essentially requires that the primary care provider and myself talk to each other in order to coordinate care.

And then if one can then pull out that population and look at, for example, the relative degree of diabetic control or of control of hypertension and so on, or the degree to which they access preventive health care services as compared to the general population, that gives you kind of a hook to kind of look at number one,

setting a priority but also looking at how one can improve in that, especially when there's a disparity.

So I guess what I'm encouraging -- and it's begun to do that because in fact there's an earlier point in time where this came up. I guess Helen stepped out. There was a question about whether the -- if you're looking at a segment of a denominator, does that have to be a separate measure or not? And the ultimate decision was that it is a separate measure.

And so there's actually now a number of different measures that are actually pulling out severe mental illness as a separate category, and looking at that from the point of view of the disparities population, and actually -- you know, we actually have sort of an editorial under review to -- with respect to that review about sort of actually adding this to the National Disparities Report as an example of that.

So I just wanted to sort of introduce that notion. There's a couple of measures that

have been added to the adult core set that do look at this, and there's a number of measures that have been approved by the -- or have been endorsed by the Standing Committee for Behavioral Health in this area.

So I just wanted to sort of raise that issue and to think about, you know, to what extent -- and I know we had a little bit of discussion about this the other day Karen, in terms of like how much additional burden does it add to do that, because it's not without any burden, and to think about when's the best time and under the best circumstances to do that.

DR. MATSUOKA: I would actually turn it over to our state representatives here, because it certainly has come from the context of -- I forget which specific measures you were talking about last time -- or yesterday, gosh, yesterday. But certainly one of the --

CO-CHAIR PINCUS: Because there were several of the measures that were not -- that we had recommended that were not --

DR. MATSUOKA: That's right. Yes, and among the reasons for why we didn't move forward with them is because we heard from the state perspective that in fact stratification is essentially like having another new measure. It's not as simple -- it's not as simple as it may seem from the point of view of, you know, typical data. You have a data set and you just slice it in a different way.

So I would actually, you know, be curious to hear from our state folks in the room who would be best able to answer that particular kind of question.

MS. COGAN: Sure, I can speak to that. Harold, I know we had presented some data at a behavioral health summit a couple of weeks ago, where we showed some of our data stratified. So we do stratify all of our quality measures by things like serious mental illness. I'm going to talk about this a little bit tomorrow. We're going to start doing this more in the child space with children with special health care needs, or

seriously emotionally disturbed children.

Stratification is one of the most powerful tools that we have. It's a way of using the data that you already have in the best possible way, into trying to determine where the needs are or where you may need to dig a little deeper, or those alternative reasons why you may see a lower rate in a certain population may relate to something totally unrelated. But it gives you that great starting point.

I was very strongly against having separate measures that are pulling out sort of the stratified population and standing them on their own, because it kind of loses context. You take it out of the framework of wow, this population is doing so poor. You put it on its own, it loses that power back to the health care setting that really says hey, there's something not right here.

So I was pretty vocal when CMS asked for some of the adult Medicaid states to comment on whether you should do poor control, for

instance, for just seriously mentally ill. We were very against that. We felt it was duplicative. We felt that looking through our stratifications, that actually that population, that wasn't where the issue was, that there were other issues, and that we know that that population is younger. Maybe they haven't gotten there yet.

But we felt like having an additional measure would have been -- it's just too much burden. Doing the stratification would have been much more powerful we felt.

DR. APPLEGATE: So perhaps it's no surprise that states are already slicing and dicing existing measures by populations and by criteria to try to develop insight into what's actually going on. So I think one of the challenges is we actually may not be doing it the same way you are, and your way might be better than our way.

So perhaps there's some cooperation that could be helpful. Once we figure out what's

meaningful, then that's actually when it should become an official measure, particularly in the context of transformation of the health care delivery system. So for example, if we had children, 50 percent of whom died because they had a behavioral health condition, people would be shrieking, absolutely shrieking. That is exactly what we have with the SPMI population related to cardiovascular disease and diabetes.

