

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

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

2 (9:04 a.m.)

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

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

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

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

1 the Child Task Force.

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

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

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

22 So let me just turn things over to

1 Marsha and Renee to introduce yourselves.

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

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

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

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

22 I think there are others here from

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

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

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

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

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

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

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

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

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

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

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

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

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

1 of quality and I have nothing to disclose.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 The mic does move. Please move the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 develop measures that are important.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 MEMBER DUNN: Yes. Thank you very

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

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

13 So looking forward to today's
14 discussion.

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

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

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

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

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

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

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

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

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

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

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

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

22 If a measure has consistently high

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

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

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

1 is a red light.

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

6 And the first one was Measure Number
7 2152, preventive care and screening unhealthy
8 alcohol use. Measure 0541: Proportion of Days
9 Covered, three rates by therapeutic category.
10 Measure 2067: Diabetes Care for People with
11 Serious Mental Illness, hemoglobin A1c port
12 control.

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

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

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

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

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

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

1 data but actually looking at the validity of the
2 data.

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

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

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

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

1 should be an actionable outcome related to that
2 measurement.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 MEMBER LACEY: I have a question. I

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

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

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

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

22 So I'm just wondering if you could say

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15 CO-CHAIR PINCUS: Terry.

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

1 endorsement be?

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

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

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

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

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

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

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

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

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

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

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

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

22 In addition to having untested

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

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

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

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

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

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

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

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

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

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

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

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

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

20 CO-CHAIR PINCUS: Marsha.

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

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

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

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

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

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

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

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

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

22 But the access rule was finalized in

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 So there are lots of different names.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17 CO-CHAIR GESTEN: Trust me.

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

20 CO-CHAIR GESTEN: Sure.

21 DR. LILLIE-BLANTON: -- says that.

22 But the main thing is that there will be

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

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

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

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

19 DR. LILLIE-BLANTON: Right.

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

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

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

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

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

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

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

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

12 CO-CHAIR GESTEN: Meg.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16 DR. LILLIE-BLANTON: Absolutely.

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

22 MEMBER LACEY: Thanks, Marsha, that

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 And I would say that would not be the

1 ideal of what we seek to achieve.

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

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

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

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

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

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

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

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

10 MEMBER SCHLAIFER: Okay.

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

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

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

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

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

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

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

1 Adult Health Policy group level.

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

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

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

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

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

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

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

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

4 FEMALE PARTICIPANT: She's on the
5 phone.

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

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

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

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

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

3 There was also the effort to use the
4 measures in improvement efforts. And of course
5 we have several other quality improvement
6 projects. We call them Quality Improvement 101,
7 201 and 301 where we have, we feel like we have
8 grown in our understanding of how to do this.

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

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

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

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

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

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

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

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

4 You know our 25th percentile rate is
5 42.5 and our 75th percentile rate is 50.6. So
6 we're clustered, you know, in that 40 to 50
7 percent range in general.

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

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

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

22 So what did we do? We worked for the

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

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

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

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

1 collect and report the data.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10 And it, this is from before the advent
11 of PDENT. We collect this data on our 416 and
12 have for quite a number of years. So we were
13 able to go back to 2000 and see our trend through
14 2014.

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

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

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

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

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

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

22 So these again, may not be the states

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

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

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

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

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

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

1 measure and the CMCS maternal and infant health
2 initiative.

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

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

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

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

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

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

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

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

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

1 change.

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

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

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

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

1 breastfeeding rates.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19 CO-CHAIR GESTEN: Great, thanks. Meg.

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

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

5 MS. NORRIS: So I think we all would
6 hope that if it was carved in there would be
7 integration and it would be strengthened. But
8 what we actually found is that at least as of
9 2014 the states that were struggling most were
10 the states that have had it carved into managed
11 care.

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

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

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

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

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

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

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

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

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

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

8 CO-CHAIR GESTEN: Susan.

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

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

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

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

11 CO-CHAIR GESTEN: Thank you, Bob.

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

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

1 importance of taking care of their children's
2 teeth.

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

5 CO-CHAIR GESTEN: Thank you. Rich.

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

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

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

22 DR. ANTONELLI: So PDENT is a dental

1 provider's --

2 MS. NORRIS: Dental.

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

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

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

1 of a dynamic to make those other things change?

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

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

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

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

1 focus on outcomes and less on individual
2 services.

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

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

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

22 Here's the role the payer is going to

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 So it's shared measures with the
2 different, with different age groups reported
3 would be one the chlamydia screening measure,
4 0033. And also follow up after hospitalization
5 for mental illness, 0576 are shared with both
6 core sets.

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

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

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

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

1 we'll be talking about.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11 You know, how can we support that
12 further?

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

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

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

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

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

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

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

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

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

22 It reflects the longstanding

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

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

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

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

22 Many women giving birth are not old

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

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

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

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

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

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

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

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

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

19 FEMALE PARTICIPANT: In May.

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

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

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

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

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

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

19 MEMBER PELLEGRINI: I'll wait.

20 CO-CHAIR GESTEN: Okay, thanks.

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

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

3 But we wanted to give you information
4 from state reporting from 2014. So the number of
5 states reporting the frequency of ongoing
6 prenatal care increased from 25 states in 2012 to
7 27 states in 2013 and 28 states in 2014.

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

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

22 Two TA requests were submitted by

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

4 Okay. So that's 1391 and there's one
5 more measure before we start discussion. It's
6 1517 that we wanted to give you an update on.
7 The Perinatal Committee did not reach consensus
8 on this measure because no evidence for the
9 timing of the visits is sufficient with
10 exception.

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

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

1 available.

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

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

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

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

22 So the number of states in the child

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

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

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

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

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

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

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

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

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

1 of questioning or revisiting the measures.

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

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

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

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

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

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

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

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

1 them there's going to be a gaping hole.

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

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

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

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

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

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

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

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

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

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

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

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

22 MEMBER SAKALA: I agree with not

1 recommending for continued endorsement of 1391.

2 And I think what you heard is my ambivalence
3 about the other one. I've for a long time
4 thought these are really low bar measures.

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

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

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

22 I guess what I'm really, I guess what

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

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

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

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

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

8 CO-CHAIR GESTEN: Thank you. Susan.

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

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

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

1 And I guess then my only other
2 question is on Page, a different topic on Slide
3 87 the, one, two, three, four, fourth bullet
4 concerns about validity limited numbers of codes.
5 So now we have like a million more codes.

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

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

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

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

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

1 is postpartum.

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

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

7 (Off microphone comment.)

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

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

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

1 don't report.

2 So we don't know what's happening.

3 But in general I mean we have worked I can say in
4 our improvement effort not just on whether the
5 visit occurred but improving the content of the
6 visit. So we have recognized that this is just,
7 the measure itself is not all of what needs to be
8 approved.

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

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

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

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

5 CO-CHAIR GESTEN: Thank you. Diane.

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

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

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

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

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

11 CO-CHAIR GESTEN: Thank you. Michael.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 And we've been having learning

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

5 Another thing we found is that a lot
6 of women get a postpartum visit after that 56 or
7 60 day window as well. And so if we extended the
8 window our rates would go up.

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

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

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

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

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

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

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

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

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

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

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

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

17 CO-CHAIR GESTEN: Thank you. Ann.

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

22 The visit is important even though you

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 CO-CHAIR GESTEN: Great. Hi, Larry,

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

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

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

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

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

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

1 the availability of data in the clinical record.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 sure that the information is reliable.

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

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

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

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

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

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

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

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

18 DR. HUDSON SCHOLLE: -- implement.

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

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

1 you want to respond?

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

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

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

22 We think that, we don't think that

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

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

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

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

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

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

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

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

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

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

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

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

22 DR. GALLIA: I'm Charles Gallia and

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

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

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

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

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

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

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

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

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

1 the, just for the child for this measure.

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

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

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

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

20 (Off microphone comment.)

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

1 And in order to pass it would be 60 percent?

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

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

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

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

22 As we heard earlier, we're not sure

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

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

9 CO-CHAIR GESTEN: Do we have a second?

10 MEMBER SAKALA: Second.

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

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

20 (Off microphone comment.)

21 MS. GORHAM: Alexandra has it ready so

22 --

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

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

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

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

16 (Voting)

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

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

22 MS. OGUNGBEMI: We have 11 for Child

1 and also 11 for adult.

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

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

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

11 (Voting)

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

14 MS. OGUNGBEMI: Yes, we do.

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

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

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

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

4 MS. OGUNGBEMI: 1517.

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

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

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

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

1 discomfort is in having the gaping hole.

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

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

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

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

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

22 MS. GORHAM: Yes. So pull your Excel

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

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

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

11 MS. GORHAM: No.

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

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

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

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

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

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

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

22 I think this addresses the issue that

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

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

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

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

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

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

7 CO-CHAIR GESTEN: Is there a second?

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

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

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

22 DR. LILLIE-BLANTON: We still, we take

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

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

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

9 CO-CHAIR GESTEN: So vote now?

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

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

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

20 (Voting)

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

1 recommended that the measure be kept on the core
2 set.

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

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

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

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

1 do those?

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

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

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

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

22 So first, next slide. Let's look at

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

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

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

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

22 The measure was recommended by both

1 the Adult and Child Task Forces last year.

2 Again, at the time of recommendation it was two
3 different measures. The developer combined the
4 measure now includes women ages 15 to 14 who have
5 had a, 44 who have had a live birth.

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

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

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

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

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

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

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

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

15 CO-CHAIR GESTEN: Okay.

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

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

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

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

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

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

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

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

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

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

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

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

1 think.

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

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

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

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

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

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

22 CO-CHAIR GESTEN: Do you want to go

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

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

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

13 CO-CHAIR GESTEN: Carol.

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

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

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

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

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

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

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

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

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

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

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

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

17 MS. GORHAM: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

1 we just did.

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

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

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

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

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

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

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

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

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

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

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

22 CO-CHAIR GESTEN: While they're

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

5 So what's the implications of voting
6 yes, voting yes. So if it's in fact we say, yes,
7 do we, is there a working assumption that we're
8 going to split the measure up for child and
9 adult?

10 Is there a working assumption that the
11 age span which spans child and adult will be in
12 one or the other category as a child measure or
13 an adult measure? I'm not, I'm uncertain what it
14 means to vote yes, what the implications of that
15 are. Carol.

16 MEMBER SAKALA: So this is a place
17 where I think the example that I gave earlier of
18 the relevance to both is good. Like healthy
19 birth spacing is great for babies.

20 So I just think we should consider
21 that a lot of these are doing important things
22 for mothers and babies.

1 CO-CHAIR GESTEN: So I have actually
2 a much more boring, my question is much more
3 boring than that. It's if we approve it which
4 bucket does it go in and does it mean that folks
5 who are reporting on the child are now going to
6 be reporting on the enlarged denominator or are
7 we going to task, if you will, to people
8 reporting adult measures to when you're reporting
9 it include down to the age of 15 or are we going
10 to say 15 to 18 will go in child and 18 and above
11 will go in adult or maybe there's some other
12 option?

13 I don't know who would answer that
14 question frankly.

15 MS. GORHAM: So I can answer process
16 for the voting. But I think that is more a CMS
17 question about how the reporting would go. For
18 our purposes for voting we will vote for, the
19 Child Task Force Members would vote for those two
20 measures for the child core set.

21 And then we would take a vote for the
22 adults for those two measures to sit on the adult

1 core set because it's two different core sets.

2 CO-CHAIR GESTEN: And then reserve for
3 Marsha since she's not here so we can give her
4 work to do to figure out which it would be
5 reported in? All right. This looks complicated.
6 Do we need a break to discuss this issue or, you
7 guys all get it, right.

8 CO-CHAIR PINCUS: I think we should
9 take a break now because we need to get some
10 input from CMS and we're going to have a long
11 discussion about each of the measures. And so
12 rather than break --

13 CO-CHAIR GESTEN: Yes. After lunch,
14 okay. So you want to try to come back and have a
15 working lunch? What do you think?

16 So let's try to take 15 minutes which
17 means that we would restart at 12:25 and we will
18 resume and hopefully have the answer to this.
19 Okay.

20 (Whereupon, the above-entitled matter
21 went off the record at 12:07 p.m. and resumed at
22 12:33 p.m.)

1 CO-CHAIR GESTEN: Hey, I think we're
2 going to reconvene and get going. It's okay to
3 chew and talk.

4 So we have I think some clarifying
5 questions -- issues to talk about. I'll give it
6 over to Debjani first and I have a couple as
7 well. Just to make sure we're all on the same
8 page and get a sense of what we're doing and why
9 we're doing it and what the process is going to
10 be.

11 But Debjani, you want to start and
12 then I'll go after you.

13 MS. MUKHERJEE: Sure. We just wanted
14 to go over why there has to be two voting for the
15 adult versus the child.

16 It's two different core sets, two
17 different task forces, and so it has to be two
18 different votes.

19 Because we want to make sure we can
20 attribute 60 percent plus for one task force when
21 we say over 60 percent of task force members
22 either of the child or the adult group voted to

1 include it or recommend it for consideration.

