NATIONAL QUALITY FORUM

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MEASURE APPLICATION PARTNERSHIP

JOINT MEETING OF THE MEDICAID ADULT TASK FORCE

AND THE MEDICAID CHILD TASK FORCE

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WEDNESDAY

MAY 25, 2016

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The Joint Meeting was held at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 8:30 a.m., Harold Pincus and Foster Gesten, Co-Chairs, presiding.

MEMBERS PRESENT:

FOSTER GESTEN, MD, FACP, Child Task Force Chair
HAROLD PINCUS, MD, Adult Task Force Chair
TERRY ADIRIM, MD, MPH, FAAP, Drexel University College of Medicine
GEORGE ANDREWS, MD, MBA, CPE, FACP, FACC, FCCP, Humana, Inc.
KATHRYN BEATTIE, MD, St. Luke's Children's Hospital
ANDREA BENIN, MD, Children's Hospital Association
DIANE CALMUS, JD, National Rural Health Association
KATHLEEN DUNN, RN, MPH, NH Department of Health and Human Services*
SUE KENDIG, JD, MSN, WHNP-BC, FAANP, American Association of Nurse Practitioners
SUSAN LACEY, RN, PhD, FAAN, American Nurses Association
MARGARET A. MURRAY, MPA, Association for Community Affiliated Plans
CYNTHIA PELLEGRINI, March of Dimes
GRANT PICARILLO, America's Health Insurance Plans*
BO RIEWERTZ, MD, Kaiser Permanente
MARISSA SCHLAIFER, RPh, MS, CVS Health
MICHAEL SHA, MD, FACP, Indiana University School of Medicine
CAROL SAKALA, PhD, MSPH, National Partnership for Women & Families
FATEMA SALAM, MPH, Patient-Centered Primary Care Collaborative

SUBJECT MATTER EXPERTS PRESENT:

RICHARD ANTONELLI, MD, Boston Children's Hospital; Harvard Medical School
LUTHER CLARK, MD, Merck
KIM ELLIOTT, PhD, Health Services Advisory Group
ANN MARIE SULLIVAN, MD, New York State Office of Mental Health

ORGANIZATIONAL MEMBERS (NON-VOTING):

DEIDRE GIFFORD, MD, MPH, National Association of Medicaid Directors

FEDERAL GOVERNMENT MEMBERS PRESENT (NON-VOTING):

LAURA DE NOBEL, JD, RN, Centers for Medicare and Medicaid Services
DAVID HUNT, Office of the National Coordinator for Health Information Technology
KAMILA MISTRY, PhD, MPH, Agency for Healthcare Research and Quality
LISA PATTON, PhD, Substance Abuse and Mental Health Services Administration*
GOPAL SINGH, PhD, Health Resources and Services Administration*

NQF STAFF:

HELEN BURSTIN, MD, Chief Scientific Officer

MARSHA WILSON, PhD, MBA, Senior Vice President, Quality Management

ELISA MUNTHALI, Vice President, Quality Measurement

SHACONNA GORHAM, MS, PMP, Senior Project Manager

DEBJANI MUKHERJEE, MPH, Senior Director

YETUNDE ALEXANDRA OGUNGBEMI, Project Analyst

REVA WINKLER, Senior Director*

ALSO PRESENT:

SEAN CURRIGAN, MPH, American College of Obstetricians and Gynecologists
LEKISHA DANIEL-ROBINSON, Centers for Medicare and Medicaid Services*
CHARLES GALLIA, PhD, Oregon Health Authority

BEN HAMLIN, MPH, National Committee for Quality Assurance*

LARRY KLEINMAN, MD, MPH, Icahn School of Medicine at Mount Sinai*

MARSHA LILLIE-BLANTON, DrPH, Centers for Medicare and Medicaid Services

JULIA LOGAN, MD, PhD, California Department of Health Care Services

KAREN MATSUOKA, PhD, Centers for Medicare and Medicaid Services

LAURIE NORRIS, JD, Centers for Medicare and Medicaid Services

GIGI RANEY, LCSW, Centers for Medicare and Medicaid Services

SARAH HUDSON SCHOLLE, DrPH, MPH, National Committee for Quality Assurance

*** present by teleconference**

C-O-N-T-E-N-T-S

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

(9:04 a.m.)

CO-CHAIR PINCUS: So why don't we get started. I'm Harold Pincus. I co-chair these two committees, two task forces with Foster Gesten to my right.

I'm a professor and vice chair of psychiatry at Columbia University, Department of Psychiatry and also Director of Quality and Outcomes Research at New York Presbyterian Hospital. I'm delighted to be here today.

We had a very busy and full day yesterday of the Adult Medicaid Task Force and today we're joined with the Child Medicaid Task Force to discuss common issues. We'll let Foster introduce himself.

CO-CHAIR GESTEN: Thanks, Harold. It's a pleasure to be here. I'm Foster Gesten. I chair the Child Task Force and I think this is my third time around. Maybe for some of you it's your third time around. Welcome back, folks who have been here before and welcome new folks to

the Child Task Force.

I think it's a pretty fun group and we really look forward to the day in which we can sort of have the interchange between the Adult and the Child Task Forces. We'll talk about a number of different important alignment issues and issues that we have in common for obvious reasons.

And so today gives us a chance to work through those jointly. I work at the New York State Health Department in the Office of Quality and Patient Safety as their chief medical officer and have the pleasure of serving on the Coordinating Committee for the MAP representing the National Association of Medicaid Directors.

So look forward to hearing about yesterday. I heard it was a good day. I think the, we will start by introducing, allowing our CMS colleagues to introduce themselves and then go around the room and do introductions. Does that sound right?

So let me just turn things over to

Marsha and Renee to introduce yourselves.

CO-CHAIR PINCUS: It's important that everybody open their mic, speak into the mic and then shut it off.

DR. LILLIE-BLANTON: Real basics, right, you know. So I'm Marsha Lillie-Blanton and I am senior policy advisor with the Center for Medicaid and CHIP Services. And I want to welcome all of you all and thank you for taking the time to be a part of our MAP.

We greatly value the input that you provide, the direction that you give to us and the, just willingness to take the time to help Medicaid grow and be the program that it really can be for the beneficiaries we serve. So I'm going to stop there.

We have others from CMS. Our new chief quality officer is I'm sure on her way. Metro is not the most reliable as all of you all know. So when she comes I'll let her introduce herself.

I think there are others here from

CMS. So I would like for them to introduce themselves if you don't mind.

DR. FOX: Good morning. I'm Renee Fox from the Division of Quality and I'm a pediatrician and working on the child core set.

DR. PERRAULT: Good morning. My name is Kimberly Perrault. I am a social science researcher within the Division of Quality.

MS. RANEY: Good morning. I'm Gigi Raney and I'm also in the Division of Quality and I work on the adult quality grants.

MS. THOMAS: Hi. Good morning. I'm Megan Thomas. I'm a technical director in the Division of Quality and Health Outcomes and I am the team lead for our performance measurement work.

MS. NORRIS: And I'm Laurie Norris. I'm a senior policy advisor in the Division of Quality and children's oral health is my thing.

CO-CHAIR GESTEN: So why don't we go around and maybe start with you, Marissa, and have folks introduce themselves and where they're

from briefly and so everyone knows whose here and remind us all which task force everybody is on.

MEMBER SCHLAIFER: I'm Marissa Schlaifer. I'm on the Adult Task Force. I represent the Academy of Managed Care Pharmacy but work for CVS Health.

MEMBER CALMUS: I'm Diane Calmus. I'm also on the Adult Task Force and I represent the National Rural Health Association.

MEMBER KENDIG: Hi. I'm Sue Kendig. I am a women's health nurse practitioner and attorney from St. Louis, Missouri and I'm here representing the American Academy of Nurse Practitioners.

MEMBER PELLEGRINI: Good morning. I'm Cindy Pellegrini. I'm with the March of Dimes. I'm a twofer. I'm sitting on both the Adult and the Child Task Forces. And for the record, I have no disclosures.

MEMBER ANDREWS: Good morning. I'm George Andrews. I'm a cardiologist and I represent Humana. I'm Humana's corporate chief

of quality and I have nothing to disclose.

MEMBER SHA: Michael Sha. I'm a general internist as well as a geriatrician. I work for the Indianapolis VA. I'm here representing the American College Physicians.

DR. ELLIOTT: Kim Elliott. I'm on the Adult Task Force. I have nothing to disclose. I work for Health Services Advisory Group which is an PQRO. And prior to that I worked for about 15 years for the Medicaid program in Arizona.

DR. SULLIVAN: Hi. Ann Sullivan on the Adult Task Force. Commissioner of Mental Health New York State and I'm a mental health expert to the Adult Task Force.

DR. LOGAN: Good morning. My name is Julia Logan and I am not on a task force. But I'm representing the California Department of Healthcare Services where I'm chief quality officer and a family physician and preventive medicine physician.

DR. SCHIFF: Hi. My name is Jeff Schiff. I'm the medical director for the

Medicaid Program in Minnesota and pediatric emergency department doc. And I'm not on any task force but I'm here connected to the pediatric side.

DR. MISTRY: I'm Kamila Mistry. I'm from AHRQ, Agency for Healthcare Research and Quality. I'm the senior advisor for child health and quality improvement.

MS. DE NOBEL: Hi. Laura de Nobel from CMS and the Center for Clinical Standards and Quality and I'm on the Child Task Force.

MEMBER SALAM: Hi. I'm Fatema Salam. I'm with the Patient Centered Primary Care Collaborative on the Child Task Force.

DR. ANTONELLI: Good morning. I'm Rich Antonelli, Medical Director of Integrated Care at Boston Children's Hospital and general pediatrician. I'm also on the MAP Steering Committee and I'm on the Child Health Task Force and have no disclosures.

MS. SAKALA: Good morning. I'm Carol Sakala. I'm with the National Partnership for

Women and Families and I'm on the Child Task Force.

MEMBER RIEWERTS: Bob Riewerts. I'm on the Child Task Force. I'm from California and I work for Kaiser Permanente as a pediatrician.

MEMBER LACEY: Susan Lacey, Medical University of South Carolina, professor of College of Nursing. I represent the American Nurses Association and I have nothing to disclose.

MEMBER BENIN: Hi. I'm Andrea Benin. I'm the senior vice president for Quality and Patient Safety at Connecticut Children's Medical Center in Hartford and I'm representing the Children's Hospital Association. I'm a pediatric infectious disease doctor and I have nothing to disclose.

MEMBER BEATTIE: Good morning. I'm Kathryn Beattie. I am from St. Luke's Children's Hospital in Boise, Idaho as their executive medical director and administrator and I'm representing America's Essential Hospitals.

MEMBER ADIRIM: Hi. I'm Terry Adirim. I'm a pediatric emergency physician and professor of pediatrics emergency medicine at Drexel University College of Medicine here representing the American Academy of Pediatrics and like you this is my third round on the Child Task Force.

DR. BURSTIN: Good morning, not on the committee. I'm Helen Burstin. I'm the chief scientific officer here at NQF. Just want to add my welcome to all of you. Thank you. We look forward to it being a very exciting and productive day. Thanks.

MS. MUNTHALI: Good morning. My name is Elisa Munthali. I'm vice president for quality measurement at NQF. Welcome and thank you.

MS. MUKHERJEE: Good morning. My name is Debjani Mukherjee. I'm the senior director for the Adult and Child Medicaid MAP Task Force. And I'm just going to quickly go over a couple of housekeeping items today.

The mic does move. Please move the

mic closer to you when you speak and make sure the light is on red otherwise we won't be able to get all the recordings and the transcripts and we do use that to appropriately and correctly attribute any discussions.

Please keep your cell phones to vibrate or silent. We know you have other obligations. If you need to take a call there are some chairs outside where you signed in and you're more than welcome to use that area for any calls.

Restrooms, down the hall past the elevators, down the hallway to the right. Public comments are spaced throughout the day and what we will do is during public commenting time we will open, say we're open for public comments. We'll go to people in the audience, then people on the phone and then finally we'll make sure that anybody in the chat who has chatted as a public comment that gets acknowledged.

Breakfast, lunch are provided for group members and NQF staff. For members of the

public you are welcome to the beverages and we can recommend restaurants in the area for you.

And just as a quick reminder, organizational and subject matter experts are asked to vote while our federal representatives are encouraged to participate throughout the day in all our discussions you are requested to abstain from voting. Thank you. Shaconna.

MS. GORHAM: Hi. My name is Shaconna Gorham. I'm the senior project manager for the Medicaid Child and Adult Task Forces.

MS. ALLEN: Hi. I'm Nadine Allen. I'm the project manager for the Child Task Force.

CO-CHAIR GESTEN: Great. Well why don't we, I think you had my script for the objectives on the next slide. Why don't we talk a little bit today about what we're here to do.

As the adult group did yesterday today we're here to talk about and think about what the experience has been to date in both reporting on and making use of measures both for the Medicaid Adult and the Child. Of course that, I think CMS

folks will talk a little bit about what their overall objectives are.

But, you know, just to steal the show a little bit, you know, there's a three-part goal of having more states report, more states report and more measures. And most importantly I think to those of us around the table is the use of these measures for the purpose of quality improvement.

And clearly the group wants to, we want to be informed by what the experience has been to date as we think about refining the measure set both for adult and for children.

We're also here to talk about not just the specifics or some of the measures in the weeds but really talk about sort of the strategy, some of the overarching themes which is part of why we're gathered today, the two groups to be able to do that, talk about how we think about priority measures and gaps and how, what our approach is both in terms of specific measures and other approaches to encourage the field to

develop measures that are important.

And then really to look at measures that may have been, for whatever reason, either the science has changed or they have proven to not be of use in the purposes for improvement or not much opportunity for improvement and so on. So to consider potential measures for removal.

And that has happened over the course of the past number of years. As you might imagine it's a whole lot easier to add than it is to subtract. It's part of the challenge of how we got where we are on measures.

But our obligation is to think about both of those. And I don't think yesterday you guys threw any off the island. Is that correct? Not yet anyway.

We're also asked to really give advice and wise counsel to CMS around how we think about improving and strengthening the measurement set over time to meet the goals of the programs to ensure access and quality and care coordination and so on and then really discuss any overarching

issues to help us think about how we do these updates.

And they can include anything from larger issues about where health policy is going to, you know, more micro issues about the role of electronic health reporting and how that should weave into how we think about our work. So the next slide.

So we're going to, as I mentioned, review the states experience and the measures to date. I suspect you probably did some of that yesterday. We'll do some of that today and we'll do some of it tomorrow as well.

So for those of you that are on both committees you get to hear some of this three times. Aren't you lucky? We want to talk about specifically the issue of measure gap areas and recommend potential measures for that addition and then also talk about potential removal of measures if that's appropriate, as I mentioned.

And just in terms of, if it's not clear we have our task force is a mix of

membership that includes both folks who are kind of listening in or experts that have graciously traveled to provide expertise or experience working from the states as well as individuals that are part of the MAP Coordinating Committee and some of the individual MAP Work Groups that are relevant to the specific topics or content of the areas that we'll be discussing when we get into the specific measures.

Next slide. Is it still me? Okay. So measure alignment. And I think, I don't know if you had a chance to talk about alignment at all. I think it was one of our homework assignments was to think about what we mean by it.

This is one of those buzzwords that everyone talks about but very frequently, at least at this table, we find it useful to re-steep in what we mean by it and what's important about alignment and understand it relative to other important values as well. We have a number of measures that we share, if you will.

I mean there's some degree of, I would say history and arbitrariness about where some measures, whether some measures are in the child set, some measures are in the adult set. So, but we have some measures in common as well where the same exact measure currently is in for adults as well as for children and adolescents.

We have, I think, an overall goal of trying to think about how we fill out the portfolio of measures that relate to outcomes that are important to patients and families. And I would say both at this table in this work and most of the tables that I sit at that's very much a work in progress.

The, how we take all this energy and work and measures and data and convert it into really useful and productive improvement is, I think, the North Star for a lot of this activity and then how do we support states ability to participate in reporting understanding that while we've seen tremendous increases in states reporting, more states reporting, more states

reporting more measures and as Marsha and her colleagues will talk about really using a lot of this data for quality improvement projects but we still have a ways to go in terms of the kind of full participation that we would like.

We understand that states are challenged to have a number of things going on in addition to reporting core measures. So how do we integrate this activity with some of that other work that states are doing is part of our challenge and things that we'll likely talk about.

So this I can't do. So this is you. I could make it up. But I think I won't.

MS. GORHAM: Before we move further, we have a couple of committee members on the line. So I just wanted to give them the opportunity to introduce themselves. Katie, Grant and then, Lisa, can you introduce yourself please and let us know what task force you're representing?

MEMBER DUNN: Yes. Thank you very

much. Good morning, everyone. My name is Katie Dunn. I'm an associate commissioner and Medicaid director for the State of New Hampshire. I'm on the Adult Task Force and I'm representing the National Association of Medicaid Directors.

DR. PATTON: Good morning, everyone. This is Lisa Patton. I'm sorry I wasn't able to join you in person today. I'm on the Adult Task Force and I'm the division director in SAMHSA for the Evaluation, Analysis and Quality Division in the Center for Behavioral Health Statistics and Quality.

So looking forward to today's discussion.

CO-CHAIR GESTEN: And, Meg, do you want to introduce yourself? We all got a chance to but you did not.

MEMBER MURRAY: Hi. I'm Meg Murray. I'm with the Association for Community Affiliated Plans, the Medicaid non-profit plans.

CO-CHAIR GESTEN: Great. I guess I was remiss. Is there, does anybody have any

questions about the agenda or what we're here to do today? Okay. All right.

You haven't had enough coffee yet. If you had enough coffee you would have a question. All right, Debjani or Harold.

MS. MUKHERJEE: So in the next couple of slides what I will do is provide a quick recap of everything we did today, did yesterday, sorry not today and will do today. So basically why are we were?

So we are here for the three part goal for child and adult core sets which is to increase the number of states reporting the core set measures, increase the number of measures reported by each state as well as increase the number of states using core set measure to drive quality improvement.

And where do we find this data and how does CMS use this data? CMS uses the core set data to obtain a snapshot of quality across the Medicaid and CHIP programs. And you should have gotten a packet with the quality reports for the

child and adult as well as chart packs with state snapshots and all of this information is then used to inform policy and program decisions.

And how do we use, how do we select the measures that we recommend for consideration by CMS? We use the MAP measure selection criteria. And there's just a couple of ones I'm going to mention.

Number seven, program measure set promotes parsimony and alignment and that gets to some of our discussions today of alignment. Also program measure set includes consideration of healthcare disparities and cultural competency is something else we had discussed yesterday and highlighted.

The appropriate mix of measure types is something we talked about as well as sort of this beneficiary focus measurement set that enables measurement of person and family-centered care and services. So how do we decide if a measure is up for removal from the core set?

If a measure has consistently high

levels of performance indicating that there is little or no room for additional improvement or there have been multiple years of very low numbers, and I want to pause here a minute and say that some of the measures that we considered yesterday and will consider today have not been in the core set for too long, a year or two years.

So based on that staff felt uncomfortable recommending any for consideration for removal at least on the adult side this year. Change in clinical evidence that makes the measure obsolete. The measure does not provide actionable information for state Medicaid programs and then there's a secure measure available on the same topic.

And the decision categories are support for immediate use and consideration. Conditional support based on pending endorsement by NQF pending a change by the measure steward and pending CMS confirmation of feasibility. And then the last final one is do not support which

is a red light.

So now I'm going to provide a quick highlight of yesterday. Yesterday the Adult Task Force voted to recommend four measures for consideration by CMS for adding to the core set.

And the first one was Measure Number 2152, preventive care and screening unhealthy alcohol use. Measure 0541: Proportion of Days Covered, three rates by therapeutic category. Measure 2067: Diabetes Care for People with Serious Mental Illness, hemoglobin A1c port control.

And Measure 2605: Follow-up After Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence. And with that I'm going to go over some of the policy and measure related discussions we had.

One of the things discussed were the three types of measures we see in the core set or just in general. Analytic measures which have unclear benchmarks and are used to explore

variation. Improvement related measures which are used for performance improvement and for greater transparency of care. And then finally, accountability measures.

And when talking about measures we talk about data, data linkage, having data warehouses but not having the longitudinal data because of expansion of Medicaid. So not having a baseline or a benchmark.

The lack of a clear and precise care coordination definition and also when we talked about linkage to community and linkage of clinical providers with community supports and services this notion of not burdening the non-medical grass roots entities who might not be prepared to welcome the number of beneficiaries who might need behavioral and mental health supports.

Also as far as data goes, one of the discussions we had was actual face validity of the measure versus what is being reported, what is being captured. So not only looking at the

data but actually looking at the validity of the data.

It was noted that comparative information on states is very important especially when states want to see how they're performing as well as improve their performance. Interestingly, one of the discussions we had was about a mandate.

So reporting mandate versus the voluntary nature of reporting and what does it incentivize. Mandate might incentivize compliance. But quality improvement might be highly incentivized through a voluntary system.

The last sort of focus of policy was the beneficiary. Whose interests are we trying to serve, the beneficiaries. And that got us to the notion of population health, whole person care and also the concept of burden.

And the concept of burden was defined relative to the perception of value. So the value versus effort and then finally actionable outcomes. If something is being measured there

should be an actionable outcome related to that measurement.

And that's a brief overview of everything. Now I'm going to turn it over to Harold just to see if he has anything to add.

CO-CHAIR PINCUS: So just a couple of things to mention in slightly more depth about the discussion yesterday and other members of the Adult Task Force might want to chime in.

One is, you know, thinking about those three categories of measures we had some discussion about the fact that at least for right now for the most part these are not accountability, the states are not using this and CMS is not using this for accountability per se because it's voluntary.

Not every state reports. Not every state reports on every measure. So there's a little bit more flexibility in terms of how we apply the criteria that may not be as high as the overall MAP standard in term, and for that matter NQF endorsement standard in terms of

accountability, that there may be some ways in which there are possibilities of experimentations to see if something can in fact be collected and used in a way that's helpful for beneficiaries.

So to think about that a little bit and be a little bit more flexible in terms of how one thinks about these for the purposes of, for analytic purposes or for improvement purposes as compared to accountability purposes.

Number two, we also talked a little bit about enlarging some concept of disparities, particularly thinking about disparities in terms of people with severe mental illness so that there have been a couple of measures that have been added with regard to that sort of segmentation of an existing chronic disease measure for individuals with severe and persistent, chronic mental illness.

And that's another way of thinking about disparities. Those people have a life span that's on average shortened by almost two decades and a lot of it is because of poor chronic

illness care for general medical conditions. So that's, again, another thing that we talked about a bit.

Number three, the whole issue of removing measures because of low number of states reporting. We were very conservative about that. In fact, we didn't add any. And part of it goes back to some of the issues around experimentation and where things are and where things are in the evolution of state's capabilities to report different measures.

So, you know, if we were looking at what could the most, the measures that most states could use it's almost exclusively claims, measures using claims data. The ones that are reported very infrequently are those that require some kind of clinical data from medical records.

And clearly there's a curve that's happening in terms of states over time being more able to do that as electronic records get more frequently used, get sort of repositories of data from medical records become more available. And

so rather than, sort of shutting things off simply because states are not reporting them to actually let them stay for a while and see whether there is an evolution to be able to report some of that data.

And so that was a point of discussion. And then finally, despite adding several measures, four measures that we recommended being added and others that were sort of close calls, there wasn't a sense that any of the gaps are really being filled, that the gaps that we identified which are very similar to the gaps that the overall MAP has identified, are really need some more heavy duty investment in measure development.

And there's some hopefulness that with some of the new efforts at NQF in terms of the incubator concept and so forth that might be a way to move this forward more quickly. So that's, anything else that I might have left out from people on the Adult Task Force?

MEMBER LACEY: I have a question. I

noticed you said that the adult group nominated three measures, four. Can you direct us to our, is that anywhere that we could find that so we could take a look?

MS. GORHAM: I added them to a slide later on in the day and will pull them up. It would be hard for me to pull it up right now. But I definitely have a list of them so that we'll see them.

CO-CHAIR PINCUS: They're on the dreaded spreadsheet.

DR. ANTONELLI: Harold, I don't know if I'm having deja vu all over again. But I wasn't sure, when you talked about the discussion about care coordination and not having a singular definition, is that presenting a barrier because that seems to be a recurring theme getting into that space between providers and especially with respect to connecting to community providers with people that have significant risk factors for negative outcomes including behavioral health.

So I'm just wondering if you could say

a little bit more about what the implications were for those deliberations.

CO-CHAIR PINCUS: So I think it's not just care coordination. Care coordination represents sort of a special kind of issue partly because it's, care coordination is kind of like a projected test.

You know, different people have different views of what's meant by that. But it's an example, it's on the extreme end that, you know, it often requires data from more than one source to really get good information about care coordination.

And so again, it requires collecting data and having it in a repository where it can be combined. The same thing with, you know, just in general data from the electronic health records or from medical records that may be embedded in, you know, in tax and other kinds of things.

Any time you add an additional step it's much harder especially at a state level to

get that information unless there's some systematic repository of that information from which it can be called.

So I think that's, you know, and I think care coordination is a particularly problematic thing because it's not only is it more sort of clinically, often require more clinically textured information but it requires the information from more than one source often.

DR. ANTONELLI: There are recommendations that came from the task force about how to address what those gaps would be because it continues to be a huge gap area on quality. And as we try to integrate behavioral health and physical health not to mention other social determinants of health I guess if this body should be putting out recommendations to give some guidance.

CO-CHAIR PINCUS: There was some discussion about the particular issue of, you know, problems when states contracted managed care companies that carve out behavioral health

and may not have access to the data from the behavioral health organization.

You know, and there were two views of it. One is like it's a problem and it needs to be fixed. Others think well, you know, by having measures that require that it's kind of moves the needle.

States actually may want to put that in their contracts making the managed care companies accountable for getting the behavioral health data so that it's not an insurmountable problem, it just needs to be pushed.

DR. BURSTIN: Just to add to that, Harold, this is Helen, one of the things we've also seen in a lot of the developers who have tried really hard to come up with good care coordination measures of, you know this better than anybody, Rich, one of the things people often do then is just logically if the data sources aren't there ask the patients.

So there are a series of new measures based on the family evaluation of healthcare for

children with special healthcare needs. And the developers really struggled with trying to find measure of care coordination for kids.

And frankly the only way to get this information at this point in time was directly from the voice of the parent. So it continues to be an area where having interoperability, having linked data sets is going to be critical. But we're surely not quite there yet.

MS. GORHAM: So, Susan. I just wanted to bring up on the screen in front of you are all of the measures that the Adult Task Force voted on yesterday. The ones in bold are the ones that actually passed.

CO-CHAIR PINCUS: Terry.

MEMBER ADIRIM: Yes, related to what, something Harold said and what Helen just said you had mentioned using this core set for innovation. In the pediatric measures community a lot of the measures that are probably more innovative and perhaps may get us to outcomes that we're interested in, how important will NQF

endorsement be?

I mean it looks like that they can only be conditionally supported until they are NQF endorsed. Was there any discussion around including measures in the core set that perhaps are not NQF endorsed or how --

CO-CHAIR PINCUS: I don't recall having an explicit discussion about that. But, you know, but I did raise a question about, you know, if there are some things that are, you know, really highly relevant and important for this population that have not been endorsed and that there's some reason that, you know, we might want to encourage states to think about, you know, to explore the possibility of reporting that not so much for accountability purposes but for quality improvement purposes that certainly, you know we should not necessarily be automatically off the table.

CO-CHAIR GESTEN: So I mean I think, when I think about the endorsement issue I think it's important to, I have to remind myself

actually that the endorsement is not an end in itself but it's sort of what it means. And when I think about from the point of view of the states and other folks trying to implement this the challenge is measures that have not really been tested.

And sort of the issues of validity and reliability and the science and whether or it really makes a difference have not really been discussed and concluded. It's difficult. It makes it difficult in an otherwise crowded set in a crowded world of doing measurement and improvement to sign up and raise your hand and say, yes.

I think that there are exceptions as you talked about. There are certainly areas where there's development that, you know, it's just things are not ready in the context of, as you were describing, Harold, sort of experimentation or improvement.

There may be a role for it. I think the challenge is for states is in signing up for

measures and we've had the experience of measures that have not been fully vetted, have not been fully specified and not only for comparability but even for state use it sort of starts to fall apart.

So it's, you know, I think the, just a reminder to folks, particularly folks that are new that NQF and, yes, we're sitting in NQF headquarters. It's not all about a commercial for NQF.

It's about what the NQF groups do in the process of actually vetting a measure. And I think that it still remains important work doing that testing and asking those hard questions about the measures.

CO-CHAIR PINCUS: Katie on the phone I think you have a comment.

MEMBER DUNN: Yes, thank you very much. A quick comment picking up on the last speaker's comments about untested questions and referring back to earlier introductory remarks.

In addition to having untested

measures and the difficulty in implementing them within a state Medicaid program I would offer to you that the party that needs to, that we work most closely with who drives the finances of our program, meaning our individual state legislators outcome measures on care coordination probably not at the top of their list in terms of a proof that the Medicaid program is actually being effective.

So I would hope we would keep that in mind. Interoperability has proven to be a challenge even between the larger healthcare providers in our healthcare system such as the hospitals and the Medicaid programs.

So if you can imagine these smaller community based agencies that are, started off as small, little siloed maybe prenatal or family planning agencies or a community action program, you know, their ability to develop the, not only the IT capability but the staffing infrastructure to assure validity of data is really questionable at least particularly in the rural states.

And my last comment, and I appreciate your patience with this, is there was a comment made about the responsibility of the task force to make recommendations on how perhaps to execute on such reporting of care coordination measures. And I think that actually goes beyond the work of the task force.

But I would say to my colleagues at CMS that it would be an incredible project for Medicaid directors and CMS to work on together.

CO-CHAIR PINCUS: Thank you. Other comments, questions? Andrea.

MEMBER BENIN: Are there any discussions that have been had or that need to be had about ICD-10 and the implications for the various metrics that might rely on the administrative data? Have we, is that something that we need to talk about or that just plays out?

DR. BURSTIN: I'll just venture that it's something that's considered through the course of the endorsement of the project. So

measures need to come in, Elisa just walked out, but I believe with both ICD-9 and ICD-10 to make it clear for the transition to be able to go smoothly.

CO-CHAIR PINCUS: So could we go back to the, where we left off with the slides? Any questions about the four that were added and the others that were not? So let's go back to where we left off on the slides.

CO-CHAIR GESTEN: While you're doing that, Dr. Singh, I know you joined on the phone. Do you want to introduce yourself?