So as we're shifting and carving in behavioral health services, as we're bringing our behavioral health partners to value-based purchasing and paying for six months of ADHD care, and I'd like to do my first episode psychosis -- I'm not a psychiatrist -- first episode psychosis episode of care.

Now, we're using data and transparency in this feedback loop that actually can drive performance, but in order to figure out what's meaningful, we actually have to do some testing on the ground. So to come out first and say this is the measure, you may be aiming for something

that's not right.

So a little one degree error here is a 35 degree error, you know, down the road. So I think we have to be super careful. We also have to listen to our stakeholders. So you can slice and dice your information, but when I get to the community, then my numbers are so small I can't do anything. In the end, what we're trying to transform is care in that community.

So I think there are a few anxieties, I suppose, about specifying exactly how stratification happens when and in which context, depending on what the objective is. I do think the one stratification that would be helpful are in areas where the measures are gargantuan and the disparities are huge, and this is specifically around racial disparities.

So we absolutely should measure the most common first public health kinds of measures -- infant mortality, pre-term birth -- by this racial divide. Otherwise, we can't come up with a plan to specifically close that gap. So since

that's so big, no matter what community I go to in Ohio, there's a two and a half to threefold difference. And until I put it in front of people -- you know, even the communities that have, you know, the worst issues, they actually don't quite understand it until we line them up according to everyone else.

So I do think that if there's a place to start, we absolutely have to learn how to talk about disparities around racial and ethnic and those minority populations before we ever get into diagnosis-based ones, realizing that the diagnosis doesn't tell you severity.

CO-CHAIR ANTONELLI: Yes.

DR. PATTON: Yeah, so just a couple of points I was going to mention. As part of the group that led the development of the SMI and the physical health comorbidity measures, you know, the immediate driver for those was the sense of health disparities around the SMI population, and really trying to move the needle on diabetes and cardiovascular screening and kind of get at some

of those mortality issues that Harold raised.

Sort the larger driver -- where I think we have great news to report at this point -- is that, you know, in looking at accountability, we're also very aware of the disconnect between primary care and specialty care, between community mental health centers and hospitals and so forth, and where that kind of falls off. But we were -- we had lots of conversations about the accountability issue.

And so CMS and SAMHSA are partnering now -- along with others -- in the 223 program, so the certified community behavioral health clinics. So we now have a package of quality measures that are being used by these clinics that are involved in this program, and we're now in the demonstration phase of that.

I think, you know, our hope is that that will alleviate some of that disconnect and some of the accountability around, you know, when people are in the communities and some of the ways to better track over time with those

outcomes.

CO-CHAIR ANTONELLI: Can I just ask you to expound? When you use the word accountability, are you using it in the capital A, ACO sense, or small A, which means the patient-family caregiver unit just wants to know who the go-to entity is?

DR. PATTON: So our thinking, you know, early on with the development of the measures was the small A, and over time with the context of health care and so forth it should -- yeah.

CO-CHAIR ANTONELLI: Yeah, that's great. Okay. I had Clarke and then Rachel.

MEMBER ROSS: So I wanted to reinforce Harold's observations but broaden them, and there are three other entities here at the National Quality Forum that demonstrate the broader approach. So June 6th and 7th, the Medicaid Innovation Committee meets, and who are the four targeted populations?

People with serious mental illness,

people with substance use disorder, people who need long-term services and supports, particularly long-term -- home and community-based services, and individuals with, quote, complex medical needs. So that's one forum.

The second forum is the work group on persons dually eligible for Medicare and Medicaid. So we've had a committee here since 2011 on dually eligible people. We have a set aside program in the ACA targeted to dually eligible people.

We have demos, we have an office in CMS, because a proxy for these challenges is the severity and complexity of illness and poverty reflected in the dually eligible population, and we know who they are, or at least we can count -- we can identify them.