2 So the voting will be separate and we
3 will let you know that now the child side is
4 voting and then we'll let you know that the adult
5 task force is voting.

6 And we will make sure that you get to
7 see the measures as you're going voting and we'll
8 -- Shaconna will give you a quick recap of all
9 the measures we talked about, but then when we
10 vote you'll see them one by one, just to make
11 sure. But it has to be two separate votes.

12 CO-CHAIR GESTEN: The other -- a
13 couple of other clarifying -- hopefully
14 clarifying comments.

15 One, for folks that are new, just to
16 -- and folks who have been here, just to refresh,
17 that the recommendations from these task force
18 are exactly that.

19 They're recommendations to CMS, who I
20 think you probably saw yesterday in the trial
21 tests whereas we'll see tomorrow the history of
22 CMS taking very seriously the recommendations and

1 the prioritization of the task force, but CMS is
2 the decision maker about what they do with our
3 recommendations.

4 So just to understand that, you know,
5 when we vote and we recommend something that's
6 what it is. It's advisory to CMS.

7 The second point I would make is that
8 -- so we have right in front of us five --
9 potentially five measures, maybe four depending
10 on what we hear about the two exclusive breast
11 milk feeding measures.

12 But we teed them up today again even
13 though some of them are voted in child and not in
14 adult to take advantage of input from the adult
15 group on issues that are crosscutting and that
16 are closely connected to perinatal, maternal and
17 child health.

18 So we recognize that some of these
19 measures, you know, the folks on the adult side
20 aren't going to be voting on, but we want to take
21 advantage of your input and the discussion
22 leading up to these measures.

1 And these are the measures that were
2 recommended by members of the task force for us
3 to consider, and that's how and why they made
4 this list.

5 Some of them as Shaconna mentioned
6 have been voted on previously or recommended, and
7 some of them I think not, or some of them have
8 been changed.

9 Also, we can -- in terms of the age
10 issue and how it's going to get reported, I would
11 suggest that -- we will go through the discussion
12 of the measures and we can separately, if we
13 choose to, make a recommendation to CMS about how
14 to handle measures that are crosscut -- go from
15 15 to 44, for example.

16 Whether it's the same measures
17 reported in both sets, whether you break up the
18 age groups, or some very -- or decide, make a
19 decision that it's in one set or the other.

20 And there are -- I don't think there's
21 a right answer to that, but if folks want to
22 weigh in on that we can see if we have consensus

1 or want to make a recommendation.

2 So I forgot to tell you this,
3 Shaconna, I'm sorry. Before we do any of this,
4 there was a recommendation -- there was a request
5 by somebody in the group to potentially re-vote a
6 measure based on the outcome of the last voting
7 that potentially might have changed votes.

8 And so there was a proposal to request
9 that we re-vote the measure on frequency of
10 prenatal care visits. That is -- help me out, 15
11 -- is that 1517? So much for my memory. 1391.
12 I'm sorry, can you guys -- can we post it? I
13 know you're looking at me like I'm crazy, but
14 sorry I didn't tell you about this.

15 Just trying to keep, you know, just
16 trying to keep it improvisational and jazz-like.
17 But anyhow, Kathryn, do you want to -- do you
18 want to just tee it, you know, describe what you
19 --

20 MEMBER BEATTIE: Sure. So because we
21 voted on 1517 second, after, and have voted that
22 we would endorse keeping the timeliness of

1 prenatal measure, then that changes how -- at
2 least for me -- I feel about having a gaping hole
3 regarding prenatal care and the importance of a
4 measure driving towards access.

5 And so 1391, which is the much more
6 complex around frequency of prenatal care, may
7 not be a necessary measure in my mind knowing
8 that we are keeping 1517.

9 And they're both in -- those both were
10 in the child core set. So I would please
11 recommend or request that we re-vote on 1391.

12 CO-CHAIR GESTEN: And I checked and
13 this is okay with Robert's Rules, just in case
14 you're wondering. So is there a second?

15 MEMBER ADIRIM: Second.

16 CO-CHAIR GESTEN: Second, okay. So
17 can you tee up the vote again for 1391? So if
18 memory serves, a yes vote is a yes for removal.
19 A no vote would retain it in the child core set.

20 MS. GORHAM: And to be very clear,
21 this is only the child task force members voting
22 now.

1 CO-CHAIR GESTEN: While we're teeing
2 it up, anybody have any questions about either
3 what we're doing here? You all refreshed?

4 Susan, you notice I gave people an
5 extra five minutes based on your comment. How we
6 doing team? We almost there? Okay, so what
7 we're voting on -- and this is just the child
8 task force -- is whether measure 1391, frequency
9 of ongoing prenatal care, should -- the proposal
10 is to remove it from the child core set.

11 A yes vote, a 1 vote would be voting
12 for removal. A no vote would retain it in the
13 set. So are we ready?

14 MS. OGUNGBEMI: Yes, we are ready.
15 Voting is open. Results are 73 percent yes and
16 27 percent no.

17 So the task force has recommended that
18 CMS remove measure 1391 from the child core set.

19 CO-CHAIR GESTEN: Great, thank you.
20 So now can you take us back to where we were
21 before with the five measures?

22 Thank you so much for doing that. At

1 least there are no hanging chads to contend with,
2 right?

3 So here's the suggestion for process
4 going forward, which is that we -- measure by
5 measure -- have a discussion among the group.

6 Before we go to a vote we take any
7 public comments on any of these measures. And
8 then we would go and vote them individually.

9 So why don't we start with -- and I
10 don't know if you can put it up there. 2903
11 which again, my -- I think you're going the wrong
12 way but maybe not. Go the other way. Yes, or
13 maybe not.

14 2903 would -- is a measure that we saw
15 last year -- I think both tasks forces saw this -
16 - but the measure has been changed by the U.S.
17 Office of Population Affairs to include -- be
18 inclusive of the age range of 15 to 44.

19 And the status of this in terms of NQF
20 endorsement is not yet but it's in -- not
21 endorsed? And does that mean it hasn't come up
22 for endorsement, or --

1 MS. GORHAM: So that means that the
2 perinatal committee reviewed this measure. It
3 was recommended for endorsement but it has not
4 been ratified. So the measure is not endorsed
5 yet. It's in the pipeline.

6 CO-CHAIR GESTEN: Comments on this?
7 Carol?

8 MEMBER SAKALA: Yes, I just wanted to
9 share with you the gist of that conversation. I
10 think that we were very supportive overall of all
11 three of the contraceptive care measures that
12 came before us.

13 The one concern that came up and does
14 come up from the reproductive health community
15 are issues of coercion, and I think we did
16 discuss that a little bit last year as well.

17 And it was very gratifying to know
18 that the U.S. Office of Population Affairs, which
19 works in a very collaborative way with -- across
20 stakeholder groups, has a measure in the pipeline
21 that deals with the experience of receiving
22 contraceptive care and that that people felt

1 would be a very good measure to pair along with
2 these when it's available.

3 CO-CHAIR GESTEN: Thank you, any other
4 comments? Andrea?

5 MEMBER BENIN: I would just want to
6 reiterate my comments from last year around the
7 concerns about coercion. To me this is a metric
8 that essentially says all women with Medicaid
9 should be, you know, on contraception.

10 Since there's no target for it,
11 there's no known -- it's not actually known what
12 the right number is, it's much more of an
13 epidemiological measure. And I could see how it
14 has real purposes for the states to understand
15 what's going on in their environment and real
16 purpose for the states to understand how they're
17 using contraception.

18 But as far as it being a quality
19 metric around the quality of a plan, I would
20 think that a better metric would actually be
21 around contraception being offered, and not --
22 you know, the stock that we think that all women

1 should have contraception is -- and we're not
2 even saying that all women, we're saying that all
3 women on Medicaid should have contraception -- is
4 concerning to me.

5 And so it's a hard metric for me to be
6 supportive of. While I support the idea of it
7 conceptually and I can support the idea of women
8 being offered contraception, since it's not
9 exactly known what the right level is, it's hard
10 to know what to do with that.

11 CO-CHAIR GESTEN: Thank you, Kim?

12 DR. ELLIOT: My comments follow very
13 much in Andrea's steps. I think if I had seen
14 some exclusions for people that were offered and
15 declined I'd be a lot more comfortable with the
16 measure, but there are no exclusion criteria in
17 the specifications that I saw.

18 CO-CHAIR GESTEN: Thank you, Cindy?

19 MEMBER PELLEGRINI: So we had a lot of
20 these conversations in the perinatal committee.
21 And while I understand the concerns completely --
22 and there isn't a target in this, it is not meant

1 to be a 100 percent measure or necessarily a 50
2 percent measure or anything else.

3 It's meant to show tracking over time.
4 The denominator is women age 15 to 44 who are at
5 risk of unintended pregnancy.

6 It's not an all women measure. So it
7 is a matter of docs going in and -- or providers
8 -- and screening for unintended pregnancy and
9 risk.

10 Now if this is a woman who is not
11 sexually active, she's not in the denominator.
12 If she wants to get pregnant, she's not the
13 denominator.

14 So this is something that I think is
15 going to require a good deal of education about
16 the appropriate use.

17 But the consensus in the committee was
18 this is an incredibly important measure. It
19 fills some real gaps in women's health and in
20 preconception and intraconception care.

21 And people are really very anxious to
22 get this into use and out there in the field so

1 we can start working on it.

2 MEMBER BENIN: I'm not familiar with
3 the ICD-9 codes or ICD-10 codes around those
4 things.

5 Are those ICD-10 codes that are
6 readily specified and easily used by people to
7 say -- like do doctors code this women is not --
8 these are the exclusions?

9 I'm -- that's just not my level of
10 familiarity with how coding works, but I may not
11 be super familiar with that area and what those
12 codes are.

13 CO-CHAIR GESTEN: If anyone is in the
14 queue that wants to respond to -- Sean.

15 MR. CURRIGAN: Yes, that does work.
16 There is no current code for sexual activity, but
17 it has been -- it's being -- sexual activity, and
18 I think it's like sexual activity within ever and
19 sexual activity within the last three months, are
20 the two codes that are being sought after.

21 And I work -- they're going for a
22 SNOMED code I believe. We applied for a SNOMED

1 code for the pregnancy intention within the next
2 year, and that has been rejected for a SNOMED
3 code but recommended for a LOINC code.

4 So we will have these codes whenever
5 LOINC gets to it, probably within the next year.
6 So those codes don't exist currently, you'd have
7 to get that from the electronic medical record.

8 So I think we don't have the sexual
9 activity exactly yet or the pregnancy intention,
10 but -- if you are currently seeking fertility
11 treatments or there's other things that they've
12 identified within their denominator so that they
13 can kind of make the denominator as tight as
14 possible. But it's not a tight denominator, which
15 is why we have to go get these codes.

16 CO-CHAIR GESTEN: Thank you.

17 MR. CURRIGAN: But it was endorsed.
18 It's a wonkier denominator than we would like,
19 but I think for the LARC, specifically the LARC
20 portion of the -- is this -- are we doing these
21 as two measures or is it the LARC portion is the
22 same measure?

1 The LARC is really about access and
2 we're really looking for more than zero percent
3 for the LARC measure. And then the most is just
4 to kind of prepare the benchmark that we need to
5 have.

6 MEMBER SAKALA: LARC is not in here,
7 it's just the other two.

8 MR. CURRIGAN: Oh, okay.

9 CO-CHAIR GESTEN: Thank you, Sean.
10 Rich?

11 DR. ANTONELLI: I'm just wondering
12 about the definition of being at risk for
13 unintended pregnancies.

14 I know that there's been a lot of
15 tension in adolescent healthcare providers around
16 doing chlamydia screening and how that has really
17 been challenged at the level of clinicians.

18 So with respect to this, and I'm --
19 being very mindful that I'm speaking specifically
20 about the 15 to 18 age range here, can somebody
21 give me some elaboration on what defines risk for
22 unintended pregnancy?

1 Because otherwise it looks like every
2 adolescent female that I take care of for well
3 child or well care, to hit this measure I have to
4 prescribe birth control.

5 CO-CHAIR GESTEN: Somebody have a
6 response? Carol are you able to, or anyone else?
7 Michael, do you have an answer, or --

8 MEMBER SHA: Sorry. I would offer the
9 adult corollary that you're essentially dealing
10 with every adult female from 18 to 44.

11 CO-CHAIR GESTEN: So Rich, maybe when
12 Cindy comes back in we can ask if she has a
13 comment to that. Charles?

14 DR. GALLIA: The effective
15 contraceptive use, including LARC, is important
16 in Oregon.

17 We have -- even before the initiative
18 that was occurring at the federal level, we
19 started incorporating -- or almost developed --
20 our own measure in parallel. Just for a variety
21 of reasons.