DR. SINGH: Yes. This is Gopal Singh. I'm the Medicaid Child Task Force and I'm representing Mental and Child Health Bureau of the Health Resources and Services Administration.

CO-CHAIR GESTEN: Great, welcome. Anyone else on the phone that didn't get a chance to introduce themselves? Okay.

CO-CHAIR PINCUS: Marsha.

DR. LILLIE-BLANTON: So I'm going to give a few updates from CMS and I'm assuming, am

hopeful that Karen Matsuoka will join us because she's going to talk about the broader landscape and then we're going to have some kind of overview of some of our improvement initiatives.

So we've got a slot here and we'll try to make sure we stay within our time frame. So yesterday we talked a little bit about and of course in the orientation, the work that we have done for the last five years in terms of developing a quality measurement and reporting program for Medicaid and CHIP.

And it is a program that, as you know, is required by CHIP, the CHIP Reauthorization Act and the Affordable Care Act. It is a voluntary reporting program which is something we talked a little bit about yesterday.

And I want to say that while it is voluntary I would say we have made, we have created a solid foundation. I think the partnership between the federal government and the states has resulted in reporting and information that we consider to have great value

in helping us understand performance but also helping us to guide our work on improvement.

Having said where we, the journey we've been on in the past five years let me say that I think our landscape is changing. And our landscape is changing in large part because of two rules that were just issued in 2016.

One, the access rule and the other the managed care rule. And so in terms of an update I want to make sure that you all are living in the shoes that we are living in right now because our sense is that what we have done in the past in terms of quality measurement and reporting is going to take a giant leap forward as we look at the new landscape that we are under with these rules.

So let me just talk a little bit about each of these rules. In terms of the access rule we actually sent you the material on the notice of proposed rulemaking and then on the final rule to give you a sense of what the expectations are.

But the access rule was finalized in

March of 2016. And it is largely focused on fee-for-service. Not largely, it is focused on fee-for-service. But it requires states every three years to produce an access monitoring plan for five different areas.

And those areas are primary care, physician specialty, behavioral health, pre and postnatal care and home health. Within primary care it's a broad group but it certainly includes dental for those of you who are focused on a subgroup which we did not define as a separate category but considered it as a part of primary care.

States are expected to produce their first plan in October of 2016. So for the first time we will have at least the plans from the states of how they plan to monitor access and then every three years on a periodic basis some assessment of how well they're doing.

I raise the access monitoring plan because we talked a lot about alignment and we talked about how our measures are being used.

What we see as ideal would be to have alignment across what states are now, will be producing and what's in our core set because for the purposes of both providers and for states we want a core set of measures that can be used across the different measurement and monitoring efforts that CMS is requiring.

So we need to think about within our core set what's now in our core set that could help a state better measure access to care across these five areas. And I think one clue of what's in the core set is the NQF crosswalk that they did looking for vital records at how each of the core measures fits into the IOM framework of the major domains identified by IOM.

One thing when you, if you haven't looked at it we talked about it yesterday and I presume there will be some discussion about it today I did take a second look at it. The one thing I want to suggest that at some point today we, you know, or tomorrow we talk a little bit further, they identified a set of measures both

from the adult and the child that they defined as being, as a part of the, as measures of access.

The only other measure I would add to that list would be our CAHPS measures which as you know are defined by CMS as a part of the experience of care but they're also well tested, well used access measures in that CAHPS survey.

So I certainly feel like that there is some alignment for access monitoring plans that are now in our core set and would welcome your input on what other measures or whether there's some repurposing or at least redefining of the measures as NQF has now defined them.

But one thing NQF has made clear is that while they have defined which domain these measures fit in the measures could fit into multiple domains. So they're not mutually exclusive categories.

So that's the first new kind of landscape that I think I want to make sure you all are familiar with. The second is our managed care rule which unfortunately the briefing that

was scheduled for the managed care rule, I think it was last week we had technical difficulties.

So for those of you who were on it I want to apologize. We are rescheduling a quality managed care briefing for June 2nd. So you'll have another opportunity if your available during the time for that briefing.

But I want to talk a little bit about the managed care because within the managed care rule is a requirement that states would set up quality rating systems. We call them the QRS.

And those quality rating systems will be modeled after the quality rating systems that now exist in the marketplace. And within the marketplace there are three major domains or areas that are a part of the rating system.

One is clinical care management. The other one is member experience and the third major domain is health plan efficiency and management.

The performance measures that will be included within each of those domains will be a

part of an extensive outreach effort, listening sessions, engagement with thought leaders like yourself, with clinical care specialists in different areas and certainly with our state partners will help us define the specifics of the performance measures.

The performance measures framework we're still working through our Office of General Counsel. But we will have to issue a notice of proposed rulemaking to identify at least the framework and we're still trying to understand how precise do we have to be because for the marketplace much of the guidance was subregulatory guidance as opposed to in a proposed notice of rulemaking.

But what we are certain about is that there will be opportunity for public comment. There will be opportunity for input. But what I want to bring to the attention of this group is that once again there's this issue of alignment.

I mean we would very much like to have the measures that come, that are defined or

identified for our core set from our, for the QRS to come from the child and adult core sets. As I said, we think it helps to reduce burden on providers.

It helps to reduce burden on states. So to the extent that we can align we think that it is a win-win for states and providers. So I want you to think more as we move forward the next few days with how we can better serve the future.

And I say the future because while we have a new rule the plan is that in 2018 we will issue the notice of proposed rulemaking. But states will not actually be developing their, they won't be required to be in full compliance until 2021.

So we really have a five year period where we will be developing, refining and actually rolling out the quality rating systems. So we have time. But it is, I think moves us into this area where we began to talk a little bit yesterday about accountability.

You know, measures that are used for accountability purposes. And while there certainly are no financial incentives tied to performance our expectation, thank you, our expectation is that over time the transparency of information about performance will help to drive beneficiaries into higher performing plans.

It will help plans to become higher performing plans as information about performance is more transparent and is more easily accessible to states, to beneficiaries and to providers and of course to advocacy groups. So our sense is that the landscape is changing.

You know, we're, it's still voluntary for the core sets. But the requirement for health plans to develop or for states to develop quality rating systems is a requirement and it will, I think, change what has been, the systems for the core sets will still be voluntary reporting.

But if you consider the fact that about, you know, we say when we talk about the

rule that about three-quarters of beneficiaries are enrolled in some kind of managed care arrangements. Now that three-quarters includes the primary care case management which is not risk-bearing systems.

But our estimates are that about two out of three children are in risk-bearing managed care plans and about one out of two adults are now in risk-bearing managed care plans. Even that is growing.

I mean we are seeing an increasing number of persons with disabilities, duals moving into managed care plans. So the sense is that managed care that are risk-bearing entities are becoming more of the predominant form of healthcare delivery in Medicaid.

So the systems and even having said that, we understand that in states like Oregon you have CCOs and in Colorado you have regional care organizations. And, you know, in Arkansas there are different names.

So there are lots of different names.

But those are that are risk-bearing and meet the criteria for how managed care is defined in our, in statutes will be subject to the quality rating system.

So that in itself will change performance measurement and reporting of performance measurement in Medicaid. It will be a gradual shift. This will not happen overnight.

But I do feel like this body can help us ease that transition by helping to identify measures that fit into those different clinical, those three buckets of areas that are defined in the rule. It is a transition in Medicaid that I think we are well poised to make.

I mean I think our last five years have been years of learning. It's been years of growing. I mean, performance measurement in Medicaid is still relatively new.

But in the next five years we would have had almost ten years of performance measurement and certainly a history in managed care that predated what was happening with our

statewide measurement. So while this may seem as if it is, for some, a big change I think it has been a gradual transition.

So I just wanted to raise that change and help this body understand how we think that, say we need your help in making sure that this is a transition that does not burden our providers or our state partners, but is one that we coordinate our efforts across these two, both fee-for-service and managed care systems.

So before, I mean I don't know if there are any questions about that or if we should --

CO-CHAIR GESTEN: Thank you for that. It's very helpful. I get that the NPRM will talk about a framework. What wasn't clear to me and maybe I missed it is that is there going to be within the NPRM or some other process a prescription of which measure states must report on?

DR. LILLIE-BLANTON: Well, as I said, well first of all ultimately before we finalize

there will be precise definitions of or listening of measures. What we are unclear of is whether our Office of the General Counsel is going to require us to put that in, those precise measures in a rule or whether we can identify the framework in the NPRM and then identify the precise measures in subregulatory guidance similar to as we do now with core measures.

It's not in a rule. We issue what we call subregulatory guidance. And our preference would be to do it in subregulatory guidance because otherwise we have to do a rule every year if we change the measures.

CO-CHAIR GESTEN: Yes, you don't want to do that. But --

DR. LILLIE-BLANTON: Yes, we don't.

CO-CHAIR GESTEN: Trust me.

DR. LILLIE-BLANTON: But we might have to if our Office of General Counsel --

CO-CHAIR GESTEN: Sure.

DR. LILLIE-BLANTON: -- says that. But the main thing is that there will be

opportunity for public comment. There will be listening sessions and we will get your input and we will get the input of a body such as this.

What we've not resolved is whether or not it will, there needs to be some overlap in coordination and we're still thinking through how that process is going to work. But NQF, from my understanding, now works with the marketplace QRS.

And so our sense is that there will still be some engagement of the NQF process as we define the specific measures.

CO-CHAIR GESTEN: I'm sure you know this. The net result of having, this is not a comment good, bad or indifferent but just an observation and a prediction that once there are mandatory measures those are the measures that states will report.

DR. LILLIE-BLANTON: Right.

CO-CHAIR GESTEN: And the voluntary measures will be interesting. But will likely not, you won't see very much of it.

DR. LILLIE-BLANTON: And remember this reg only applies to, in terms of requirements, for managed care. But that is the large body of what we are doing.

CO-CHAIR PINCUS: Is it the answer to that will be mandatory measures or the states will have flexibility?

DR. LILLIE-BLANTON: Well we don't call, we're not calling them mandatory. But in essence if they're in the notice of proposed rulemaking or if they're in subregulatory guidance as the measures which are a part of how the quality rating system is, will be operationalized they in effect become required reporting for managed care.

But they will not have that same level of requirement in the fee-for-service world. So there's still a need for the core sets because that's where we'll get statewide data and there's still a lot of concern and interest in trying to understand how managed care and fee-for-service compare in terms of performance.

And as you will notice in the rule, we have it's called PCCM entities which some have financial incentives and those entities fall under some of the requirements for managed care.

CO-CHAIR GESTEN: So like I said, I opened up this box or you did. Megan and then Susan and then we'll get back to, you have more that you want to present, right?

DR. LILLIE-BLANTON: Well we have a next phase of this which is using the measures on improvement.

CO-CHAIR GESTEN: Meg.

MEMBER MURRAY: Just to build off of what you just said that fee-for-service is not going to subject to this and I just have a question why is CMS letting fee-for-service off the hook, you know, in the reg? What's the thought when, so --

DR. LILLIE-BLANTON: Well we don't think we're letting fee-for-service off the hook. We actually think that the access rule, which certainly is not quality of care but at least it

begins to provide us with some information on performance measurement and some ability to measure and monitor what's happening in fee-for-service.

The challenge with bringing fee-for-service into this arena for us had to do with the many changes we were making in managed care with the managed care rule. So for example you may know that we initially, in the proposed notice of rulemaking were asking states to develop a quality strategy that would have included managed care and fee-for-service.

And that was one of the provisions we did not finalize. And it was, you know, as you look at how much change a state can tackle at one point in time, you know, we had to think about what was realistic.

And we had just finalized the access rule. And the question of what authority do we have in a managed care rule to expand in a managed care rule beyond managed care was raised to us.

And so there were some questions about our ability to do what we wanted to do. There were some questions about at the federal level, you know, the ability but also at the state level there was some concern about CMS' ability to bring, to develop, you know, a quality rating system that would have included, for example, fee-for-service providers.

I mean it's a, the fee-for-service providers and the measurement of fee-for-service I think is growing particularly with our work for ACOs and other forms of care. But by and large there's some coordinated structure, you know.

And with fee-for-service providers the system of trying to measure performance across those providers, you know, some who are in different systems of care, others who are not, it just, it posed some challenges that we questioned our ability to move in that direction now.

It doesn't mean that five years from now we won't. But the concern about our ability to broadly bring in fee-for-service just raised

lots of questions in our mind. I mean we just, in this rule I think we have done a lot to strengthen and move us into a direction of providing better quality care in Medicaid.

And I think between the access rule and the managed care rule, you know, we are leaps ahead of where we were five years ago. And sometimes incremental change is all you can do and do well.

You can do a lot. You can try and do a lot. But the question is can you do it all and do it well.

MEMBER MURRAY: So you're hoping there will be some alignment though between the access requirements and the managed care?

DR. LILLIE-BLANTON: Absolutely.

CO-CHAIR GESTEN: Yes, so they pay me the big bucks to watch the clock. So why don't we move on, Susan, to your question. Thank you, Meg, for that, the question and for the answer. Go ahead.

MEMBER LACEY: Thanks, Marsha, that

was really helpful and it is an advance so that's great. So with the access rule and the entities having to demonstrate that they have developed a quality program in I believe those three domains the clinical, the experience and in the --

DR. LILLIE-BLANTON: That's the managed care rule with those three domains.

MEMBER LACEY: -- managed care rule, okay. So is it a subregulatory guidance that you guys gave them to develop this or is it, how robust does it have to be? Does everybody kind of do it differently and is it we do it, we don't do it? How does that work? Thanks.

DR. LILLIE-BLANTON: So there's a requirement that all managed care organizations whether they are defined as a managed care organization, whether they're a prepaid inpatient health plan or whether they are a prepaid ambulatory health plan would create a quality rating system.

And the state actually would create that rating system. At the federal level what

we're going to do is create a model that then a state can use. But, yes, there is a requirement that there will some uniformity though there will be variability.

And the one variability that I did not mention is that states can develop an alternative system and it still has to be approved by CMS. But there are some states now that currently have quality rating systems.

So New York, for example, Florida, I think Hawaii has a quality rating. There are about five or six states that currently have quality rating systems.

But our sense is that other states may want to develop an alternate and that alternate though would then have to be the rule says substantially comparable. Now that will be a big challenge for us to define what that means.

But I would think that at the very least those three domains have got to be well measured even though the measures might differ because part of the challenge we're going to face

is that, for example, many behavioral health plans are prepaid ambulatory health plans. And the measurement set will not be the same for a behavioral health plan as you would find for a comprehensive managed care plan.

So the measures will vary depending on the type of plan. The dental plans will not have the same quality measurement or, that the comprehensive plans have.

So we will be working with our contractors. We will be working with our Center for Clinical Quality and Standards who have been managing the work on the marketplace. There's expertise, there's experience within CMS that has done this and so we're not starting without any knowledge base and experience internally.

And there are states that have already done this. So we're going to rely on our state partners to help us understand what challenges they have faced and how we can at least reduce the chances or reduce the problems that they've already experienced.

So we will learn at the federal level. We will learn at the state level. And by the time we get to the 2021 which is when we expect to this to be operationalized, hopefully our learnings will create a system that works well for all of us.

CO-CHAIR GESTEN: Thank you. Thank you for that question. Jeff.

DR. SCHIFF: Just a quick question. The, are you considering a, perhaps for lack of a better word, a Chinese menu of what the measures could be or will there only be one set of required measures?

And I guess the reason I'm bringing this up or maybe even requesting that is that I'm concerned that if we have one set of measures without any variation that's required we'll go to a claim's based set of measures that's easy to report and we won't have any growth in the measure quality.

So it would be nice if there was a way to use the measures as you can do this which may

be claims based but you can also do this which may be more hybrid and maybe a better measure.

DR. LILLIE-BLANTON: So all I can say now is that we will hear from our many partners and stakeholders in the listening groups in the process of whatever multi-stakeholder groups we set up to identify the measures. My sense is though that there will be alternate sets of measures for different types of plans.

But it's not likely that it will be a menu, as you defined it as we have now in our adult and child core set. You know, I think that the plans that are behavioral health or the plans that are dental will likely have a defined set of measures.

But there will be input in those measures so that the measures are not the lowest common denominator. I mean I think that's what your big concern was, whether or not all our measures would be just claims based and the lowest common denominator.

And I would say that would not be the

ideal of what we seek to achieve.

CO-CHAIR GESTEN: Thank you. Thank you for the question. You're on the fence. Are you down, are you up?

MEMBER SCHLAIFER: I think you may have answered my question. I think it was kind of the opposite of that question but probably the same answer.

And I think it's, one thing I mentioned yesterday as we were talking is that so many managed care plans are now national or growing to be national managed care plans. And I think there was a lot of hope that this would get to alignment.

And it sounds like we're not, potentially every state could be doing something different.

DR. LILLIE-BLANTON: I think that's highly unlikely that every state will be doing something different. But I do think there will be a handful of states that will do something that's alternative to what the model is created.

But it still has to be substantially comparable. Now defining what that means will be our big challenge.

MEMBER SCHLAIFER: So we could have the same, we could have a similar measure, a measure that measures the same thing, probably not 50, 14 different ways across the country?

DR. LILLIE-BLANTON: I would think that's highly unlikely.

MEMBER SCHLAIFER: Okay.

CO-CHAIR GESTEN: During the listening sessions you're going to hear probably that comment, right from Marissa and others.

DR. LILLIE-BLANTON: I mean just as we've now developed technical specifications for our measures I think once we define that this is the measure then and it's, and particularly if it's, you know, whether it's NQF endorsed or not but it's likely that, you know, most of the measures will be NQF endorsed, it will have defined technical specifications. So I don't think we'll have --

MEMBER SCHLAIFER: Okay. That would be good news, good news.

CO-CHAIR GESTEN: So, Marsha, thanks for all that. And, Karen, just in time do you want to introduce yourself and I think you have other slides and another presentation from you guys that you want the group to know about. Is that right?

DR. MATSUOKA: So I'm Karen Matsuoka. Hello again to those of you who I saw yesterday and hello to those of you I'm meeting today. I am the new Medicaid and CHIP chief quality officer and also the Director of the Division of Quality and Health Outcomes.

I will be taking over the position that Marsha formerly filled although I'm sure that she's let you know that she's not moving far away. So we still have the benefit of her expertise.

But I will be fulfilling the role that she used to play and she has now assumed a new position as senior advisor at the Children and

Adult Health Policy group level.

My only update given the full agenda that we have today and it draws heavily from, I think, a lot of the themes that we're going to be hearing later today is around the need for alignment and ensuring that as we're thinking through and voting on what we think will be the revisions to our 2017 core measures that we very much need to keep in mind issues of utility.

So what is that we want these measures to perform at the state level? How do they align with the work that's already underway and will be developing soon with especially the Medicaid managed care regulation, the measurement that's happening at the plan level, all the work that's happening at the provider ACO group level?

How does it all roll up to improvement that we want to see at the state level? And the alignment piece, as critical as it has always been is actually even more critical now because a lot of the funding that has been supporting the states' works to date in helping them build up

the infrastructure and providing the technical assistance to help them report these measures, that funding as of fiscal year '15 has ended.

We don't know what the impact is going to be. Congress may always in the future authorize more funding. But at this point that funding has ended.

So I know that the issues of balancing, you know, the burden of the measure, the feasibility of the measure with the value that will be obtained if states were to report it, that's always going to the forefront of all of your minds as you're thinking through which measures to include and what to drop.

I just wanted to underline that and underscore it for purposes of this year because I think that issue becomes more important this year than ever before. So that's my only other additional update from the CMS perspective. Unless there are other questions I think we can hand it over to our oral health and infant health initiative colleagues.

DR. LILLIE-BLANTON: So I want to ask Laurie if you could come forward and has Lekisha arrived yet? Yes, she has.

FEMALE PARTICIPANT: She's on the phone.

DR. LILLIE-BLANTON: She's on the phone, okay. So we have, is there room at the table, I can move if you, okay, there's a seat here but I can also move.

CO-CHAIR GESTEN: Thank you. Come close. That's too far away.

DR. LILLIE-BLANTON: So Lekisha is on the phone. But let me just kind of set this up a little bit. We were asked to share with you some of the work we've been doing to use the measures in improvement efforts.

And as Karen mentioned, we have a number of efforts underway to use our measures. I mean through the adult quality grants there is a requirement that states would conduct at least two performance improvement projects linked to our core measures or our CHIPRA grantees which is

what we call them because they were funded under the CHIP Reauthorization Act.

There was also the effort to use the measures in improvement efforts. And of course we have several other quality improvement projects. We call them Quality Improvement 101, 201 and 301 where we have, we feel like we have grown in our understanding of how to do this.

But we have a number of efforts. But what we wanted to spotlight today were two of the nationwide improvement efforts because all of the efforts I previously described were state specific, state initiated and state driven with our supporting them.

So I'm going to ask Laurie Norris to start with the oral health initiative and then we're going to ask Lekisha to talk about our maternal and infant health initiative and with the oral health initiative she'll and both of them will talk to you about the specific measures that they're trying to drive improvements on. So, Laurie.

MS. NORRIS: Thanks, Marsha. Hi, everyone. So we took one of the measures in the child core set, PDENT, Preventive Dental Services and we built a campaign around it.

We essentially started an oral health initiative back in 2011 and involved, as Marsha said, all 50 states and the District of Columbia. We set a baseline based on 2011 data and we set an improvement goal of ten percentage points improvement both nationally and for all states.

Every single state had the same improvement goal though every state started at a different place. So nationally we started at 42 percent of children ages one to 20 getting a preventive dental service.

Our goal therefore was 52 percent. And so far as of the 2014 data we have advanced three percentage points to 45 percent as the national average. And as I mentioned every state has its own goal.

So this is just a quick snapshot of where we are across the board with PDENT. Again,

as of 2014 our most recent data, our median rate is 48 percent. And you can see that the states are clustered.

You know our 25th percentile rate is 42.5 and our 75th percentile rate is 50.6. So we're clustered, you know, in that 40 to 50 percent range in general.

We do have a couple of states that are high performers that are 61, 62, 63 and we have a few states that are hanging out around 25 or 26. But most states are clustered in that middle range.

On this map you can see where we have our strongest performers and our weakest performers. The weakest ones are the tan colored states and the strongest performers are the dark blue.

So some of these might come as a bit of a surprise to you. Some of the states that are strong in other things are not strong in children's oral health and vice versa.

So what did we do? We worked for the

first four years on this initiative in a number of ways to support states to reach their improvement goals. We asked states to create oral health action plans.

It was not a mandatory exercise. We had 26 states who took us up on it and created plans for how they were going to reach their goal. We also had several learning collaboratives that operated. Thirteen states participated in one of three learning collaboratives.

We hosted a vast array of technical assistance webinars, 17 of them over four years. And we developed quite a set of technical assistance tools that gathered best practices, that focused on consumer education around children's oral health.

We put together a template for oral health performance improvement projects that states could use with their plans. We created training modules for states to understand and train their staff and their contractors on how to

collect and report the data.

Of course, data quality is really important in this effort. And recognizing that managed care is also important in oral health as it is in overall health we have more than 50 percent of our children receiving dental services through managed care.

We created a Medicaid dental contracting tool kit to support states to strengthen their contracting around dental managed care. So in addition to these sort of overall efforts to support everybody, we did some work with individual states.

So I'll just highlight a few of those. Florida was really our first guinea pig. They were our lowest performer and had been, you know, steadfastly holding out as a low performer for several years.

And we were able to work with them when they came to CMS to review their -- to renew their 1115 waiver to put some requirements in their special terms and conditions in terms of

having a more robust program around children's oral health.

And that involved requiring, for example, that they require their plans to do oral health PIPS which they did. In addition, on their own they put in their MCO contracts a requirement that the MCOs meet the ten percentage point improvement goal.

And they put some financial penalties attached to that requirement. And Florida is our success story. Over the last two years they've actually made quite a jump in performance, 19 percentage points they've achieved on PDENT.

So they are no longer the lowest performing state. California we've also been working with for years. They're also a relatively low performing state and have had steady performance at around 38 percent for quite a few years.

And we were very pleased in December of 2015 also in the context of an 1115 waiver renewal to be able to invest $740 million over

five years in a dental transformation initiative which is focused on getting California to their ten percentage point improvement goal.

Most of that money will be going to provider incentives to essentially prop up the reimbursement rates for dental services in California to get more providers to perform preventive dental services, to give continuity of care, to see the same child year over year as well as doing some work in early childhood carries in the under six age group to really focus to see if we can make a difference at the beginning of a child's life.

It's too soon to know whether we have performance improvement. This just went into effect six months ago. But we're hopeful. In Kentucky we've been working with them on a learning collaborative with all five of their MCOs to do a collaborative oral health PIP.

And they chose for their aim a subset of PDENT. They're looking at the age three and under group to try to impact the number of

children age three and under who get a fluoride varnish treatment as a preventive dental service and to increase by ten percentage points that age group.

So those are just a few examples. I know my time is short here. Just wanted to show you that we are continuing to make improvement. This graph that you're looking at right now, PDENT is the red line in the middle.

And it, this is from before the advent of PDENT. We collect this data on our 416 and have for quite a number of years. So we were able to go back to 2000 and see our trend through 2014.

So PDENT has improved significantly over the last 15 years. But we're still below, absolutely below where we want to be. The green line at the bottom is what used to be known as TDENT. That's the treatment measure for kids.

And that one was removed from the child core set last year partly because we don't really know whether that line should be going up

or down because we don't have a good denominator. We don't know how many kids need treatment so it's hard for us to know whether we're making progress.

And then the top line is the children who got any kind of dental service at all. So treatment, prevention, diagnostic, whatever. So you can see that line is also on an improving trend.

I'm going to skip the next slide and just wanted to show you the way we're thinking about our work going forward is we're going to really invest our technical assistance resources in partnering with our lowest performing states. And these are the states you see here.

The red states are the ones that are currently below 40 percent on PDENT. Fewer than four out of ten children are getting a preventive dental service. And then the yellow states are the states that are between 40 percent and 45 percent which is currently the national average.

So these again, may not be the states

you would necessarily have expected to show up in that group. But we're collaborating with our state partners working through state Medicaid directors, working as states come into CMS to renew their waivers or their contracts or their state plans, make state plan amendments.

We're engaging in the conversation about children's oral health and how we can support them to improve.

DR. LILLIE-BLANTON: Do we have time for questions or should we go straight to Lekisha and then take questions at the end? Okay. So, Lekisha, are you on?

MS. DANIEL-ROBINSON: Hello. Can you hear me?

CO-CHAIR GESTEN: Yes, we can. Thank you, Lekisha.

MS. DANIEL-ROBINSON: Okay, great. I recognize this is not the most ideal way to do a presentation but I injured myself this weekend. But at any rate, I'm going to provide a brief overview of the use of the postpartum care visit

measure and the CMCS maternal and infant health initiative.

As many of you know we launched an, the initiative in 2014 based on a series of stakeholder discussions as part of an expert panel on improving maternal and infant health outcomes in Medicaid and CHIP. And the initiative is focused on two primary goals.

And should I be advancing the slides or will someone else advance?

FEMALE PARTICIPANT: Do you need her to say next slide?

MS. DANIEL-ROBINSON: Okay. Next slide please. Thank you. Okay, well mine hasn't caught up yet but I'll keep talking. So we had two primary goals with the initiative. The first is improving postpartum visit rates and content of care and the second is increasing access and use of effective methods of contraception.

Next slide. So many of you are, you know, certainly familiar with the reason a postpartum visit is so important because of the

opportunity to not only assess physical and psychosocial well-being of the mother but also provide counseling, family planning, addressing a pre-existing or chronic conditions, et cetera.

And so in our most recent secretaries report we show a 58 percent median of women delivering a live birth had a postpartum visit between 21 and 56 days. This is, 58 percent is the median for 34 reporting states.

The next slide shows the geographic distribution of these rates. And I would say the range is from 21 to 94, I'm sorry, 90 percent receiving these visits. Next slide.

So given the information that you just saw on the previous slides we found that there was perhaps an opportunity to do some additional quality improvements in postpartum care to increase those rates. And so as part of the initiative we worked with 11 states in a learning series which was really a series designed to provide targeted technical assistance to support these states in their rapid cycle tests of

change.

So we worked with 11 states additionally. Five states had funding as part of their Adult Medicaid Quality Grants to support their infrastructure development but also to look at quality improvement opportunities. So we had some additional states as a part of that.

And we've really just folded all of those states under the umbrella of the action learning series. Next slide please.

So the activities that these states have undertaken included identifying strategies to improve postpartum visits through care coordination, appointment reminders, working at the site of delivery to provide some of the follow up appointments, clinical checklists, incentives, addressing transportation issues and of course reimbursement.

The states also focused on a few subtopical areas. Reproductive life planning was primary among those. Looking a little bit at chronic conditions and also trying to improve

breastfeeding rates.

Next slide please. But there are a few challenges that seem to be across the board with the states that use the postpartum visit measure to assess progress in their pilot projects.

One being that tracking the postpartum care visits is actually difficult for states who have global billing since the payment typically occurs once the woman delivers. So the payment for the maternity, the entire maternity care episode occurs typically at delivery.

The measure alone does not often reflect the range of routine care that's provided in the postpartum visit and as well the time frame doesn't seem to necessarily align with care that some of the states believe is actually happening that is quality care but may not fit within the time frame that the measure specifies.

Next slide. Nevertheless I think that all of our states find that tracking the postpartum care visit rate is an important

mechanism to drive quality improvement and in fact have made some adjustments to the measure in order to effectively measure the visits.

They've found that working through their managed care organizations is, you know, a primary tool given relationships that the managed care entities have with both providers, excuse me, as well as the members. Reforms in the payment methods, you know, is obviously a big issue.

And while there were some immediate or a few changes noted with changes in reimbursement I think there needs to be additional modeling, testing and evaluation of that to determine the real effectiveness of some of those types of changes and whether or not other types of changes might be appropriate.

And I think finally while we worked with the postpartum care learning series space for a ten month, you know, rapid cycled test period we continue to support them and link their efforts to other QI efforts within their states

because regardless I think they still find this to be a really important issue that needs to be addressed and provides so much of an opportunity to, for well women care and to ultimately impact subsequent pregnancies.

So that's all I have for now. Thank you.

CO-CHAIR GESTEN: Thank you so much. Both great examples of sort of with the utility of collecting this data and using it to target states, to target activities, to track progress over time, to learn lessons.

So I mean I think this is really helpful to kind of get regrounded in what the measures are really about. So thank you for both presentations. I think we have time for a couple of quick questions if folks have them. Carol.