And then third is National Quality Forum has a disparities committee, and an issue that's been discussed in the last several months -- I wish Helen was here -- Rich probably knows Dr. Lisa Iezzoni from Harvard, who's a leading

disability researcher in the country, and she makes the same arguments Harold just made, except she uses severe disability, not severe mental illness, although severe mental illness is part of severe disability with paralysis, spina bifida, MS, Parkinson's.

So the National Quality Forum is obviously grappling with how to define and put parameters around this complex issue. It is broader than severe mental illness, but severe mental illness is obviously a most unmet and severe population.

The last point is who's responsible. Like it or not, whatever the performance, every state in this country has a state mental health authority, and every state in this country has an intellectual and developmental disability authority, and that's created a lot of problems. But it also is a historic recognition that those two populations -- so that reinforces Harold's point -- are unique and have -- require unique responses, or they're so prejudiced and biased

against that we created these two silo state systems for them.

But so just random thoughts about the complexity in response to Harold's points.

CO-CHAIR ANTONELLI: Thank you. I think Rachel, Diane, Deb and Karen, are you in the queue? So I think you might have been. So Rachel, Karen, Deb, then Diane.

MEMBER LA CROIX: For Florida Medicaid, we primarily are often looking at our performance measure data at plan level, and then using our plan level data to then come up with our statewide weighted rate, depending on plan size for performance measures. We are not running all of these measures in-house based on claims and encounter data.

So the extent to which we could stratify the data, we could do that using claims and encounter data. But based on our plan-reported data, we haven't really been at a point where we could do that with the information they're reporting. It's typically the aggregate

rates and it's been audited by an NCQA certified auditor.

One new thing we are requiring plans to do this year is to support that patient-level data file that NCQA started having. So we will be receiving that patient level data and could then do some stratified analyses on our end. I can't go ahead and commit resources to that. I'd have to run that through my management first.

But that is something we'd be able to do. One thing that we did take a look at, kind of coming at it from the other direction -- and it's interesting you brought up the SMI population as an area of stratification. We do have an SMI specialty managed care plan in our Florida Medicaid program, and we found that they actually have been performing less while on a number of the mental and behavioral health measures than our standard managed care plans.

So one thing that we have just started exploring internally is looking at the populations within those plans that they used for

those measures, and then seeing whether the average risk scores for their populations are markedly different, whether that's correlated at all to the plan's rates for some of these measures, looking at their rural versus urban populations, looking at racial and ethnic make-ups for those populations, specific to some of those mental health measures, age breakouts.

We also -- since we do have an SMI specialty plan, we have an SMI algorithm so we can identify everyone who meets that algorithm, whether they're in the specialty plan or not. So also looking at within all of the plans what percentage of their population for those mental health measures -- meaning the eligible member criteria -- what percentage meet that SMI algorithm.

So we have been trying to drill down and look at some of those things. But it hasn't been looking at the varied, just a specific group with a diagnosis and then how they have done on different measures.

CO-CHAIR ANTONELLI: Karen.

DR. MATSUOKA: So this is just a follow-up question, just to probe a little bit more deeply into making -- turning the recommendation into some concrete action. So first I want to hear from the state folks in the room, but then I also want to put it out to the rest of the group too. So Lindsay if I hear you right -- and maybe Mary you too -- rather than calling out -- so in the adult core set we've got not only the diabetes poor control measure, we've got the diabetes poor control measure specifically for those individuals who also are SMI.

So if I hear you correctly, for you guys it would have been preferable to just say we should just have the diabetes A1c poor control measure, and then maybe suggest to the states that you think about stratifying by different condition groups like SMI.

So one is I just want to make sure I'm hearing that correctly. And if that's

preferable, I'm curious to know what that would mean for you Rachel in Florida. Does it mean that we would -- because you do, sounds like, rely on NCQA having a spec at the plan level. But you actually would want us to somewhere indicate that another way to operationalize that would be for you to pull NCQA 2607.

MEMBER LA CROIX: Yes.