22 And during the course of

1 implementation we've discovered a couple of
2 challenges in the assessment and accuracy of, you
3 know, there's -- there's an education program
4 about -- asking questions in it as part of a
5 woman's health visit on a routine basis that
6 we're implementing about pregnancy intention.

7 And we've also on the administrative
8 side discovered that we have some issues that
9 aren't only around exclusion and inclusion
10 criteria about past obstetric care, but even
11 gender identity as a component that we have to
12 take into consideration that we haven't in the
13 past.

14 And so while it's an evolution, this
15 particular measure is in our -- I'd say it's in
16 our top ten in terms of priority areas for focus.

17 CO-CHAIR GESTEN: Cindy, when you were
18 out there was a question Rich asked about what
19 counts for at risk of unintended pregnancy,
20 specifically focused on adolescents.

21 And I think Rich -- correct me if I'm
22 wrong -- part of the comment was it would seem as

1 if it's potentially true that every adolescent
2 that he sees, to pass this measure would need to
3 be on contraception.

4 Is that -- so what's the granularity
5 about how that's defined?

6 MEMBER PELLEGRINI: Carol, it's my
7 recollection from the conversation a couple weeks
8 ago that the two questions basically are, are you
9 sexually active, and do you want to get pregnant.
10 And depending on the answers --

11 DR. ANTONELLI: But are those in the
12 measure spec?

13 MEMBER PELLEGRINI: I don't recall.
14 I would have to go back to the really long
15 document --

16 DR. ANTONELLI: Okay.

17 MEMBER PELLEGRINI: -- if that's
18 exactly.

19 DR. ANTONELLI: Is that something the
20 staff can pull up? Because it's -- I don't mind
21 revealing my leaning.

22 I would heavily lean toward no if

1 those things aren't in there. If those things --
2 because you know it's been a very long row to hoe
3 just getting chlamydia screening for adolescents.

4 Specifically because of I'm not -- you
5 know, I'm not sexually active and I don't want my
6 parents to see that on the bill. So I just want
7 to pull that out there.

8 CO-CHAIR GESTEN: Well folks are
9 looking for that. Any other questions or
10 comments from the group? Yes, Andrea?

11 MEMBER ADIRIM: Yes, I hear what
12 everybody is saying about coercion, but I think
13 what I'm struggling with is understanding how
14 just by having this measure, how it directly
15 impacts how a practitioner practices.

16 So, I mean this is, to me seems like
17 it's a measure to determine if there's
18 improvements in prescribing of these types of
19 contraceptives. So can somebody help me with
20 this?

21 Because I think it's a good measure.
22 Whether or not you include it in the core set is

1 another issue, but I'm just not sure how this
2 core set would necessarily lead to coercion
3 directly by the practitioner, so help me with
4 that.

5 MEMBER DUNN: This is Katie, could I
6 add to that?

7 CO-CHAIR GESTEN: Sure.

8 MEMBER DUNN: Thank you. I agree with
9 what the last speaker just said. If you're
10 looking at wanting to make sure that
11 contraception is offered as part of a standard of
12 care that's one thing. I think that there would
13 be a fair amount of concern with using measures
14 that speak to unintended pregnancy and/or an
15 assumption that is directly related to personal
16 behavior. In the past there have been measures,
17 and they may -- if they've already been talked
18 about and I'm new to the conversation I apologize
19 for my ignorance.

20 But you know if we were going to look
21 at measures about birth intervals that are
22 related to positive birth outcomes and overall

1 health as a mother, I think that that would be a
2 better way to look at this only from the
3 perspective of that birth intervals can be and
4 are influenced by so many other psycho social,
5 emotional and physical issues, not just whether
6 contraception was prescribed or actually given to
7 a particular person. So thank you.

8 CO-CHAIR GESTEN: Thanks, Katie.
9 Helen?

10 DR. BURSTIN: Just a quick process
11 point. You know, what we try to do is not have
12 these tables readjudicate the sort of the measure
13 itself.

14 It's not necessary. We had a committee
15 or co-chairs here but another member of the
16 committee at the table, they looked at it through
17 the lens.

18 Overall this is a good measure. It's
19 high quality. They have recommended it. I want
20 you to just consider the discussion today really
21 in the context of how would you use -- would you
22 recommend this measure for the Medicaid

1 population.

2 Please don't readjudicate the measure.
3 You'll be here for days, and they've already
4 taken care of that. Thanks.

5 CO-CHAIR GESTEN: Ann?

6 MEMBER DUNN: I was -- it was no
7 intention to readjudicate the measure. I think I
8 was trying to get to the point of saying no it
9 doesn't belong for Medicaid population.

10 CO-CHAIR GESTEN: Thank you. I think
11 that came across, Katie, thank you. Ann?

12 DR. SULLIVAN: I was just curious if
13 this kind of measure is used for any other
14 population other than the Medicaid population?

15 Is this in anybody else's kind of
16 quality armamentarium? Because I think if it's
17 not, then I think, you know, you have to consider
18 the way policy is driven.

19 And I think you also have to --
20 whether you like it or not -- consider
21 perception. And I think that there's a little
22 bit of danger here of this is something we're

1 pushing forward for the Medicaid population but
2 not for other populations at this point in time.

3 And if that's the first population out
4 of the box, I think that could be somewhat
5 problematic because it has a tone of a little bit
6 of -- while I think well-intentioned -- of a
7 possible push towards making sure this population
8 gets a little more contraception than another
9 population might get.

10 And I think that that -- you just have
11 to consider that when you look at measures.

12 CO-CHAIR GESTEN: That's an
13 interesting point. You know, Carol can probably
14 make this point better than I do, but my
15 understanding is that unintended pregnancy is
16 sort of an equal opportunity happening.

17 And so -- but I think you're not wrong
18 that a lot of the efforts that have gone on have
19 been targeting -- have been around Medicaid or
20 low income.

21 But I think that there are also a
22 number of initiatives -- and Carol or Cindy might

1 be able to speak to them -- that are aimed at
2 trying to have better planning, spacing,
3 intrapregnancy care that is really focused on the
4 broad population.

5 DR. SULLIVAN: And to that point --
6 and offering it is one thing I think. I'm just
7 saying that offering it I think would be
8 tremendous and to monitor that -- but not redoing
9 the measure. But this is not offering it, this is
10 monitoring it, which I think is a little
11 different, that's all.

12 CO-CHAIR GESTEN: All right, Carol?

13 MEMBER SAKALA: I just wanted to speak
14 to the question of whether it's in other programs
15 already. These are brand new measures and in fact
16 there has been a dearth of reproductive health
17 measures. So we were very excited to have what we
18 considered to be robust measures, especially
19 knowing that this other measure is in the
20 pipeline.

21 So no they're not in any programs
22 right now, and this would be the first

1 opportunity to do so.

2 CO-CHAIR GESTEN: Charles?

3 DR. GALLIA: So we're using this
4 measure as a -- or building this measure into a
5 shared data set Maternity Data Center that
6 incorporates the hospital measures that we will
7 be pushing back out.

8 So it's a cross-payer in how we're
9 applying it. Because one of the other lessons
10 we've learned early on in doing measurement at a
11 practice level is it kind of drives providers
12 crazy if you have one measure for one population
13 and not for another.

14 So fundamentally we did address that,
15 making sure that it would be transferable between
16 groups. You can't hear me? I'll speak up next
17 time more.

18 CO-CHAIR GESTEN: Cindy?

19 MEMBER PELLEGRINI: Just a quick
20 point, because it's very top of mind for me. I'm
21 spending most of my time these days working on
22 Zika.

1 The population that we're talking
2 about here is going to be at the highest risk for
3 Zika virus. It is low income people who don't
4 have air conditioning, who don't have screens,
5 who have outdoor jobs, et cetera.

6 And so I think it's just a timely
7 issue to add here to say we've been thinking
8 about -- we've been thinking about access to
9 contraception for other populations like through
10 the Affordable Care Act's mandate of coverage
11 without cost sharing.

12 And this is another way to look at
13 needs in this very high risk, high need
14 population.

15 CO-CHAIR GESTEN: I'm sorry?

16 MEMBER LACEY: I move we call the
17 question.

18 CO-CHAIR GESTEN: Want to vote?

19 MEMBER LACEY: Yes.

20 CO-CHAIR GESTEN: So I'm not sure what
21 the rules say, but we wanted to have public
22 comment before we voted on the measures.

1 So if it's okay with you, my plan was,
2 Susan, to talk about the two contraceptive care
3 measures in the group after public comment and
4 then vote. Is that -- is that okay, can I?

5 Any other conversation about 2903, the
6 measure that's up there, most and moderately
7 effective methods?

8 MEMBER ADIRIM: One quick thing, and
9 I just want to support something that Cindy said,
10 just to extend on that a little bit.

11 What I was asking before is I really
12 don't see a direct link between physician
13 practice and this measure. I think it's good for
14 monitoring, because I think the real issue is
15 that these are not being offered, are not being
16 offered reliably. And so I think it's not only a
17 good measure but I think it's also a good measure
18 for the Medicaid core measure set.

19 CO-CHAIR GESTEN: So I would ask that
20 we move to the next contraceptive care measure,
21 which is the postpartum measure, if we can put
22 that up on the screen. And would invite

1 conversation about this measure for inclusion in
2 that adult and child core set.

3 So this is from the same steward, the
4 U.S. Office of Population Affairs. It's in the
5 process of endorsement. It's been recommended by
6 the perinatal committee, is that right? Yes.

7 Yes, this is 2902, contraceptive care
8 for postpartum, and there are -- this is two
9 measures? It's the most effective and there's
10 most and then there's LARC measure, right, within
11 it?

12 MEMBER SAKALA: So there are two
13 layers of effectiveness that can be looked at
14 separately, and there are also two timeframes
15 within three days and within 60 days.

16 With the -- what we've had in recent
17 years is a lifting of the idea that it's not
18 appropriate to provide some of these measures
19 early on. And in fact some -- they can be
20 provided at the time of birth as well as in the
21 postpartum visits.

22 CO-CHAIR GESTEN: Carol or anyone

1 else, do you want to make the specific point
2 about the relationship or why this is
3 particularly important and separate from the
4 previous measure that we saw?

5 MEMBER SAKALA: It's a different
6 population. This population is not included.
7 Women, we've talked about getting -- how many
8 Medicaid mothers don't get back for the prenatal
9 visit -- the postpartum visit.

10 So if you can get this while you're in
11 the hospital, I think it pushes conversations
12 about this into pregnancy, that a part of
13 pregnancy care should be these kinds of
14 discussions about having the opportunity to make
15 these decisions shortly after the birth or in the
16 postpartum visit.

17 And also CMS has been working with
18 states to -- especially on LARCs -- to find new
19 ways of paying for them and lifting some of the
20 barriers that have occurred.

21 So, and with -- it also fits as well
22 with the focus on postpartum contraception. It's

1 a good fit there.

2 CO-CHAIR GESTEN: Thank you. Any
3 other comments about this, this potential
4 inclusion in the core set? Andrea?

5 MEMBER BENIN: You know, I'll just
6 echo my comments from the previous metric. While
7 I believe these to be strong measures of
8 epidemiological interest and probably payor
9 interest, and relevant around use of access to
10 contraception potentially, it -- if it's truly a
11 measure of access, it's not about whether or not
12 the contraception was given.

13 It would be a metric about it being
14 offered. And so as a metric of -- as of it being
15 given, but these are -- I don't believe it's
16 appropriate to use these in this setting.

17 If we were doing an epidemiological
18 project that would be great. Or writing a
19 treatise on the best thing for women perhaps,
20 maybe. But to say that all women on Medicaid
21 should be, you know, sterilized is a little
22 controversial to me.

1 CO-CHAIR GESTEN: So let me just
2 remind -- thank you for -- let me just remind
3 folks that these measures -- we're going to be
4 voting on -- both tasks forces are going to be
5 voting on these measures, both the child and the
6 adult.

7 So this is a time for both sides of
8 the aisle, if you will, to make any comments or
9 questions and so on.

10 Not just the child task force but the
11 adult one. And we're going to vote them
12 separately, as we've talked about. Sue?

13 MEMBER KENDIG: I think this is more
14 of a policy comment but may get to some of the
15 other comments.

16 In my view this one is especially
17 important, particularly with regards to the
18 timing. In those non-Medicaid expansion states,
19 if this does not occur and a woman does not want
20 to become pregnant within the next year, it is
21 really critical that this issue is addressed in
22 that 60-day timeframe. And this is one more

1 trigger to help assure that this conversation
2 takes place and she has access to the most
3 effective method for her.

4 So if you want to talk about a
5 vulnerable population, the women in those states
6 are exceptionally vulnerable and this becomes a
7 critical timing issue.

8 CO-CHAIR GESTEN: Great, thank you.
9 Michael?

10 MEMBER SHA: I would agree with
11 everything that Sue said, that this is -- that
12 for the non-Medicaid expansion states that this
13 time window is very key.