MEMBER SAKALA: Yes. I was interested in the unbundling of the postnatal visit for payment and wonder if you could mention what the mechanism is and how extensive that applies across states.

MS. DANIEL-ROBINSON: I would say that mechanism is not extensive. One of the states did do a test to look at, you know, a methodology to unbundle.

And essentially, I'm sorry just trying to get to it. Essentially, you know, perhaps it wasn't really an unbundling as opposed to ensuring that a visit actually occurred before the final payment was provided.

So that's something that's sort of being tested. I would say that other states are looking at ways to break up the payment such that a postpartum fee would occur after the labor and delivery fee.

But it's still I think kind of early in their testing to really, you know, identify how successful a potential approach such as that might be.

CO-CHAIR GESTEN: Great, thanks. Meg.

MEMBER MURRAY: Yes, I had a question about the dental. And I was just curious did you find that dental rates were better if it was

carved into the whole physical health managed care plan or a fee-for-service or a dental managed care plan? Was there any trend that you saw there?

MS. NORRIS: So I think we all would hope that if it was carved in there would be integration and it would be strengthened. But what we actually found is that at least as of 2014 the states that were struggling most were the states that have had it carved into managed care.

MEMBER BENIN: Thanks. That, your dental project is, that's like one of the best things I've seen all week. I don't know. It's been a long week.

So it's just Wednesday. I mean it's sort of a sad statement of affairs, you know, sort of is a sad statement of where we are but it's phenomenal progress.

But it seems to me that there was a lot of resources and sort of dollars and brute force put into that one piece of things. What is

the, is there some lesson in that for the whole picture that we should understand?

MS. NORRIS: Well I first want to say there were really not a lot of dollars put into it. There weren't any grants to states. There was, that was maybe, we at CMS always felt that was one of the weaknesses of the campaign was that states were always like well if you could give us money, you know, maybe we would pay attention to this.

So there was no money. California managed to, California decided to prioritize it in its waiver renewal and was able to repurpose some, you know, dollars. That's where they got their $740 million.

But that's just regular Medicaid money. It's not, you know, extra grant money that we had to give the state. But brute force is a good description and it has sort of felt like that.

And it has felt like it's really hard work to get a state focused on this, to get the

right team together, to get them to figure out what the gaps are in their state and what they need to do and then to do it. It has been a long slog.

Lessons learned, I leave that to Marsha and Karen in terms of translating to other efforts.

CO-CHAIR GESTEN: Susan.

MEMBER LACEY: So that was great about the dental. So my question is about the postpartum visit on any of the states that are doing really well or any kind of experimentation with just doing this visit at the patient's home. Okay, well thanks.

MS. DANIEL-ROBINSON: I'm sorry. I didn't mean to cut you off. But, yes, I would say there were a couple of interventions that in the short test that occurred that seemed to be the most promising and that would definitely include the visits, home health visits occurring either to encourage the woman to go into her physician's office for the care or providing the

care during the home visit so providing that home, that postpartum visit at the home site.

And then I think the other thing was, you know, just simply the scheduling assistance while the woman was in the hospital was the other item that was really, were the interventions that probably were the most successful to this point. We will be coming out with a brief that describes some of the preliminary findings in the near term.

CO-CHAIR GESTEN: Thank you, Bob.

MEMBER RIEWERTS: I just want to share my excitement about the oral health initiative also. It's really great work. I think one of the comments that you made that was missing is the public awareness of the importance of oral health.

I can tell you as a pediatrician we often see children who need dental care and the parents are like okay, whatever and sugared drinks. There's just so much public education we need to do still to convince people of the

importance of taking care of their children's teeth.

And so I, we're working on it in California but we have a ways to go.

CO-CHAIR GESTEN: Thank you. Rich.

DR. ANTONELLI: Thank you for both of those presentations. I'm going to ask, frame this question at a strategic level. So both of these opportunities for me excite me when I think about, you know, are we somehow integrating services.

With all due respect to the dental I'm thinking that if you had a primary care provider do an evaluation, slap on some varnish when appropriate that that probably would have met this measure, correct?

MS. NORRIS: Actually not because of the way we collect the data. We have a separate line on our 416 that collects when a primary care physician does an oral health service. But that's not part of the specification of PDENT.

DR. ANTONELLI: So PDENT is a dental

provider's --

MS. NORRIS: Dental.

DR. ANTONELLI: Okay. I apologize if I missed that. So that actually is potentially more exciting. So where I'm thinking about where a lot of the spend is for those of us trying to build accountability into systems of care is the bridge, if you will, or maybe it's more of an abyss right now between the behavioral health community and the medical community.

So what are some of the learnings from this that we can use strategically? And I'm especially intrigued with the fact that this was CMS driving this, right. So, you know, from where I sit on the children's side of the house CMS is this really cool thing and it's really nice.

But it's very hard to get from, you know, CMS central to the front line. So what can we do going forward to really integrate some of these vulnerable, high risk, high resource utilizing populations because we need this kind

of a dynamic to make those other things change?

MS. NORRIS: Can I make a quick comment about that? So the, there's an oral health integration tool kit that is on the verge of being released by the, some really long, we can provide it to this group. I have, some really long name that I can't remember.

But I have reviewed it in draft and it really is a step by step and very strategic handbook for how to integrate into primary care practices children's oral health as well as adult oral health actually. And I'm really excited about that because I think it will give front line practitioners the tools they need to do it.

The second comment I have is that payment is really an issue in this area. The way we pay for these services is fee-for-service to the provider even in a managed care setting while the plan might be at risk typically in oral health the provider is not at risk.

We're beginning to think about how to reform the way we pay for oral health services to

focus on outcomes and less on individual services.

DR. ANTONELLI: So it's actually that second point that I would like to maybe have you guys dig into a little bit. And, Marsha, I'm going back to your presentation where there was an access component, a managed care component and some of the rules and guidance in that space.

So for years we've been giving tool kits on you name it, lead poisoning, breastfeeding, developmental screening, maternal depression. That doesn't change behavior especially as we're moving to an era of accountability and an expectation around outcomes that leverage integration across a specialty.

So I'm wondering in that second space, so here's my fantasy. My fantasy is as you're handing this provider that integrated dental health took kit there is a concomitant delivery of here's the funding stream, here's the performance measurement.

Here's the role the payer is going to

play. Here's what the regulatory folks in your executive branch, all you need to do is fill in the blank. That's utopian and I guess I'm challenging you.

And, Marsha, forgive me if I'm misreading your original presentation. Could some of this methodology be baked into the guidance in your second domain or the second theme, if you will, of the managed care looking to the access because for me that's what's going to change care in the communities.

CO-CHAIR GESTEN: So this is a really interesting discussion and point. I would urge you though to have a quick response so that we, because we have a lot of other stuff to get to.

This is sort of getting into the guts of how you do improvement and how you set up programs and align things. But do you have a quick response for Rich's great --

DR. LILLIE-BLANTON: I don't think I have a quick response. But I do think that you have identified a key issue that we have to

figure out how we better connect with providers on the ground with beneficiaries with the healthcare delivery system on the ground.

And unfortunately at the federal level we don't do it all that well. But we're learning how to do it better. And for managed care we at least have our external review organizations which have some greater capacity in the improvement space to help better direct the guidance so that we can make those connections.

And that's, I think that's our biggest hope right now at least for managed care.

CO-CHAIR GESTEN: Thank you. Katie. You had, on the phone you had a question or a comment?

MEMBER DUNN: No, I'm all set. Thank you very much.

CO-CHAIR GESTEN: Great. Well these were definitely, had the cutest pictures so far that we've seen on slides. Thank you for that. And, you know, thank you for a redefinition of what a red state is.

I just want to say that. There are no red states and yellow states. There's just a lot of states that need help with oral health. That's what I would say. I'm just channeling somebody.

So we're going to move on and talk first at a conceptual level about some of the issues around measures between adults and children and then we're going to get to the all important reviewing specific measures and some voting. And taking a lesson, I think, from yesterday we're going to try to tee this up, have some discussion, allow public input prior to any voting and then there will be some voting on some of the measures.

So I think the next slide. Is this you? Could you go on to the next slide?

MS. GORHAM: If we can have the next slide please. Okay. So as Foster spoke earlier about alignment a little bit. So we have a couple of measures that are in the adult and child core set which are already aligned.

So it's shared measures with the different, with different age groups reported would be one the chlamydia screening measure, 0033. And also follow up after hospitalization for mental illness, 0576 are shared with both core sets.

Single measure with rate split across the measure sets, 1517. In the child core set it is the timeliness of prenatal care and the adult core set it is the postpartum care measure.

Similar but separate measures for different age groups the BMI screening and counseling. That is not endorsed. But the measure number is 0024.

So those are the measures that both groups have in common. So we just wanted to give you a picture of that. Next slide.

CO-CHAIR GESTEN: So here's the question, I think the way this is structured is to kind of talk at a higher level first about this issue of alignment before we get into looking at some of the individual measures that

we'll be talking about.

But the questions that they want to discuss are on the slide. The question is, is there an issue right now relative to alignment between two sets that we should think about and what is it and what's the fix for it?

You know, the question about alignment is not only between adult and child but also are there issues relative to alignment of the core sets with other activities. Marsha mentioned a huge new initiative on the horizon that I think this group will have to think about relative to alignment.

But in the existing space there's also, I can't even list them all, all the various and sundry programs relative to measures that states and providers are trying to respond to. Is there work that we should do relative to better alignment across those core sets?

We didn't mention, I don't know if it came up yesterday the AHIP CMS core set measure for adults. My understanding is that there's a

similar activity going on or maybe it's completed for pediatric measures. Is that yet another set of measures that as we think about this we need to think about alignment?

And among all those different measure sets are there some that are more important than others? And then last is there some guidance or some input we should think about relative to the recent IOM vital signs report that also helps us think about this issue of alignment?

So I think we have a little bit of time dedicated to talking about these issues sort of at a high level before we get into some of the nitty gritty. Shaconna talked about and mentioned sort of some of the issues or what we see currently relative to measures.

And again, just reflecting that part of the point of today's joint meeting is to really work explicitly on this issue about alignment and connectivity between the adult set and the child set. So, Cindy, you want to start us out?

MEMBER PELLEGRINI: Thank you. I know we've got some time on our agenda to talk specifically about the maternity and sort of reproductive measures.

But from March of Dimes' perspective that's one of the areas that we'd like to see a lot of focus right now on the alignment issues for a couple different reasons. First of all the current framework of having an adult core set and a child core set necessarily requires you to look at the mother child dyad as two separate people instead of together, right.

And we think that the efforts by CMS to sort of informally put together a perinatal measure set are a great step in the right direction. We'd like to see that institutionalized more and in fact there's a bill in Congress that we're supporting that would say, yes, go for it CMS.

You know, make this a perinatal core set that we can use in that way. There are also a number of areas, particularly around maternity

care where again we want to look at those teen pregnancies.

And so sort of the 13 or 14 or 15 year old up through 18 years old may or may not get caught in the maternity measures that are right now sort of siloed into the core set, into the adult core set. So I kind of want to put that forward as perhaps a logical starting place for a lot of this alignment work some of which is already underway, totally to CMS' credit.

You know, how can we support that further?

CO-CHAIR GESTEN: Thank you, Cindy. Carol.

MEMBER SAKALA: Yes, just to continue with what Cindy was saying. Our previous discussions about alignment have often been about age stratification.

But in my mind there's always been a tension because most of these measures have good things and good implications for both mothers and babies.

CO-CHAIR GESTEN: Any comments from folks on the phone? Should we go into the weeds? Shaconna, take us into the swamp.

MS. GORHAM: Let's go into the weeds.

CO-CHAIR GESTEN: Let's get into the weeds.

MS. GORHAM: So first let's look at the perinatal and maternity care measures. So this may be a good time to take out your huge Excel document. You can pull it up on your computers.

Both the Adult and the Child Task Force have Excel sheets. The maternity and perinatal tab are the same. So we made sure that you all can look at the same measures.

So the perinatal measures have a large presence in the child core set. But a few are contained in the adult core set. There are 11 total measures. Perinatal and maternity care is most frequently again, a topic in the child core set.

It reflects the longstanding

importance of Medicaid in providing health coverage to low income women and babies. We know that nearly three-quarters of women enrolled in Medicaid are in their reproductive years, 18 through 44.

Next slide. So this slide demonstrates the measures in the child core set, the shared measures and then the measures in the adult core set.

In the child core set the measures are relevant to the health of the infant and pregnant women in order to encompass both prenatal and postpartum quality of care issues. We have seven measures currently in the child core set.

In the adult core set we have measures focused on the mother. There are four maternity related measures currently in the adult core set. So a question was raised in previous discussions should all measures of the mother's health be present in both the adult and the child core sets.

Many women giving birth are not old

enough to be included in the adult core set measurement. But there are some concerns that we are missing information about 17, for example, year old women or young ladies who are receiving postpartum care for example.

And then you see the measures that are shared in the middle as well. We talked a little bit about that earlier and we will go into more discussion later. Next slide.

So the potential perinatal and maternity care measures, the measures that we listed on your Excel sheet and we gave you a total of 23 measures in the area, four were endorsed and 19 were not endorsed but they mostly come from the Pediatric Quality Measures Program or PQMP.

And in past conversations the Child Task Force group reviewed PQMP measures under development. That was a recommendation.

And for the Adult Task Force members because we have not had conversations about PQMP the Pediatrics Quality Measures Program was

established under CHIPRA and intended to improve and strengthen the core set of measures, specifically to generally expand their availability of pediatric quality measures for use by all sources of public and private healthcare purchasers.

There are seven centers of excellence funded. They have been supported by cooperative agreement grants with AHRQ funded by CMS in a multi-level partnership. So that's just a brief kind of definition of PQMP.

Okay. So we wanted to update you on two measures, 1391 and 1517. They have recently went through our endorsement process. And so just some of the things that the new updates for the measures.

So the Perinatal Committee, which I believe they met in February.

FEMALE PARTICIPANT: In May.

MS. GORHAM: In May, okay. Did not recommend this measure for continued endorsement. And the reasons are listed on the slide. The

evidence indicates that outcomes are worse if a mother has no prenatal care.

However, there is no empirical evidence that relates frequency of prenatal visits to outcomes for moms and babies. So ACOG guidelines are based on opinion only.

And this is just information from the actual Standing Committee meeting. So the measure is called a proxy for access but does not assess the capacity of a plan to provide prenatal care.

The measure reflects the challenges women face taking time off work, transportation and child care. The measure inhibits innovative strategies and new models of care. Next slide.

CO-CHAIR GESTEN: We'll discuss these. But do you have a clarifying question about the slide versus how you feel about it?

MEMBER PELLEGRINI: I'll wait.

CO-CHAIR GESTEN: Okay, thanks.

MS. GORHAM: Okay. So that was information from the Standing Committee and Cindy

was on that committee. So she can add more information.

But we wanted to give you information from state reporting from 2014. So the number of states reporting the frequency of ongoing prenatal care increased from 25 states in 2012 to 27 states in 2013 and 28 states in 2014.

Thirty-one states reported the measure at least once during the three years. Of the 28 states reporting the measure in 2014, 23 reported the measure for both their Medicaid and CHIP populations.

In 2014, 28 states reported the measure using the child core set specifications which were based on the HEDIS 2014 specifications. And the most common reason for not reporting were that the data were not available and other reasons such as information was not collected because of budget constraints, staff constraints, data source not easily accessible and information not collected.

Two TA requests were submitted by

three states. The TA requests were about calculations of the denominator, data sources and sampling methods.

Okay. So that's 1391 and there's one more measure before we start discussion. It's 1517 that we wanted to give you an update on. The Perinatal Committee did not reach consensus on this measure because no evidence for the timing of the visits is sufficient with exception.

Early postpartum visit often indicated breastfeeding support, post-op wound check, follow up for BP and depression, moms being seen in pediatrics for depression screening, breastfeeding support. There were concerns about validity and those concerns including limited number of codes, nothing about the contents of the visit and the usability.

Lots of effort against headwinds discourages early care. Unclear whether quality is improving. The Standing Committee is reluctant to remove until something better is

available.

So just to give you a little bit about process on the CDP side. So consensus development does not, I mean I'm sorry, the committee did not reach consensus does not mean that they are not recommending the measure.

It means that they want to have more discussion. After the Standing Committee members meet then the NQF staff develops the draft report. The draft report is put online for public comment.

Public comment comes back. The Standing Committee will meet again via phone, discuss the public comments and then see if they can reach consensus on the measure.

So they have, they're still going through the process. Okay. So again, we wanted to give you information about the states reporting. And so this is the measure that is shared across the child core set as well as the adult core set.

So the number of states in the child

core set reporting the measure in 2012, 13 states reported in 2012. Thirty-three states reported in 2013. Thirty-six states reported in 2014.

There were three TA requests received from two states on the topics of calculation of denominator, data sources and sampling methods. Of the 36 states reporting in 2014, 29 reported the measure for both Medicaid and the CHIP populations.

Among the states reporting in 2014 the most common reason for not reporting were that the data were not available and other reasons including information was not collected because of staff constraints, data inconsistencies and accuracy, data source not easily available and information not collected.

There were two TA requests submitted by three states. The TA requests were about calculation of the denominator, data sources and sampling methods. So for the postpartum side and the adult core set in FY '13 29 states reported the measure, 34 states in 2014.

TA requests received by one state on the topic of reporting of populations. One state reported a reason for not reporting the measure and that was due to data inconsistencies, accuracy and staff constraints.

So that is an update on those two measures. And now we'll turn it over for discussion.

CO-CHAIR GESTEN: Great. Thank you, Shaconna. So these measures are, as you can see, you know, some a decision was made. Some of them span, I mean they are measures that are split. I guess I was trying to find the concept here.

I guess anything prenatal is in the child and anything postpartum is in the adult. But obviously they're linked and there is some artificiality to doing that as Cindy and others have talked about trying to put things together in a perinatal set.

These are literally mom and apple pie measures. So it may be a little startling I guess to some to see, you know, the groups sort

of questioning or revisiting the measures.

But again this is part of, I think, the process of reupping and relooking at each and every measure for validity, for new science to make sure that it's doing what it's supposed to do. So we welcome, you know, the housekeeping part of relooking at measures and the input from the groups.

Why don't we just open things up. I don't know. That's too complicated. Why don't we open things up to discussion about what was raised and then before we get to any sort of voting or nominations. Cindy, I think you had a question before.

MEMBER PELLEGRINI: Thank you. I just wanted to add a little bit more texture to this description because this was a really interesting conversation in the Perinatal Measures Committee which about what, three weeks ago I think.

So it was pretty recent. I don't think anybody else here was on, Carol was the co-chair. So, Carol, back me up on this. This was

such an interesting discussion because I think certainly the objections took me by surprise because these measures have been around for a long time and they're pretty well established.

But I think perhaps the best way to put it was a lot of the committee members were losing patience with these measures as not being evidence based, as simply being, following the ACOG recommendations that didn't have a lot of hard science behind them about what the right number of visits was, what the right timing of visits was.

And then of course this is a measure of actually quantity of visits not quality of the care delivered in them. So they really wanted to send a strong message to NCQA that these need to be improved. We need much, or to whoever else would like to develop these new measures.

At the same time there were a few of us and I put myself in this category that said okay, it's not that we think these are the best measures in the world. But if we don't endorse

them there's going to be a gaping hole.

And the NCQA representative who was at the meeting sort of made it pretty clear to us saying well, you know, we'll bring back your input, your feedback. But updating these measures to that extent would be a long and laborious process.

So don't expect a new version for like three years. So the idea that, it was interesting that the vote was slightly different between the two, that it was actually a negative on 1391 and sort of ambivalent on 1517 when they kind of had the same issues or very similar issues.

But that was what was going on there. And, you know, I still would love, I personally would love to see better measures. But I certainly have concerns about removing these from the core sets and having no data at all on prenatal visits and postpartum visits.

CO-CHAIR GESTEN: Thank you, Cindy. That's very helpful context in this complicated

note which I didn't get was call on Carol because she was the co-chair. So, Carol, sorry. It wasn't that complicated. It's just my brain isn't firing.

MEMBER SAKALA: Thank you. So, yes, these are mom and apple pie measures and I think that means that they've gotten a real pass before around the NQF criteria.

So this time around first one take a look expert opinion is about the fact of a visit rather than about what happened in the visit or what it accomplished. So right then and there the committee said these really don't hold up very well even though we have the opportunity to override that.

And I think at least speaking from my assessment the 1517, this paired measure has more significance for this group because getting an early visit is often tied to getting access to Medicaid and coming on board. And we have a longstanding disparity around any postpartum visit at all for Medicaid versus other women.

So there are some considerations here that would make this important for our group. That being said, the postpartum visit is 21 to 60 days. So that, you know, the argument was this is a disincentive to get women in earlier when that's when they're going to need certain kinds of care.

And that don't we want to have higher bar measures around, you know, what is happening, the content of care. And we do have some of those, for example, in the pipeline with the PCPI measure set in for both prenatal and postpartum.

And don't we want to also be looking at outcomes. That's what we're all tasked to move along that pipeline.

CO-CHAIR GESTEN: So that's helpful too. I mean, Cindy, you I think gave a clue to how you feel about the removal or go forward. Carol, I was less clear about it. Are you willing or wanting to say given all of that where you think we should end up?

MEMBER SAKALA: I agree with not

recommending for continued endorsement of 1391. And I think what you heard is my ambivalence about the other one. I've for a long time thought these are really low bar measures.

But I think in this context there are some good arguments for keeping them. And also the issue of getting people on board and taking very seriously removing a measure from the set. I really respect, you know, the challenges that states are facing around those issues.

CO-CHAIR GESTEN: Thank you, Carol. Jeff.

DR. SCHIFF: So I want to talk to the issue of whether to admire the gaping hole or to try to fill it in a little bit because I think that, I think that what you guys brought up when we did the expert, CMS expert panel I was one of the co-chairs of the group that looked at perinatal care and we actually talked about the content of these visits and the need for some, need for better content.

I guess what I'm really, I guess what

I want to say maybe with a little bit of caution is maybe a gaping hole isn't a bad idea because what happens is at the state level we get these measures and we know that they're, if we have to do them there's a lot of effort that gets put into them.

And we sometimes will do some. I mean it's not like there's not any perinatal quality efforts happening. It's just that we do it without looking at these measures if we feel like the measures are too much of a burden.

And I think, thinking of the content when I think about us working to get home visiting nurses out there or community health workers or other things that won't count as a visit out there it may be really worthwhile to, I almost feel like there's another category of measures that we need.

When we did the first child health, child core set we filled every category in because we felt like we had to and that was eight years ago. And maybe we need to say let's leave

some categories there but blank rather than fill them in because otherwise we get people, that translates on the provider level to people seeing a set of measures and then thinking this is what they want and then what doesn't translate is this conversation about how we know the measures are inadequate.

CO-CHAIR GESTEN: Thank you. Susan.

MEMBER LACEY: Yes. To your point but when I think about identifying a gap the next place that my head goes is then we better do some rigorous studies to fill the gap of the knowledge we have.

So I think actually I'm encouraged when we get to a point like this because we, I'm a maternal child person too. I feel passionate about people getting this type of care.

But if we've been just going on the anecdotal information from ACOG I think that is a very good thing and we need to talk to the people who do the funding to try to get some carve outs so we can close the gaps on the evidence.

And I guess then my only other question is on Page, a different topic on Slide 87 the, one, two, three, four, fourth bullet concerns about validity limited numbers of codes. So now we have like a million more codes.

This was pre ICD-10 I'm assuming. So do you think that is now going to be kind of mitigated with all the extra codes? I don't know the codes. But just in a general sense.

CO-CHAIR GESTEN: Carol, did you have an answer to that? Okay. Anybody know? Good question. Harold. Somebody does know.

MR. CURRIGAN: We do have ICD-10 codes for gestational age by week. So technically it is easier to report like the frequency by like which week is the visit happening.

But the uptake of those ICD-10 codes with, into practice is kind of slow so far.

DR. HUDSON SCHOLLE: And the other issue is that really you code the visit based on the CPT code for postpartum visit. You don't code according to the diagnosis code. The woman

is postpartum.

CO-CHAIR GESTEN: Great. Thank you for clarifying that. Harold.

CO-CHAIR PINCUS: Two questions. One is, you know, what is the actual performance on this?

(Off microphone comment.)

DR. LILLIE-BLANTON: Somebody can pull it up. The median was 58 percent for postpartum visit. The 25th quartile I think was about 42. And I can't remember what the 75 quartile was. But somebody can pull it up.

CO-CHAIR PINCUS: So suffice it to say it's not wonderful.

DR. LILLIE-BLANTON: No, absolutely not. But I think the measurement issues that were raised here, the fact that many women come in earlier and so then they don't get coded as the postpartum visit and also the fact that because of the bundling of the payment sometimes it's not even coded, the postpartum visit isn't coded because a physician gets paid and then they

don't report.

So we don't know what's happening. But in general I mean we have worked I can say in our improvement effort not just on whether the visit occurred but improving the content of the visit. So we have recognized that this is just, the measure itself is not all of what needs to be approved.

CO-CHAIR PINCUS: So my view is I, you know, there is clearly a problem with these measures. But also in thinking about it, it's kind of a more of an improvement kind of framework that the gaping hole would not be as great, not be a good idea to just admire it.

But I think to actually maintain this, keep working on it. But I think that in some ways it also may be kind of a labeling issue rather than looking at it as a purely quality kind of thing to think of it more as an access kind of thing.

And that may also sort of reframe it a little bit. But I think that, you know, it's

going to be a long time before we're really able to get a content of a visit. So that's not going to be, there's not going to be an immediate fix for this.

CO-CHAIR GESTEN: Thank you. Diane.

MEMBER CALMUS: So my concern with having this gaping hole is that, you know, as Cindy said it was about three years until a measure would be developed. Then, as we've discussed before there's a couple more years until the infrastructure gets put in place.

So that's a long time to be without any sort of measure of this important access which is a real problem in rural America. I mean we're seeing fewer and fewer rural providers that are able to provide delivery services and trying to figure out how that's translating back to those important prenatal care.

We know where all women are later in starting receiving their prenatal care already under the current paradigm. And so as we're seeing more and more of these providers stopping

providing OB services both OBs not practicing in rural areas as well as family physicians that are no longer providing OB care I'm really concerned about having this sort of hole and having no data.

And so my concern is that imperfect data isn't my desired goal. But I would rather have imperfect data than none at all and have there be, you know, five or seven years without anything.

CO-CHAIR GESTEN: Thank you. Michael.

MEMBER SHA: Being new to the task force this is a little bit more of a process question. So the Perinatal Committee is recommending that this measure have its endorsement removed.

Does that mean that the measure is destined to have its endorsement removed or --

CO-CHAIR GESTEN: Helen or Shaconna, what happens after the --

DR. BURSTIN: So that's not quite right. What the committee said is they basically

deadlocked. They didn't reach a threshold of 60 percent approval. So they're asking, the first one right, so they're asking for additional input.

But it's likely that one of them potentially would be removed from endorsement.

CO-CHAIR GESTEN: But they're not yet officially removed, right. And just illuminate the next step is that it goes to?

DR. BURSTIN: Public comment. Public comment comes back to the committee. They reconsider it. They revote. It then has still a longer process to go through our board level committee that presents to full committee.

We've seen those decisions reversed and in fact discussions like this are essentially public comment. So that information we'll make sure flows back and in fact with the chair and several members here we'll make sure that information flows back directly.

Yes, so even the one that was not recommended. All measures go out for comment

regardless of what the committee said. So there can be comments brought back even on measures that were otherwise not recommended by the committee.

CO-CHAIR GESTEN: So in other words the Supreme Court has not ruled on this yet. There are still lower courts that it needs to go through. Is that fair? I think, Julia, were you next?

DR. LOGAN: Yes, so in California we have about, Medicaid covers about 250,000 births a year and half of those births are in our fee-for-service population which means that most, about half of them are for undocumented women. And undocumented women's benefits expire after delivery.

And so what we've found and we've looked at the data is that a lot of those women hurry up and get their postpartum visit before that 21 to 56 day period. So our performance on the measure is very, very low.

And we've been having learning

collaboratives. It was part of our adult Medicaid quality grant. We had a QI project around it and we really haven't been able to increase our rates.

Another thing we found is that a lot of women get a postpartum visit after that 56 or 60 day window as well. And so if we extended the window our rates would go up.

If we extended the window on the other end our rates would go up significantly. So it really feels like a very artificial time frame for a woman to get a postpartum visit.

CO-CHAIR GESTEN: Thank you, Julia. Carol.

MEMBER SAKALA: So whether these measures go forward or not I would like to, I raised the issue of PCPI. And I think HEDIS has some limits around, you know, good substitutions.

But my understanding is that the PCPI measure set and also a really interesting one that we appreciate from AWON for nursing care are basically languishing. They've gone through a

lot of consensus process and discussion and multi-stakeholder bodies, et cetera.

Basically languishing for lack of resources for testing. So I would encourage our CMS colleagues to take a serious look at moving those measure sets forward with something like IAP or there are some kind of mechanisms to help get measures that are already in the pipeline that would be better measures available for us.

CO-CHAIR GESTEN: Thank you, Carol. Sue.

MEMBER KENDIG: Thank you. Yes, I'm really ambivalent about these two from a provider perspective because I understand the rationale in terms of the lack of evidence, particularly around frequency.

But I am very concerned about having the gaping hole that triggers the thought about women getting into prenatal visits and consistent prenatal visits.

And when I think about this the part that I know this doesn't capture, but the part I

worry about basically based on evidence from mortality and morbidity reviews is oftentimes when you have women who are the most vulnerable from, based on social determinants and so forth, I'm thinking about women who have substance use disorders, women who may begin to experience antenatal depressions and so forth they may tend to drop off of prenatal care for a while.

And if you're lucky they may reenter. So you're going to see a decrease in frequency. And when that trigger to think about the frequency of making sure my patient is coming in for those prenatal visits goes away I worry about that portion of vulnerable women falling off the radar and not being as aggressively tracked, if that makes sense.

CO-CHAIR GESTEN: Thank you. Ann.

DR. SULLIVAN: Just two things. One, I think we still have a fair number of measures that at least on the adult side we have a couple that we have and recommend.

The visit is important even though you

don't really kind of qualify what's happening in the visit. So I don't think it's, just because you're not saying what's in the visit that counting visits is necessarily bad.

I think that, you know, follow up after hospitalization, et cetera visits doesn't say what happens after the visit. But it's still important.

The second thing is I think you have to be a little careful about expert opinion. It's not just somebody's opinion when ACOG or other groups do these expert opinions.