DR. MATSUOKA: So if that's the direction that we would go in, then I wonder if we can throw out to the group, you know, what are your all thoughts about that as an approach?

CO-CHAIR PINCUS: Let me just add sort of an intermediate approach, which is to think of it as a set of two nested measures, you know, sort of the full population and then nestle it in the specific population, segmented population.

CO-CHAIR ANTONELLI: Yes. Well I have to pause for a second, because we've got other comments and/or questions, and then we will be -- I can't wait to hear the conversation on that, but I don't want to derail the people that have

gotten in the line. So if you can hold that thought, and then our state folks and everybody else get your responses ready.

But Deborah, then we're going to do Diane, and then I actually want to get in the queue, and then we'll open it up to Karen's provocative thought-provoking questions. Okay.

MEMBER KILSTEIN: Well, my comment relates to both what Rachel and Karen was asking, which is stratification. A lot of it depends on what is the reporting level. So for example, a health plan that doesn't get race and ethnicity data from their state, or has a behavioral health carve-out can't report on some of these measures. That has to be done at the state level. If at all, it would have to be done at the state level.

So there are decisions that states make that can, you know, decide whether or not it can even be done at a plan level and rolled up, or whether it can only be done at the state level.

MEMBER CALMUS: So I think from a

policy perspective, this is actually really desirable and something that we're seeing, you know, talked about in Washington a lot, the desire to kind of use this data to eliminate silos and hopefully to kind of figure out what non-health care, you know, social services can improve health outcomes and kind of really have a better way to judge and get to that data.

I think it's important that it's really dependent on the measure, you know. For some measures, looking at the rurality versus urban might be very important. For others, it might not be. We're seeing a lot of disturbing data coming out looking at reduced life expectancy in rural areas that I think, you know, gets back to some of these issues.

It would be really helpful to have some of this data separated out to be more actionable, and we were talking yesterday a lot about being actionable data. And so I think that's a way that this could be used additionally to really look at -- we talked about access to

maternity and OB services in rural. So you know, looking at it as a way also to identify kind of failures of access within the system.

Having this data can be really helpful in making sure -- in sending information to either the states or to Washington to say here's where more resources are needed. So I think that's another benefit for this sort of stratification.

CO-CHAIR ANTONELLI: So I'm stepping out of my role as the chair and wearing my medical director hat of integrated care for Boston Children's, and I want to -- this perspective is coming from the delivery system side, with the hope that I've got a payer that basically is saying how can we do this together, right. So from the delivery system side.

If you think about the vignette that Harold articulated, a patient with schizophrenia and with diabetes, we know there's fragmentation there. And if that fragmentation occurs just when there's multiple medical conditions, and then you

superimpose a behavioral health condition or two and things explode.

So what we do on the delivery system side is actually look at those -- look at the data, look at the utilization and presume that those patients -- the term that I use is they're medically homeless. Everything is essentially reactive. There's no single point of entry to the system except the emergency department, etcetera, but we're actually measuring in those spaces.

So I want to bring this conversation -- for me, the idea here -- and Harold teed this up, QI versus accountability, capital A versus small A. So how do you attack fragmentation? You measure it. You can get data flows from claims. We actually go to the families and caregivers themselves, so we actually -- some of our earliest data when we look at fragmentation for these patients that have complex and multiple chronic conditions actually comes from the families themselves.

So to the degree that there's a capital A opportunity, meaning that we can meaningfully pull in, for example, housing, food security, appropriate behavioral health capacity, that is great. The slicing and dicing on the quality side I also want to encourage that. I do react a little bit to having a different set of measures for the population, and I really like the notion of let's just look at the measures that we have, and then maybe decide that we need to add some on top of that.

So that's what it feels like from the delivery system side, and I do want to make the final comment as -- these are not mutually exclusive, right? So depending on the receptivity of your Medicaid leadership, your state, your region, you may start with a capital A accountability and say figure it out.