14 But I think where this measure perhaps
15 -- that I have a problem with, is that this is an
16 outcomes measure instead of a process measure.
17 That if we were measuring the active discussing
18 the idea of contraception in this age population,
19 I would be completely supportive of it. Because,
20 you know, spacing is very important, not only for
21 the health of the mother but also for the recent
22 newborn.

1 But I think that this -- I'm having
2 difficulty with the fact that this is an outcomes
3 measure.

4 That actually that, you know, when I
5 first read the measure I really did think that
6 there was a coercive component to it. Because as
7 a practitioner, if you're going to be measured,
8 or the organization's going to be measured on the
9 number of women who are going to be receiving
10 contraception, there is an implicit encouragement
11 that more contraception be offered to this
12 population. Not just the active discussion, but
13 the actual delivery of this medication.

14 CO-CHAIR GESTEN: Thank you. Fatema?

15 MEMBER SALAM: I just wanted to ask a
16 clarifying question. Because I heard Carol say
17 that this was the first opportunity for this
18 measure to be used.

19 It wasn't that it was specifically
20 targeting any particular population. Is that
21 accurate? That it was just the first opportunity
22 for it to get entered into a measurement program?

1 MEMBER SAKALA: It's a brand new
2 measure that was just recommended for endorsement
3 and needs to go through the process, but it had a
4 lot of strong support.

5 MEMBER SALAM: Yes, but it wasn't
6 written specifically for a target population. It
7 was all women.

8 MEMBER SAKALA: So the previous one
9 that we discussed does not include childbearing
10 women and this one does. So this is specific to
11 the period between birth and 60 days.

12 CO-CHAIR GESTEN: But the measure
13 description doesn't say Medicaid. The measure
14 description is for -- that's what your question
15 is, right? Kim?

16 DR. ELLIOT: I just want to again
17 reiterate my concerns about the coercion and also
18 choice of Medicaid families. And I think that the
19 way this is phrased with it being delivered
20 versus offered is a strong statement to be making
21 for a Medicaid measure.

22 CO-CHAIR GESTEN: Susan?

1 MEMBER LACEY: So the only thing I
2 wanted to say is what do you do about the
3 provider that is -- because of his or her faith -
4 - they will not want to do this?

5 We brought this up just ever so
6 briefly, but I mean so those people are just
7 going to have to always get the ding. So we -- I
8 remember we had a brief conversation about that
9 but I think that's also problematic.

10 CO-CHAIR GESTEN: Any other comments?
11 Rich?

12 DR. ANTONELLI: I'm just wondering if
13 -- I don't know, maybe this is for the person
14 sitting next to me.

15 Just the fact that this measure
16 actually is, was this prescribed versus was it
17 proffered. Is there some logic that we should
18 understand about what went into the process?
19 Because it is two different measures.

20 An intermediate outcome versus a
21 process, I get that. But it would maybe help me
22 with my thinking a little bit to know -- clearly

1 somebody made a decision that proffering wasn't
2 enough.

3 MEMBER SAKALA: Cindy, do you recall
4 this? Because I believe it's about the decision
5 being made rather than the actual, for example,
6 IUD being inserted.

7 MEMBER PELLEGRINI: Yes, so this got
8 to the issues around there are some providers, as
9 I understand it -- Sean could elaborate on this a
10 lot more.

11 Some providers are not stocking IUDs
12 because they say well I've got to pay for it up
13 front and then I may or may not have patients who
14 come in and actually use them. Some of them are
15 not getting trained on how to insert them. So
16 this is really about trying to push -- actually
17 practice, sorry, Terry's gone.

18 But push practice to say, not just did
19 you talk about it and then give somebody a
20 referral or expect them to go find somewhere else
21 that they could actually get the product, but are
22 you doing everything you need to to be able to

1 serve these patients from start to finish.

2 MS. MUKHERJEE: Hey Reva, do you want
3 to say something about this measure as well?

4 MS. WINKLER: Hi, this is Reva
5 Winkler, I'm the Senior Director on the Perinatal
6 Project. Essentially the interest in
7 contraceptive measures has been so great that
8 these measures have been being worked on and
9 being developed for several years.

10 The biggest constraint is for use in
11 -- you know, widespread use is really available
12 of appropriate data. And so this measure is based
13 on administrative data, and we all know that that
14 data has limitations. But that is the reason that
15 the measure is structured the way it is, because
16 that's the data that's available to be collected.

17 CO-CHAIR GESTEN: Thank you, Reva.
18 Operator, can we go to any public comments? And
19 we're entertaining public comments on either of
20 the two contraceptive care measures, 2903 or
21 2902, for public comment.

22 OPERATOR: Yes, sir. At this time if

1 you would like to make a comment please press
2 star, then the number one. And there are no
3 public comments from the phone lines.

4 CO-CHAIR GESTEN: Thank you, operator.
5 Public comments in the room?

6 MR. CURRIGAN: Sean from ACOG. Number
7 one, just to remind you this is a health plan
8 measure, this is not a provider or like clinical
9 professional level measure.

10 So conscientious refusal -- like if a
11 provider wants to not offer, you know,
12 contraception and not refer them to another
13 provider, that's the health plan's choice on how
14 they deal with that provider and how they
15 interact with that health plan.

16 This is a health plan measure. So a
17 woman could choose, do I want to go to this
18 health plan that offers this LARC or offers this
19 moderately effective and gives me very easy
20 access to the methods that I would like to use?
21 Or am I going to use this other health plan who
22 has providers who are not offering those and

1 getting those contraceptive methods to those
2 women who do not want to be pregnant.

3 Health on level, we did -- ACOG did
4 recommend this for use in the America's Health
5 Insurance Plan's core OB/GYN set. We asked not to
6 be recognized in the work of the AHIP core set
7 because they did not choose to include them and
8 that was because at that time they were not NQF-
9 endorsed. So that was like a year ago. Now they
10 are NQF-endorsed, so we will be revisiting those
11 conversations with the commercial health plans
12 very shortly. But we think that these are
13 perfectly fine for both commercial and Medicaid
14 populations.

15 Unplanned pregnancies -- like if you
16 want to talk about having better birth outcomes,
17 you know, the frequency of the prenatal care, I
18 can tell you a planned pregnancy is going to have
19 a better birth outcome than an unplanned
20 pregnancy. And I think that if you got rid of
21 those frequency of prenatal care, this is a very
22 good measure to stick in there.

1 And just to remind you that there are
2 patient-reported outcomes that are in
3 development. Dr. Burstin was on the panel
4 selecting those for the OPA, as well as we are
5 trying to upgrade the data system so that we can
6 get the LOINC code and sexual activity and
7 pregnancy intention to improve this measure. This
8 measure should probably not be a use after five
9 years. Like, we will have something better to
10 replace it because we'll have better data.

11 And then just a recommendation that
12 perhaps you may consider voting for this twice,
13 because there is the LARC submeasure, which is
14 one piece of the most and moderately effective,
15 and then the moderately effective which is like
16 the pills. You might want to vote for it twice
17 because there are two rates within the measure,
18 and LARC access might be considered separately.

19 CO-CHAIR GESTEN: Thank you. Any
20 other comments from the room? Questions now?
21 Kathryn and then Susan?

22 MEMBER BEATTIE: Just a comment. I

1 don't think that the majority of planned
2 participants are particularly educated in the
3 details of their plan when they select it. And
4 I'd be concerned that they may make a selection
5 not knowing that this measure could potentially
6 change the direction of their care.

7 MEMBER LACEY: Yes, so to elaborate on
8 that. So on the one hand we're saying these
9 people are not ready to make these decisions
10 because they don't know enough information, they
11 need to be approached, et cetera, et cetera.

12 On the other hand, it sounded like the
13 recommendation was also well if someone has
14 decided they're not going to give the individual
15 birth control or right for birth control, then
16 the plan can deal with that person and then the
17 woman can pick another plan.

18 So I think we're saying two things --
19 two very different things about the capability of
20 this population. Not that I am, I think that is
21 what I'm hearing. Very different thoughts about
22 what these people are capable of doing for

1 themselves.

2 CO-CHAIR GESTEN: Charles?

3 DR. GALLIA: So I am certain that
4 whatever I say is not going to persuade people to
5 think differently than what they do.

6 But part of the reason the emphasis we
7 placed on effective contraceptive use was based
8 on thinking, as I said yesterday, about a -- like
9 a life course perspective. And part of that
10 includes starting healthy. And that means
11 emphasis on preconception health.

12 And then -- and this is one facet of
13 a very important starting point that I think that
14 Medicaid programs, who are responsible for the
15 majority of births, ought to be -- and we are --
16 paying attention to.

17 CO-CHAIR GESTEN: Thank you, Harold?

18 CO-CHAIR PINCUS: So in some ways this
19 gets back to the issue we talked about in the
20 very beginning today about -- that we also talked
21 about yesterday in terms of sort of what is the
22 sort of fit for purpose of this kind of measure.

1 You know, in some ways we're not
2 really talking about using it as an
3 accountability measure for plans or something
4 that would be used with -- we're really -- and in
5 some ways how it would be used at a state level
6 in terms of, you know, their Medicaid program.

7 It is kind of a dipstick into the
8 overall population to see well how -- you know,
9 in our population, you know, what is the degree
10 to which, you know, this measure is being met.

11 And then it could indicate more for
12 sort of analytic purposes or trying to understand
13 what's going on in the state as a way for
14 improvement, to see if there are certain areas of
15 the state or certain populations that may be at -
16 - sort of more likely of not getting these kind
17 of services or obtaining these kind of services.

18 And thinking of ways to improve the
19 availability of these services or to try to
20 understand why certain groups are not getting
21 them.

22 So, you know, so I think one question

1 that comes up is how would states actually use
2 this. You know, if it's not -- you know, for the
3 purposes of communicating information about
4 plans.

5 CO-CHAIR GESTEN: Charles, did you
6 have another comment or was that card just still
7 up?

8 DR. GALLIA: I could answer the
9 question. How we're using it in Oregon is we're
10 seeing where there are -- in some of the
11 background work in developing the measure and
12 using the temporary measure at the beginning, we
13 also incorporated survey work and patient
14 preferences.

15 And there was a gap area -- and this
16 is one of the gap areas that we discovered, was
17 that particularly at postpartum that preference
18 for IUDs are -- was a lot higher than was
19 actually being done.

20 And so that gap created -- said so why
21 is that happening. And one of the things we
22 discovered was that there was some -- we had some

1 administrative reimbursement barriers that
2 actually had nothing to do with the patient
3 preferences that were impeding the ability to
4 deliver long-acting reversible contraceptives
5 postpartum.

6 And so that's one of the ways that we
7 use this measure.

8 CO-CHAIR GESTEN: Thank you. So
9 here's where the fun begins. So we have -- we're
10 going to start voting and the voting will be
11 child task force, adult task force for each
12 measure at a time.

13 But part of the challenge -- part of
14 the question that we have to confront is the
15 measures are not yet NQF-endorsed. And as you may
16 recall, there are categories of, you know, no,
17 yes, and conditional endorsement based upon NQF
18 endorsement.

19 So why don't we start with 2903 which
20 is contraceptive care most and moderately
21 effective methods. And before we vote, let's make
22 sure and know we're voting on -- we're looking

1 for -- Cindy? Yes?

2 MEMBER PELLEGRINI: Just a technical
3 question. Could the NQF staff clarify for us,
4 this has been a recommended -- these measures
5 were recommended by the perinatal panel. Now they
6 go to the NQF Board? CSAC, I'm sorry. And then
7 do they have another step beyond that or is the
8 CSAC it? Then Board.

9 So can you give us like a general
10 timeframe? Is that within the next -- do those
11 things happen in the next couple months, six
12 months, three months? Okay. So these are like on
13 the five yard line.

14 MS. ALLEN: So this is not going to
15 happen -- the measures don't go to the Board
16 until probably around October before it goes to
17 the Board.

18 We have to go through public comment
19 first, which is 30 days. Then after public
20 comment, the Committee will reconvene. Then it
21 has to go through membership vote. Then to CSAC.
22 Then to the Board. So it's a process.

1 CO-CHAIR GESTEN: So I'm just trying
2 to get a sense of what it is we should vote on at
3 least first.

4 So is there -- does somebody want to
5 make a motion of either we're voting yes without
6 conditions, yes with conditions --

7 MS. GORHAM: So for clarification to
8 bring you back to your decision categories,
9 because this measure is not NQF-endorsed, we
10 would need a motion first from the child task
11 force to vote yes, the measure should be -- we
12 recommend to CMS that this measure is included
13 into the core set on the condition that it is
14 NQF-endorsed.

15 So this would be a motion to
16 conditionally support the measure.

17 CO-CHAIR GESTEN: But is there
18 anything that forbids somebody from saying we
19 want to vote on it without conditions?