I mean there's a lot of thought and effort that goes into it. Often expert opinion is because there isn't an evidence base. So I don't know if we know how many are the right number of prenatal visits.

My guess is we don't know for sure unless somebody knows and I don't. So expert opinion is something that guides you. So it's not just, you know, I mean it's very strong usually when these guys come up with it.

Now I think there could be some relook at that. I mean maybe it is based on some older way of looking at prenatal care. And then I do agree with what was said about the importance of tracking prenatal care.

From my experience in visits, my experience in underserved areas where there's lots of immigrant populations and some of those underserved areas have large Medicaid populations. The fact that somebody is coming is an indicator that something is going on and that somebody is being watched.

So I realize it's not as strong as maybe people would like, what you're doing at the visit, do you really need this number of visits. But I also would be concerned about just leaving that gaping hole and saying that we're not going to be tracking that these women are really getting some degree of robust prenatal care.

CO-CHAIR GESTEN: Great. Thank you. So why don't we open up, operator, if you can open up to public comment on this before we start

entertaining any motions or about potential changes and vote and then we'll go to the room and then we'll tee up the process for voting.

So is there anyone on the phone, any public comment on the discussion that we've just had about these measures?

OPERATOR: At this time if you would like to make a public comment please press star then a number one. Okay. You have a public comment from Larry Kleinman.

DR. KLEINMAN: Thank you. I just wanted to say from the perspective of CAPQuaM, one of the centers of excellence, I very strongly support the last point that was made about the need to do measurement even when there are shortages of evidence.

When there's been a formal process involving experts and that I think that these are, there are critical gaps in measurement that will not be filled unless those measures are taken into account and used.

CO-CHAIR GESTEN: Great. Hi, Larry,

and thank you for your comment. Other public comments on the phone?

DR. KLEINMAN: All right, Foster, thank you.

OPERATOR: Okay. At this time there are no public comments.

CO-CHAIR GESTEN: Okay. We're going to turn to the room and, Sarah, I think you're up first and then Sean. Just introduce yourself.

DR. HUDSON SCHOLLE: Sure. I'm Sarah Hudson Scholle. I'm vice president for research and analysis at NCQA. And I actually I think about six years ago we created a conceptual framework in collaboration with AMA PCPI on how we would like to measure the content of perinatal healthcare.

So we're fully supportive of a move to better measures in this content area. And I think kind of the trepidation that my colleague probably expressed with the committee is that we're actually working to develop measures that are taking advantage of new coding systems and

the availability of data in the clinical record.

And it's very hard. And so but we are doing that. We started that first with measures on depression and it's our goal to really move to better, more detailed measures that we can obtain from the clinical record.

And so if we're thinking about Marsha's idea of, you know, by 2021 what measures would we want to have in a quality rating system for Medicaid managed care, it certainly would be measures that look at the content of prenatal care as well as measures that look at the content of postpartum care and in particular where we have a measure that looks at maternal depression screening and we would love to incorporate that kind of content measure in our work coordination of information about gestational diabetes to the primary care provider.

So we're fully supportive of that. But this question of whether you leave a gap and if you do what's the worry there and whether there are ways that CMS and the states might

support organizations to work hard on getting the clinical data that exists in EHRs and other systems available for this kind of reporting.

I think it's critical but it means that a huge amount of resources, attention to workflow taking full advantage of all the code sets that are available. But it has to be a deliberate and move that requires resources.

And we'd be thrilled to participate in that kind of work in collaboration with organizations represented here.

CO-CHAIR PINCUS: Sarah, just one quick question. What's your prognostication on when the likely time frame of teeing up a measure that gets to some of these issues?

DR. HUDSON SCHOLLE: So I think there's already a measure in the core set, the one, the behavioral health risk assessment for pregnant women. So to do that, so we're actually doing this like, how quickly could you tee it up?

Well you can specify that, you can build it will they come is really the question.

So I think the specification of the measure is one issue. It's really trying to figure out how do you get the information out of those systems.

And we actually have a learning collaborative. We've created a new reporting system for HEDIS that's called electronic clinical data where it requires that data be electronic.

So claims count, but you also want other electronic data sources. And the real key is that the information has to be available at the point of care as well as for reporting.

The challenge there and we see that some plans are starting to use, you know, integrated delivery systems are reporting HEDIS measures using electronic data and, but they do it through a supplemental data set.

And so we're actually looking at ways to validate the measures that are coming out of the EHR systems to validate the scoring, I mean the actual calculation of the measure but also the auditing process that we would use to make

sure that the information is reliable.

So could we create those specifications, I think relatively quickly. The time frame is really how long will it be before a proportion of people, of organizations and a proportion of population is covered.

As we're rolling out our depression measures we're actually including a coverage measure so that we can tell what proportion of people are covered by this electronic clinical data that we have. So I would say that being a very nice model.

But we're in -- but I would imagine it might be five years where we get to reporting on some portion of the population. And maybe there would be a way to try to think about how you line up these existing measures with an option for reporting the other measures at the clinical measures that get at the content so that organizations could and states and plans could work in parallel, right.

But I think it will be, it's going to

be really hard for some places. And, you know, how much can you push the market and what do you, how do you handle really the organizations, the states and plans that have limited resources to do this work because, you know, if you have a health information exchange in your state this is going to be easier.

If you have a lot of integrated delivery systems, if you have a lot of data sharing happening it would be easier.

CO-CHAIR PINCUS: So this is something that came up several times yesterday as well. So it sounds like that there is sort of a plausible pathway to get there.

But it's going to be slow to actually develop tests, not so much to develop but to test and spread and --

DR. HUDSON SCHOLLE: -- implement.

CO-CHAIR PINUCS: -- implement this over time. And so that's going to be years.

CO-CHAIR GESTEN: Just agree with him. Say, yes. No, go ahead, Sarah, I'm sorry. Do

you want to respond?

DR. HUDSON SCHOLLE: My question is really what might be the mechanism that CMS and states have to really push this forward faster and are there, you know, are there some states and this really gets back to Jeff's question of, you know, could there be menus or ways to do this so that you're bringing along people that you can bring along, but you don't put so much of a, you allow the states that are really strapped to kind of catch up a little bit more slowly.

CO-CHAIR GESTEN: Well this relates to the earlier conversation about the quality of the reporting of system as well which may be a potential. Sean, thank you so much, Sarah. Sean.

MR. CURRIGAN: Sean from ACOG, American College of Obstetricians and Gynecologists. 1391, the college no longer, does not continue to support frequency of ongoing prenatal care.

We think that, we don't think that

this is going to, getting rid of this measure from the core Medicaid Adult CHIPRA set is going to stop women from getting prenatal care. I think women are, we're still having trouble with women still wanting pap smears every year.

So like I don't think that's going to change practice immediately. We think we can make room for new measures. The frequency is not like a particularly good measure. So we want to move on to another measure.

We'd like you to consider the, not the healthy term newborn. It's called unexpected complications in newborns, something like that. That measure which is NQF endorsed and is also mostly claims based.

So you can still calculate it from your Medicaid data. 1517, I'd just like to remind you that there are two rates in this measure.

And the reason that most of my members that were on the Perinatal Panel probably were against that measure is mostly the postpartum

rate because you can't do a two week visit which we think is probably better practice to do depression screening and your referrals, breastfeeding counseling, postpartum contraception and all of the other inventions that might want to do happens better at two weeks than six weeks.

And six weeks is probably a little bit outdated and we want to move there. But we can't move there if there's a measure that's dinging everybody for doing two week visits. So getting rid of that measure is more important to us.

But we do think that the first part of the prenatal and postpartum measure which is like the timeliness of prenatal care, how early are you getting in might still be useful for the Medicaid population. So maybe trying to separate.

The measure went as a composite measure into the Perinatal Panel. You may want to look at it as like two measures, how we used to do composite measures.

And then I would just like to remind you since yesterday we did talk about some data issues and wanting electronic medical record data. There is still a national data set that is the birth certificate and you can, this is basically interoperable and standardized and we could leverage this.

There's only probably six states, state Medicaid agencies that actually match their data to do stuff like the first term singleton or c-sections and other things. So if you can't be with EMR we'd like you to at least match with the birth certificate data because there are clinical data points like nulliparity that are very useful for calculating some of the obstetric measures.

CO-CHAIR GESTEN: Thank you, Sean. Thanks for that nuanced description of the different measures. I think we will be voting those two separately even though they're together because one applies to the child and one applies to the Adult Task Force. Go ahead.

DR. GALLIA: I'm Charles Gallia and

I'm glad to be in the weeds with you all. And there's two components to this measure that I think are important to understand, at least the one about the frequency is that one of them is an exception for, based on enrollment.

So at the point of enrollment is a trigger point for counting the measurement time. So components of those, the number of visits and thinking about what I mentioned yesterday was the eligibility component.

We're not going to find all the things we need to find out in the chart if they haven't had that visit. So it's part of the concern is looking at what population you're counting and it's really capturing the characteristics of the Medicaid population.

Since pregnancy is a basis for eligibility things change. And so that trigger point when it gets started is actually an important consideration in the, in calculating the frequency.

So that's not to say that this isn't

a good measure. It's to say that it's, there's interpreting it at a federal level and again, I'm kind of, there's some qualifications that I would have and the initiation of prenatal care is important.

And even if the count or the number are not known it does help us discern high risk pregnancies fairly early on and create a different pathway for care. And so the offer that Sarah made about laying out potential measures to consider and explore down the road would be really great and I laud that idea. So it's, that's just two observations.

CO-CHAIR GESTEN: I thought I saw a card. But maybe you changed your mind. So let's, I think we have to -- well let's do them one at a time, right. So if we, should we start with 1391 and this is frequency of ongoing prenatal care.

And I think the way this is going to go, correct me if I'm wrong, is there would need to be a motion. We're doing this separately for

the, just for the child for this measure.

So somebody who, from the Child Task Force, are them some folks who can't make a motion that are part of the Child Task Force, just members or consultants, anyone?

MS. GORHAM: So all of the Child Task Force Members can make a motion for 1391 excluding the federal representatives because you are all not voting.

CO-CHAIR GESTEN: Okay. So we would be looking for a motion and a second from anyone on the Child Task Force for 1391 which is frequency of ongoing prenatal care to remove it.

That's how we pose that as the proposal and see if anyone wants to pose that, if there was a second and then there would be a vote. And is this the fancy thing we're voting now, okay. You'll explain that when we get to voting.

(Off microphone comment.)

CO-CHAIR GESTEN: It's just the Child Task Force that would be voting, voting members.

And in order to pass it would be 60 percent?

MS. GORHAM: And just to clarify the reason why only Child Task Force Members are voting because 1391 is only in the child core set. And the Child Task Force Members have been conveniently seated on the left side of the room and Cindy is also on the Child Task Force.

CO-CHAIR GESTEN: Is that right? God, it took me this long to and your comment to figure that out, wow, slow. So any questions about process or what it is that we're going to do? Rich.

DR. ANTONELLI: Can you put the measure up so we can see it? I'm especially interested to see what's in 1517 as well because there's a child piece of 1517, yes.

CO-CHAIR GESTEN: Let's do 1391 first. And this is the frequency of ongoing prenatal care. This is the one that the committee, the Perinatal Committee had suggested to, made a suggestion to remove NQF endorsement.

As we heard earlier, we're not sure

how that process will unfold. But that was the recommendation for the reasons that we talked about. So is there a motion from someone on the Child Task Force to remove this measure from the list?

MEMBER ADIRIM: I move that we remove Measure 1391, frequency of ongoing prenatal care from the child core set.

CO-CHAIR GESTEN: Do we have a second?

MEMBER SAKALA: Second.

CO-CHAIR GESTEN: So want to explain the voting.

MS. GORHAM: So what I think would be best is we have a list of measures that we're going to vote on. So what we'll do because it will give Alexandra time to put it on the voting slides, we'll add this to the list so that when vote on all of the child measures pertaining to maternity perinatal care this will be included.

(Off microphone comment.)

MS. GORHAM: Alexandra has it ready so --

MS. MUKHERJEE: Do you need to do a test, Alexandra, a test, yes? So first we'll do a test voting and then we'll do the actual voting.

CO-CHAIR GESTEN: And again, this is just for the folks on the Child Task Force. If you're not sure if you're on the Child Task Force let us know. We'll set you straight.

It has something to do with being on that side of the table. So what's, the test is? So we're supposed to press one of these. Okay.

MS. OGUNGBEMI: Hello. We are now voting for this test question. So please respond and point your clickers towards me. Thank you. Voting is open.

(Voting)

Okay. Results are as follows, 82 percent, yes and 18 percent, no. This passes per se.

CO-CHAIR GESTEN: And what's the end, what's our total number of voting members?

MS. OGUNGBEMI: We have 11 for Child

and also 11 for adult.

CO-CHAIR GESTEN: Okay. So ready to tee up a real question, although that's pretty real, but a relevant question to why we're here.

MS. ALLEN: So we're voting to consider whether Measure 1391, frequency of ongoing prenatal care. One, yes, two, no, voting starts now.

CO-CHAIR GESTEN: So, yes, is removal, no, is keeping it.

(Voting)

CO-CHAIR GESTEN: So it looks like, do we have all 11 votes?

MS. OGUNGBEMI: Yes, we do.

CO-CHAIR GESTEN: And we have no voting folks on the phone, right?

MS. OGUNGBEMI: No voting folks on the phone for child.

CO-CHAIR GESTEN: Okay. So it had to be greater than 60 percent. It's 55 percent for removal, 45 percent to keep. So it looks like it stays. Thank you.

Okay. So we've moving to the next, maybe we can put up the next measure which is, no, we just did 1391, 15 --

MS. OGUNGBEMI: 1517.

CO-CHAIR GESTEN: 1517, can you put that on the slide so folks can take a look at what it is? And as I understand there are two, this is one measure but there are two components.

The prenatal portion of the measure which relates to timeliness of prenatal care is in the child core set so again it would be the Child Task Force Members who could propose and second and vote on whether to remove this and then the postpartum would be for the adults. We'll do those separately.

But we'll check, are there some questions? Kathryn.

MEMBER BEATTIE: I just have a comment on 1391 that perhaps is we were able to identify a replacement measure then have that conversation concurrently it would be something that the voting came up differently. Personally my

discomfort is in having the gaping hole.

So the gentleman from ACOG mentioned some other opportunities. I think if that were to come back it might come out differently.

CO-CHAIR GESTEN: So let me just, are there, I don't think that there's any replacement measures being discussed by the Child group that are on the list. Is that, Shaconna, is that true?

MS. GORHAM: I don't know that there will be replacement measures. But all of the available measures are listed on your Excel sheet. So if you identified a measure on your Excel sheet that you thought would be comparable we can definitely discuss that.

CO-CHAIR GESTEN: Okay. Susan, and then Carol.

MEMBER LACEY: So what we have here is the information from the meeting. So can we actually have the measure up there so we can look at the real measure.

MS. GORHAM: Yes. So pull your Excel

sheet out and you have all of your specifications. And if you give me one minute I can tell you what line. It is on your, Row 17 on your perinatal maternity tab. Okay. Give me one minute.

MS. ALLEN: It's located on a core set tab.

CO-CHAIR GESTEN: So I take it there isn't a handy dandy slide that actually has a numerator and denominator on this?

MS. GORHAM: No.

CO-CHAIR GESTEN: Okay. It may come out in your Trip Advisor scores. But, okay. Can we have a -- Sarah, I don't really want to put you on the spot. But I think I actually might.

Do you have this measure memorized in your head? What's that, okay. Carol, do you want to --

MEMBER SAKALA: Yes, I just wanted to respond to the question about whether there are any substitute measures. So last year we discussed the postpartum contraception measure

and put it on a list of things that we are interested in considering.

And earlier this month that was recommended for endorsement by the Perinatal and Reproductive Health Standing Committee. So that is one more content of care measure on the postpartum side of things that will be available to us today.

CO-CHAIR GESTEN: So do we have it up? I don't know if folks can read it. There's two rates in this. The percentage, the overall is the percentage of deliveries of live births between November 6th of the year prior to the measurement year and November 5th of the measurement year.

And there's two rates. Rate one is the timeliness of prenatal care. It's the percentage of deliveries that received their prenatal care visit as a patient of the organization in the first trimester or within 42 days of enrollment in the organization.

I think this addresses the issue that

one of the speakers was talking about in terms of the relationship of this to enrollment. And the second that's in the adult set is postpartum care and the percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.

Thank you, Sarah. So is there a, for the timeliness measure which is in the child core set is there a member of the Child Task Force that wants to propose, recommend that measure be removed? Go ahead.

DR. LILLIE-BLANTON: I can't propose one way or the other. But I think it might be helpful to know that our median rate for performance is 81 percent of beneficiaries report having, I guess that's prenatal care in the first trimester.

CO-CHAIR GESTEN: So seeing no hands go up or no cards go up my working presumption is that if there's not a motion to remove then it just stays. We don't have to take a vote to stay. Is that correct, okay.

So we want to go to the second part of this which is the postpartum. Is there a member of the Adult Task Force that wants to nominate this for removal?

DR. ELLIOTT: I would recommend removing it as a core measure on the adult.

CO-CHAIR GESTEN: Is there a second?

MEMBER SHA: I'll second it primarily for the purpose of discussion.

CO-CHAIR GESTEN: So I think we discussed unless there's any other comments we would go straight to a vote at this point. So this is a vote for members of the Adult Task Force on the removal of the second part, if you will, of 1517 which is the measure on postpartum care. Cindy.

MEMBER PELLEGRINI: Sorry. Just a quick question for Marsha. Does this affect the ability of CMS at all to continue doing what you're doing under the maternal and infant health initiative using that measure?

DR. LILLIE-BLANTON: We still, we take

your guidance. But we still would review the guidance and our understanding of the need for it and how we're using it.

CO-CHAIR GESTEN: Okay. Are we ready for the vote?

MS. GORHAM: The Adult Task Force Members on the line please chat your vote and we will vote for you.

CO-CHAIR GESTEN: So vote now?

MS. OGUNGBEMI: Yes. The Task Force is now voting whether Measure 1517 should be removed from the adult core set on the potential recommendation to CMS.

CO-CHAIR PINCUS: Yes, means it's removed and no, means it says.

MS. OGUNGBEMI: So one is yes, the measure will be removed. Two, is no, the measure stays in the core set for those on the phone. Grant, can you please chat your vote?

(Voting)

So we should have ten members voting. We only have, okay, so nine. The task force has

recommended that the measure be kept on the core set.

CO-CHAIR GESTEN: So we are staying the course, okay. Thank you, everybody. Thank you for all the voting assistance and help. I think we're now moving to, well a couple of things.

Let me just make a, just a process check. We are running behind. I'm not sure how far behind but I know we're behind and we know it. So we're talking about potentially working lunch and/or for shortening some of the policy conversation in the afternoon.

We do want to, need to get through the voting and the discussion of the measures. So we're going to prioritize that. Obviously if folks need to take a break please do it and come back.

We need you for the votes so don't tarry or linger. Is there, the next set of slides I believe will be a set of potential additions, okay. And, Shaconna, you're going to

do those?

MS. GORHAM: So can we take a temperature from the task force members if we need to take a ten minute break because we really want you all in the room for discussion and voting of the measures. So if we need to take a ten minute break let us do that now. Can we plow through? Okay, we can move on.

CO-CHAIR GESTEN: It's a hearty group. I told you they were tough.

MS. GORHAM: Okay. So your screen shows all of the potential measures for addition. These are measures that have been recommended by your fellow task force members and we're going to start with the child core set first.

You will recognize that 2903 and 2902 was actually voted last year. We voted on that last year and it was also placed on the list of recommendations. So it has been renominated, if you will, for vote again for potential addition to this year.

So first, next slide. Let's look at

Measure 2903: Contraceptive Care -- Most & Moderately Effective Methods. This is a new measure from the U.S. Office of Population Affairs. This measure was recommended by both the Adult and Child Task Forces last year.

At the time of recommendations it was two different measures, if you remember. The developer made some changes. It is now one measure including women ages 15 to 44 at risk of unintended pregnancy.

The measure was reviewed in the recent CDP Perinatal and Reproductive Health Project and it was recommended for endorsement. It has not been ratified by the board. It is an intermediate outcome health plan measure, data sources administrative claims.

I mean of course this measure is also on your Excel sheet if you want more information. The next measure is 2902: Contraceptive Care -- Postpartum. This is also a new measure from the U.S. Office of Population Affairs.

The measure was recommended by both

the Adult and Child Task Forces last year. Again, at the time of recommendation it was two different measures. The developer combined the measure now includes women ages 15 to 14 who have had a, 44 who have had a live birth.

Again, this measure was reviewed in the Perinatal Project and was recommended for endorsement. It is an intermediate outcome health plan measure. And the data source is administrative claims.

The next measure is 0480: PC-05 Exclusive Breastfeeding. This measure was actually recommended in 2014 and 2015 by the Child Task Force. In 2015, after we prioritized the measure did not actually make the cut.

But it was in discussion and recommended. This measure is a Joint Commission measure. The measure was reviewed by the Perinatal Committee and was recommended for continued endorsement.

It has not been ratified. It is a process measure, a facility level measure. The

data source is administrative claims. It is electronic clinical data and paper medical records.

So last year the task force just to kind of job your memory a little bit about some of the conversation, the task force considered the changes the Joint Commission made or were making to the measure. If, should I review some of that? All right. So the next measure.

CO-CHAIR GESTEN: I'm sorry. Can you just refresh my, was this measure under adult, child, both previously?

MS. GORHAM: This measure was considered by the Child Task Force.

CO-CHAIR GESTEN: Okay.

MS. GORHAM: And so there is an e-measure version. This is a new measure by Joint Commission, the PC-05 Exclusive Breast Milk Feeding.

It was reviewed by the Reproductive Health Project and it was also recommended for endorsement. This is a process measure, facility

level. The data source is also electronic clinical data and electronic health record. The last measure 071 --

CO-CHAIR PINCUS: Just one quick question. Could you just say something about the difference between the electronic measure versus the non electronic measure?

MS. MUKHERJEE: It's just the data source. It's just an electronic form of data collection.

CO-CHAIR PINCUS: Right, but I'm just trying to think about if we're going to be making recommendations or voting on this, you know, the, how we understand the difference between the two. And typically, you know, when there's the implementation of or the availability of both an electronic and a non electronic are they typically both endorsed or only one of them? What's the typical way this is done?

DR. BURSTIN: We're now endorsing them both separately because they have a different review and different review requirements.

But again it may be a question for the Medicaid folks would they envision having, and I know Karen and Marsha had to step out, right, would they look towards potentially giving the flexibility to people to use either or are they specifically looking towards one or the other. I don't know.

DR. ANTONELLI: Just a point. So it looks like that one takes into account electronic data sources. But there's potentially two cohorts in the numerator which, is that and it looks like on the e-measure there's only one cohort in the numerator.

I'm sorry that I'm asking fundamental questions. This is the first time that I'm scanning the actual language.

CO-CHAIR GESTEN: Just go back to the other. Carol, did you want to weigh in on this?

MEMBER SAKALA: Yes. I believe that the PC-05A information is obsolete. The Joint Commission has eliminated that subpopulation and it was not included in what we considered, I

think.

Is that, is that your understanding, Cindy? There was no submeasure in the exclusive breast milk feeding earlier this month.

MEMBER PELLEGRINI: I'm not sure. I don't remember.

DR. ANTONELLI: So, Carol, are you suggesting that this measure is not what it was intended to be that we're going to be asked to vote on?

MEMBER SAKALA: I think the present Joint Commission measure is PC-05 straight up without the submeasure available.

CO-CHAIR GESTEN: That's correct. Yes, go ahead.

DR. LOGAN: So I believe the other, the e-measure is for the EHR incentive program. So it might be for, it might make sense just to have the PC-05 without the e, because that's more in line with the core set rather than the EHR incentive program.

CO-CHAIR GESTEN: Do you want to go

back to the slide? Where are we? Yes. Where were you in this slide presentation? I think we're --

MS. GORHAM: So the next measure recommended by the task force member is 0716: Healthy Term Newborn. And this is an endorsed measure. The measure was reviewed in the Perinatal Project and was recommended for continued endorsement.

It is an outcome measure, a clinical level measure and data source is administrative claims.

CO-CHAIR GESTEN: Carol.

MEMBER SAKALA: So there's another update on this one. This is what we discussed last year. But the developer, California Maternal Quality Care Collaborative have for a number of years flipped this.

That's what Sean referred to earlier. It's now called unexpected newborn complications so that instead of saying what percentage of babies that you would have expected to do very

well are not, are doing well it's now what perspective of babies that you would have expected to do very well at the time of birth are in the postpartum hospital stay are not doing well.

And this has been extensively tested in California, the flipped version and it was recommended for endorsement earlier this month by the Perinatal and Reproductive Health Standing Committee.

CO-CHAIR GESTEN: But it's not the measure that's, we have in our packet.

MS. GORHAM: This measure was recommended by a task force member. So it's not currently on the core set and we don't have the specifications in the Excel sheet because it was just submitted. But Nadine is pulling it up on QPS just to see the specifications.

CO-CHAIR GESTEN: While we're doing that, Susan, did you want to --

MEMBER LACEY: So on Slide 91 in the overall packet about 2830: Breast Milk or 0480:

Exclusive Breast Milk one's an e-measure one is not, we, nobody has to or no task force has to do any kind of action on that because I thought we had said we weren't going to take them collectively.

So is that slide indicating to us there's no action needed by either of the task force?

MS. GORHAM: So the slides that we just reviewed on those measures are for the Child Task Force. They were task force member recommendations that you're going to vote on those measures individually to see if you reach greater than 60 percent consensus to recommend.

MEMBER LACEY: Right. On those the regular and then the e-measure?

MS. GORHAM: Yes.

MEMBER LACEY: I thought you were moving to the next one and so I was asking for sort of like Harold asked are we going to vote on things while they're present and in front of our screen or we're going to move to the next one.

I thought we had decided not to move to the next one.

CO-CHAIR GESTEN: Shaconna, just went through the one, two, three, four, five recommendations that came to us from task force members for us to consider and vote on. They were put on today's docket I assume because they transcend both child and adult, at least a couple of them do.

And right, and that's why we're doing these together. The measure changed and/or they were proposed previously and are being reintroduced.

So after she's done with her slide and I think you actually are done but you can correct me if I'm wrong, we are going to go measure by measure, see if there's a proposal to include it and a second and vote on whether we propose it for inclusion or not. Susan, is that responsive to your question or did I miss your comment?

MEMBER LACEY: Well not really. So when we first started we talked about a measure,

I don't know the numbers anymore. My head is swimming with numbers.

We, you said we're going to queue them all up and then we're going to vote, vote, vote. And everybody said, no, that's not the way we're going to do it. We're going to do it one at a time.

And so far that's what we've been doing. But now it feels like you're moving to the next one without us making --

MS. GORHAM: Well we're going to go back. So I'm going to put those measures back up on the screen and then we're going to vote.

MEMBER LACEY: I just want to make sure the process is the same to ensure that we're doing it like we're supposed to do it.

CO-CHAIR GESTEN: We just lumped together previously removals and now we've lumped together potential additions. But before we move on to any other slides we're going to start at the 2903 and decide whether there's, you know, discussion, votes, seconds, all the things that

we just did.

CO-CHAIR PINCUS: Yes, so this is, what was just done was an overview. Now we're going to go measure by measure for discussion and then do the voting after that.

MEMBER ADIRIM: Point of clarification. On the healthy newborn one this, the whatever the flipped measure is, which measure is that and is it in the core set? It's a brand new one that we're going to consider.

MS. GORHAM: It is a new measure to the core set if it's voted on for addition. So it is not currently in the core set. A task force member recommended it.

MEMBER ADIRIM: There was some discussion about a flipped one already being in the set.

CO-CHAIR PINCUS: Right. So I think what Carol was referring to is the fact that this is a measure that the endorsement group has endorsed and so it's in process of going to the endorsement process. It's not currently --

MEMBER ADIRIM: Right but somebody mentioned that it's just a flipped, that there's already one in the core set that's just a flipped measure. I might have missed what they meant by that.

I just didn't see it in the core set. I know the healthy newborn one is not. I know these are all new. But that was all.

MEMBER SAKALA: Could I just clarify? Last year we considered healthy term newborn which was an NQF endorsed measure. It was, came up for measure maintenance with new specifications.

So now if there's a new version of that, that is recommended for going forward. But this one has not been in either form in either core set.

CO-CHAIR GESTEN: So where are we? Are we at 2903?

MS. GORHAM: So they need to just put our screen share, our PowerPoint again.

CO-CHAIR GESTEN: While they're

getting that I have a question about so as I understand it 2903, 2902 the measure developer changed the measure to mush together ages that span the child and adult.

So what's the implications of voting yes, voting yes. So if it's in fact we say, yes, do we, is there a working assumption that we're going to split the measure up for child and adult?

Is there a working assumption that the age span which spans child and adult will be in one or the other category as a child measure or an adult measure? I'm not, I'm uncertain what it means to vote yes, what the implications of that are. Carol.

MEMBER SAKALA: So this is a place where I think the example that I gave earlier of the relevance to both is good. Like healthy birth spacing is great for babies.

So I just think we should consider that a lot of these are doing important things for mothers and babies.

CO-CHAIR GESTEN: So I have actually a much more boring, my question is much more boring than that. It's if we approve it which bucket does it go in and does it mean that folks who are reporting on the child are now going to be reporting on the enlarged denominator or are we going to task, if you will, to people reporting adult measures to when you're reporting it include down to the age of 15 or are we going to say 15 to 18 will go in child and 18 and above will go in adult or maybe there's some other option?

I don't know who would answer that question frankly.

MS. GORHAM: So I can answer process for the voting. But I think that is more a CMS question about how the reporting would go. For our purposes for voting we will vote for, the Child Task Force Members would vote for those two measures for the child core set.

And then we would take a vote for the adults for those two measures to sit on the adult

core set because it's two different core sets.

CO-CHAIR GESTEN: And then reserve for Marsha since she's not here so we can give her work to do to figure out which it would be reported in? All right. This looks complicated. Do we need a break to discuss this issue or, you guys all get it, right.

CO-CHAIR PINCUS: I think we should take a break now because we need to get some input from CMS and we're going to have a long discussion about each of the measures. And so rather than break --

CO-CHAIR GESTEN: Yes. After lunch, okay. So you want to try to come back and have a working lunch? What do you think?

So let's try to take 15 minutes which means that we would restart at 12:25 and we will resume and hopefully have the answer to this. Okay.