Or you may start in the QI space, for people who are sitting and scrambling like where are we going to get appropriate housing resources, etcetera. So I really like that

approach to thinking about stratification. Okay, Harold had a comment. And then Karen, I'm going to ask you to tee up the question that you did, and then we're going to poll the group's thoughts on that.

CO-CHAIR PINCUS: So I think there's been a very productive conversation. I look forward to hearing some of the responses. Just a couple of responses back, I agree with Clarke that, you know, part of the issue in terms -- especially the SMI and more broadly the disabled population -- is that they do face discrimination, both stigma as well as, you know -- especially for people with physical disabilities -- there's practical discrimination in terms of accessing, you know, general medical services.

Also for, you know, for behavioral health populations, people don't want them in their waiting rooms. They also have, you know, poor health hygiene. The medications they take can interfere with or in some ways exacerbate the

conditions they have. So it really requires some kind of coordination.

The issue of carve-outs is kind of an interesting issue because, you know, ultimately to get adequate care for these populations, the carve-outs have to talk to the med-surg plans, and that's -- you know, either they have to be an integrated plan or there has to be some way by which they communicate about their populations so there can be an overall population management.

That's some ways -- you know, depending on how things are set up with the state, that's partly something to build into contracts, you know, with both the carve-outs and the med-surg plans or, you know, within the so-called integrated plans, because integrated plans are not so integrated often, you know, as you see those.

But I think one of the really important things is the actionability. I think that having this sort of segmentation really enhances the actionability to be able to use that

to pinpoint where the problems are. You know, both at a population level but also begin to understand what actually are some potential ways to fix things.

I mean is it -- and just -- to even just put it down at a clinical level, I mean is the problem with my sort of patient with diabetes, is it the fact that I'm not at all encouraging that individual to adjust their diet or to inquire, from my point of view, about how they've been sort of utilizing their -- you know, utilizing their insulin levels, adjusting their insulin levels, or for that matter maybe it's up to me to adjust the anti-psychotic medication, so that it's less likely to cause metabolic disturbances, and to be in touch with their primary care provider with regard to what I'm doing, so that there is a kind of joint strategy.

But like I said, it also goes up in terms of how my practice at an organizational or clinical level, what kind of information am I getting back. What kind of relationships exist

between the CMHCs and the FQHCs in order to share information to grease referral pathways and things like that. What kind of obligations are put in place at the managed care plan level in terms of that sharing of information, that sharing of efforts around quality improvement?

So you know, it sort of forces a lot of actions to respond by maintaining this kind of sort of longitudinal follow-up on the data around this segmentation.

CO-CHAIR ANTONELLI: Thank you. Okay, Karen. You ask the question again and then people, I'd love to have you riff on your thoughts with that.

DR. MATSUOKA: So in a nutshell -- and if we were to just use the A1c control measure as an example, we have an A1c control measure for anyone who has diabetes. But then to kind of be a gauge for this behavioral health integration, we also added in Measure 2607 for the 2017 core set which specifically looked at A1c control for those individuals with diabetes who also happen

to have a serious mental illness.

So the question becomes, you know, is it better to just have the global A1c measure, and then suggest -- encourage states to stratify it by different kinds of, you know, condition groups or population groups? Or do we call out a separate measure, which seems to be the NQF way as well, which also happens to be the method that states who really depend on their health plans to submit aggregated data to the state would most likely be reporting these kinds of measures, or is there some kind of hybrid approach?

MS. COGAN: I mean, I would agree with the hybrid approach. So I think where we stand is not having a separate measure to stratify the existing measure. The way that we do our stratification -- and Rachel we do the same thing that you're thinking of doing -- we've been collecting patient level data from our health plans for years.

Taking that Medicaid ID and linking it back to our enrollment and eligibility, and then

we know things like race, age, region. We can look at their entire claims history, run a very simple algorithm to pull out SMI diagnoses, right, and we'd be happy to share that and spread that and have everybody do that, if they have those internal resources.