20 MS. GORHAM: So historically we only
21 vote on support with condition, because it is not
22 NQF-endorsed.

1 CO-CHAIR GESTEN: Okay, so let me --
2 so you're looking for a motion to start to
3 conditionally support.

4 Is there a motion from the child task
5 force to do that? Is there a second?

6 MEMBER SAKALA: Second.

7 CO-CHAIR GESTEN: Okay. The child
8 task force for right now is voting on whether to
9 add this measure, the 2903, to the child core set
10 to recommend its addition. It's a conditional
11 support. The condition is that it be NQF-
12 endorsed. And are we ready to vote?

13 Again this is child task force. The
14 adults will get their turn next. A yes vote is to
15 include it. A no vote is to not include it. Is
16 that what you were going to say?

17 MS. GORHAM: Yes, I was going to say
18 a yes vote is a vote to say that I recommend to
19 CMS with the condition of NQF endorsement, and no
20 is I do not recommend the measure with
21 conditional support. For child task force
22 members only.

1 MS. OGUNGBEMI: Voting is open.

2 CO-CHAIR GESTEN: And I'm sorry, how
3 many votes do you have? Is it still 11?

4 MS. GORHAM: Eleven.

5 CO-CHAIR GESTEN: Eleven? Okay. So
6 this does not pass.

7 MS. GORHAM: Yes, in order for this
8 measure to have passed, it would have needed more
9 than 60 percent --

10 CO-CHAIR GESTEN: Sixty percent.

11 MS. GORHAM: -- of the votes.

12 CO-CHAIR GESTEN: Okay.

13 MS. GORHAM: So the child task force
14 members do not wish to include 2903 as
15 conditionally supported into the core set.

16 So now we will take a vote with the
17 adult task force members.

18 CO-CHAIR PINCUS: And do we have the
19 adult task force members on the line?

20 MS. OGUNGBEMI: Voting is open.

21 CO-CHAIR PINCUS: No, no. No, we need
22 a motion. We need a motion.

1 MS. GORHAM: So do we have a motion
2 from the adult task force members to --

3 MEMBER KENDIG: So moved.

4 CO-CHAIR PINCUS: Is there a second?

5 MEMBER PELLEGRINI: Second.

6 MS. GORHAM: So we have 11 adult task
7 force members. We have one member on the phone,
8 and she can chat her vote.

9 We are voting on the adult task force
10 for 2903 contraceptive care most and moderately
11 effective method. Yes, you press 1 and that is a
12 vote to conditionally support the measure for
13 addition to the core set. Two is no, I do not
14 conditionally support the measure for addition.

15 MS. OGUNGBEMI: And now voting is
16 open.

17 CO-CHAIR GESTEN: We really need some
18 voting music.

19 MS. GORHAM: Katie, can you please
20 send your vote through your chat?

21 MEMBER DUNN: I just did.

22 CO-CHAIR GESTEN: Still missing?

1 MS. GORHAM: George is out of the room
2 so there's actually -- yes, but I don't have
3 Katie's vote. Katie, can you vote again, please?

4 MEMBER DUNN: I just typed it in
5 again.

6 MS. GORHAM: Okay, so the adult task
7 force members have decided -- or have voted not
8 to include or not to recommend the addition of
9 2903 to the core set.

10 CO-CHAIR GESTEN: Okay, we're --

11 CO-CHAIR PINCUS: I just wanted to say
12 that we have voted to not recommend. Not that we
13 had voted to not recommend.

14 We have not voted to recommend. It's
15 not that we voted to not recommend.

16 CO-CHAIR GESTEN: I think I got that
17 but I'm not sure. One more cup of coffee. 2902
18 is what we're going to vote on next.

19 This is contraceptive care postpartum,
20 and again we're going to start with the child
21 task force and the -- we're looking for a
22 proposal to vote on this support with conditions,

1 the condition being NQF endorsement.

2 Is there a motion to vote on that from
3 the child task force?

4 DR. ANTONELLI: So moved.

5 CO-CHAIR GESTEN: Is there a second?

6 MEMBER SAKALA: Second.

7 CO-CHAIR GESTEN: Okay. So we're
8 voting to recommend what the inclusion in the
9 child core set number 2902, which is
10 contraceptive care postpartum conditional
11 support.

12 A yes vote is that it would be
13 recommended to be added. A no vote is that it
14 would not be recommended to be added. Are we
15 ready to vote?

16 MS. OGUNGBEMI: Yes, voting is open.

17 CO-CHAIR GESTEN: Okay.

18 MS. GORHAM: For measure 2902,
19 contraceptive care postpartum, the child task
20 force members are recommending -- is that right,
21 recommending addition with conditional support,
22 the condition being NQF endorsement.

1 CO-CHAIR PINCUS: So do we have a
2 motion from the adult task force members
3 regarding making a recommendation on this
4 measure?

5 MEMBER KENDIG: So moved.

6 CO-CHAIR PINCUS: Is there a second?

7 MEMBER PELLEGRINI: Second.

8 CO-CHAIR PINCUS: So are we ready to
9 vote?

10 MS. OGUNGBEMI: Yes, voting is open.

11 MS. GORHAM: The adult task force
12 members are voting on 2902, contraceptive care
13 postpartum. Yes for conditional support. No --

14 CO-CHAIR PINCUS: And again, those on
15 the phone would chat their vote.

16 MS. GORHAM: The adult task force
17 members have voted and they do not wish to
18 recommend the measure, 2902, contraceptive care
19 postpartum.

20 CO-CHAIR GESTEN: So we have our first
21 interesting nonalignment. I think we've had a
22 pretty good record of alignment, so this is

1 interesting.

2 We might, I don't know, we might
3 circle back to at least discuss this after we
4 finish the voting. I don't know. Unless you
5 want to --

6 MEMBER SCHLAIFER: It's not really an
7 important comment. I just think that the scores
8 got lower as people realize -- it's more
9 accumulative giving up on this measure kind of
10 thing.

11 PARTICIPANT: It just passed.

12 MEMBER SCHLAIFER: Oh it --

13 CO-CHAIR GESTEN: Passed the child.
14 It passed the child but didn't pass adult.

15 MEMBER SCHLAIFER: No, yes, you're
16 right. Okay, sorry.

17 CO-CHAIR GESTEN: Yes.

18 MEMBER SCHLAIFER: I was thinking the
19 measure before, yes.

20 CO-CHAIR GESTEN: Somebody else will
21 have to explain that one. Rich?

22 DR. ANTONELLI: Yes, I'll offer a

1 possible explanation. I see this as potentially
2 two different populations.

3 So a pregnant teenager, a postpartum
4 teenager, I can imagine a one in a million
5 opportunity where they want to get pregnant
6 again.

7 But for the vast majority, that is a
8 big oops if I missed that. On the adult side,
9 it's potentially a very different dynamic.

10 And so I guess I would even challenge
11 our well-intentioned notion of even trying to
12 find alignments.

13 I actually think that this measure is
14 trying to cross two potential different dynamics,
15 social and biosocial dynamics.

16 So I'm, I guess I don't have much
17 egodystonia with all due respect to our
18 psychiatric co-chair with that.

19 CO-CHAIR GESTEN: I guess I have more
20 because again you guys, Cindy or Carol may be
21 able to fill in the facts.

22 But again I think that, I don't know

1 that there's a huge delta between the rate of
2 unintended pregnancy at the line that you
3 described.

4 I understand perfectly what you said.
5 But I think if you, and even if you look at the
6 overall total number of unintended pregnancies it
7 would be, I would guess the volume would be
8 higher in the older age group. So I remain with
9 a little bit of dystonia, as you say.

10 DR. ANTONELLI: I wasn't offering an
11 explanation. I was offering an observation as a
12 pediatric primary care provider.

13 CO-CHAIR GESTEN: Yes.

14 DR. ANTONELLI: That's where I was
15 coming from.

16 CO-CHAIR GESTEN: Kathryn?

17 MEMBER BEATTIE: I have a question.
18 Maybe I'm misunderstanding, but in the child core
19 set, does it only include postpartum between 15
20 and 18?

21 I really thought it was for all of the
22 postpartum moms, that it was -- that the child

1 core set wasn't just including teenage
2 pregnancies but all pregnancies.

3 So there isn't really a difference in
4 what the child task force or the adult task force
5 was voting on. Is that --

6 So what he's saying makes me think
7 that, but I was thinking that the inclusion
8 criteria for consideration by the child task
9 force was for all postpartum moms between 18 and
10 44 as described here.

11 CO-CHAIR PINCUS: Well that's
12 interesting, because based on what Helen was
13 saying, the measure is the measure. Yes.

14 MEMBER BEATTIE: So again I think what
15 he was -- I'm sorry, I don't know who was
16 speaking, but the most recent speaker in saying
17 that we were voting on the decision to try and
18 support unintended teenage pregnancy is only a
19 tiny subset of three years between 18 and 44.

20 CO-CHAIR GESTEN: So I had posed, but
21 it could be challenged that we voted on the
22 measure with the ages that they were, and then --

1 because that's the measure.

2 And then as a secondary conversation
3 that we could have, which we could start now, is
4 what, if anything, what do we want to recommend
5 to CMS relative to this measure as part of the
6 child core set which could include -- which could
7 say to them we think you should take it as is and
8 include the entire age range.

9 It could say, we could say to them we
10 understand the measure is 15 to 44. We think
11 that the measure should report it in only the
12 child age group. So we can have that
13 conversation again.

14 CO-CHAIR PINCUS: Well, there's a
15 third option which is doing it in both ways.

16 CO-CHAIR GESTEN: But it wasn't, it
17 wasn't voted on in for the adult. Because the
18 adult group voted it down.

19 MEMBER BEATTIE: So when we just took
20 the vote as the child task force, and it changed
21 between the first measure and the second measure
22 because the second measure was a subset of just

1 postpartum between 18 and 44.

2 If individuals on our task force
3 thought that they were voting for the pediatric
4 population and not the entire population, that is
5 not the way the measure is written.

6 And so I'm calling into question as to
7 whether we all understood fully. Because the
8 statement that was made is saying the reason that
9 we voted differently is because it was addressing
10 the issue of pregnancy in those under 18.

11 And that's not what the measure
12 addresses. Do you see what I'm saying?

13 CO-CHAIR GESTEN: Well, Rich's comment
14 notwithstanding, the measure, we voted on the
15 measure as it's written.

16 And then the second issue is an
17 implementation issue, which is as -- this is how
18 I see it, but again you can correct me if I'm
19 wrong.

20 The implementation issue to CMS would
21 be here's the measure that's been done, here's
22 what's been approved.

1 Do you believe that this measure
2 should be reported by the child's, you know, by
3 under the heading of child core measures by
4 states going up to 44?

5 Or do you think that it should be
6 restricted to an age group, and that will be this
7 --

8 DR. BURSTIN: Just to be clear, the
9 measure is the measure. It can't be restricted.
10 We don't have a separate adolescent measure at
11 this point. There is one measure, 18 to 44.

12 And again, these are just
13 recommendations to CMS. So they will have this
14 recommendation that clearly shows support from
15 those in the child task force and not as much
16 support in the adult tasks force.

17 And certainly they have, they're
18 sitting right here so they've heard the
19 discussion.

20 I don't know that you need to parse it
21 further since there is not a separate adolescent
22 postpartum measure before this committee.

1 CO-CHAIR GESTEN: Okay. So you would
2 say that the only thing that CMS can do is to
3 either accept it as is, and it would be reported
4 under the child core measures with the age group
5 --

6 CO-CHAIR PINCUS: No, no. I think
7 there's a point -- yes, this goes back to
8 actually the discussion we had at the MAP
9 Coordinating Committee.

10 That what CMS told us overall was that
11 what they find is the voting is important, it
12 gives them direction, but the discussion is also
13 important.

14 And that we don't have to specify all
15 kinds of things in a vote. And so the discussion
16 we just had right now about the interpretation of
17 this I think is useful to them as they move
18 towards however they choose to implement this.

19 CO-CHAIR GESTEN: So does that mean we
20 should have no conversation about this as an
21 issue? Are we done? Okay, Bo?

22 MEMBER RIEWERTS: Well, I just wanted

1 to clarify for one that voted for the child side
2 of the house that I didn't have any confusion
3 about this voting.

4 I was merely voting for the
5 opportunity for women to have access to
6 contraception, and I think that is an issue in
7 our country.

8 So, I don't believe it is -- I don't
9 believe there are providers out there that are
10 going to, you know, push contraception on people
11 unnecessarily just to meet this metric. I don't
12 believe that will happen.

13 CO-CHAIR GESTEN: Kathryn, did you
14 still have a question or comment, or, your card
15 was up? Okay, so why don't we discuss PC measure
16 0480 and 2830 together.

17 This is exclusive breast milk feeding,
18 and I think we were looking -- Marge, I'm glad
19 you're back -- for a little bit of clarification
20 maybe before we start the discussion about how --
21 I guess part of the question that came up is are
22 these two measures in competition?

1 You know, sort of a one or the other
2 and weighing one against the other is -- do you
3 CMS have -- want to make a statement about having
4 two measures, one of which has a methodology that
5 has specifications and one that does not?