(Whereupon, the above-entitled matter went off the record at 12:07 p.m. and resumed at 12:33 p.m.)

CO-CHAIR GESTEN: Hey, I think we're going to reconvene and get going. It's okay to chew and talk.

So we have I think some clarifying questions -- issues to talk about. I'll give it over to Debjani first and I have a couple as well. Just to make sure we're all on the same page and get a sense of what we're doing and why we're doing it and what the process is going to be.

But Debjani, you want to start and then I'll go after you.

MS. MUKHERJEE: Sure. We just wanted to go over why there has to be two voting for the adult versus the child.

It's two different core sets, two different task forces, and so it has to be two different votes.

Because we want to make sure we can attribute 60 percent plus for one task force when we say over 60 percent of task force members either of the child or the adult group voted to

include it or recommend it for consideration.

So the voting will be separate and we will let you know that now the child side is voting and then we'll let you know that the adult task force is voting.

And we will make sure that you get to see the measures as you're going voting and we'll -- Shaconna will give you a quick recap of all the measures we talked about, but then when we vote you'll see them one by one, just to make sure. But it has to be two separate votes.

CO-CHAIR GESTEN: The other -- a couple of other clarifying -- hopefully clarifying comments.

One, for folks that are new, just to -- and folks who have been here, just to refresh, that the recommendations from these task force are exactly that.

They're recommendations to CMS, who I think you probably saw yesterday in the trial tests whereas we'll see tomorrow the history of CMS taking very seriously the recommendations and

the prioritization of the task force, but CMS is the decision maker about what they do with our recommendations.

So just to understand that, you know, when we vote and we recommend something that's what it is. It's advisory to CMS.

The second point I would make is that -- so we have right in front of us five -- potentially five measures, maybe four depending on what we hear about the two exclusive breast milk feeding measures.

But we teed them up today again even though some of them are voted in child and not in adult to take advantage of input from the adult group on issues that are crosscutting and that are closely connected to perinatal, maternal and child health.

So we recognize that some of these measures, you know, the folks on the adult side aren't going to be voting on, but we want to take advantage of your input and the discussion leading up to these measures.

And these are the measures that were recommended by members of the task force for us to consider, and that's how and why they made this list.

Some of them as Shaconna mentioned have been voted on previously or recommended, and some of them I think not, or some of them have been changed.

Also, we can -- in terms of the age issue and how it's going to get reported, I would suggest that -- we will go through the discussion of the measures and we can separately, if we choose to, make a recommendation to CMS about how to handle measures that are crosscut -- go from 15 to 44, for example.

Whether it's the same measures reported in both sets, whether you break up the age groups, or some very -- or decide, make a decision that it's in one set or the other.

And there are -- I don't think there's a right answer to that, but if folks want to weigh in on that we can see if we have consensus

or want to make a recommendation.

So I forgot to tell you this, Shaconna, I'm sorry. Before we do any of this, there was a recommendation -- there was a request by somebody in the group to potentially re-vote a measure based on the outcome of the last voting that potentially might have changed votes.

And so there was a proposal to request that we re-vote the measure on frequency of prenatal care visits. That is -- help me out, 15 -- is that 1517? So much for my memory. 1391. I'm sorry, can you guys -- can we post it? I know you're looking at me like I'm crazy, but sorry I didn't tell you about this.

Just trying to keep, you know, just trying to keep it improvisational and jazz-like. But anyhow, Kathryn, do you want to -- do you want to just tee it, you know, describe what you --

MEMBER BEATTIE: Sure. So because we voted on 1517 second, after, and have voted that we would endorse keeping the timeliness of

prenatal measure, then that changes how -- at least for me -- I feel about having a gaping hole regarding prenatal care and the importance of a measure driving towards access.

And so 1391, which is the much more complex around frequency of prenatal care, may not be a necessary measure in my mind knowing that we are keeping 1517.

And they're both in -- those both were in the child core set. So I would please recommend or request that we re-vote on 1391.

CO-CHAIR GESTEN: And I checked and this is okay with Robert's Rules, just in case you're wondering. So is there a second?

MEMBER ADIRIM: Second.

CO-CHAIR GESTEN: Second, okay. So can you tee up the vote again for 1391? So if memory serves, a yes vote is a yes for removal. A no vote would retain it in the child core set.

MS. GORHAM: And to be very clear, this is only the child task force members voting now.

CO-CHAIR GESTEN: While we're teeing it up, anybody have any questions about either what we're doing here? You all refreshed?

Susan, you notice I gave people an extra five minutes based on your comment. How we doing team? We almost there? Okay, so what we're voting on -- and this is just the child task force -- is whether measure 1391, frequency of ongoing prenatal care, should -- the proposal is to remove it from the child core set.

A yes vote, a 1 vote would be voting for removal. A no vote would retain it in the set. So are we ready?

MS. OGUNGBEMI: Yes, we are ready. Voting is open. Results are 73 percent yes and 27 percent no.

So the task force has recommended that CMS remove measure 1391 from the child core set.

CO-CHAIR GESTEN: Great, thank you. So now can you take us back to where we were before with the five measures?

Thank you so much for doing that. At

least there are no hanging chads to contend with, right?

So here's the suggestion for process going forward, which is that we -- measure by measure -- have a discussion among the group.

Before we go to a vote we take any public comments on any of these measures. And then we would go and vote them individually.

So why don't we start with -- and I don't know if you can put it up there. 2903 which again, my -- I think you're going the wrong way but maybe not. Go the other way. Yes, or maybe not.

2903 would -- is a measure that we saw last year -- I think both tasks forces saw this -- but the measure has been changed by the U.S. Office of Population Affairs to include -- be inclusive of the age range of 15 to 44.

And the status of this in terms of NQF endorsement is not yet but it's in -- not endorsed? And does that mean it hasn't come up for endorsement, or --

MS. GORHAM: So that means that the perinatal committee reviewed this measure. It was recommended for endorsement but it has not been ratified. So the measure is not endorsed yet. It's in the pipeline.

CO-CHAIR GESTEN: Comments on this? Carol?

MEMBER SAKALA: Yes, I just wanted to share with you the gist of that conversation. I think that we were very supportive overall of all three of the contraceptive care measures that came before us.

The one concern that came up and does come up from the reproductive health community are issues of coercion, and I think we did discuss that a little bit last year as well.

And it was very gratifying to know that the U.S. Office of Population Affairs, which works in a very collaborative way with -- across stakeholder groups, has a measure in the pipeline that deals with the experience of receiving contraceptive care and that that people felt

would be a very good measure to pair along with these when it's available.

CO-CHAIR GESTEN: Thank you, any other comments? Andrea?

MEMBER BENIN: I would just want to reiterate my comments from last year around the concerns about coercion. To me this is a metric that essentially says all women with Medicaid should be, you know, on contraception.

Since there's no target for it, there's no known -- it's not actually known what the right number is, it's much more of an epidemiological measure. And I could see how it has real purposes for the states to understand what's going on in their environment and real purpose for the states to understand how they're using contraception.

But as far as it being a quality metric around the quality of a plan, I would think that a better metric would actually be around contraception being offered, and not -- you know, the stock that we think that all women

should have contraception is -- and we're not even saying that all women, we're saying that all women on Medicaid should have contraception -- is concerning to me.

And so it's a hard metric for me to be supportive of. While I support the idea of it conceptually and I can support the idea of women being offered contraception, since it's not exactly known what the right level is, it's hard to know what to do with that.

CO-CHAIR GESTEN: Thank you, Kim?

DR. ELLIOT: My comments follow very much in Andrea's steps. I think if I had seen some exclusions for people that were offered and declined I'd be a lot more comfortable with the measure, but there are no exclusion criteria in the specifications that I saw.

CO-CHAIR GESTEN: Thank you, Cindy?

MEMBER PELLEGRINI: So we had a lot of these conversations in the perinatal committee. And while I understand the concerns completely -- and there isn't a target in this, it is not meant

to be a 100 percent measure or necessarily a 50 percent measure or anything else.

It's meant to show tracking over time. The denominator is women age 15 to 44 who are at risk of unintended pregnancy.

It's not an all women measure. So it is a matter of docs going in and -- or providers -- and screening for unintended pregnancy and risk.

Now if this is a woman who is not sexually active, she's not in the denominator. If she wants to get pregnant, she's not the denominator.

So this is something that I think is going to require a good deal of education about the appropriate use.

But the consensus in the committee was this is an incredibly important measure. It fills some real gaps in women's health and in preconception and intraconception care.

And people are really very anxious to get this into use and out there in the field so

we can start working on it.

MEMBER BENIN: I'm not familiar with the ICD-9 codes or ICD-10 codes around those things.

Are those ICD-10 codes that are readily specified and easily used by people to say -- like do doctors code this women is not -- these are the exclusions?

I'm -- that's just not my level of familiarity with how coding works, but I may not be super familiar with that area and what those codes are.

CO-CHAIR GESTEN: If anyone is in the queue that wants to respond to -- Sean.

MR. CURRIGAN: Yes, that does work. There is no current code for sexual activity, but it has been -- it's being -- sexual activity, and I think it's like sexual activity within ever and sexual activity within the last three months, are the two codes that are being sought after.

And I work -- they're going for a SNOMED code I believe. We applied for a SNOMED

code for the pregnancy intention within the next year, and that has been rejected for a SNOMED code but recommended for a LOINC code.

So we will have these codes whenever LOINC gets to it, probably within the next year. So those codes don't exist currently, you'd have to get that from the electronic medical record.

So I think we don't have the sexual activity exactly yet or the pregnancy intention, but -- if you are currently seeking fertility treatments or there's other things that they've identified within their denominator so that they can kind of make the denominator as tight as possible. But it's not a tight denominator, which is why we have to go get these codes.

CO-CHAIR GESTEN: Thank you.

MR. CURRIGAN: But it was endorsed. It's a wonkier denominator than we would like, but I think for the LARC, specifically the LARC portion of the -- is this -- are we doing these as two measures or is it the LARC portion is the same measure?

The LARC is really about access and we're really looking for more than zero percent for the LARC measure. And then the most is just to kind of prepare the benchmark that we need to have.

MEMBER SAKALA: LARC is not in here, it's just the other two.

MR. CURRIGAN: Oh, okay.

CO-CHAIR GESTEN: Thank you, Sean. Rich?

DR. ANTONELLI: I'm just wondering about the definition of being at risk for unintended pregnancies.

I know that there's been a lot of tension in adolescent healthcare providers around doing chlamydia screening and how that has really been challenged at the level of clinicians.

So with respect to this, and I'm -- being very mindful that I'm speaking specifically about the 15 to 18 age range here, can somebody give me some elaboration on what defines risk for unintended pregnancy?

Because otherwise it looks like every adolescent female that I take care of for well child or well care, to hit this measure I have to prescribe birth control.

CO-CHAIR GESTEN: Somebody have a response? Carol are you able to, or anyone else? Michael, do you have an answer, or --

MEMBER SHA: Sorry. I would offer the adult corollary that you're essentially dealing with every adult female from 18 to 44.

CO-CHAIR GESTEN: So Rich, maybe when Cindy comes back in we can ask if she has a comment to that. Charles?

DR. GALLIA: The effective contraceptive use, including LARC, is important in Oregon.

We have -- even before the initiative that was occurring at the federal level, we started incorporating -- or almost developed -- our own measure in parallel. Just for a variety of reasons.

And during the course of

implementation we've discovered a couple of challenges in the assessment and accuracy of, you know, there's -- there's an education program about -- asking questions in it as part of a woman's health visit on a routine basis that we're implementing about pregnancy intention.

And we've also on the administrative side discovered that we have some issues that aren't only around exclusion and inclusion criteria about past obstetric care, but even gender identity as a component that we have to take into consideration that we haven't in the past.

And so while it's an evolution, this particular measure is in our -- I'd say it's in our top ten in terms of priority areas for focus.

CO-CHAIR GESTEN: Cindy, when you were out there was a question Rich asked about what counts for at risk of unintended pregnancy, specifically focused on adolescents.

And I think Rich -- correct me if I'm wrong -- part of the comment was it would seem as

if it's potentially true that every adolescent that he sees, to pass this measure would need to be on contraception.

Is that -- so what's the granularity about how that's defined?

MEMBER PELLEGRINI: Carol, it's my recollection from the conversation a couple weeks ago that the two questions basically are, are you sexually active, and do you want to get pregnant. And depending on the answers --

DR. ANTONELLI: But are those in the measure spec?

MEMBER PELLEGRINI: I don't recall. I would have to go back to the really long document --

DR. ANTONELLI: Okay.

MEMBER PELLEGRINI: -- if that's exactly.

DR. ANTONELLI: Is that something the staff can pull up? Because it's -- I don't mind revealing my leaning.

I would heavily lean toward no if

those things aren't in there. If those things -- because you know it's been a very long row to hoe just getting chlamydia screening for adolescents.

Specifically because of I'm not -- you know, I'm not sexually active and I don't want my parents to see that on the bill. So I just want to pull that out there.

CO-CHAIR GESTEN: Well folks are looking for that. Any other questions or comments from the group? Yes, Andrea?

MEMBER ADIRIM: Yes, I hear what everybody is saying about coercion, but I think what I'm struggling with is understanding how just by having this measure, how it directly impacts how a practitioner practices.

So, I mean this is, to me seems like it's a measure to determine if there's improvements in prescribing of these types of contraceptives. So can somebody help me with this?

Because I think it's a good measure. Whether or not you include it in the core set is

another issue, but I'm just not sure how this core set would necessarily lead to coercion directly by the practitioner, so help me with that.

MEMBER DUNN: This is Katie, could I add to that?

CO-CHAIR GESTEN: Sure.

MEMBER DUNN: Thank you. I agree with what the last speaker just said. If you're looking at wanting to make sure that contraception is offered as part of a standard of care that's one thing. I think that there would be a fair amount of concern with using measures that speak to unintended pregnancy and/or an assumption that is directly related to personal behavior. In the past there have been measures, and they may -- if they've already been talked about and I'm new to the conversation I apologize for my ignorance.

But you know if we were going to look at measures about birth intervals that are related to positive birth outcomes and overall

health as a mother, I think that that would be a better way to look at this only from the perspective of that birth intervals can be and are influenced by so many other psycho social, emotional and physical issues, not just whether contraception was prescribed or actually given to a particular person. So thank you.

CO-CHAIR GESTEN: Thanks, Katie. Helen?

DR. BURSTIN: Just a quick process point. You know, what we try to do is not have these tables readjudicate the sort of the measure itself.

It's not necessary. We had a committee or co-chairs here but another member of the committee at the table, they looked at it through the lens.

Overall this is a good measure. It's high quality. They have recommended it. I want you to just consider the discussion today really in the context of how would you use -- would you recommend this measure for the Medicaid

population.

Please don't readjudicate the measure. You'll be here for days, and they've already taken care of that. Thanks.

CO-CHAIR GESTEN: Ann?

MEMBER DUNN: I was -- it was no intention to readjudicate the measure. I think I was trying to get to the point of saying no it doesn't belong for Medicaid population.

CO-CHAIR GESTEN: Thank you. I think that came across, Katie, thank you. Ann?

DR. SULLIVAN: I was just curious if this kind of measure is used for any other population other than the Medicaid population?

Is this in anybody else's kind of quality armamentarium? Because I think if it's not, then I think, you know, you have to consider the way policy is driven.

And I think you also have to -- whether you like it or not -- consider perception. And I think that there's a little bit of danger here of this is something we're

pushing forward for the Medicaid population but not for other populations at this point in time.

And if that's the first population out of the box, I think that could be somewhat problematic because it has a tone of a little bit of -- while I think well-intentioned -- of a possible push towards making sure this population gets a little more contraception than another population might get.

And I think that that -- you just have to consider that when you look at measures.

CO-CHAIR GESTEN: That's an interesting point. You know, Carol can probably make this point better than I do, but my understanding is that unintended pregnancy is sort of an equal opportunity happening.

And so -- but I think you're not wrong that a lot of the efforts that have gone on have been targeting -- have been around Medicaid or low income.

But I think that there are also a number of initiatives -- and Carol or Cindy might

be able to speak to them -- that are aimed at trying to have better planning, spacing, intrapregnancy care that is really focused on the broad population.

DR. SULLIVAN: And to that point -- and offering it is one thing I think. I'm just saying that offering it I think would be tremendous and to monitor that -- but not redoing the measure. But this is not offering it, this is monitoring it, which I think is a little different, that's all.

CO-CHAIR GESTEN: All right, Carol?

MEMBER SAKALA: I just wanted to speak to the question of whether it's in other programs already. These are brand new measures and in fact there has been a dearth of reproductive health measures. So we were very excited to have what we considered to be robust measures, especially knowing that this other measure is in the pipeline.

So no they're not in any programs right now, and this would be the first

opportunity to do so.

CO-CHAIR GESTEN: Charles?

DR. GALLIA: So we're using this measure as a -- or building this measure into a shared data set Maternity Data Center that incorporates the hospital measures that we will be pushing back out.

So it's a cross-payer in how we're applying it. Because one of the other lessons we've learned early on in doing measurement at a practice level is it kind of drives providers crazy if you have one measure for one population and not for another.

So fundamentally we did address that, making sure that it would be transferable between groups. You can't hear me? I'll speak up next time more.

CO-CHAIR GESTEN: Cindy?

MEMBER PELLEGRINI: Just a quick point, because it's very top of mind for me. I'm spending most of my time these days working on Zika.

The population that we're talking about here is going to be at the highest risk for Zika virus. It is low income people who don't have air conditioning, who don't have screens, who have outdoor jobs, et cetera.

And so I think it's just a timely issue to add here to say we've been thinking about -- we've been thinking about access to contraception for other populations like through the Affordable Care Act's mandate of coverage without cost sharing.

And this is another way to look at needs in this very high risk, high need population.

CO-CHAIR GESTEN: I'm sorry?

MEMBER LACEY: I move we call the question.

CO-CHAIR GESTEN: Want to vote?

MEMBER LACEY: Yes.

CO-CHAIR GESTEN: So I'm not sure what the rules say, but we wanted to have public comment before we voted on the measures.

So if it's okay with you, my plan was, Susan, to talk about the two contraceptive care measures in the group after public comment and then vote. Is that -- is that okay, can I?

Any other conversation about 2903, the measure that's up there, most and moderately effective methods?

MEMBER ADIRIM: One quick thing, and I just want to support something that Cindy said, just to extend on that a little bit.

What I was asking before is I really don't see a direct link between physician practice and this measure. I think it's good for monitoring, because I think the real issue is that these are not being offered, are not being offered reliably. And so I think it's not only a good measure but I think it's also a good measure for the Medicaid core measure set.

CO-CHAIR GESTEN: So I would ask that we move to the next contraceptive care measure, which is the postpartum measure, if we can put that up on the screen. And would invite

conversation about this measure for inclusion in that adult and child core set.

So this is from the same steward, the U.S. Office of Population Affairs. It's in the process of endorsement. It's been recommended by the perinatal committee, is that right? Yes.

Yes, this is 2902, contraceptive care for postpartum, and there are -- this is two measures? It's the most effective and there's most and then there's LARC measure, right, within it?

MEMBER SAKALA: So there are two layers of effectiveness that can be looked at separately, and there are also two timeframes within three days and within 60 days.

With the -- what we've had in recent years is a lifting of the idea that it's not appropriate to provide some of these measures early on. And in fact some -- they can be provided at the time of birth as well as in the postpartum visits.

CO-CHAIR GESTEN: Carol or anyone

else, do you want to make the specific point about the relationship or why this is particularly important and separate from the previous measure that we saw?

MEMBER SAKALA: It's a different population. This population is not included. Women, we've talked about getting -- how many Medicaid mothers don't get back for the prenatal visit -- the postpartum visit.

So if you can get this while you're in the hospital, I think it pushes conversations about this into pregnancy, that a part of pregnancy care should be these kinds of discussions about having the opportunity to make these decisions shortly after the birth or in the postpartum visit.

And also CMS has been working with states to -- especially on LARCs -- to find new ways of paying for them and lifting some of the barriers that have occurred.

So, and with -- it also fits as well with the focus on postpartum contraception. It's

a good fit there.

CO-CHAIR GESTEN: Thank you. Any other comments about this, this potential inclusion in the core set? Andrea?

MEMBER BENIN: You know, I'll just echo my comments from the previous metric. While I believe these to be strong measures of epidemiological interest and probably payor interest, and relevant around use of access to contraception potentially, it -- if it's truly a measure of access, it's not about whether or not the contraception was given.

It would be a metric about it being offered. And so as a metric of -- as of it being given, but these are -- I don't believe it's appropriate to use these in this setting.

If we were doing an epidemiological project that would be great. Or writing a treatise on the best thing for women perhaps, maybe. But to say that all women on Medicaid should be, you know, sterilized is a little controversial to me.

CO-CHAIR GESTEN: So let me just remind -- thank you for -- let me just remind folks that these measures -- we're going to be voting on -- both tasks forces are going to be voting on these measures, both the child and the adult.

So this is a time for both sides of the aisle, if you will, to make any comments or questions and so on.

Not just the child task force but the adult one. And we're going to vote them separately, as we've talked about. Sue?

MEMBER KENDIG: I think this is more of a policy comment but may get to some of the other comments.

In my view this one is especially important, particularly with regards to the timing. In those non-Medicaid expansion states, if this does not occur and a woman does not want to become pregnant within the next year, it is really critical that this issue is addressed in that 60-day timeframe. And this is one more

trigger to help assure that this conversation takes place and she has access to the most effective method for her.

So if you want to talk about a vulnerable population, the women in those states are exceptionally vulnerable and this becomes a critical timing issue.

CO-CHAIR GESTEN: Great, thank you. Michael?

MEMBER SHA: I would agree with everything that Sue said, that this is -- that for the non-Medicaid expansion states that this time window is very key.

But I think where this measure perhaps -- that I have a problem with, is that this is an outcomes measure instead of a process measure. That if we were measuring the active discussing the idea of contraception in this age population, I would be completely supportive of it. Because, you know, spacing is very important, not only for the health of the mother but also for the recent newborn.

But I think that this -- I'm having difficulty with the fact that this is an outcomes measure.

That actually that, you know, when I first read the measure I really did think that there was a coercive component to it. Because as a practitioner, if you're going to be measured, or the organization's going to be measured on the number of women who are going to be receiving contraception, there is an implicit encouragement that more contraception be offered to this population. Not just the active discussion, but the actual delivery of this medication.

CO-CHAIR GESTEN: Thank you. Fatema?

MEMBER SALAM: I just wanted to ask a clarifying question. Because I heard Carol say that this was the first opportunity for this measure to be used.

It wasn't that it was specifically targeting any particular population. Is that accurate? That it was just the first opportunity for it to get entered into a measurement program?

MEMBER SAKALA: It's a brand new measure that was just recommended for endorsement and needs to go through the process, but it had a lot of strong support.

MEMBER SALAM: Yes, but it wasn't written specifically for a target population. It was all women.

MEMBER SAKALA: So the previous one that we discussed does not include childbearing women and this one does. So this is specific to the period between birth and 60 days.

CO-CHAIR GESTEN: But the measure description doesn't say Medicaid. The measure description is for -- that's what your question is, right? Kim?

DR. ELLIOT: I just want to again reiterate my concerns about the coercion and also choice of Medicaid families. And I think that the way this is phrased with it being delivered versus offered is a strong statement to be making for a Medicaid measure.

CO-CHAIR GESTEN: Susan?

MEMBER LACEY: So the only thing I wanted to say is what do you do about the provider that is -- because of his or her faith -- they will not want to do this?

We brought this up just ever so briefly, but I mean so those people are just going to have to always get the ding. So we -- I remember we had a brief conversation about that but I think that's also problematic.

CO-CHAIR GESTEN: Any other comments? Rich?

DR. ANTONELLI: I'm just wondering if -- I don't know, maybe this is for the person sitting next to me.

Just the fact that this measure actually is, was this prescribed versus was it proffered. Is there some logic that we should understand about what went into the process? Because it is two different measures.

An intermediate outcome versus a process, I get that. But it would maybe help me with my thinking a little bit to know -- clearly

somebody made a decision that proffering wasn't enough.

MEMBER SAKALA: Cindy, do you recall this? Because I believe it's about the decision being made rather than the actual, for example, IUD being inserted.

MEMBER PELLEGRINI: Yes, so this got to the issues around there are some providers, as I understand it -- Sean could elaborate on this a lot more.

Some providers are not stocking IUDs because they say well I've got to pay for it up front and then I may or may not have patients who come in and actually use them. Some of them are not getting trained on how to insert them. So this is really about trying to push -- actually practice, sorry, Terry's gone.

But push practice to say, not just did you talk about it and then give somebody a referral or expect them to go find somewhere else that they could actually get the product, but are you doing everything you need to to be able to

serve these patients from start to finish.

MS. MUKHERJEE: Hey Reva, do you want to say something about this measure as well?

MS. WINKLER: Hi, this is Reva Winkler, I'm the Senior Director on the Perinatal Project. Essentially the interest in contraceptive measures has been so great that these measures have been being worked on and being developed for several years.

The biggest constraint is for use in -- you know, widespread use is really available of appropriate data. And so this measure is based on administrative data, and we all know that that data has limitations. But that is the reason that the measure is structured the way it is, because that's the data that's available to be collected.

CO-CHAIR GESTEN: Thank you, Reva. Operator, can we go to any public comments? And we're entertaining public comments on either of the two contraceptive care measures, 2903 or 2902, for public comment.

OPERATOR: Yes, sir. At this time if

you would like to make a comment please press star, then the number one. And there are no public comments from the phone lines.

CO-CHAIR GESTEN: Thank you, operator. Public comments in the room?

MR. CURRIGAN: Sean from ACOG. Number one, just to remind you this is a health plan measure, this is not a provider or like clinical professional level measure.

So conscientious refusal -- like if a provider wants to not offer, you know, contraception and not refer them to another provider, that's the health plan's choice on how they deal with that provider and how they interact with that health plan.

This is a health plan measure. So a woman could choose, do I want to go to this health plan that offers this LARC or offers this moderately effective and gives me very easy access to the methods that I would like to use? Or am I going to use this other health plan who has providers who are not offering those and

getting those contraceptive methods to those women who do not want to be pregnant.

Health on level, we did -- ACOG did recommend this for use in the America's Health Insurance Plan's core OB/GYN set. We asked not to be recognized in the work of the AHIP core set because they did not choose to include them and that was because at that time they were not NQF-endorsed. So that was like a year ago. Now they are NQF-endorsed, so we will be revisiting those conversations with the commercial health plans very shortly. But we think that these are perfectly fine for both commercial and Medicaid populations.

Unplanned pregnancies -- like if you want to talk about having better birth outcomes, you know, the frequency of the prenatal care, I can tell you a planned pregnancy is going to have a better birth outcome than an unplanned pregnancy. And I think that if you got rid of those frequency of prenatal care, this is a very good measure to stick in there.

And just to remind you that there are patient-reported outcomes that are in development. Dr. Burstin was on the panel selecting those for the OPA, as well as we are trying to upgrade the data system so that we can get the LOINC code and sexual activity and pregnancy intention to improve this measure. This measure should probably not be a use after five years. Like, we will have something better to replace it because we'll have better data.

And then just a recommendation that perhaps you may consider voting for this twice, because there is the LARC submeasure, which is one piece of the most and moderately effective, and then the moderately effective which is like the pills. You might want to vote for it twice because there are two rates within the measure, and LARC access might be considered separately.

CO-CHAIR GESTEN: Thank you. Any other comments from the room? Questions now? Kathryn and then Susan?

MEMBER BEATTIE: Just a comment. I

don't think that the majority of planned participants are particularly educated in the details of their plan when they select it. And I'd be concerned that they may make a selection not knowing that this measure could potentially change the direction of their care.

MEMBER LACEY: Yes, so to elaborate on that. So on the one hand we're saying these people are not ready to make these decisions because they don't know enough information, they need to be approached, et cetera, et cetera.

On the other hand, it sounded like the recommendation was also well if someone has decided they're not going to give the individual birth control or right for birth control, then the plan can deal with that person and then the woman can pick another plan.

So I think we're saying two things -- two very different things about the capability of this population. Not that I am, I think that is what I'm hearing. Very different thoughts about what these people are capable of doing for

themselves.

CO-CHAIR GESTEN: Charles?

DR. GALLIA: So I am certain that whatever I say is not going to persuade people to think differently than what they do.

But part of the reason the emphasis we placed on effective contraceptive use was based on thinking, as I said yesterday, about a -- like a life course perspective. And part of that includes starting healthy. And that means emphasis on preconception health.

And then -- and this is one facet of a very important starting point that I think that Medicaid programs, who are responsible for the majority of births, ought to be -- and we are -- paying attention to.

CO-CHAIR GESTEN: Thank you, Harold?

CO-CHAIR PINCUS: So in some ways this gets back to the issue we talked about in the very beginning today about -- that we also talked about yesterday in terms of sort of what is the sort of fit for purpose of this kind of measure.

You know, in some ways we're not really talking about using it as an accountability measure for plans or something that would be used with -- we're really -- and in some ways how it would be used at a state level in terms of, you know, their Medicaid program.

It is kind of a dipstick into the overall population to see well how -- you know, in our population, you know, what is the degree to which, you know, this measure is being met.

And then it could indicate more for sort of analytic purposes or trying to understand what's going on in the state as a way for improvement, to see if there are certain areas of the state or certain populations that may be at -- sort of more likely of not getting these kind of services or obtaining these kind of services.

And thinking of ways to improve the availability of these services or to try to understand why certain groups are not getting them.

So, you know, so I think one question

that comes up is how would states actually use this. You know, if it's not -- you know, for the purposes of communicating information about plans.

CO-CHAIR GESTEN: Charles, did you have another comment or was that card just still up?

DR. GALLIA: I could answer the question. How we're using it in Oregon is we're seeing where there are -- in some of the background work in developing the measure and using the temporary measure at the beginning, we also incorporated survey work and patient preferences.

And there was a gap area -- and this is one of the gap areas that we discovered, was that particularly at postpartum that preference for IUDs are -- was a lot higher than was actually being done.

And so that gap created -- said so why is that happening. And one of the things we discovered was that there was some -- we had some

administrative reimbursement barriers that actually had nothing to do with the patient preferences that were impeding the ability to deliver long-acting reversible contraceptives postpartum.

And so that's one of the ways that we use this measure.

CO-CHAIR GESTEN: Thank you. So here's where the fun begins. So we have -- we're going to start voting and the voting will be child task force, adult task force for each measure at a time.

But part of the challenge -- part of the question that we have to confront is the measures are not yet NQF-endorsed. And as you may recall, there are categories of, you know, no, yes, and conditional endorsement based upon NQF endorsement.