But it is resource intensive. So I think a hybrid approach would probably be the best. I just worry that going down this path of having separate measures, when does it end, right? So you put one out there for SMI. So IDD is next. Medically fragile children are right behind them, and then foster kids are here too.

So it just -- you're already at 27. So let's use what we have to the fullest ability before we start tacking on additional measures would be our suggestion.

CO-CHAIR ANTONELLI: So what's the piece, Lindsay, of the hybrid component that's attractive?

MS. COGAN: Because if a state like Florida cannot pull together internally to

stratify what comes in from the health plans, you're essentially doing the same thing. So if you have the leverage to gather that from the health plans and pull in a separate measure for individuals with SMI, you're essentially doing the same thing.

At our state, we aren't going to add another measure -- another hybrid Measure 411 on top of the plans. We're just not going to do it. So we're not going to report that measure. We're going to stratify the one we have.

CO-CHAIR ANTONELLI: Yeah. But I guess I'm just trying to figure out the hybrid component from the state Medicaid perspective. The status is you're going to use the measures that you have and stratify?

MS. COGAN: Yes. I think the hybrid approach I'm talking about is across other states. It's not within my state.

CO-CHAIR ANTONELLI: Okay. Oh okay, okay. You've brought that up.

(Simultaneous speaking.)

MS. COGAN: But so if I wanted to do it my way and Florida wanted to do it their way, we're still getting to the same -- I think we're still getting to the same path, which is you want to look at this measure by individuals, serious mental illness.

CO-CHAIR ANTONELLI: Thank you.

MS. COGAN: Fair enough, yeah. Sorry. It's doing hybrid.

CO-CHAIR ANTONELLI: Okay, Mary.

DR. APPLEGATE: So not to make things more complicated, but your diagnosis by itself is not necessarily the only variable that gets you to a terrible outcome, for example. So one of the things that we're doing in our stratification process is we actually look at the -- we do the linkage that you talked about, and then in the claims history we actually have an algorithm for what counts for uncoordinated care, and it's those people with the diagnosis that actually we need to target.

So the measure itself, stratified by

SPMI, is not enough. It's the people who actually have no indication of coordination in care. So if all of their claims only come from the CMHC, we're in trouble. If they only come from the physical health side of the world, we're in trouble. If they have inpatient stays either utilization, kind of five pharmacies and six different prescribers, we're actually in trouble.

So our slicing and dicing also gets to the context. So that's actually what we need to develop a plan for how do you systematically get people better is focus on the folks who are most likely to do poorly, and in our system it ends up being those who actually don't seem to be connected in any kind of logical way.

CO-CHAIR ANTONELLI: Looking for fragmentation. Yes.

DR. PATTON: Yeah. I was just going to say, you know, the long view for the measures -- for the SMI physical health comorbidity measures was certainly not that they would be needed, you know, forever. I mean the real hope

in developing those measures was that health care would catch up, that that population -- the health disparities would be reduced and that would -- we wouldn't need it to be separated.

I'll give you just a quick example. There's an NQF measure, depression with a suicide screen. So it's a similar kind of issue in that, you know, most of us working in mental health would anticipate if you have a client with depression, you'd screen for suicide. That doesn't always happen.

So it's about driving the standard of care, because over time what we would hope is that any person presenting with a diagnosis of depression would also have an accompanying suicide screen. And so that it would just become standard practice, and there would no longer be a need to measure that because no one would ever think about working with someone with depression without assessing for suicidality.

CO-CHAIR PINCUS: Just one comment actually to Mary. Lisa Kern from Weill Cornell

actually has a grant from the Commonwealth to actually develop different ways of looking at fragmentation in terms of care, and she's actually sort of testing out different alternative models. Actually Larry Costello and I are both sort of on the grant as well.

(Pause.)

CO-CHAIR ANTONELLI: Okay. I think we're good. Okay. I think we're about to get to the slide that talks about a public comment. Operator, could you see if anybody would like to weigh in for public comment please?