6 How should the group think about these
7 two measures which are the same measure with the
8 exception of the collection modality as we
9 discuss it and vote on it? Do you want to weigh
10 in?

11 DR. MATSUOKA: So the question is does
12 the modality of the data collection matter to us?

13 CO-CHAIR GESTEN: In terms of our
14 voting to the core set. I mean do you for
15 example see a day, maybe a day soon or into the
16 future, where each measure would have two
17 flavors, electronic and non, and states could
18 decide which one they want to use?

19 Do you envision that states would
20 report both an electronic version and a non-
21 electronic version of the same measure?

22 Are these -- so we're trying to -- I

1 guess trying to understand how to think about two
2 measures that are the same only differ in terms
3 of their methodology of collection with respect
4 to where CMS is.

5 And then we can take the temperature
6 of the group about how they think of it.

7 DR. MATSUOKA: And this is another
8 question. So is there the option to -- I think
9 given that different states are at different
10 stages with regard to EHR adoption, and it looks
11 like this is a hospital-based measure and there's
12 a different EHR adoption rate already for the
13 hospitals. I think the extent to which we have
14 flexibility as to whether states can report
15 electronic versus not would be preferable.

16 So if the e-specified measure has an
17 option, or if the measure can be specified in a
18 collection agnostic way, that would be the best.

19 And that states could then choose to
20 decide how they can -- what is the most feasible
21 way for them to have a state level measure.

22 CO-CHAIR GESTEN: It's helpful. Helen

1 just corrected me, however, that we can't change
2 the measure. The measures are what they are.

3 So we have two measures and two
4 different numbers, right? Yes, they're two
5 different measures.

6 DR. BURSTIN: The question would be if
7 CMS has indicated their willingness to entertain
8 potentially having that flexibility.

9 You can look at both measures, and I
10 did confirm with Reva as well as Carol that in
11 fact the measure specs are the same now.

12 That exclusion has been removed --
13 that second rate's been removed even from the
14 traditional measure.

15 So they really are the same, and I
16 mean I think you could vote on both essentially
17 it's the same measure for them if they want that
18 flexibility.

19 CO-CHAIR PINCUS: So for efficiency
20 sake, can we have one vote?

21 HELEN BURSTIN: Sure. Yes, say it's
22 capturing both measures, unless anybody has any

1 particular issue with the eMeasure.

2 CO-CHAIR GESTEN: Discussion of the
3 measure? Carol?

4 MEMBER SAKALA: So I went back to the
5 arch evidence report. It's being redone at this
6 point in time.

7 I agree with the comment that was
8 stated about birth spacing. It's an out-of-the-
9 gate, beginning of life prevention measure that I
10 think is really of value.

11 And in this case I believe that this
12 measure is prevention, short-term, long-term for
13 mother and baby.

14 And for the baby, the conditions in
15 developed countries that were associated with any
16 breast-feeding were reduced otitis,
17 gastroenteritis, severe lower respiratory
18 infection, atopic dermatitis, asthma, obesity,
19 type 1 and type 2 diabetes, childhood leukemia,
20 SIDS, necrotizing enterocolitis.

21 And for mothers, type 2 diabetes,
22 breast and ovarian cancer, and since that time

1 hypertension, hyperlipidemia and cardiovascular
2 disease have been added.

3 So I think when we look at individual
4 measures around specific health conditions, this
5 is so powerful in terms of prevention for both
6 parties of such a broad range of items.

7 As far as alignment, it's now in the
8 AHIP CMS core set that happened in the past year.
9 And the joint commission is collecting from
10 hospitals now with 300 or more births per year
11 beginning this January.

12 So I would strongly recommend that we
13 add this to the adults as well.

14 CO-CHAIR PINCUS: Andrea and then
15 Susan?

16 MEMBER BENIN: Hi, sorry, I'll -- I'm
17 just going to reiterate my comments from last
18 year.

19 I, you know, I am absolutely the
20 biggest -- I'm a pediatric infectious disease
21 doctor.

22 I am the biggest fan of breast-feeding

1 that you could possibly have, personally and
2 professionally, you name it.

3 The problem with this metric is that
4 there's a small set of exclusions where you can
5 write in the chart the reason why you didn't
6 breast-feed exclusively during the
7 hospitalization, and that list is very narrow and
8 it's limited to a handful of infections.

9 You know, it's sort of limited to HIV,
10 varicella, there's a small set of reasons that
11 you can write in the chart why there was a reason
12 not to exclusively breast-feed during a
13 hospitalization.

14 But there are other reasons why
15 sometimes a baby needs a little bit of formula in
16 that time period that would, well you can still
17 get a baby out exclusively breast-feeding, there
18 are times when you need to top them off in the
19 hospital.

20 Or they come out and their sugars are
21 a little low, et cetera, et cetera. And those
22 exclusions as far as reasons not to, there's an

1 exclusion that says if the doctor or the APRN or
2 what have you writes reason not to not done
3 exclusively, they can write that in the chart,
4 but those reasons are really narrow to this kind
5 of set of infections.

6 So while I really would love to love
7 this metric, I have sort of repeatedly been
8 stymied by what it's actually measuring.

9 And so I -- it's hard for me to
10 advocate for it on a broader scale although I
11 would love to be able to advocate for it having a
12 few other things to it.

13 But it's really limited to exclusive
14 breast-feeding. So a baby who got a handful of
15 ounces, got topped off from a feeding that might
16 be rough, you know, those days are rough.

17 And sometimes it's actually better for
18 the baby to get topped off, so I'm a little bit,
19 you know, I always have some ambivalence about
20 this metric.

21 MEMBER LACEY: In looking at this list
22 of exclusions and then looking at what we had on

1 slides, so those lists are a little bit
2 different.

3 The list for the eMeasure has three.
4 This list has a very large group of exclusions.
5 Right, so that one has three.

6 But now we're saying the measure is
7 exactly the same. So do we go with the exclusion
8 list on the slide above?

9 Because I'll just be honest. I don't
10 see anything about maternal preference. And I
11 know that you all say, well, you just have to
12 breast-feed, but there are some women that just
13 do not want to do that.

14 And we don't seem to have a maternal
15 preference option as an exclusion. And I know
16 for one person who tried and failed terribly, you
17 know, I finally just decided I wanted my baby to
18 eat.

19 CO-CHAIR PINCUS: Bo and Meg? And
20 then Carol?

21 MEMBER RIEWERTS: My vantage point
22 from this is we definitely want all babies to

1 breast-feed if possible.

2 I totally agree that there are many
3 reasons why people don't breast-feed. The goal
4 isn't, I mean, obviously if we could get 100
5 percent of the world to breast-feed, the world
6 would be a better place.

7 Everyone agrees to that. There's
8 incredible medical evidence to say that. But I
9 don't understand why we wouldn't support this
10 metric which is going to encourage people to
11 support breast-feeding.

12 I can tell you until our organization
13 began to focus on rates, which is what this is,
14 this is a rate of breast-feeding in the hospital,
15 our rates didn't start to go up.

16 And our rates have improved incredibly
17 in our organization. We deliver about one out of
18 every five babies in California.

19 And I am all for this metric. I think
20 it will improve breast-feeding rates. And we
21 aren't going to get to a hundred percent because
22 there are people who don't breast-feed for

1 reasons which have already been stated.

2 But we're not talking about them,
3 we're talking about supporting mothers who want
4 to breast-feed.

5 MEMBER MURRAY: My concern with this
6 from the health plan perspective is that when we
7 add more and more measures, there is a cost to
8 the health plans.

9 And if it's not using claims data,
10 then it's much harder for plans to collect. So I
11 just have to, I want to put that out there that
12 there is -- can be fatigue in terms of the health
13 plan's ability to collect all of this.

14 So in terms of ranking them, given
15 that there is no claims data for it, it would be
16 harder for the plans.

17 CO-CHAIR PINCUS: Carol?

18 MEMBER SAKALA: So I am sympathetic to
19 the conversation earlier about circumstances
20 where it's not possible.

21 The developer and steward are totally
22 clear that there's no way we're expected to get a

1 hundred percent.

2 This is -- the program is voluntary.
3 There's no accountability aspects to it. And I
4 would just like to share that, two things.

5 One is that they have heard
6 discussions at California hospitals of all kinds
7 of different populations with different cultural
8 backgrounds and preferences that this method was
9 -- this measure was very effective in helping a
10 lot of women to achieve these goals.

11 And that we heard testimonials earlier
12 this month from places that thought they had done
13 very well on this measure without a coercive,
14 overbearing approach to it just by providing good
15 information and support and respecting women's
16 informed choices.

17 CO-CHAIR PINCUS: Cindy?

18 MEMBER PELLEGRINI: So I'm concerned
19 that over the many years that this measure has
20 been out there, it really does seem to be held to
21 a different standard than a lot of the others
22 that we consider.

1 There are a lot of reasons people
2 decide not to quit smoking. There are a lot of
3 reasons people don't take their medications.

4 There are a lot of reasons people
5 don't get the screenings that we want them to
6 when we want them to, you know.

7 I'm sure my doctor is deeply
8 frustrated that I've decided not to get another
9 mammogram until I'm after 50, right, because they
10 suck.

11 But this is one where nobody's
12 expected to get to a hundred percent. And it can
13 be we think so important in helping to move those
14 rates as you said, Bo, at different institutions.

15 So, you know, March of Dimes obviously
16 is all on board with breast-feeding. There are
17 absolutely going to be circumstances where women
18 can't or won't breast-feed and that is just the
19 way it is.

20 But there's a lot more we could do in
21 a lot of institutions to move these rates in the
22 right direction.

1 CO-CHAIR PINCUS: Diane?

2 MEMBER CALMUS: I guess my question on
3 the conversation is is there a better measure? I
4 mean it seems that everybody's agreeing that
5 encouraging breast-feeding and more women breast-
6 feeding is a good thing.

7 And I know I've heard a number of
8 concerns about, you know, the specifics of this
9 measure.

10 And, you know, I'm not an expert on
11 this, but I can see where all of those are valid
12 concerns.

13 But I guess my question is is there
14 something better to get to that information? And
15 I don't know.

16 CO-CHAIR PINCUS: To my knowledge
17 there's not an endorsed measure.

18 MEMBER LACEY: So my only question is
19 we have, I'm pro-breast-feeding, love it, love
20 it, love it.

21 But we have all of these different
22 sheets that have different exclusions listed. So

1 I'm just trying to understand which one of those
2 do we go by?

3 And if it really does fall down to
4 wanting to add one more being the -- which of
5 course we can't change, but we've been told we
6 can't change, we can't change, the measure is the
7 measure.

8 But I see different words on the
9 sheets connected to the same measure. So I'm
10 trying to get clarity around which one do we look
11 at to, you know, which one do we look at the
12 exclusion criteria?

13 Because they're different. That's all
14 I'm asking.

15 CO-CHAIR GESTEN: Reva, are you still
16 on the phone and maybe you can ask the question
17 that Susan's asking about which of that exclusion
18 criteria?

19 MS. WINKLER: Yes, Foster I'm here.
20 I have to sit here and look at, I'll have to look
21 them up, I can do that in a couple of minutes.

22 I'm not sure where they pulled the

1 data that you're looking at, so give me a minute
2 and I'll take a look.

3 CO-CHAIR GESTEN: Meg, do you still,
4 do you have question, or no? Is that it? Okay.

5 So while you're looking that up why
6 don't we -- my suggestion is this is going to be
7 a child task force vote, just to clarify.

8 This is a child measure, this is
9 around newborns, correct? That's what Shaconna's
10 telling me and she never lies to me. Not once.
11 Well maybe once, twice, but.

12 So it's a child measure. But before
13 we do that, Rich, and then we'll take public
14 comment quickly and then we'll go to a vote.

15 Because we have to get through these
16 measures, we have to get through asthma measures,
17 and we have about three hours' worth of content.

18 DR. ANTONELLI: So when we talked
19 about this before, there are two numerators for
20 the first one.

21 And Carol mentioned that it was going
22 to change. And so I just want to know are we

1 going to see that version or should we be looking
2 at, what did you say, PC-05A got pulled out?

3 PARTICIPANT: It's gone, yes.

4 DR. ANTONELLI: Yes. So she's saying
5 it's an error.

6 CO-CHAIR GESTEN: Numerators are the
7 same. We've clarified the numerators are the
8 same in both --

9 DR. ANTONELLI: Okay, so the slides
10 that I have on my laptop are not correct, is what
11 you're saying? This is the corrected slide,
12 okay.

13 CO-CHAIR GESTEN: Yes, we're just
14 looking up the exclusion issues because the
15 exclusions that Susan is describing, they are --
16 these exclusions which we're looking at right now
17 for 0480 which look a little different than, not
18 the same as the -- go to the eMeasure, what does
19 that one?

20 MEMBER LACEY: Well, and then one more
21 thing, when you look at the eMeasure which we're
22 saying is the same, it just says see Excel

1 spreadsheet. So it's really confusing.