So why don't we start with 2903 which is contraceptive care most and moderately effective methods. And before we vote, let's make sure and know we're voting on -- we're looking

for -- Cindy? Yes?

MEMBER PELLEGRINI: Just a technical question. Could the NQF staff clarify for us, this has been a recommended -- these measures were recommended by the perinatal panel. Now they go to the NQF Board? CSAC, I'm sorry. And then do they have another step beyond that or is the CSAC it? Then Board.

So can you give us like a general timeframe? Is that within the next -- do those things happen in the next couple months, six months, three months? Okay. So these are like on the five yard line.

MS. ALLEN: So this is not going to happen -- the measures don't go to the Board until probably around October before it goes to the Board.

We have to go through public comment first, which is 30 days. Then after public comment, the Committee will reconvene. Then it has to go through membership vote. Then to CSAC. Then to the Board. So it's a process.

CO-CHAIR GESTEN: So I'm just trying to get a sense of what it is we should vote on at least first.

So is there -- does somebody want to make a motion of either we're voting yes without conditions, yes with conditions --

MS. GORHAM: So for clarification to bring you back to your decision categories, because this measure is not NQF-endorsed, we would need a motion first from the child task force to vote yes, the measure should be -- we recommend to CMS that this measure is included into the core set on the condition that it is NQF-endorsed.

So this would be a motion to conditionally support the measure.

CO-CHAIR GESTEN: But is there anything that forbids somebody from saying we want to vote on it without conditions?

MS. GORHAM: So historically we only vote on support with condition, because it is not NQF-endorsed.

CO-CHAIR GESTEN: Okay, so let me -- so you're looking for a motion to start to conditionally support.

Is there a motion from the child task force to do that? Is there a second?

MEMBER SAKALA: Second.

CO-CHAIR GESTEN: Okay. The child task force for right now is voting on whether to add this measure, the 2903, to the child core set to recommend its addition. It's a conditional support. The condition is that it be NQF-endorsed. And are we ready to vote?

Again this is child task force. The adults will get their turn next. A yes vote is to include it. A no vote is to not include it. Is that what you were going to say?

MS. GORHAM: Yes, I was going to say a yes vote is a vote to say that I recommend to CMS with the condition of NQF endorsement, and no is I do not recommend the measure with conditional support. For child task force members only.

MS. OGUNGBEMI: Voting is open.

CO-CHAIR GESTEN: And I'm sorry, how many votes do you have? Is it still 11?

MS. GORHAM: Eleven.

CO-CHAIR GESTEN: Eleven? Okay. So this does not pass.

MS. GORHAM: Yes, in order for this measure to have passed, it would have needed more than 60 percent --

CO-CHAIR GESTEN: Sixty percent.

MS. GORHAM: -- of the votes.

CO-CHAIR GESTEN: Okay.

MS. GORHAM: So the child task force members do not wish to include 2903 as conditionally supported into the core set.

So now we will take a vote with the adult task force members.

CO-CHAIR PINCUS: And do we have the adult task force members on the line?

MS. OGUNGBEMI: Voting is open.

CO-CHAIR PINCUS: No, no. No, we need a motion. We need a motion.

MS. GORHAM: So do we have a motion from the adult task force members to --

MEMBER KENDIG: So moved.

CO-CHAIR PINCUS: Is there a second?

MEMBER PELLEGRINI: Second.

MS. GORHAM: So we have 11 adult task force members. We have one member on the phone, and she can chat her vote.

We are voting on the adult task force for 2903 contraceptive care most and moderately effective method. Yes, you press 1 and that is a vote to conditionally support the measure for addition to the core set. Two is no, I do not conditionally support the measure for addition.

MS. OGUNGBEMI: And now voting is open.

CO-CHAIR GESTEN: We really need some voting music.

MS. GORHAM: Katie, can you please send your vote through your chat?

MEMBER DUNN: I just did.

CO-CHAIR GESTEN: Still missing?

MS. GORHAM: George is out of the room so there's actually -- yes, but I don't have Katie's vote. Katie, can you vote again, please?

MEMBER DUNN: I just typed it in again.

MS. GORHAM: Okay, so the adult task force members have decided -- or have voted not to include or not to recommend the addition of 2903 to the core set.

CO-CHAIR GESTEN: Okay, we're --

CO-CHAIR PINCUS: I just wanted to say that we have voted to not recommend. Not that we had voted to not recommend.

We have not voted to recommend. It's not that we voted to not recommend.

CO-CHAIR GESTEN: I think I got that but I'm not sure. One more cup of coffee. 2902 is what we're going to vote on next.

This is contraceptive care postpartum, and again we're going to start with the child task force and the -- we're looking for a proposal to vote on this support with conditions,

the condition being NQF endorsement.

Is there a motion to vote on that from the child task force?

DR. ANTONELLI: So moved.

CO-CHAIR GESTEN: Is there a second?

MEMBER SAKALA: Second.

CO-CHAIR GESTEN: Okay. So we're voting to recommend what the inclusion in the child core set number 2902, which is contraceptive care postpartum conditional support.

A yes vote is that it would be recommended to be added. A no vote is that it would not be recommended to be added. Are we ready to vote?

MS. OGUNGBEMI: Yes, voting is open.

CO-CHAIR GESTEN: Okay.

MS. GORHAM: For measure 2902, contraceptive care postpartum, the child task force members are recommending -- is that right, recommending addition with conditional support, the condition being NQF endorsement.

CO-CHAIR PINCUS: So do we have a motion from the adult task force members regarding making a recommendation on this measure?

MEMBER KENDIG: So moved.

CO-CHAIR PINCUS: Is there a second?

MEMBER PELLEGRINI: Second.

CO-CHAIR PINCUS: So are we ready to vote?

MS. OGUNGBEMI: Yes, voting is open.

MS. GORHAM: The adult task force members are voting on 2902, contraceptive care postpartum. Yes for conditional support. No --

CO-CHAIR PINCUS: And again, those on the phone would chat their vote.

MS. GORHAM: The adult task force members have voted and they do not wish to recommend the measure, 2902, contraceptive care postpartum.

CO-CHAIR GESTEN: So we have our first interesting nonalignment. I think we've had a pretty good record of alignment, so this is

interesting.

We might, I don't know, we might circle back to at least discuss this after we finish the voting. I don't know. Unless you want to --

MEMBER SCHLAIFER: It's not really an important comment. I just think that the scores got lower as people realize -- it's more accumulative giving up on this measure kind of thing.

PARTICIPANT: It just passed.

MEMBER SCHLAIFER: Oh it --

CO-CHAIR GESTEN: Passed the child. It passed the child but didn't pass adult.

MEMBER SCHLAIFER: No, yes, you're right. Okay, sorry.

CO-CHAIR GESTEN: Yes.

MEMBER SCHLAIFER: I was thinking the measure before, yes.

CO-CHAIR GESTEN: Somebody else will have to explain that one. Rich?

DR. ANTONELLI: Yes, I'll offer a

possible explanation. I see this as potentially two different populations.

So a pregnant teenager, a postpartum teenager, I can imagine a one in a million opportunity where they want to get pregnant again.

But for the vast majority, that is a big oops if I missed that. On the adult side, it's potentially a very different dynamic.

And so I guess I would even challenge our well-intentioned notion of even trying to find alignments.

I actually think that this measure is trying to cross two potential different dynamics, social and biosocial dynamics.

So I'm, I guess I don't have much egodystonia with all due respect to our psychiatric co-chair with that.

CO-CHAIR GESTEN: I guess I have more because again you guys, Cindy or Carol may be able to fill in the facts.

But again I think that, I don't know

that there's a huge delta between the rate of unintended pregnancy at the line that you described.

I understand perfectly what you said. But I think if you, and even if you look at the overall total number of unintended pregnancies it would be, I would guess the volume would be higher in the older age group. So I remain with a little bit of dystonia, as you say.

DR. ANTONELLI: I wasn't offering an explanation. I was offering an observation as a pediatric primary care provider.

CO-CHAIR GESTEN: Yes.

DR. ANTONELLI: That's where I was coming from.

CO-CHAIR GESTEN: Kathryn?

MEMBER BEATTIE: I have a question. Maybe I'm misunderstanding, but in the child core set, does it only include postpartum between 15 and 18?

I really thought it was for all of the postpartum moms, that it was -- that the child

core set wasn't just including teenage pregnancies but all pregnancies.

So there isn't really a difference in what the child task force or the adult task force was voting on. Is that --

So what he's saying makes me think that, but I was thinking that the inclusion criteria for consideration by the child task force was for all postpartum moms between 18 and 44 as described here.

CO-CHAIR PINCUS: Well that's interesting, because based on what Helen was saying, the measure is the measure. Yes.

MEMBER BEATTIE: So again I think what he was -- I'm sorry, I don't know who was speaking, but the most recent speaker in saying that we were voting on the decision to try and support unintended teenage pregnancy is only a tiny subset of three years between 18 and 44.

CO-CHAIR GESTEN: So I had posed, but it could be challenged that we voted on the measure with the ages that they were, and then --

because that's the measure.

And then as a secondary conversation that we could have, which we could start now, is what, if anything, what do we want to recommend to CMS relative to this measure as part of the child core set which could include -- which could say to them we think you should take it as is and include the entire age range.

It could say, we could say to them we understand the measure is 15 to 44. We think that the measure should report it in only the child age group. So we can have that conversation again.

CO-CHAIR PINCUS: Well, there's a third option which is doing it in both ways.

CO-CHAIR GESTEN: But it wasn't, it wasn't voted on in for the adult. Because the adult group voted it down.

MEMBER BEATTIE: So when we just took the vote as the child task force, and it changed between the first measure and the second measure because the second measure was a subset of just

postpartum between 18 and 44.

If individuals on our task force thought that they were voting for the pediatric population and not the entire population, that is not the way the measure is written.

And so I'm calling into question as to whether we all understood fully. Because the statement that was made is saying the reason that we voted differently is because it was addressing the issue of pregnancy in those under 18.

And that's not what the measure addresses. Do you see what I'm saying?

CO-CHAIR GESTEN: Well, Rich's comment notwithstanding, the measure, we voted on the measure as it's written.

And then the second issue is an implementation issue, which is as -- this is how I see it, but again you can correct me if I'm wrong.

The implementation issue to CMS would be here's the measure that's been done, here's what's been approved.

Do you believe that this measure should be reported by the child's, you know, by under the heading of child core measures by states going up to 44?

Or do you think that it should be restricted to an age group, and that will be this --

DR. BURSTIN: Just to be clear, the measure is the measure. It can't be restricted. We don't have a separate adolescent measure at this point. There is one measure, 18 to 44.

And again, these are just recommendations to CMS. So they will have this recommendation that clearly shows support from those in the child task force and not as much support in the adult tasks force.

And certainly they have, they're sitting right here so they've heard the discussion.

I don't know that you need to parse it further since there is not a separate adolescent postpartum measure before this committee.

CO-CHAIR GESTEN: Okay. So you would say that the only thing that CMS can do is to either accept it as is, and it would be reported under the child core measures with the age group --

CO-CHAIR PINCUS: No, no. I think there's a point -- yes, this goes back to actually the discussion we had at the MAP Coordinating Committee.

That what CMS told us overall was that what they find is the voting is important, it gives them direction, but the discussion is also important.

And that we don't have to specify all kinds of things in a vote. And so the discussion we just had right now about the interpretation of this I think is useful to them as they move towards however they choose to implement this.

CO-CHAIR GESTEN: So does that mean we should have no conversation about this as an issue? Are we done? Okay, Bo?

MEMBER RIEWERTS: Well, I just wanted

to clarify for one that voted for the child side of the house that I didn't have any confusion about this voting.

I was merely voting for the opportunity for women to have access to contraception, and I think that is an issue in our country.

So, I don't believe it is -- I don't believe there are providers out there that are going to, you know, push contraception on people unnecessarily just to meet this metric. I don't believe that will happen.

CO-CHAIR GESTEN: Kathryn, did you still have a question or comment, or, your card was up? Okay, so why don't we discuss PC measure 0480 and 2830 together.

This is exclusive breast milk feeding, and I think we were looking -- Marge, I'm glad you're back -- for a little bit of clarification maybe before we start the discussion about how -- I guess part of the question that came up is are these two measures in competition?

You know, sort of a one or the other and weighing one against the other is -- do you CMS have -- want to make a statement about having two measures, one of which has a methodology that has specifications and one that does not?

How should the group think about these two measures which are the same measure with the exception of the collection modality as we discuss it and vote on it? Do you want to weigh in?

DR. MATSUOKA: So the question is does the modality of the data collection matter to us?

CO-CHAIR GESTEN: In terms of our voting to the core set. I mean do you for example see a day, maybe a day soon or into the future, where each measure would have two flavors, electronic and non, and states could decide which one they want to use?

Do you envision that states would report both an electronic version and a non-electronic version of the same measure?

Are these -- so we're trying to -- I

guess trying to understand how to think about two measures that are the same only differ in terms of their methodology of collection with respect to where CMS is.

And then we can take the temperature of the group about how they think of it.

DR. MATSUOKA: And this is another question. So is there the option to -- I think given that different states are at different stages with regard to EHR adoption, and it looks like this is a hospital-based measure and there's a different EHR adoption rate already for the hospitals. I think the extent to which we have flexibility as to whether states can report electronic versus not would be preferable.

So if the e-specified measure has an option, or if the measure can be specified in a collection agnostic way, that would be the best.

And that states could then choose to decide how they can -- what is the most feasible way for them to have a state level measure.

CO-CHAIR GESTEN: It's helpful. Helen

just corrected me, however, that we can't change the measure. The measures are what they are.

So we have two measures and two different numbers, right? Yes, they're two different measures.

DR. BURSTIN: The question would be if CMS has indicated their willingness to entertain potentially having that flexibility.

You can look at both measures, and I did confirm with Reva as well as Carol that in fact the measure specs are the same now.

That exclusion has been removed -- that second rate's been removed even from the traditional measure.

So they really are the same, and I mean I think you could vote on both essentially it's the same measure for them if they want that flexibility.

CO-CHAIR PINCUS: So for efficiency sake, can we have one vote?

HELEN BURSTIN: Sure. Yes, say it's capturing both measures, unless anybody has any

particular issue with the eMeasure.

CO-CHAIR GESTEN: Discussion of the measure? Carol?

MEMBER SAKALA: So I went back to the arch evidence report. It's being redone at this point in time.

I agree with the comment that was stated about birth spacing. It's an out-of-the-gate, beginning of life prevention measure that I think is really of value.

And in this case I believe that this measure is prevention, short-term, long-term for mother and baby.

And for the baby, the conditions in developed countries that were associated with any breast-feeding were reduced otitis, gastroenteritis, severe lower respiratory infection, atopic dermatitis, asthma, obesity, type 1 and type 2 diabetes, childhood leukemia, SIDS, necrotizing enterocolitis.

And for mothers, type 2 diabetes, breast and ovarian cancer, and since that time

hypertension, hyperlipidemia and cardiovascular disease have been added.

So I think when we look at individual measures around specific health conditions, this is so powerful in terms of prevention for both parties of such a broad range of items.

As far as alignment, it's now in the AHIP CMS core set that happened in the past year. And the joint commission is collecting from hospitals now with 300 or more births per year beginning this January.

So I would strongly recommend that we add this to the adults as well.

CO-CHAIR PINCUS: Andrea and then Susan?

MEMBER BENIN: Hi, sorry, I'll -- I'm just going to reiterate my comments from last year.

I, you know, I am absolutely the biggest -- I'm a pediatric infectious disease doctor.

I am the biggest fan of breast-feeding

that you could possibly have, personally and professionally, you name it.

The problem with this metric is that there's a small set of exclusions where you can write in the chart the reason why you didn't breast-feed exclusively during the hospitalization, and that list is very narrow and it's limited to a handful of infections.

You know, it's sort of limited to HIV, varicella, there's a small set of reasons that you can write in the chart why there was a reason not to exclusively breast-feed during a hospitalization.

But there are other reasons why sometimes a baby needs a little bit of formula in that time period that would, well you can still get a baby out exclusively breast-feeding, there are times when you need to top them off in the hospital.

Or they come out and their sugars are a little low, et cetera, et cetera. And those exclusions as far as reasons not to, there's an

exclusion that says if the doctor or the APRN or what have you writes reason not to not done exclusively, they can write that in the chart, but those reasons are really narrow to this kind of set of infections.

So while I really would love to love this metric, I have sort of repeatedly been stymied by what it's actually measuring.

And so I -- it's hard for me to advocate for it on a broader scale although I would love to be able to advocate for it having a few other things to it.

But it's really limited to exclusive breast-feeding. So a baby who got a handful of ounces, got topped off from a feeding that might be rough, you know, those days are rough.

And sometimes it's actually better for the baby to get topped off, so I'm a little bit, you know, I always have some ambivalence about this metric.

MEMBER LACEY: In looking at this list of exclusions and then looking at what we had on

slides, so those lists are a little bit different.

The list for the eMeasure has three. This list has a very large group of exclusions. Right, so that one has three.

But now we're saying the measure is exactly the same. So do we go with the exclusion list on the slide above?

Because I'll just be honest. I don't see anything about maternal preference. And I know that you all say, well, you just have to breast-feed, but there are some women that just do not want to do that.

And we don't seem to have a maternal preference option as an exclusion. And I know for one person who tried and failed terribly, you know, I finally just decided I wanted my baby to eat.

CO-CHAIR PINCUS: Bo and Meg? And then Carol?

MEMBER RIEWERTS: My vantage point from this is we definitely want all babies to

breast-feed if possible.

I totally agree that there are many reasons why people don't breast-feed. The goal isn't, I mean, obviously if we could get 100 percent of the world to breast-feed, the world would be a better place.

Everyone agrees to that. There's incredible medical evidence to say that. But I don't understand why we wouldn't support this metric which is going to encourage people to support breast-feeding.

I can tell you until our organization began to focus on rates, which is what this is, this is a rate of breast-feeding in the hospital, our rates didn't start to go up.

And our rates have improved incredibly in our organization. We deliver about one out of every five babies in California.

And I am all for this metric. I think it will improve breast-feeding rates. And we aren't going to get to a hundred percent because there are people who don't breast-feed for

reasons which have already been stated.

But we're not talking about them, we're talking about supporting mothers who want to breast-feed.

MEMBER MURRAY: My concern with this from the health plan perspective is that when we add more and more measures, there is a cost to the health plans.

And if it's not using claims data, then it's much harder for plans to collect. So I just have to, I want to put that out there that there is -- can be fatigue in terms of the health plan's ability to collect all of this.

So in terms of ranking them, given that there is no claims data for it, it would be harder for the plans.

CO-CHAIR PINCUS: Carol?

MEMBER SAKALA: So I am sympathetic to the conversation earlier about circumstances where it's not possible.

The developer and steward are totally clear that there's no way we're expected to get a

hundred percent.

This is -- the program is voluntary. There's no accountability aspects to it. And I would just like to share that, two things.

One is that they have heard discussions at California hospitals of all kinds of different populations with different cultural backgrounds and preferences that this method was -- this measure was very effective in helping a lot of women to achieve these goals.

And that we heard testimonials earlier this month from places that thought they had done very well on this measure without a coercive, overbearing approach to it just by providing good information and support and respecting women's informed choices.

CO-CHAIR PINCUS: Cindy?

MEMBER PELLEGRINI: So I'm concerned that over the many years that this measure has been out there, it really does seem to be held to a different standard than a lot of the others that we consider.

There are a lot of reasons people decide not to quit smoking. There are a lot of reasons people don't take their medications.

There are a lot of reasons people don't get the screenings that we want them to when we want them to, you know.

I'm sure my doctor is deeply frustrated that I've decided not to get another mammogram until I'm after 50, right, because they suck.

But this is one where nobody's expected to get to a hundred percent. And it can be we think so important in helping to move those rates as you said, Bo, at different institutions.

So, you know, March of Dimes obviously is all on board with breast-feeding. There are absolutely going to be circumstances where women can't or won't breast-feed and that is just the way it is.

But there's a lot more we could do in a lot of institutions to move these rates in the right direction.

CO-CHAIR PINCUS: Diane?

MEMBER CALMUS: I guess my question on the conversation is is there a better measure? I mean it seems that everybody's agreeing that encouraging breast-feeding and more women breast-feeding is a good thing.

And I know I've heard a number of concerns about, you know, the specifics of this measure.

And, you know, I'm not an expert on this, but I can see where all of those are valid concerns.

But I guess my question is is there something better to get to that information? And I don't know.

CO-CHAIR PINCUS: To my knowledge there's not an endorsed measure.

MEMBER LACEY: So my only question is we have, I'm pro-breast-feeding, love it, love it, love it.

But we have all of these different sheets that have different exclusions listed. So

I'm just trying to understand which one of those do we go by?

And if it really does fall down to wanting to add one more being the -- which of course we can't change, but we've been told we can't change, we can't change, the measure is the measure.

But I see different words on the sheets connected to the same measure. So I'm trying to get clarity around which one do we look at to, you know, which one do we look at the exclusion criteria?

Because they're different. That's all I'm asking.

CO-CHAIR GESTEN: Reva, are you still on the phone and maybe you can ask the question that Susan's asking about which of that exclusion criteria?

MS. WINKLER: Yes, Foster I'm here. I have to sit here and look at, I'll have to look them up, I can do that in a couple of minutes.

I'm not sure where they pulled the

data that you're looking at, so give me a minute and I'll take a look.

CO-CHAIR GESTEN: Meg, do you still, do you have question, or no? Is that it? Okay.

So while you're looking that up why don't we -- my suggestion is this is going to be a child task force vote, just to clarify.

This is a child measure, this is around newborns, correct? That's what Shaconna's telling me and she never lies to me. Not once. Well maybe once, twice, but.

So it's a child measure. But before we do that, Rich, and then we'll take public comment quickly and then we'll go to a vote.

Because we have to get through these measures, we have to get through asthma measures, and we have about three hours' worth of content.

DR. ANTONELLI: So when we talked about this before, there are two numerators for the first one.

And Carol mentioned that it was going to change. And so I just want to know are we

going to see that version or should we be looking at, what did you say, PC-05A got pulled out?

PARTICIPANT: It's gone, yes.

DR. ANTONELLI: Yes. So she's saying it's an error.

CO-CHAIR GESTEN: Numerators are the same. We've clarified the numerators are the same in both --

DR. ANTONELLI: Okay, so the slides that I have on my laptop are not correct, is what you're saying? This is the corrected slide, okay.

CO-CHAIR GESTEN: Yes, we're just looking up the exclusion issues because the exclusions that Susan is describing, they are -- these exclusions which we're looking at right now for 0480 which look a little different than, not the same as the -- go to the eMeasure, what does that one?

MEMBER LACEY: Well, and then one more thing, when you look at the eMeasure which we're saying is the same, it just says see Excel

spreadsheet. So it's really confusing.

DR. BURSTIN: And just keep in mind because these measures are still going through the endorsement process, they're almost, they're kind of winding their way through, that's where that change was made.

You're only going to support them conditionally anyway on endorsement where those issues will be sorted out by people like Carol and Cindy and others who know these measures in great depth.

So again keep in mind these will be very similar measures. They don't have that exclusion as was in the original Joint Commission measure and Reva can add more details.

But either way, you're still voting it conditional on endorsement of it getting through the Perinatal Committee and full process.

CO-CHAIR GESTEN: But I think the question is are these -- can we vote on these together.

And it sounds like if they at least

currently have different specifications then we might want to vote on them different? Okay.

MS. WINKLER: Foster, it's Reva. I've got them up side by side right now, and yes, the way they were written by the developer makes it look like they are very different.

But when you actually read the details, you'll see that the measure on 480 has exclusions that are not so much specific to this measure but are sort of Joint Commission specific measures such as enrolled in clinical trials, length of stay greater than 100 days, those sorts of things.

Which really they did not put into the eMeasure per se because that tends to be around the way that hospital program was working.

But if you look, the exclusions are really, newborns who are admitted to the NICU, newborns who expired, and newborns who were transferred to an acute care facility.

CO-CHAIR GESTEN: And you're saying those are in both?

MS. WINKLER: Yes.

CO-CHAIR GESTEN: Because I think Susan's raising the question, you know, for all of us, which is is there any substantive difference between the two measures that we should think about as think about voting.

And it sounds like you're making an argument that there is not.

MS. WINKLER: No. For instance, there is an exclusion in 480 about patients who are not at term, but the numerator and the denominator statements on both measures specify that these are term newborns.

So I think it would be nice if the wording was aligned, but if you really put them side by side and look at them, the intent is exactly the same.

CO-CHAIR GESTEN: Okay, that's helpful to me. Susan, is that helpful? Okay. So why don't -- we will take public comment on both of these measures before the child task force votes.

Why don't we start with the room?

Sean, are you coming to make a comment, or not? Okay. Sean? Tick-tock.

MR. CURRIGAN: Oh, sorry. Just to remind you this isn't breast-feeding, this is breast milk feeding, so you can use a breast bank.

There's a lot of innovations people are doing that does not require the woman to use her own breast milk if she cannot do that or does not want to do that.

So I mean there are ways around still providing breast milk. Again, the goal is not a hundred percent.

The goal is probably 70 percent, and we all recognize that and I think we're very comfortable just moving towards the 70 percent.

05A, when 05A was endorsed, we were chasing those exclusions looking for -- and people were spending way more time looking for the exclusion than they were actually doing any improvements in breast milk feeding or lactation support.

And to reiterate what Cindy was saying, we're talking about optimal care here. We're talking about like what are we offering our patients and how are we getting them the most effective or the optimal healthcare that we can provide.

And like if this was immunization, much like the contraception measures which I don't understand what happened, but if this was immunization would you have the same issues with it?

Because immunization, people choose not to have it and it affects the pertussis rate. But, you know, we still measure whether the immunization was provided, not whether they counseled about immunization.

So I think that just to reiterate the college supports both of these measures.

CO-CHAIR GESTEN: Thank you. Any other comments from the room? Public comments? On the phone, operator, public comments?

OPERATOR: Okay, once again, to make

a public comment please press star, then the number 1. There are no public comments at this time.

CO-CHAIR GESTEN: Thank you, operator. So I guess I'm looking for somebody to propose. We're talking about the child task force now voting on these measures.

The proposal would be that we vote on them together. I'll see if there's a proposal. 0480 is NQF endorsed. 2830 is not yet endorsed but is in the process.

So this vote of yes would be half conditional, half not conditional. I don't know what the right words are.

MS. GORHAM: If you vote on them together, you're voting conditional support.

CO-CHAIR GESTEN: Conditionally, okay.

MS. GORHAM: The eMeasure has not been ratified. It was recommended by the standing committee but it still needs to be ratified.

CO-CHAIR GESTEN: So folks can say they don't want to propose that, but that's, I'm

looking to see if somebody on the child task force wants to propose a vote for conditional support of these two measures together. Yes, you may, sure.

MEMBER ADIRIM: I just want to make sure that we understand that there are real unintended consequences of putting high pressure on hospitals to breast-feed exclusively, especially hospitals without a lot of resources to bank.

You know banked breast milk, it's really, it's a big deal. It's an expensive proposition.

And if you don't have the support of lactation consultants which of course this is what this is trying to drive is to get the lactation consultants there.

But what happens then if there's a real pressure to do nothing but breast-feed, you have babies who potentially go home at two days who have been unfed properly for several days with this -- that they're going to be, they're

set up for failure.

I mean I personally took home at five days a shriveled up yellow baby and went to a lactation consultant who took the baby out of my hands and said what the heck, this breast-feeding only thing, give me the bottle, like, and put a bottle in that baby's mouth.

And when my second baby was born, and they had to top him off, like I was like fine, top him off. And we see that in these nurseries.

Like you have to either make sure that places have the resources to attend to this, and I understand that this is the epi of it, that this isn't the pressure, there's no accountability and that we're trying to understand what the true metrics are.

But I just want to make sure that we understand where some of the risks are around how that looks.

And maybe this is the way to provide more resources for people to do it. But the metrics have these other sides to them.

CO-CHAIR GESTEN: Bo a new point?

MEMBER RIEWERTS: Well I just, I have to wholeheartedly disagree. I think to say that you're not going to support breast-feeding because you don't have the resources, that's like saying you're not going to give vaccines because you don't have the resources, or you're not going to do anything else that is right for a patient.

And I also disagree that patients are going to go home shriveled. With appropriate care in medical care, there are babies that will need formula after a day or two, but it's not in the first day or two.

And this is talking about providing breast-feeding support while the baby is hospitalized.

Most babies go home within two days, not five days, so it just, I don't get it.

CO-CHAIR GESTEN: Thank you. New comment?

MEMBER ADIRIM: No, I wanted to support what you're saying and to reemphasize

that this is not a measure of the practitioner's practice, it's the plan measure.

So how is, and again I feel like I'm repeating what somebody already said, but it's how the plan -- the state and their plans choose to create quality improvement programs around this measure.

So I think from a population standpoint it's a very good measure and I think it's really important that we do promote breast-feeding and do what we can to support women who want to and can breast-feed.

CO-CHAIR GESTEN: Okay. Bo, you're done right, your card's up. So you guys didn't like my proposal.

Would somebody want to make a voting type proposal so that we can get to voting?

DR. ANTONELLI: I move we vote on the measures.

CO-CHAIR GESTEN: Can you clarify together?

DR. ANTONELLI: Together, I think

Shaconna who never lies said that we'd be voting for the --

CO-CHAIR GESTEN: Rarely lies.

DR. ANTONELLI: -- with the condition on it.

CO-CHAIR GESTEN: Is there a second?

MEMBER SAKALA: Second.

CO-CHAIR GESTEN: Okay. We're setting up for vote. We are voting whether to include to -- in the child core set, make a recommendation whether to include 0480 and 2830 conditionally, that condition being a NQF endorsement of 2830 regarding exclusive breast milk feeding.

A yes vote is a yes to include. A no vote is to not include, recommend inclusion.

MS. OGUNGBEMI: Voting is open.

CO-CHAIR GESTEN: We have 11 votes. Great, looks like this one will be recommended for inclusion, conditionally recommended in the child set. Susan?

MEMBER LACEY: So I just want to clarify something that I thought I heard just

said just a few minutes ago about we don't need to worry about things like exclusion criteria and things like that, we just need to focus on the measure.

And so how, you know, so if you look at the way you have the measure, say on this slide right here.

If we were given information to review, to ponder before we came, and so when the information changes, it would seem to me an appropriate thing to do to challenge that we're seeing different things, but now I'm kind of hearing, and I've been here several years, that we don't need to worry about that.