OPERATOR: If you would like to make a public comment, please press star 1 on your telephone keypad.

(No audible response.)

OPERATOR: And we currently have no public comments at this time.

CO-CHAIR ANTONELLI: Okay.

CO-CHAIR PINCUS: Wait. Can we have that open for a few more seconds?

OPERATOR: Of course. Again, if you

would like to make a public comment, press star 1.

(Pause.)

(No audible response.)

CO-CHAIR ANTONELLI: Public comments in the room?

(No audible response.)

OPERATOR: No public comments on the phone.

CO-CHAIR ANTONELLI: Okay, Miranda.

MS. KUWAHARA: All right, everyone. Here we have our next steps. Tonight, our Adult Task Force will be leaving us and we'll continue tomorrow with our Child Task Force. We have on the screen a timeline of what's coming up. Some highlights for you all.

We have public comment on our draft report July 7th through August 6th, and then we have our MAP Coordinating Committee. It's to be determined. It will be some time in August, and then final reports will be submitted to CMS August 31. We will expect CMS to issue its

annual update to the Medicaid adult and child core sets late 2017.

Here we have listed the NQF project staff if you ever need to reach out to us. All of you may contact us directly on the Committee SharePoint site. Our contact information is listed there, and then our project contact information is listed on this slide. We have separate email addresses for both adult and child, and you can always visit our project page for any meeting materials. All right.

CO-CHAIR PINCUS: So I just -- so I just want to really thank actually the NQF staff for their really sort of remarkable ability to keep things organized and to provide us with the information we need, and to sort of keep on moving us ahead. I also want to thank the CMS staff, in terms of it's really been I think an excellent partnership in terms of moving this agenda ahead, and certainly, you know, with representatives from the states that are so well informed and active. It's really good to have

that as part of this as well.

I want to thank the members of the Adult Task Force. I mean, we did a lot of work and got a lot done, and you know, we really had very good discussions, and I think that helped inform the process going forward. So thank you all.

DR. MATSUOKA: And I just want to join in and also thank the great NQF staff, all of you, the Adult Task Force members before you leave, you know. Thank you very much. But a special shout out to Harold. Thank you so much for chairing the Adult Committee very gracefully and keeping us on time. So thank you Rich.

MS. MUKHERJEE: Staff definitely would like to thank our Chairs.

(Applause.)

MS. MUKHERJEE: Because without our Chairs, we would pretty much be a ship without a captain. So thank you.

CO-CHAIR ANTONELLI: All right.

(Simultaneous speaking.)

CO-CHAIR ANTONELLI: And to remind the Child Task Force here that we're only halfway done actually in a journey that will last decades, but that's why we do the work we do. The Adult Task Force, it's really gratifying to actually sit in a room and look for the similarities rather than always looking for the differences. So thanks to the Adult Task Force.

So I'm actually going to go in reverse order, just because it's different and it feels fresh. To CMS, thank you for the opportunity of this partnership. I'm mindful of tremendous pressures on Medicaid in general, and yet we're sitting in this room pruning out measures that don't really fit the bill.

Hearing from the front lines of Medicaid leadership, we need better measures. I didn't get a sense in today's entire conversation that we should take our foot off the gas pedal. I'm grateful for that, and I'm proud of the leadership that we saw today and the vision of CMS and our state leaders.

Then finally NQF, you guys are absolutely phenomenal. So thanks for making this really hard job actually easy enough for a simple PCP to do.

MS. GORHAM: I want to echo all the thanks, but I made the joke earlier that yesterday, we ended at 4:03, and perhaps we would end at 3:59. But actually you all were so fantastic today that we're actually ending at 3:25. So if you don't mind, then, definitely you are free for the day and again, thank you. We'll see the Child Task Force tomorrow.

CO-CHAIR PINCUS: Thank you.

(Whereupon, the above-entitled matter 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

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R. Gross

Court Reporter