2 DR. BURSTIN: And just keep in mind
3 because these measures are still going through
4 the endorsement process, they're almost, they're
5 kind of winding their way through, that's where
6 that change was made.

7 You're only going to support them
8 conditionally anyway on endorsement where those
9 issues will be sorted out by people like Carol
10 and Cindy and others who know these measures in
11 great depth.

12 So again keep in mind these will be
13 very similar measures. They don't have that
14 exclusion as was in the original Joint Commission
15 measure and Reva can add more details.

16 But either way, you're still voting it
17 conditional on endorsement of it getting through
18 the Perinatal Committee and full process.

19 CO-CHAIR GESTEN: But I think the
20 question is are these -- can we vote on these
21 together.

22 And it sounds like if they at least

1 currently have different specifications then we
2 might want to vote on them different? Okay.

3 MS. WINKLER: Foster, it's Reva. I've
4 got them up side by side right now, and yes, the
5 way they were written by the developer makes it
6 look like they are very different.

7 But when you actually read the
8 details, you'll see that the measure on 480 has
9 exclusions that are not so much specific to this
10 measure but are sort of Joint Commission specific
11 measures such as enrolled in clinical trials,
12 length of stay greater than 100 days, those sorts
13 of things.

14 Which really they did not put into the
15 eMeasure per se because that tends to be around
16 the way that hospital program was working.

17 But if you look, the exclusions are
18 really, newborns who are admitted to the NICU,
19 newborns who expired, and newborns who were
20 transferred to an acute care facility.

21 CO-CHAIR GESTEN: And you're saying
22 those are in both?

1 MS. WINKLER: Yes.

2 CO-CHAIR GESTEN: Because I think
3 Susan's raising the question, you know, for all
4 of us, which is is there any substantive
5 difference between the two measures that we
6 should think about as think about voting.

7 And it sounds like you're making an
8 argument that there is not.

9 MS. WINKLER: No. For instance, there
10 is an exclusion in 480 about patients who are not
11 at term, but the numerator and the denominator
12 statements on both measures specify that these
13 are term newborns.

14 So I think it would be nice if the
15 wording was aligned, but if you really put them
16 side by side and look at them, the intent is
17 exactly the same.

18 CO-CHAIR GESTEN: Okay, that's helpful
19 to me. Susan, is that helpful? Okay. So why
20 don't -- we will take public comment on both of
21 these measures before the child task force votes.

22 Why don't we start with the room?

1 Sean, are you coming to make a comment, or not?

2 Okay. Sean? Tick-tock.

3 MR. CURRIGAN: Oh, sorry. Just to
4 remind you this isn't breast-feeding, this is
5 breast milk feeding, so you can use a breast
6 bank.

7 There's a lot of innovations people
8 are doing that does not require the woman to use
9 her own breast milk if she cannot do that or does
10 not want to do that.

11 So I mean there are ways around still
12 providing breast milk. Again, the goal is not a
13 hundred percent.

14 The goal is probably 70 percent, and
15 we all recognize that and I think we're very
16 comfortable just moving towards the 70 percent.

17 05A, when 05A was endorsed, we were
18 chasing those exclusions looking for -- and
19 people were spending way more time looking for
20 the exclusion than they were actually doing any
21 improvements in breast milk feeding or lactation
22 support.

1 And to reiterate what Cindy was
2 saying, we're talking about optimal care here.
3 We're talking about like what are we offering our
4 patients and how are we getting them the most
5 effective or the optimal healthcare that we can
6 provide.

7 And like if this was immunization,
8 much like the contraception measures which I
9 don't understand what happened, but if this was
10 immunization would you have the same issues with
11 it?

12 Because immunization, people choose
13 not to have it and it affects the pertussis rate.
14 But, you know, we still measure whether the
15 immunization was provided, not whether they
16 counseled about immunization.

17 So I think that just to reiterate the
18 college supports both of these measures.

19 CO-CHAIR GESTEN: Thank you. Any
20 other comments from the room? Public comments?
21 On the phone, operator, public comments?

22 OPERATOR: Okay, once again, to make

1 a public comment please press star, then the
2 number 1. There are no public comments at this
3 time.

4 CO-CHAIR GESTEN: Thank you, operator.
5 So I guess I'm looking for somebody to propose.
6 We're talking about the child task force now
7 voting on these measures.

8 The proposal would be that we vote on
9 them together. I'll see if there's a proposal.
10 0480 is NQF endorsed. 2830 is not yet endorsed
11 but is in the process.

12 So this vote of yes would be half
13 conditional, half not conditional. I don't know
14 what the right words are.

15 MS. GORHAM: If you vote on them
16 together, you're voting conditional support.

17 CO-CHAIR GESTEN: Conditionally, okay.

18 MS. GORHAM: The eMeasure has not been
19 ratified. It was recommended by the standing
20 committee but it still needs to be ratified.

21 CO-CHAIR GESTEN: So folks can say
22 they don't want to propose that, but that's, I'm

1 looking to see if somebody on the child task
2 force wants to propose a vote for conditional
3 support of these two measures together. Yes, you
4 may, sure.

5 MEMBER ADIRIM: I just want to make
6 sure that we understand that there are real
7 unintended consequences of putting high pressure
8 on hospitals to breast-feed exclusively,
9 especially hospitals without a lot of resources
10 to bank.

11 You know banked breast milk, it's
12 really, it's a big deal. It's an expensive
13 proposition.

14 And if you don't have the support of
15 lactation consultants which of course this is
16 what this is trying to drive is to get the
17 lactation consultants there.

18 But what happens then if there's a
19 real pressure to do nothing but breast-feed, you
20 have babies who potentially go home at two days
21 who have been unfed properly for several days
22 with this -- that they're going to be, they're

1 set up for failure.

2 I mean I personally took home at five
3 days a shriveled up yellow baby and went to a
4 lactation consultant who took the baby out of my
5 hands and said what the heck, this breast-feeding
6 only thing, give me the bottle, like, and put a
7 bottle in that baby's mouth.

8 And when my second baby was born, and
9 they had to top him off, like I was like fine,
10 top him off. And we see that in these nurseries.

11 Like you have to either make sure that
12 places have the resources to attend to this, and
13 I understand that this is the epi of it, that
14 this isn't the pressure, there's no
15 accountability and that we're trying to
16 understand what the true metrics are.

17 But I just want to make sure that we
18 understand where some of the risks are around how
19 that looks.

20 And maybe this is the way to provide
21 more resources for people to do it. But the
22 metrics have these other sides to them.

1 CO-CHAIR GESTEN: Bo a new point?

2 MEMBER RIEWERTS: Well I just, I have
3 to wholeheartedly disagree. I think to say that
4 you're not going to support breast-feeding
5 because you don't have the resources, that's like
6 saying you're not going to give vaccines because
7 you don't have the resources, or you're not going
8 to do anything else that is right for a patient.

9 And I also disagree that patients are
10 going to go home shriveled. With appropriate
11 care in medical care, there are babies that will
12 need formula after a day or two, but it's not in
13 the first day or two.

14 And this is talking about providing
15 breast-feeding support while the baby is
16 hospitalized.

17 Most babies go home within two days,
18 not five days, so it just, I don't get it.

19 CO-CHAIR GESTEN: Thank you. New
20 comment?

21 MEMBER ADIRIM: No, I wanted to
22 support what you're saying and to reemphasize

1 that this is not a measure of the practitioner's
2 practice, it's the plan measure.

3 So how is, and again I feel like I'm
4 repeating what somebody already said, but it's
5 how the plan -- the state and their plans choose
6 to create quality improvement programs around
7 this measure.

8 So I think from a population
9 standpoint it's a very good measure and I think
10 it's really important that we do promote breast-
11 feeding and do what we can to support women who
12 want to and can breast-feed.

13 CO-CHAIR GESTEN: Okay. Bo, you're
14 done right, your card's up. So you guys didn't
15 like my proposal.

16 Would somebody want to make a voting
17 type proposal so that we can get to voting?

18 DR. ANTONELLI: I move we vote on the
19 measures.

20 CO-CHAIR GESTEN: Can you clarify
21 together?

22 DR. ANTONELLI: Together, I think

1 Shaonna who never lies said that we'd be voting
2 for the --

3 CO-CHAIR GESTEN: Rarely lies.

4 DR. ANTONELLI: -- with the condition
5 on it.

6 CO-CHAIR GESTEN: Is there a second?

7 MEMBER SAKALA: Second.

8 CO-CHAIR GESTEN: Okay. We're setting
9 up for vote. We are voting whether to include to
10 -- in the child core set, make a recommendation
11 whether to include 0480 and 2830 conditionally,
12 that condition being a NQF endorsement of 2830
13 regarding exclusive breast milk feeding.

14 A yes vote is a yes to include. A no
15 vote is to not include, recommend inclusion.

16 MS. OGUNGBEMI: Voting is open.

17 CO-CHAIR GESTEN: We have 11 votes.
18 Great, looks like this one will be recommended
19 for inclusion, conditionally recommended in the
20 child set. Susan?

21 MEMBER LACEY: So I just want to
22 clarify something that I thought I heard just

1 said just a few minutes ago about we don't need
2 to worry about things like exclusion criteria and
3 things like that, we just need to focus on the
4 measure.

5 And so how, you know, so if you look
6 at the way you have the measure, say on this
7 slide right here.

8 If we were given information to
9 review, to ponder before we came, and so when the
10 information changes, it would seem to me an
11 appropriate thing to do to challenge that we're
12 seeing different things, but now I'm kind of
13 hearing, and I've been here several years, that
14 we don't need to worry about that.

15 That we're just -- the intent of the
16 measure is what we're endorsing or pending
17 endorsement of NQF or however.

18 So I need some clarity around that
19 because that seems very different. It just seems
20 very different.

21 CO-CHAIR PINCUS: Just I think to
22 clarify, I think for this particular issue, are

1 you referring to the distinctions between the two
2 measures? Or any exclusions?

3 MEMBER LACEY: Well I think -- I'm so
4 sorry she's not here. So I think what was said,
5 Helen, is that we don't need to worry about, it's
6 not that important what the exclusion criteria
7 are.

8 That it's really just the description
9 and the operational definition that we should
10 really focus on and that's what we should either,
11 you know, vote on to recommend or not recommend.

12 So that seems very different from the
13 two previous times I've been here. I thought we
14 were supposed to look at the entire item that was
15 given to us.

16 And so when it's presented to us
17 differently, it would seem to me that that's in
18 stark contrast to what I thought we were tasked
19 to do.

20 CO-CHAIR PINCUS: My interpretation,
21 again Helen is not here, but my interpretation of
22 what Helen said, and Reva correct me if I'm wrong

1 if you're still on, was that with regard to these
2 two measures, that the differences between these
3 two measures with regard to exclusions are
4 basically at this point distinctions without a
5 difference.

6 That they're so completely aligned and
7 harmonized. There are some minor differences
8 that are relevant to the joint commission, but
9 that the ultimate sort of exclusions are not
10 important. So that was the point being made.

11 CO-CHAIR GESTEN: The other thing I
12 would say, Susan, is that I heard you, maybe I
13 misheard, I heard you raise questions about
14 exclusions that aren't on either of these.

15 So it's not as if hidden in the
16 exclusions is the one that you might care about
17 which is patient choice.

18 They're in neither of them. So when
19 you voted, however you voted for these, it's not
20 as if somehow it was uncertain whether that
21 exclusion was in there. It's not in there.

22 So I hear you saying something that I

1 think staff and we strive for which is the
2 information that you have prior to the meeting is
3 accurate, complete, up-to-date, not going to
4 change minute by minute, and so on, and that
5 everyone will have read it and understood it.

6 And so when making votes, I wouldn't
7 say that, I wouldn't interpret Helen's comment to
8 be exclusions don't matter. I think sometimes
9 they matter a lot. All the details of the
10 measure.

11 So I think the question is do the
12 details, are there hidden details around the
13 exclusions that make you unable to make an
14 intelligent vote and/or are there differences in
15 the exclusions of these two measures that are
16 germane and should be discussed that were not
17 discussed.

18 And my understanding of what Reva said
19 was exactly what Harold said which is that there
20 are no substantive differences between the
21 exclusions and that at least for the measure that
22 is yet to be endorsed they're still in a process

1 whereby some of the language of this may change.
2 May be modified. Is that right?

3 MEMBER LACEY: I guess I would say --
4 but we can't just say it's conditional because we
5 can't say the numerator might be conditional or
6 the denominator might.

7 So I just want to make sure that we'll
8 know in advance, or at the table, when the
9 exclusion criteria don't, you know, don't vastly
10 be -- they're not vastly different.

11 Because in measurement work that I've
12 been used to, what you see is what you deal with.
13 And that's why it made me uncomfortable to know
14 that things had changed, and then to hear but
15 you're just kind of voting on the, you know,
16 endorsing the intent.