That we're just -- the intent of the measure is what we're endorsing or pending endorsement of NQF or however.

So I need some clarity around that because that seems very different. It just seems very different.

CO-CHAIR PINCUS: Just I think to clarify, I think for this particular issue, are

you referring to the distinctions between the two measures? Or any exclusions?

MEMBER LACEY: Well I think -- I'm so sorry she's not here. So I think what was said, Helen, is that we don't need to worry about, it's not that important what the exclusion criteria are.

That it's really just the description and the operational definition that we should really focus on and that's what we should either, you know, vote on to recommend or not recommend.

So that seems very different from the two previous times I've been here. I thought we were supposed to look at the entire item that was given to us.

And so when it's presented to us differently, it would seem to me that that's in stark contrast to what I thought we were tasked to do.

CO-CHAIR PINCUS: My interpretation, again Helen is not here, but my interpretation of what Helen said, and Reva correct me if I'm wrong

if you're still on, was that with regard to these two measures, that the differences between these two measures with regard to exclusions are basically at this point distinctions without a difference.

That they're so completely aligned and harmonized. There are some minor differences that are relevant to the joint commission, but that the ultimate sort of exclusions are not important. So that was the point being made.

CO-CHAIR GESTEN: The other thing I would say, Susan, is that I heard you, maybe I misheard, I heard you raise questions about exclusions that aren't on either of these.

So it's not as if hidden in the exclusions is the one that you might care about which is patient choice.

They're in neither of them. So when you voted, however you voted for these, it's not as if somehow it was uncertain whether that exclusion was in there. It's not in there.

So I hear you saying something that I

think staff and we strive for which is the information that you have prior to the meeting is accurate, complete, up-to-date, not going to change minute by minute, and so on, and that everyone will have read it and understood it.

And so when making votes, I wouldn't say that, I wouldn't interpret Helen's comment to be exclusions don't matter. I think sometimes they matter a lot. All the details of the measure.

So I think the question is do the details, are there hidden details around the exclusions that make you unable to make an intelligent vote and/or are there differences in the exclusions of these two measures that are germane and should be discussed that were not discussed.

And my understanding of what Reva said was exactly what Harold said which is that there are no substantive differences between the exclusions and that at least for the measure that is yet to be endorsed they're still in a process

whereby some of the language of this may change. May be modified. Is that right?

MEMBER LACEY: I guess I would say -- but we can't just say it's conditional because we can't say the numerator might be conditional or the denominator might.

So I just want to make sure that we'll know in advance, or at the table, when the exclusion criteria don't, you know, don't vastly be -- they're not vastly different.

Because in measurement work that I've been used to, what you see is what you deal with. And that's why it made me uncomfortable to know that things had changed, and then to hear but you're just kind of voting on the, you know, endorsing the intent.

And that seemed very different. So I'm not trying to be a pain in the butt, but it just felt different.

CO-CHAIR GESTEN: So just a process point, is there an abstention option in voting? There must be, right?

If somebody feels that they don't have sufficient information to make a vote, I mean again first of all you can ask for that clarification.

Staff within the context of the meeting we can try to provide it to you. But if at the end of the day you feel you have insufficient information, does Susan have a -- can Susan not vote?

Yes. Just, and again, I don't know if that's where you're going, but just, okay.

So we have, the last measure that we have here, I think Susan probably falls into your category, at least it does for me, of like what did Carol say about inversion.

So it seems to me that we have -- this is the measure that we have in front of us to vote on.

The information about a measure and development that is an inversion of this I think is of interest, but the business right now is to decide on whether we want to include this

specific measure 0716, which is NQF endorsed, in the, this would be in the healthy newborn so it must be in the child? Yes, okay.

So we will entertain conversation and comments or questions about this measure from both child and adult, but recognize that we're heading towards a vote with the child task force only. So questions? Comments? Carol?

CO-CHAIR PINCUS: And Carol, could you just really focus on the explicit thing about what is it that is going through the NQF process. Is it this measure or is it a totally revamped measure?

MEMBER SAKALA: Great. So as with the previous PC-05 breast-feeding measure, it was, they were, they hit maintenance.

So they were endorsed. Now the current versions need to go, continue to go through and get re-endorsed, okay.

So the same thing here, but in this particular case there is a different way of understanding it.

And I think one of the main things is there have been some refinements, but one of the main things is the psychological effect of hearing 97 percent of babies are doing fine, versus three percent are struggling.

So that was I think a part of the reason for making the change. And I just wanted to share the developer considers this to be what they call a balancing measure, and feel that it goes with the cesarean measure because there's a lot of feeling that we could get overly aggressive with reducing cesarean rates and it would be dangerous.

So this is considered to be a balancing measure so that you are monitoring trends for babies that you would expect to have done well around the time of birth and in the rest of the hospital stay, who in fact aren't. So that's the thought behind this measure.

CO-CHAIR GESTEN: So this has the same -- this is 0716. It has a different title, it's not called healthy term newborn.

MEMBER SAKALA: It's been respecified, but it's the same measure concept.

CO-CHAIR GESTEN: Okay, so let me just pick up on Susan's comments because this is one which triggers my like, huh?

So I get new title, it's been re-specified in that it's now as you say an inverse. Are there any other changes?

This is the full measure description so this is what we should be looking at. I don't know if this was in the -- was this in the packet that people got?

Okay, so new information, new measure, with the explanation, Carol, that you gave. Is there anything in the inversion process other than a re-naming and the fact that you're flipping, you know, flipping the measure that changed or that the Committee should be aware of? I think your answer was no, but.

MEMBER SAKALA: So my answer is I don't know for sure. I think there were tiny refinements.

And this is, they tested with the -- both versions tested with a vast number of women in California and elsewhere, and Elliot Main is an amazing measure developer, so I think he's strengthened it, but, and maybe others have a better understanding of what the changes were.

But I think the main version, the main change was the flipping, but some minor refinements is my understanding.

CO-CHAIR GESTEN: Okay.

MEMBER BEATTIE: A question, just, we don't have any detail on this what I can look at. So if there's no prenatal care, I don't see that as being written as an exclusion.

Is it? So a mom shows up, delivers, there's no history on her. But I --

CO-CHAIR GESTEN: Correct. Was it an exclusion in the previous measure? I don't know that it was. I don't have it in front of me.

MEMBER BEATTIE: Because you would have no expectations if you'd had no previous encounter with this person, but --

CO-CHAIR GESTEN: Okay.

MEMBER BEATTIE: So I just don't see it as written as an exclusion. And so if we're considering it the way it's written, then it's not in there.

CO-CHAIR GESTEN: Okay. Rich?

MEMBER ANTONELLI: I was at the MAP when we voted on the original California measure, and I guess I just, Helen's voice keeps coming back in my mind here, which is you've got to vote on the measure.

This is not the same as the well newborn measure. So I want to be respectful that it's a pivot.

But it just seems like it feels a little bit unusual for us to be looking at a measure that hasn't been vetted somewhere else first. Or did I miss that point?

PARTICIPANT: We're recommending to continue.

MEMBER ANTONELLI: So for the prenatal. But, so but how can you continue an

endorsement on a new measure if it, because it sounds like this is pivoted from the normal.

This is the inverse or the adverse of the normal measure. So can you vote for continuing endorsement for a measure that's been changed?

MS. WINKLER: Foster, this is Reva. If you'd like I could try and answer that.

CO-CHAIR GESTEN: Please do.

MS. WINKLER: Okay. When measures come back for re-review for continued endorsement, we see all sorts of changes, revisions, updates.

And so part of the process for this measure is the fact that their revision is to invert the measure.

And so we are looking at the new version from that perspective in the current perinatal process which is going through the consensus process right now.

So this version of it won't be endorsed until we finish this process.

CO-CHAIR GESTEN: Renee did you want to make a comment?

DR. FOX: I just wanted to comment on the fact that this isn't, you would normally expect a woman who had no prenatal care to have a normal baby with no complications.

Because most babies are born normal regardless of any problem. So this doesn't mean that, the fact that you did not have prenatal care does not, you know, this is an unexpected complication.

So the baby is born with meconium aspiration. Baby is born with any number of other things that can happen. GBS, that's an unexpected complication.

And you are trying to prevent that. It doesn't necessarily be an exclusion, a reason to have an exclusion is no prenatal care.

CO-CHAIR GESTEN: Thank you, Renee. Susan?

MEMBER LACEY: So I know we're going to have to vote, but is there any way we can see

the difference?

Like Sean was showing me the difference in what we came here prepared to talk about and vote on and then what, how they flipped it, or, I don't know, it just feels kind of uncomfortable.

MS. GORHAM: Nadine is pulling it up.

CO-CHAIR GESTEN: So while she's pulling it up, Cindy?

MEMBER PELLEGRINI: The Perinatal Task Force was incredibly impressed with this measure when it came through.

It came through with this incredibly detailed voluminous information about its development, about the changes, about testing that had occurred in I want to say it was a couple hundred hospitals, Carol, in California with thousands and thousands and births to validate it.

And part of what Elliot said when they made the decision to invert this was that they were having a hard time frankly motivating some

of their hospitals to improve their healthy term newborn rate from like, you know, 94 percent to 97 percent.

But they were much more interested in reducing their adverse outcomes from like five or six percent to two or three percent.

So there was almost like an optics issue there that they found that this could be much more effective if they turned it upside down.

CO-CHAIR GESTEN: Thank you. Kathryn? Charles?

DR. GALLIA: So when this, like Rich, when I saw this set previously I was really enthusiastic and I thought great, we're going to start thinking about healthy wellness instead of these adverse events and chasing really small, specific things and thinking more comprehensively.

So the intent's still there and I would just, and I understand the motivation that that's, there's a problem that's specific.

My perspective is that again feeling responsible for population health and that's contributed to it in that framework.

And so I was supportive of the way that it was structured previously.

CO-CHAIR GESTEN: Can I just ask a clarifying question? Will this inversion replace the other measure? They wouldn't be together. Is it an either/or? Yes? It's a replacement.

So we could fall in love with the measure but it might be, we don't know yet, be replaced by yet a different one. Is that right? Is that correctly stated?

MEMBER SAKALA: It's got the same, and it's the new specifications.

MS. WINKLER: Foster? Yes, right. Foster, I think you can't, the previous measure is no longer being maintained by the developer. This is the measure that they are continuing to use and maintain.

CO-CHAIR GESTEN: Okay, so loving it is nostalgia. Andrea?

MEMBER BENIN: I would just comment that this is a great metric certainly for epidemiological understanding of what's going on and perhaps to some extent for understanding the impact that we can make from the healthcare system.

I'm not a hundred percent sure how much, what percentage of this three to four or five percent is preventable by things that we can do in healthcare.

I can't tell that from this. It's a mixed bag of diagnosis codes. And that has been my hesitation from it.

You know, it talks about, some of these categories make a lot of sense. Other categories I'm less clear on and I don't know how the coding really plays out in that scenario.

They list birth injuries, asphyxia, shock, complications of shock, respiratory complications, procedures, infections, neurologic, you know, it's sort of this listing of things.

But some of those may be preventable. Some of those may or may not be preventable. And I'm not sure if they were able to address that in the discussion.

CO-CHAIR GESTEN: Fatema?

MEMBER SALAM: But that's sort of the point. I think also as this measure was, the whole point of this is focusing your quality improvement and really nailing down to see what is preventable, especially if we look at it at a population approach.

And I think that's the whole point also of maintenance of measure maintenance. Things get tweaked all the time as they, as we mine the data, as we look at the measure, as we change things, and sort of that's the whole purpose of it.

And the Committee reviewed it, you know, bought into the concept that this was the same measurement principle.

I just want to say that. I used to work at NQF so this is like killing me inside a

little bit.

CO-CHAIR GESTEN: So I think the fair point is again sometimes details matter, sometimes they don't matter. Trying to distinguish between, you know, when they do.

And for folks who are looking at the measures beforehand and have to try to do an evaluation, they're using the data that we have about the measure as it is and trying to decide, you know, whether it's a substantive issue or not.

So I mean I think that, you know, the challenge that we all have is that things are moving fast and some things are in process.

And trying to distinguish between when a difference really matters and when it doesn't is part of what we're challenged by right now.

So Susan, we're going to, I don't know where they are in getting the side by side so that we can take a look at that, but Cindy did you have a comment?

Okay. While they're doing that -- do

you have it right now? If not I'll go to public comment.

MEMBER PELLEGRINI: I shared it.

CO-CHAIR GESTEN: You shared it with Susan? Yes the old version.

MEMBER PELLEGRINI: The old version was obsolete.

PARTICIPANT: This is the old version?

(Simultaneous speaking.)

CO-CHAIR GESTEN: But Susan your question was trying to see the two of them together, correct?

MEMBER LACEY: And just, I just want to make a very clear point. I'm not being a contrarian about trying to put a roadblock in the way of measures, in voting for measures.

My issues are not with the context. It's the process and the expectations of the task force and procedural issues. Not the measures themselves.

CO-CHAIR GESTEN: Okay, fair. As we did before, is there any public comment on the

measure that we're going to be voting on which is not healthy term newborn but it's, can you put it up there?

Unexpected complication in term newborns. It's 0716. Just again help me with the language here.

This is viewed as being endorsed even though it's, there's been, or not? Okay so it says NQF endorsed on there.

That's not technically correct, right? So this would be a conditional? Okay. Sean?

MR. CURRIGAN: I just, I provided to John and Nadine the -- in Dr. Main's new submission for unexpected complications in newborns, on page 7 it specifically states what the changes are.

Which include change in the name and adding two submeasures of severe and moderate within the measure. But the rest of it hasn't really changed.

CO-CHAIR GESTEN: Okay, thanks. Operator, any public -- I'm sorry, any other

public comments in the room?

OPERATOR: To make a comment, please press star-one. And we have no comments at this time.

CO-CHAIR GESTEN: Okay. So this is the child task force voting on, let's see, did we have a proposal yet?

I guess do we have a motion and a second? I'm blocking. No. Okay, looking for a motion to vote on the addition in the child core set measures 0716.

This would be unexpected complications in term newborns. The vote would be a conditional support, thank you.

Do I have a motion? Do I have a second? Second, okay. It is voting time. A yes vote for this would be a recommendation to include conditionally based on endorsement.

MS. GORHAM: We are now voting on measure 0716. The voting is open.

CO-CHAIR GESTEN: Eleven votes?

MS. GORHAM: Yes.

CO-CHAIR GESTEN: Okay, so this did not pass. Fifty-five percent yes, needed over 60 percent to be recommended.

So we are going to take a five minute break and then we're going to come back and we have some asthma measures in front of us. Not as many as this, right, two?

MS. GORHAM: First we have to do the adult, we have a couple of more measures on adult.

CO-CHAIR GESTEN: Okay. I'm sorry, what's the question? Harold?

CO-CHAIR PINCUS: I thought we were told to --

CO-CHAIR GESTEN: Five minute break.

(Whereupon, the foregoing matter went off the record at 2:26 p.m. and went back on the record at 2:44 p.m.)

CO-CHAIR GESTEN: So, we have a challenge, collectively, which is we have a number of different -- several more votes we need to get through. We have a couple of more

prenatal measures that were recommended. And I'll turn things over to Kim in a second, who recommended them to us, to explain those.

The recommendation is from an Adult Task Force member, so they would be voted on the by adult task force. And then we have, I believe, two asthma measures to get to.

And then the Adult Task Force members, who have planes, trains, and automobiles to catch probably starting 3:30-4:00, need to, hopefully, before they leave the room prioritize the votes that have been made. Rank order towards the recommendations to CMS. So we have a number of things to go through.

We're going to try to encourage folks to keep their comments as succinct as possible, not repeat things if they can avoid that. And we'll try to go swiftly through. So, do you want to -- what's that?

MS. GORHAM: So, I just want to make a comment acknowledging some of the feedback. So, as staff we apologize. You know that we have

tried a new process this time, whereby we had Task Force members recommend measures for possible discussion and inclusion into the core set. So, we received some of those measures as late as last night. So we understand your uneasiness, as we tried to pull the information together last night. That's why you did not have it in advance.

So, as we move forward, what we will try to do is definitely have a cut-off date. So, we initially started with the cut-off date of April 22nd, but of course we had more Task Force members recommend. And we tried to accommodate all those recommendations, but moving forward we will have a cut-off date. So that we will make sure that you have the information in a timely manner.

Okay. But as Foster said, we do have a bit of a time crunch. So, we're going to do discussions for the Adult Task Force, for the maternal and perinatal measures. Then the asthma and then we'll rank, so that we can be respectful

of your time.

CO-CHAIR GESTEN: So, Kim. These two measures, that I understand were measures that you recommended. Can you just -- do you want to briefly just give a little background about the measure? And why you're recommending them to the staff?

DR. ELLIOT: Yes. I think the elective delivery measure is really an important one. It's a lot of focus from many different organizations and different government programs. And from a Medicaid perspective, I just think it's really a critical measure on the adult side to consider.

The adverse outcomes to the infant, of course, are well-known. There are potentials for developmental delays, et cetera, and it's often very prevented -- preventable. So, even with heart stops and hospitals and things like that, for the elected deliveries before 37 weeks gestation or 39 weeks gestation. It -- I just thought it was a really important one for us to

consider.

CO-CHAIR PINUCS: Isn't this in process in some way in NQF? For endorsement?

DR. ELLIOT: I don't know the answer to that.

MS. GORHAM: Oops, sorry. This measure was reviewed by the perinatal and was recommended for endorsement. It has not been ratified by the Board. I know you'll notice that this is the e-measure version. 20469PCO1 elected delivery, that is already in the core set.

So, we have the paper version of this measure already in the adult core set and this is the e-measure version. So, what you're voting on -- what you will be voting on if there is a motion is the e-measure version.

CO-CHAIR PINUCS: And Kim, can you just clarify? So, if the non e-version is currently in the set, your feeling about the importance of having an e-version?

DR. ELLIOT: Not as important, other than that I would really like to see us move in

the direction of more e-measures being part of the core measure set. So that it's more feasible across the board, for providers, for health plans, and for states.

CO-CHAIR PINUCS: So, can I channel Susan for a second and just ask is there any substantive difference that the group should know of between the e-measure and the non e-measure?

DR. ELLIOT: Not that I'm aware of, no. I couldn't see any.

CO-CHAIR PINUCS: Carol?

DR. SAKALA: So, this is a little bit of a broader comment about this measure. Because I think if we have the one, we should have the other if they're the same measure. And offer the options, as Karen mentioned, for collection. I did the calculation on opportunity for improvement here, looking at the fact that the denominator is weeks 37 and 38, and right now the average rate is 3.3% in that population. And it's never expected to go to 0%. That means that less than 1 percent of all babies right now are

being electively delivered, according to these terms.

And so, the opportunity for improvement overall is limited. And if we wanted to reduce burden, this might be a place where we would look. So, it's a little different perspective, but I did want to share that.

CO-CHAIR PINUCS: Diane?

MEMBER. CALMUS: Well, and following on that comment, I know a number of these births do occur in rural areas where there are reasons that these early elective procedures are selected. You know, if you have a woman that lives three hours away from the hospital and there's a snowstorm coming. It may be a prudent choice to electively deliver them sooner, rather than sending them home. So, I know that's an issue that fills in what some of that 1 percent is.

DR. LACEY: I can't see the other one, the one that's not the e-measure. But -- exclusion criteria. Same, do they not matter,

what's the status on that?

DR. SAKALA: I didn't see any differences in the exclusion criteria in those two measures.

DR. LACEY: And they are important?

DR. SAKALA: Yes.

MEMBER KENDIG: I just have a question to follow up on what Carol said. With, you know, with that small window for improvement. I'm just wondering, because of all of the work around driving the early elective deliveries down. Did you all have any discussion in the perinatal committee about is this a reflection of all of that work? And if that measure goes away, is there any danger of back sliding?

DR. SAKALA: This measure was strongly supported for continued endorsement. I think that is one possibility. The other thing is that the calculation that I gave you is based both on how many babies are born in those two weeks. But the 3.3 percent is coming from Joint Commission data on hospitals with 1,100 or more births. And

so, it definitely, I think, would behoove us at least to wait until we get to 300 or more births. And see how things are playing out in smaller hospitals.

CO-CHAIR PINUCS: Jeff and then Cindy. And then we're going to ask for a motion.

MR. SCHIFF: The Medicaid Medical Directors did this calculation not with this measure, but using the Sappenfield methodology. And we had about, well, it was just under 9 percent of births that were elective and in this age range. So, I think that this 1,100 -- I think the type of hospital may make a difference.

And that measure certainly has, perhaps, some weaknesses compared to this measure. Because of the data, the way it's calculated. But I think the question for the committee is really, are we at a point yet where we -- where it would be safe to retire this? And I would think that we may not be there yet.

MS. PELLEGRINI: We did talk about retirement in the perinatal committee as well.

And there was a strong consensus that this is brand-spanking new practice change. And that if we take our eye off the ball with this measure right now, things will immediately revert right back to the way they were before.

CO-CHAIR PINUCS: So, is there a motion to recommend this measure? Second? Okay, so are we ready to vote?

FEMALE PARTICIPANT: Yes, we are ready to vote.

Adult Task Force member are voting on 2829PCO1, elective delivery

MS. GORHAM: So, the Adult Task Force member are voting on 2829PCO1, elective delivery. This is not an endorsed measure. So, you will be voting to support conditionally for recommendation for addition to the core set. One, you are voting conditionally you support it. Two, you do not.

OPERATOR: Voting is open.

CO-CHAIR PINUCS: And also there's somebody on line now.

MS. DUNN: I submitted my vote, thank you.

MS. GORHAM: I have it, thank you. So, the adult core set has voted to conditionally support 2929PCO1, elective delivery.

CO-CHAIR PINUCS: Okay. So, Kim you had a second recommendation.

DR. ELLIOT: Yes.

CO-CHAIR PINUCS: Can you speak in the microphone?

DR. ELLIOT: From a Medicaid perspective, this is a continued area of focus --

CO-CHAIR PINUCS: Get a little bit closer to the mic?

DR. ELLIOT: From a Medicaid perspective is also a very high focus area for us. Increasing -- or reducing the C-section rate in first time births, first time pregnancies of women. So, this is something that's very easily movable and I thought it would be a really good one to add to the adult core measure set.

CO-CHAIR PINUCS: So, it's my

understanding this is already in the child measure set? And is it the same measure that's in the child measure set?

MS. GORHAM: No.

CO-CHAIR GESTEN: Of course not.

MS. GORHAM: This is a different measure. This measure is a PQNP measure. It has not been submitted to NQF. So, there has not been a standing committee that has reviewed this measure. The measure that is in the child core set is a different measure, and that measure is 0471 Cesarian rate for nulliparous singleton vertex. And that is a joint commission measure that is in the child core set.

DR. ELLIOT: With that said, and our desire to really only include NQF endorsed measures, I would like to withdraw my recommendation on this measure. Until a committee has time to review it as potential NQF endorsed measure.

CO-CHAIR PINUCS: Okay, so you're withdrawing that? Okay, so why don't we move on

to the asthma measures.

MS. GORHAM: Okay, so for the second time I won't go through this bullet by bullet. But this is just some background about the asthma. And I just want to state that measure 1799 was recommended for addition to the adult core set in 2014 and 2015. It is currently a measure in the child core set. Next slide.

So, on your spreadsheet, again, you had a number of different measures for potential addition. Some of them were recommended by the task force members. And let's go into some of those measures. Before we move on to the actual recommendations for task force members, I would like to bring to your attention the themes from public comment on 1799.

Again, that measure was recommended by the Adult Task Force members. We received public comment on that measure. And as a result of that the coordinating committee asked us to bring that measure back. So that both the core sets would have time to discuss the measure is in the child

core set. We received a comment that measure 1800, the asthma medication ratio, and then also on measure 0548, the sub-optimal asthma control, may be superior over the 1799.

So we wanted to bring that back to your attention. On the next slide, we have the description and enumerated specifications for 1799. And that measure was recently reviewed by the Pulmonary Critical Care Standing Committee. And overall, the Committee did not reach consensus on this measure. On the overall suitability of the measure. The Committee had robust discussion. They had conversation about the evidence of the measure and they could not reach consensus on evidence.

The Committee felt the measure did meet the performance guide, as well as reliability, ability, and feasibility criteria. But the Committee raised the concern about the potential for unintended consequences of increasing cost and medication use within improving patient outcomes. So, the next slide

you will see just the reporting for 2014 on 1799.

Again, this measure is recorded in the child core set and in 2014, 27 states reported on this measure. And the most common reason was data not available from not reporting.

CO-CHAIR PINUCS: To clarify, it's in the child set, but not in the adult set?

MS. GORHAM: 1799 is currently in the child core set, it was recommended for the adult core set in 2014 as well as 2015.

CO-CHAIR GESTEN: CMS didn't include it?

MS. GORHAM: CMS did not accept that as a recommendation, yes.

CO-CHAIR GESTEN: Do we know if CMS didn't include it because of issues and comments related to 1800? Or is it just a black box?

MS. GORHAM: So, the Standing Committee met after CMS decided their recommendations. I'll let them speak on why they didn't choose it. But I know that the Pulmonary Committee just met in April.

DR. MATSUOKA: This predates me, so I'm going to turn it over to Gigi.

MS. RANEY: From what I recall of our discussions last year, there were a couple of factors that went into our decision not to add this to the adult core set measure. One of them was that we were trying to be very parsimonious in the measures that we added. And there were a couple of other high priority topic areas that we did want to address, such as the opioid addiction epidemic.

So, we focused on that and the second was we knew this was in the child set measure. And the number of adults with asthma as compared to these other priority areas was not as significant. So, those were the two elements that we did look at.

CO-CHAIR GESTEN: Yes, what -- I know that the measure developer -- I think we may have somebody on the phone. Right? Children's hospitals? I thought these were both NQF measures, I guess I'm confused. NCQA measures.

Ben, if you're on the phone, I don't know if you need to be unmuted. Did you -- I wonder if you want to just, if there's any light to be shed about why these two measures? How the folks have viewed these two measures that might help us before we start deliberating?

MR. HAMLIN: Yes, sure. Hi, this is Ben Hamlin from NCQA. You know, the two measures were developed simultaneously. They address slightly different aspects of asthma care. The MAM in the 1799, the Medication Adherence Measure. You know, just basically uses a simple medication persistence of days covered to, sort of, define, you know, adherence to the medications.

The thought being that people who are adherent, generally are going to, you know, have lower overall cost. Due to, you know, fewer exacerbations, and exacerbations of the condition itself. The asthma medication ratio is a little more sophisticated. A little more sensitive. It uses medications as a proxy to help define asthma

control.

It's a really well-validated numbers study that works. It can work at the provider level and at the system level. It tends to be a little complicated and a little obscure, so some people have different opinions of it. But again, they're both addressing two different issues. There have been some questions about the adherence measure, why there are multiple thresholds.

And again, those were sort of developed on a consensus-based process from our Pulmonary Advisory Committee, that was, you know, thinking about quality improvement opportunities. And how you, sort of, define the population by, you know, well-adherent and probably not needing much attention to those who are not very adherent. And perhaps, you know, probably do require some additional focus with regard to asthma care or asthma management.

CHAIR PINUCS: Thank you, Ben. So, let me just -- the vote will be on for the adult

group, but joint discussion right now?

MS. GORHAM: Yes, we can have a joint discussion right now. We'll say for measure 1800 that, again, the Pulmonary Committee reviewed this measure, which is also a maintenance measure for continued endorsement. And they recommended continued endorsement without -- consensus was reached on all of the criteria for 1800.

CO-CHAIR PINUCS: Let me just clarify. I'm trying to understand. So, this was proposed, Marissa, by you?

MEMBER SCHLAIFER: Well, yes. Although, I may elaborate slightly on that.

CO-CHAIR PINUCS: Yes, so. But just assisting with the process, so it's proposed by somebody from the adult measure group, but it's -- but a version of this is already in the child --

MEMBER SCHLAIFER: Right.

CO-CHAIR PINUCS: -- measure group, so.

CO-CHAIR GESTEN: That'd be the 1800,

or 1799.

MS. GORHAM: So, Marissa recommended -- if I may speak for you -- recommended 1799 for addition for the adult core set. And that is the measure that is in the child core set. 1800 is nowhere on either core set --

CO-CHAIR PINUCS: Right. No, I understand that.

MS. GORHAM: So, this -- so, you're right. We're not staff, we are not recommending any --

FEMALE PARTICIPANT: You sound like you're giving a staff recommendation.

MS. GORHAM: So, that measure was brought as comment from last year's recommendation to 1799. A public comment was received as a result of the recommendation for 1799. Once we put the report out for comment, the public made a public comment. And the coordinating committee asked staff to bring that measure back. Both measures back, so that both of the task forces can look at the measure. And

you all can think about the measure again.

CO-CHAIR PINUCS: So, let me clear. So, I think, for the purpose this is not just adult, it involves child as well. And so, I think we should be thinking about this in terms of a joint discussion now, you know, among the two task forces. For determination of -- and have votes from both task forces, discussion simultaneously. And then sequential votes from each of the task forces. Okay? So, Marissa do you want to say some more? About your rationale?

MEMBER SCHLAIFER: Sorry?

CO-CHAIR PINUCS: And also whether you're withdrawing the 1799 and proposing the 1800?

MEMBER SCHLAIFER: I am not. No, I'm not withdrawing 1799 and recommending the 1800. I think, number one, I think in the future it might help us to know if it's a staff recommendation or a staff recommending. Just because it was in the comments. Just because that would probably change what -- it changes

what I was thinking.

Because part of what I was going to mention is that I somewhat disagreed with the staff recommendation. Because if we are going to add another asthma measure, it seems like the child measure and the adult measure should be the same, which would be 1799 rather than 1800. But I was going to defer to staff, but if it's not really staff I may not defer.

So, just to clarify the difference between the two, which I think was just said on the phone but just to make sure everyone understands. 1799 looks at the percentage of -- once you are diagnosed with asthma through various measures in the denominator, through various conditions in the denominator. Then it's just seeing are -- do you take your medication for -- to prevent -- your asthma 50 percent of the time or 75 percent of the time?

And I think the question, really the only question, for this group is -- it's been accepted as a -- it was recommended by this group

to CMS for both. Do we want it just as a child measure, or should it be a child and an adult measure? My assumption was that CMS had not accepted it because they were trying to, you know, just add a couple measures during the year. And that this, as we were thinking about additional measures for this year, it was worth reconsidering it.

If it truly is and if we agree that, you know, asthma isn't an issue in adult, which I'm not sure that I do. But I'll leave that to the group. Then that's a good reason not to add it. But I think we just need to decide do we want to worry about asthma in adults. And if so, then I think rather than 1800, 1799 is the best measure. Both because -- I think they're both good measures -- but because I think we would want to keep harmonization between -- it does not make any sense to have one measure on the child side and a different measure on the adult side.

So, if we add one I would definitely advocate for 1799. I guess the question is just

do we add an asthma measure for adults.

CO-CHAIR PINUCS: Well, I guess for the child side I guess there's also a question. Do we change the asthma measure for the child side or do we not?

MEMBER SCHLAIFER: So, to go back. What the measure 1800 looks at, you know, the ratio of if you're using asthma medications. Both the controller medications and the rescue medications, to make sure that the one that's predominately used is the controller medication. Now, what I didn't know. I didn't realize in advance is that there is also measure 548, which could also be thrown into the mix. But that probably would just -- so, I have pulled it up and I can answer any questions about it. But that would probably confuse things more at this point.

CO-CHAIR GESTEN: 1799 for the child has an age range, as it's specified, that goes up beyond children. Is that not, is it not being reported as such?

HAMLIN: It's currently stratified for both treatments. So, there's a 5 to 12 stratification and there's a 13-18 stratification, so they can be used for a child core set. It's also stratified, you know, the adult stratifications also exist too. So, there's a wide age range but it is broken down into different cohorts. And that holds true for both measures, they both have the same age strats.

MEMBER SCHLAIFER: What's listed here is ages 5 to 64.

CO-CHAIR GESTEN: So, what we have is 1799 here is -- this is what was confusing me before -- is it says it's the Children's Hospital at Philadelphia measure. And not NCQA's measure. And in the numerator I don't see where it, I don't see those stratifications that Ben just mentioned. So, are we looking at the wrong measure, wrong name?

MEMBER SCHLAIFER: At least what's in the spreadsheet is that there's no numerator -- I

mean, there's no stratification. The denominator is all patients 5-64 years of age as of December 31st, and there's no ages in the numerator.

MR. HAMLIN: This measure should be stratified. It may be done so to have the child age range as one cohort, so it could it be used in of the, you know, child core sets. So the current strata are 5-11, 12-18, 19-50, 51-64 of the total we're reporting.

MEMBER SCHLAIFER: I'm going back to the NCQA measure specifications. I'm not sure. That's probably right.

CO-CHAIR PINUCS: So, just, the vote on the table would be whether to include 1799 in the adult set. And then, also whether to include 1800 in the adult set. And you said you might want to vote this, 1799's already in the child set. So, I don't if you were proposing that we vote, the child task force, vote on 1800. I might suggest we could do that just in terms of time. We might want to take advantage of the adult members right now and do votes if that's

what we're going to do.

MEMBER SCHLAIFER: Yes, on the NCQA specs, there's no age stratification.

DR. SULLIVAN: Can I just ask a clarification? If it's already in the child set going up to age 64, then what's the value of putting it in the adult set? Why do we do that? Are we gathering it across all the adults already? Is it just a -- I mean, what's the purpose of -- ?

MEMBER SCHLAIFER: That's my CMS question.

DR. SULLIVAN: But you're already reporting it in the child, so.

FEMALE PARTICIPANT: It's 520 in the child core set.

DR. SULLIVAN: Okay, so we would be voting just to cut -- I mean, it's not reported as it is already?

CO-CHAIR GESTEN: It's reported up to age 20 in the child.

DR. SULLIVAN: No, but the measure --

I'm sorry, I thought they were saying that it did already go to 64? No. Then I'm misunderstanding, I'm sorry.

MEMBER SCHLAIFER: What the NQF measure does, whether it's used that way to see -- NQF measure goes to 64.

DR. SULLIVAN: Okay, I've got you.

MEMBER SCHLAIFER: But whether or not CMS is using that way is --

DR. SULLIVAN: So, is CMS just using it for children then?

MEMBER SCHLAIFER: At times.

CO-CHAIR PINUCS: The measure has stratifications, right Bob? And I don't know if you or Ben want to clarify, but the measure itself has eight stratifications. And so for purposes of child core set measures, I believe although I don't have the information, that we for example in New York are reporting the eight stratifications that go up to age 20. They do not --

DR. SULLIVAN: They don't include

adults?

CO-CHAIR PINUCS: And not including the adults.

DR. SULLIVAN: Okay, thank you.

MR. HAMLIN: Yes, the measure was specifically -- there was a specific age strata cut-off of 18 years. So that 5-11 is the first strata, 12-18 was the second. So, that's 5-18 combination to be used for child reporting. And that strata was added just for that reason.

The 5-11 versus the 12-18 are different because of the different clinical approaches to treating the patients of those different ages. But we did add that cut-off so that those two could be used consistently across child core programs.

CO-CHAIR PINUCS: Well, so I think what we're asking for is, is there a motion to propose to add this to the adult measure set? So that in a harmonized way, there would be an -- this measure, in a harmonized way would be reported in both the adult and child set. And

allow the population to be extended to the full range.

FEMALE PARTICIPANT: What he said.

MEMBER SCHLAIFER: That's the motion. The motion would be to add it to the adult core measure set, so that there's harmonization between the adult and child.

CO-CHAIR PINUCS: So, is that a motion?

MEMBER SCHLAIFER: Yes.

CO-CHAIR PINUCS: Is there a second?

MEMBER SHA: I'll second it but do we want to hear --

MEMBER SCHLAIFER: Microphone.

MEMBER SHA: I second it. But do we want to hear from the child task force side to see if they want to change 1799? Add 1800? Because I think, from the Adult Task Force side, we're happy to align with the child set. But I'd be interested to hear if the child set, Child's Task Force, would want to make any changes first.

MR. GERSTEN: It's sort of like after

you get stoned, kind of thing?

MEMBER SHA: What?

CO-CHAIR GESTEN: So.

MALE PARTICIPANT: Chip and Dale, don't you remember that?

MR. GERSTEN: Okay. So, speaking on as a Chair. So, I would say that I don't have enough information to know if 1800 is a better measure than 1799. I think they're different. And so, my lens is really around parsimony. So, if there's going to be one asthma medication measure, which is a value.

The same CMS talked about, wanting to have other things. Which is the better measure? I mean, it feels like it's an -- they're different. I don't know which is better. I'm compelled to some degree by persistent comments from the Academy for Allergy, Asthma, and Immunology that says pointedly 1800. You should drop 1799, 1800's better.

They give a list of references and reasons why. There's not a lot, I mean there's

maybe one other. I think there's a drug manufacturer that also suggests that we do 1800. There's not a critical mass, if you will, of folks saying 1800 is much better than 1799. My understanding is that they're really getting a different concept, so it's kind of a challenge.

For me, there isn't anything that says we've made a terrible mistake with 1799 we need to go to 1800. But I would defer to other folks on the task force to see if you have any insights or feelings about one versus the other. And again, it doesn't have to be one or the other. You could certainly add both. But my value would be to try to pick one.

CO-CHAIR PINUCS: Any thoughts from the child task force?

MEMBER SHA: So, I think in the absence of any sort of motions from the child side, I think the adult side can proceed with the motion.

CO-CHAIR PINUCS: Okay. So, can we prepare a vote on 1799 for the adult set? So,

this would be to add 1799 to the adult set, which would have states reporting on the full age range on this measure. Okay? Are we ready to vote?

MS. OGUNGBEMI: Yes, voting is open.

MS. GORHAM: Katie, can you please send your vote for 1799, medication management for people with asthma? This is a vote to support addition of this measure.

MS. DUNN: Yes, it will be right there in just a moment.

CO-CHAIR GESTEN: What's the number I'm looking for, nine?

CO-CHAIR PINUCS: It should be nine.

MS. OGUNGBEMI: We are at eight because George Andrews has left us.

CO-CHAIR GESTEN: Eight, okay, just like the Supreme Court.

CO-CHAIR PINUCS: One, two, three, four, five, six, seven, eight. Shouldn't there be nine? So, are there any other adult measures, recommendations to be considered?

CO-CHAIR GESTEN: 1800, I think.

MR. GORHAM: Hold on for one minute. There are nine Task Force members. There are eight in the room and one on the phone, so we should actually have nine votes. Even with the absence of George. Jeff is a State Panelist.

WOMAN: There is nine.

CO-CHAIR PINUCS: Either way it would pass, I think.

MS. GORHAM: We're going to re-vote just so we can have an accurate count.

MS. OGUNGBEMI: Voting is open.

MS. GORHAM: Okay, so the Adult Task Force has voted to recommend to CMS inclusion of 1799, medication management for people with asthma, into the core set.

CO-CHAIR GESTEN: So, do we have to vote on 1800 since it was recommended? If there's a motion. And this would be for either, or for anyone Kim? Or just adult, adult or child? Anyone want to make a motion to include 1800 on, in the core set? Moving on.

MALE PARTICIPANT: What was the other

one?

MS. GORHAM: The other measure was 0725. But the Task Force member who recommended that measure withdrew her recommendation. Okay, so the fun part. The Adult Task Force members need to prioritize the measures that they voted on yesterday. The maternity neonatal and the asthma measures. So, give us one minute so we can put those measures on the voting slide so that you all can prioritize.

CO-CHAIR PINUCS: So, can you explain how we do the voting for prioritization?

MS. GORHAM: So, as we did last year we wanted to rank the measures. So, the top five measures would our recommendation to CMS. Last year, we did maybe nine measures. We want to kind of narrow that down because we know that CMS will make incremental changes.

And so this year, we are going to take the top five measures. So, we will put all of the measures on the screen, the measures from yesterday. And they'll show you those, refresh

your memory. And the measures that we voted for today for inclusion on the core set. And we'll take the top five. So, if you see on your screen we have 2152, preventive care and screening, unhealthy alcohol. We have the 0541 proportionate base covered, three rates by therapeutic category.

We also have 2607, diabetes care for people with serious mental illness, hemoglobin A1C, poor control. We have 2605, follow up after discharge from the Emergency Department for mental health or alcohol or drug dependencies.

We voted today to include 2829 for conditional support and we also voted 1799. So, we will vote on those measures and we will rank. And the top five measures will be included in the report for recommendation.

MEMBER SCHLAIFER: Just repeat which ones are conditional support?

MS. GORHAM: Yes.

MEMBER SCHLAIFER: Is it just the elective delivery? Or is there more than one?

MS. GORHAM: Give me one minute to pull it up. Okay, so the measures in bold on your screen. The 2152, 0541, 2607, 2605 are all measures with support. Because those measures are NQF endorsed. Measure 1799 is also NQF endorsed. The 2829 is not endorsed, so that is conditional support.

MEMBER SCHLAIFER: And we're going to rank five -- ?

CO-CHAIR GESTEN: Michael, do you have a question? Harold, do you have a question?

MEMBER SHA: So, I guess, if we are thinking about recommending five to move forward. So, we're deciding which one to vote off the island. 2829 seems to just be, I mean, from a pharmacy side we call it a line extension. It's just the electronic version of an approved measure and a measure already in the adult core set. It just seems to be a natural extension of something that already exists.

MS. GORHAM: Let me confirm with CMS.

DR. SAKALA: So, that was my comment

as well, or question. That we were presented with new e-measures, and told these are identical, fully aligned with the existing measures. And it's really another way of collecting them, providing more flexibility. So, my gut feeling is that they could just be, like, slid in. Rather than considered to be a whole separate measure. Because you wouldn't collect, you would never collect both of them.

CO-CHAIR PINUCS: So, just from my prerogative. It seems that to make things simpler, since five is arbitrary anyway, that we could simply endorse the five. And say that we also recommend adding this one without, you know, further adieu.

MS. GORHAM: So, I just spoke with Karen and she also agreed that they would -- CMS would give the states the option. So that would give them flexibility on reporting which measure depending on their source. The data source that they choose. So we can actually just, like you said Michael, keep the measures.

CO-CHAIR PINUCS: Terrific. So, what's next?

MS. GORHAM: So, just -- it's a matter of process. So these measures would be the measures that the Adult Task Force members would recommend to CMS. We would include these measures in the report as such. The report will go out for public comment and then CMS will have the report.

August 31 is when we send the deliverable to CMS. And then they have will have the option -- they will deliberate -- have the option to choose whichever measure. If so, if they decide to choose one of the measures or however many. And they will put a report out, usually in November or December. And we will know what recommendations they decided to accept.

CO-CHAIR PINUCS: Why don't we go to public comment? First on the phone?

Public Comment

OPERATOR: If you'd like to make a public comment, please press Star and then the

Number One. There are no public comments at this time.

CO-CHAIR PINUCS: Public comment in the room?

CO-CHAIR GESTEN: Okay. So, I think we're done.

CO-CHAIR PINUCS: Could I just take a -- sorry, I spaced out a little bit. There was a list of measures for adults that included the bold ones and then the non-bold ones? They didn't get 60%?

CO-CHAIR GESTEN: Yes. They didn't get --

CO-CHAIR PINUCS: But those are the measures that you considered, is that what this was? Got it, sorry. So, I know we had a slew of other things that we were trying to get to. Do you want to prioritize which slides you want to through? Which is particularly important to have as a together?

MAN: So, we're at lunch.

MS. MUKHERJEE: So, what I can do is

just, like, quickly flip through the slides like this one. The IOM Vital Signs, we have talked about it before. And this was where, this was the genesis of our policy discussion. So, what I'll do is just flip through slides that have either been presented before or just cover one point. And then go to the slides that have more of the discussion points.

So, we have looked at the IOM Vital Signs and done a cross walk with our core sets. Just looking at domains, and key elements, and where our core sets match up with IOM. And as Marsha had mentioned earlier today, our measures fall into many different buckets. And are not exclusive to a few domains or key elements. And just a quick, swat analysis, some of the things, the strengths were the type of measures we had. Looking at immunization, perinatal care, asthma, and behavioral health.

Some of the weaknesses were a lack of outcome measures threats, burden, resource issues. And opportunities were a meeting such as

this to revisit the gaps. So, some of the resident themes that were in the IOM key elements and domain, as well as the core sets. Were healthy people and engaged people, so the beneficiary, patient-centeredness.

Care coordination and access to care, two things we have talked about these past couple days. Resource, data collection and recording, as well as measurement alignment and data burden that comes from misalignment. So, when it came to alignment, the homework talked about alignment in different perspectives. Alignment of concepts, alignment of measurements, how you're measuring exactly. Alignment across multiple programs, and alignment through standardization of definitions. And then across pairs.

So, these were the two definitions of alignment that were provided before. And the important, just to note, is they talk about same or related measures. And the goal is to reduce duplicate of data collection, and enhance comparability and transparency. And this is

taken from the Map Coordinating Committee report. And they do say that in some cases there will be a need and compelling reason for multiple, similar and/or narrowly focused measures. And they realize that.

So, the homework was what do we mean by alignment and how do we operationalize the concept? Is it, you know, same concept being measured the same way? Same concept being measured across different programs? And this is a collation and summation of all the response that we had gotten to the homework. So, alignment was defined by looking at some of the benefits of alignment, as well as some of the challenges.

And the benefits were comparability and being able to look across states. And reducing burden, and simplifying and improving reporting. And another one was alignment across measure, measure programs, and payment models. Some of the challenges were the voluntary nature of Medicaid reporting, aligning with commercial

and private pairs, and innovation and variation in the field. Some of the considerations on the operational side were mandates. You know, would it be worthwhile thinking about a measure mandate? Maybe a methodology mandate of how you're implementing the measure. But also balancing the goal of measurement with implementation flexibility.

Some temporal considerations come up, as far as data -- longitudinal data. How long it's been followed -- infancy, childhood, adulthood. Completeness of data, and the other thing mentioned was also the appearance of comparability versus actual comparability. So, saying HVA1C was measured, yes/no. Versus the levels of measurement and the ranges captured.

And that was provided more as a caution when you're operationalizing a measure. And this is a quote that was provided which was, " measures are only as good as their design". And some of the discussion yesterday was around the difficulty in understanding measures. And

especially in an environment where measures are getting more complex and composite. And some of the elements that were mentioned for discussion for exclusions. Risk adjustment, the nature of the population, the transient nature. Resources, as well as data.

And then the next set of questions was claims data. How can we move beyond what is feasible beyond claims data. And when looking at data collection, also looking at appropriateness of data stratification. So, some of the things that were discussed was claims data as being the limit of feasibility. It's basic, but it's easy to capture and however, it doesn't provide a lot of granularity. There are resource limitations in broadening it to other types of data. Also, alignment versus other values such as purpose of measurement, comprehensiveness. There was some discussion about annotating the amount of alignment.

So fully-aligned, partially-aligned. And, sort of, annotating the variation in a way.

Also, stream lining data acquisition and collection. And identifying and developing outcome measures and patient reported outcome measures. Identifying measures that would make data collection more feasible and easier. So, some of the other considerations were ability to track system and population level health improvements. And that's something that came up in the discussion yesterday. Being able to look at the individual person's data, but then aggregate it up to look at population level data.

Interoperability, as far as data capabilities goes, and collecting data in a data warehouse. Measure design and exclusions, simplifying measures. Being able to make the measure something that a policy maker can understand, and they can understand the impact of the measure. And also, survey data came up, and it was something also discussed today when talking about care coordination and experience. Provider reporting systems, and using them as much as possible.

Too, data mine came up, as well as following the NQF SDF project to track data stratification. And, sort of, the pros and cons. And some of the factors influencing state participation were clarity of measure specifications, the feasibility of data collection, infrastructure, budgetary environment, perceived importance, political will. And this is where we paused to have a discussion among the Committee, the Task Force members. And we can do that, or we can sort of go through the stratification issues and then pause for discussion.

CO-CHAIR GESTEN: Well, does anyone have a comment or question? Or clarifying question? I mean, maybe we can go on just in the interest of time. What time do we have until? When are we supposed to end, 4:00? 3:45, okay. So, we have a grand total of ten minutes. So, why don't you keep going with it, Jani?

MS. MUKHERJEE: Okay, so some of the data stratification issues were to assess

disparities, and care in looking at data. And that was mentioned in even our state presentation yesterday to show how data can be parted and stratified to look at disparities. There was a caution not to penalize safety net providers when stratifying and having small N's. Various parameters were thrown out there for stratifying. And then, again, tracking the NQF stratification SDF project. And then care coordination was the other policy issue that was in the homework.

And one of the things mentioned was that Medicaid regulations do not define care coordination. And however, some of the components that are important for care coordination are comprehensive assessment and periodic assessment of needs. Development and periodic reassessment of care plan, based on changes in needs, referrals, regular monitoring and follow up. Just another way of defining care coordination. And then the other thing to consider is for Medicaid adults care coordination might mean chronic health condition management.

Versus for Medicaid children, care coordination services might be markedly different. Especially for kids with disabilities, especially physical, developmental, and mental. IOM also noted a connection to community and integration with community. So, that was the other part. Community linkage, linking clinical providers with community services, social workers. Clinical -- other support services in the community, and referral and referral follow up.

Also addressing availability, affordability, and accessibility of these resources in the community. And not burdening the grassroots organizations. I provided a couple of diagrams that showed community integration from the literature. And it's basically going from the individual in the clinical setting to their native community setting. Bringing the two together and then moving it up to population health. So, then there are some questions. But we can just sort of move on to shared importance, and sort of lump

everything together. So, for shared importance data collection challenges. Sort of, issues with data availability and infrastructure, along with workforce issues.

How do we move beyond that balancing process? Versus outcome measurement. Also, quality improvement action, motivating factors. Some of the tipping points that move states to embrace quality improvements. Some of the regulatory actions. And then manage care versus fee for service, and other related data implications with alternate payment models. And then, we have some questions for discussion.

CO-CHAIR GESTEN: Thanks. So, you recognize we just threw the kitchen sink at you all at the end of a really long day. Sliding the jungle, or the weeds, or whatever. The swamp, the nitty gritty of measures. And by the way, thank everybody for going through that. So, it's an opportunity, I know time is short and folks are tired, but it's an opportunity to make some -- get out of the weeds. You know, go up 10,000

feet and make some comments, observations, or suggestions. In terms of, along these lines. What we see in terms of the opportunities, comments that folks might want to make about alignment.

And how we can -- what recommendations we can make to try to deal with some of these issues. And facilitate alignment and so on and so. There are a lot of different issues thrown out there, but if anyone has comments they want to make along the lines of any these topics. Now is the time, and we're happy to start discussion. Sue, looks like you're equivocating. Go ahead, go for it.

DR. SULLIVAN: Okay, well I don't want to keep everybody. But maybe this will be a close to ending comment. Opportunities for change, and how can CMS and HHS facilitate alignment at the state level? Many of the things that we just went through in the past ten minutes that should have been a day long discussion. Really center on engaging patients and engaging

our communities.

And I would argue that if we want to move quality metrics and improve patient outcomes, those two are exceptionally important. As we look at alternate payment mechanisms and clinical integration models, we're still stuck in a medical hospital centric model. We cannot move these metrics and population health metrics, unless we are engaging our community resources. Our community resources are most of the time on soft money.

So, I would challenge us to really look at, if we are truly trying to innovate how can we set up these models? That truly leverage the community resources that will help patients access what they need. And importantly, put that into action where they live and work. So, I think would be my challenge. I always wrestle with that when we have these discussions. Because the words are there, the challenge is how do we implement it? And how do we move those resources, that we know will help to support

moving the needle, into a sustainable framework as part of our care system?

CO-CHAIR GESTEN: Good question. I mean, I think that there's probably a lot of support for the things you just said. I'm wondering whether you're also saying that you think the ability of states to do that is a measurement area? Again, we're measure people here. We're measurement. Yes, improvement and system change. But I just want to -- I don't want to jump. But as we're talking about that I was wondering whether part of what you were saying, in addition to making those investments. Is this something you think is a measurement area? Not putting words in your mouth, but just asking you a question.

DR. SULLIVAN: I think we have to maybe think about how we can measure that. But I also think it is important as we are looking at improving the metrics. How we can leverage those opportunities. So, I think it's two prongs of getting to the measurement issue.

MR. GESTEN: Thanks. Rich?

DR. ANTONELLI: I'm going to be very timely, although I could take six months to flesh this out. I actually want to tip my hat to the opportunities presented by chapter 2703 of the so called Health Home. It's going to force entities, however you want to define an entity. A hospital, an ACO, an accountable community. It'll force them to think integratively. And I think there are opportunities to measure that. So, it's something that I would like to politely push back on.

If you think about -- in fact, I love the NQF definition of care coordination. Gerri Lamb, who co-chairs a Standing Committee coordination once said that she counted 68 definitions of care coordination. I think we need to get beyond the definition, and I think we need to look at frameworks, which do exist by the way. And we need to start doing some implementation testing. So, this is really more of an observation. But it's an incredibly, an

exciting time. I think your dental example, Karen, was exciting.

But it was really, if you will, a baby step. I think we start pushing together behavioral, health, and medical, there's an awful lot of span in that space. A lot of wasted span, and if we could move things forward. So, I'd like to politely say that care coordination is agnostic of age, and it's agnostic to a body organ system. You can have care coordination activities that get a family housing. You can get care coordination activities that makes them food secure. They work for NICU graduates, they work for elderly.

So, we need to start operationalizing the activities of care coordination and measuring them. But sticking with outcomes. I'm all about outcomes, but I think, Foster, my point is I would love to partner with CMS in that health/home space. That's the only way we're going to win the game, right there.

CO-CHAIR GESTEN: Ann?

DR. SULLIVAN: I agree with everything that's been said. But just to add something, I think, on the issue of measuring for disparities. You know, one of the things that we talked about a lot yesterday was, kind of like, pulling out certain data for those who have schizophrenia and bipolar. And looking at all the disparities, perhaps, in care for them. But disparity is much bigger, it involves all the race, ethnicity, cultural issues. And I think if we're going to be moving, in terms of measuring, some day to the managed care quality spectrum.

That was talked about by, the manage care rule by CMS. That we begin now about how to talk to states about how to gather some of that data better. I think part of the problem with doing the real disparities in communities is often that what appears in the administrative databases is very thin on these areas. And also in medical records. So, to think about that and having a push that the gathering of that data is better. So that we can really shine the light on

disparities.

Because there are groups, especially smaller ethnic and racial, in communities that can get lost in big numbers. You'll think you're doing well with 60 percent or 70 percent, but you could have maybe only 20 percent of that group. Getting the kind of service you need. So, to kind of really get try to see to get ready to do that better. I know that right now we're not at a point where you can do a lot of it very well, but I think it might be something to talk about. In terms of the databases that we're gathering.

MR GESTEN: Good point, so I would point out I don't think that any instructions for states to do these measures -- that there's any instructions relative to doing any kind of stratifications currently. Although, I do think there's conversation about the value of doing that. I could be wrong, I don't think that I am. Karen, am I wrong?

MS. MATSUOKA: We do encourage stratification, it's not quite --

CO-CHAIR GESTEN: Do you define it in terms, in particular categories?

MS. MATSUOKA: I want to say race and ethnicity for sure.

CO-CHAIR GESTEN: I stand corrected. And Karen, do you have a sense of how many states are reporting the data by stratified fashion?

MS. MATSUOKA: Megan, do you know numbers? Use your microphone.

MEMBER MURRAY: I know that as part of the adult quality grant it was a requirement as part of reporting. States had to stratify I think at least three of four site measures by any one of those demographic categories. And lots of states have continued doing that after that time. After the grant ended. But I don't have specific numbers right now.

CO-CHAIR GESTEN: I'm just picking up on your comment I think it would be an interesting thing for us to have some data.

DR. SAKALA: You could see it. I think that would be helpful to see and that could

be shared in some way.

CO-CHAIR GESTEN: Yes, it's a great idea.

DR. SAKALA: I think that would be great.

CO-CHAIR GESTEN: Sue, you put your card down. Rich, are you? No? Katherine.

MS. PELLEGRINI: I just have a question. Is there any --

CO-CHAIR GESTEN: Have we voted? I'm just kidding.

MS. PELLEGRINI: Any existing time line to requiring reporting? Any existing time line to requiring reporting?

DR. MATSUOKA: You mean making it mandatory that states do these measures?

MS. PELLEGRINI: That's another word for it.

MS. MATSUOKA: Okay, I think that would require a legislative fix. So, that's not something that CMS would be able to decide. That would be something that Congress would have

authorize.

DR. ANTONELLI: But the conversation this morning was around within the manage care role. That there's a, that it moved to a requirement of -- either of framework or set of measures. You know, stay tuned news at 11. Not sure now detailed that's going to be, but they're on a separate train. I think your question was about this enterprise core measures. But there's this -- right? I heard Marsha correctly? That relative to managed care rules, there was coming a set of requirements?

CO-CHAIR GESTEN: Requirements?

MS. MATSUOKA: That's managed care, and that would be at the plan level. And that's separate from this core measure set. But we would want to ensure alignment, yes. Getting back to Debjani's, like what is alignment? But that is the goal.

CO-CHAIR GESTEN: Meg?

MEMBER MURRAY: There is a bill though in Congress, just FYI, Senator Sherry Brown

introduced it, which would make the core measures mandatory.

MS. MUKHERJEE: Based on the expansion right now that's gone on, like, how relevant is this discussion based on sort of that lens of view? Of the population growing, and the needs growing, and some of them coming in not having had much care before?

CO-CHAIR PINUCS: So, Sue -- Katherine you're -- So, why don't we before we do the thank yous and benediction and all that, and summary. Can we pull up the time line slide? So folks know kind of where we are and what happens next? In case you didn't know, the Child Task Force you're not done yet. Tomorrow's the main event. This was fun, but it was basically an appetizer.

Tomorrow's the main meal. So, I'll come back to that. So, tomorrow is the discussion of the child core set. Similar conversation to what we had today, and what the Adult Task Force talked about yesterday. Looking

at potential removal or addition, and some over-arching questions. At the end of this, between July 6 and August 5, there's public comment on a draft report that NQF develops on the recommendations.

There's a review of both the comments and recommendations from the two task force that the Map Coordinating Committee does. That happens via a web meeting, and some time in August they get to be sent. And then we have our deadline of August 31, by which the final report is due to CMS and made available to the public. And then, I'm a little -- Karen, you may help me out about the time frame of what happens then. Relative to CMS decision making about which ones are going to the core set. It's before the end of the year as I recall.

MS. MATSUOKA: Yes. Late fall, early winter. Yes.

CO-CHAIR PINUCS: Okay. Any questions around the time line, around the process? So, do you want to go back to the previous slide about

summarizing something or other? I'll make something up, summarize progress. We made a lot of progress. So, the adult group was busy yesterday.

And today, you know, we obviously went through a number of different measures. Discussed lots of over-arching and overlapping issues. I don't know that we settled on a comfortable way of thinking about perinatal health quite yet in the ages. But at least, you know, we've had the opportunity to think about how to piece those things together. And think about how they relate to one another.

I apologize that we had to skip so quickly through a number of really interesting issues that were, kind of, woven in our conversations. Tomorrow, again, the Child Task Force will meet and go through those measures. And, you know, I just want to say -- Harold had to step out, but I want to thank the Adult Task Force for all their work over the past day and a half. We certainly appreciate it.

And I'll thank in advance the folks on the Child Task Force for today and also for tomorrow. And as well, for the fantastic staff that, you know, tried to accumulate a lot of material and put it together in a relatively short period of time.

I think that, you know, we tried to balance the issue of being responsive to new ideas for measures even until the last minute, with the desire to have everything kind of in front of you. Weeks ahead of time, for review. I'm not sure, it will probably be a lively conversation about whether we got that balance right today or not. But I think that that was the spirit of it, and the desire was to really be responsive to this group and to others who made recommendations for measures.

I know I really appreciated the electronic format ahead of time. In which not only did you invite us to do homework, but also invited folks to list and describe measures. So, I think that was responsive to comments that

we've had. I don't have any -- do you guys have some comments? Yes, Debjani.

MS. MUKHERJEE: I would like to thank our co-chairs. There's a lot of work getting to this point and, sort of, they've been on call and email and responding. Also, for anybody who's submitted measures, thank you for being responsive.

Next year, we will definitely have a cut-off point. And we will hold you to that cut-off point. But thank you for all your hard work and coming here, and especially the team. It's a fairly tight team that's not fully staffed. So, we've all been, especially Shaconna and Nadine. Thank you for their, you know, working with sort of less than optimal staffing. And hopefully we'll see you back tomorrow at the child side.

CO-CHAIR GESTEN: And one on that side. Thank you all, safe travels.

MS. GORHAM: Thank you.

(Whereby, the above entitled matter went off the record at 3:53 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/Child Task Forces

Before: NQF

Date: 05-25-16

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