17 And that seemed very different. So
18 I'm not trying to be a pain in the butt, but it
19 just felt different.

20 CO-CHAIR GESTEN: So just a process
21 point, is there an abstention option in voting?
22 There must be, right?

1 If somebody feels that they don't have
2 sufficient information to make a vote, I mean
3 again first of all you can ask for that
4 clarification.

5 Staff within the context of the
6 meeting we can try to provide it to you. But if
7 at the end of the day you feel you have
8 insufficient information, does Susan have a --
9 can Susan not vote?

10 Yes. Just, and again, I don't know if
11 that's where you're going, but just, okay.

12 So we have, the last measure that we
13 have here, I think Susan probably falls into your
14 category, at least it does for me, of like what
15 did Carol say about inversion.

16 So it seems to me that we have -- this
17 is the measure that we have in front of us to
18 vote on.

19 The information about a measure and
20 development that is an inversion of this I think
21 is of interest, but the business right now is to
22 decide on whether we want to include this

1 specific measure 0716, which is NQF endorsed, in
2 the, this would be in the healthy newborn so it
3 must be in the child? Yes, okay.

4 So we will entertain conversation and
5 comments or questions about this measure from
6 both child and adult, but recognize that we're
7 heading towards a vote with the child task force
8 only. So questions? Comments? Carol?

9 CO-CHAIR PINCUS: And Carol, could you
10 just really focus on the explicit thing about
11 what is it that is going through the NQF process.
12 Is it this measure or is it a totally revamped
13 measure?

14 MEMBER SAKALA: Great. So as with the
15 previous PC-05 breast-feeding measure, it was,
16 they were, they hit maintenance.

17 So they were endorsed. Now the
18 current versions need to go, continue to go
19 through and get re-endorsed, okay.

20 So the same thing here, but in this
21 particular case there is a different way of
22 understanding it.

1 And I think one of the main things is
2 there have been some refinements, but one of the
3 main things is the psychological effect of
4 hearing 97 percent of babies are doing fine,
5 versus three percent are struggling.

6 So that was I think a part of the
7 reason for making the change. And I just wanted
8 to share the developer considers this to be what
9 they call a balancing measure, and feel that it
10 goes with the cesarean measure because there's a
11 lot of feeling that we could get overly
12 aggressive with reducing cesarean rates and it
13 would be dangerous.

14 So this is considered to be a
15 balancing measure so that you are monitoring
16 trends for babies that you would expect to have
17 done well around the time of birth and in the
18 rest of the hospital stay, who in fact aren't.
19 So that's the thought behind this measure.

20 CO-CHAIR GESTEN: So this has the same
21 -- this is 0716. It has a different title, it's
22 not called healthy term newborn.

1 MEMBER SAKALA: It's been respecified,
2 but it's the same measure concept.

3 CO-CHAIR GESTEN: Okay, so let me just
4 pick up on Susan's comments because this is one
5 which triggers my like, huh?

6 So I get new title, it's been re-
7 specified in that it's now as you say an inverse.
8 Are there any other changes?

9 This is the full measure description
10 so this is what we should be looking at. I don't
11 know if this was in the -- was this in the packet
12 that people got?

13 Okay, so new information, new measure,
14 with the explanation, Carol, that you gave. Is
15 there anything in the inversion process other
16 than a re-naming and the fact that you're
17 flipping, you know, flipping the measure that
18 changed or that the Committee should be aware of?
19 I think your answer was no, but.

20 MEMBER SAKALA: So my answer is I
21 don't know for sure. I think there were tiny
22 refinements.

1 And this is, they tested with the --
2 both versions tested with a vast number of women
3 in California and elsewhere, and Elliot Main is
4 an amazing measure developer, so I think he's
5 strengthened it, but, and maybe others have a
6 better understanding of what the changes were.

7 But I think the main version, the main
8 change was the flipping, but some minor
9 refinements is my understanding.

10 CO-CHAIR GESTEN: Okay.

11 MEMBER BEATTIE: A question, just, we
12 don't have any detail on this what I can look at.
13 So if there's no prenatal care, I don't see that
14 as being written as an exclusion.

15 Is it? So a mom shows up, delivers,
16 there's no history on her. But I --

17 CO-CHAIR GESTEN: Correct. Was it an
18 exclusion in the previous measure? I don't know
19 that it was. I don't have it in front of me.

20 MEMBER BEATTIE: Because you would
21 have no expectations if you'd had no previous
22 encounter with this person, but --

1 CO-CHAIR GESTEN: Okay.

2 MEMBER BEATTIE: So I just don't see
3 it as written as an exclusion. And so if we're
4 considering it the way it's written, then it's
5 not in there.

6 CO-CHAIR GESTEN: Okay. Rich?

7 MEMBER ANTONELLI: I was at the MAP
8 when we voted on the original California measure,
9 and I guess I just, Helen's voice keeps coming
10 back in my mind here, which is you've got to vote
11 on the measure.

12 This is not the same as the well
13 newborn measure. So I want to be respectful that
14 it's a pivot.

15 But it just seems like it feels a
16 little bit unusual for us to be looking at a
17 measure that hasn't been vetted somewhere else
18 first. Or did I miss that point?

19 PARTICIPANT: We're recommending to
20 continue.

21 MEMBER ANTONELLI: So for the
22 prenatal. But, so but how can you continue an

1 endorsement on a new measure if it, because it
2 sounds like this is pivoted from the normal.

3 This is the inverse or the adverse of
4 the normal measure. So can you vote for
5 continuing endorsement for a measure that's been
6 changed?

7 MS. WINKLER: Foster, this is Reva.
8 If you'd like I could try and answer that.

9 CO-CHAIR GESTEN: Please do.

10 MS. WINKLER: Okay. When measures
11 come back for re-review for continued
12 endorsement, we see all sorts of changes,
13 revisions, updates.

14 And so part of the process for this
15 measure is the fact that their revision is to
16 invert the measure.

17 And so we are looking at the new
18 version from that perspective in the current
19 perinatal process which is going through the
20 consensus process right now.

21 So this version of it won't be
22 endorsed until we finish this process.

1 CO-CHAIR GESTEN: Renee did you want
2 to make a comment?

3 DR. FOX: I just wanted to comment on
4 the fact that this isn't, you would normally
5 expect a woman who had no prenatal care to have a
6 normal baby with no complications.

7 Because most babies are born normal
8 regardless of any problem. So this doesn't mean
9 that, the fact that you did not have prenatal
10 care does not, you know, this is an unexpected
11 complication.

12 So the baby is born with meconium
13 aspiration. Baby is born with any number of
14 other things that can happen. GBS, that's an
15 unexpected complication.

16 And you are trying to prevent that.
17 It doesn't necessarily be an exclusion, a reason
18 to have an exclusion is no prenatal care.

19 CO-CHAIR GESTEN: Thank you, Renee.
20 Susan?

21 MEMBER LACEY: So I know we're going
22 to have to vote, but is there any way we can see

1 the difference?

2 Like Sean was showing me the
3 difference in what we came here prepared to talk
4 about and vote on and then what, how they flipped
5 it, or, I don't know, it just feels kind of
6 uncomfortable.

7 MS. GORHAM: Nadine is pulling it up.

8 CO-CHAIR GESTEN: So while she's
9 pulling it up, Cindy?

10 MEMBER PELLEGRINI: The Perinatal Task
11 Force was incredibly impressed with this measure
12 when it came through.

13 It came through with this incredibly
14 detailed voluminous information about its
15 development, about the changes, about testing
16 that had occurred in I want to say it was a
17 couple hundred hospitals, Carol, in California
18 with thousands and thousands and births to
19 validate it.

20 And part of what Elliot said when they
21 made the decision to invert this was that they
22 were having a hard time frankly motivating some

1 of their hospitals to improve their healthy term
2 newborn rate from like, you know, 94 percent to
3 97 percent.

4 But they were much more interested in
5 reducing their adverse outcomes from like five or
6 six percent to two or three percent.

7 So there was almost like an optics
8 issue there that they found that this could be
9 much more effective if they turned it upside
10 down.

11 CO-CHAIR GESTEN: Thank you. Kathryn?
12 Charles?

13 DR. GALLIA: So when this, like Rich,
14 when I saw this set previously I was really
15 enthusiastic and I thought great, we're going to
16 start thinking about healthy wellness instead of
17 these adverse events and chasing really small,
18 specific things and thinking more
19 comprehensively.

20 So the intent's still there and I
21 would just, and I understand the motivation that
22 that's, there's a problem that's specific.

1 My perspective is that again feeling
2 responsible for population health and that's
3 contributed to it in that framework.

4 And so I was supportive of the way
5 that it was structured previously.

6 CO-CHAIR GESTEN: Can I just ask a
7 clarifying question? Will this inversion replace
8 the other measure? They wouldn't be together.
9 Is it an either/or? Yes? It's a replacement.

10 So we could fall in love with the
11 measure but it might be, we don't know yet, be
12 replaced by yet a different one. Is that right?
13 Is that correctly stated?

14 MEMBER SAKALA: It's got the same, and
15 it's the new specifications.

16 MS. WINKLER: Foster? Yes, right.
17 Foster, I think you can't, the previous measure
18 is no longer being maintained by the developer.
19 This is the measure that they are continuing to
20 use and maintain.

21 CO-CHAIR GESTEN: Okay, so loving it
22 is nostalgia. Andrea?

1 MEMBER BENIN: I would just comment
2 that this is a great metric certainly for
3 epidemiological understanding of what's going on
4 and perhaps to some extent for understanding the
5 impact that we can make from the healthcare
6 system.

7 I'm not a hundred percent sure how
8 much, what percentage of this three to four or
9 five percent is preventable by things that we can
10 do in healthcare.

11 I can't tell that from this. It's a
12 mixed bag of diagnosis codes. And that has been
13 my hesitation from it.

14 You know, it talks about, some of
15 these categories make a lot of sense. Other
16 categories I'm less clear on and I don't know how
17 the coding really plays out in that scenario.

18 They list birth injuries, asphyxia,
19 shock, complications of shock, respiratory
20 complications, procedures, infections,
21 neurologic, you know, it's sort of this listing
22 of things.

1 But some of those may be preventable.
2 Some of those may or may not be preventable. And
3 I'm not sure if they were able to address that in
4 the discussion.

5 CO-CHAIR GESTEN: Fatema?

6 MEMBER SALAM: But that's sort of the
7 point. I think also as this measure was, the
8 whole point of this is focusing your quality
9 improvement and really nailing down to see what
10 is preventable, especially if we look at it at a
11 population approach.

12 And I think that's the whole point
13 also of maintenance of measure maintenance.
14 Things get tweaked all the time as they, as we
15 mine the data, as we look at the measure, as we
16 change things, and sort of that's the whole
17 purpose of it.

18 And the Committee reviewed it, you
19 know, bought into the concept that this was the
20 same measurement principle.

21 I just want to say that. I used to
22 work at NQF so this is like killing me inside a

1 little bit.

2 CO-CHAIR GESTEN: So I think the fair
3 point is again sometimes details matter,
4 sometimes they don't matter. Trying to
5 distinguish between, you know, when they do.

6 And for folks who are looking at the
7 measures beforehand and have to try to do an
8 evaluation, they're using the data that we have
9 about the measure as it is and trying to decide,
10 you know, whether it's a substantive issue or
11 not.

12 So I mean I think that, you know, the
13 challenge that we all have is that things are
14 moving fast and some things are in process.

15 And trying to distinguish between when
16 a difference really matters and when it doesn't
17 is part of what we're challenged by right now.

18 So Susan, we're going to, I don't know
19 where they are in getting the side by side so
20 that we can take a look at that, but Cindy did
21 you have a comment?

22 Okay. While they're doing that -- do

1 you have it right now? If not I'll go to public
2 comment.

3 MEMBER PELLEGRINI: I shared it.

4 CO-CHAIR GESTEN: You shared it with
5 Susan? Yes the old version.

6 MEMBER PELLEGRINI: The old version
7 was obsolete.

8 PARTICIPANT: This is the old version?
9 (Simultaneous speaking.)

10 CO-CHAIR GESTEN: But Susan your
11 question was trying to see the two of them
12 together, correct?

13 MEMBER LACEY: And just, I just want
14 to make a very clear point. I'm not being a
15 contrarian about trying to put a roadblock in the
16 way of measures, in voting for measures.

17 My issues are not with the context.
18 It's the process and the expectations of the task
19 force and procedural issues. Not the measures
20 themselves.

21 CO-CHAIR GESTEN: Okay, fair. As we
22 did before, is there any public comment on the

1 measure that we're going to be voting on which is
2 not healthy term newborn but it's, can you put it
3 up there?

4 Unexpected complication in term
5 newborns. It's 0716. Just again help me with
6 the language here.

7 This is viewed as being endorsed even
8 though it's, there's been, or not? Okay so it
9 says NQF endorsed on there.

10 That's not technically correct, right?
11 So this would be a conditional? Okay. Sean?

12 MR. CURRIGAN: I just, I provided to
13 John and Nadine the -- in Dr. Main's new
14 submission for unexpected complications in
15 newborns, on page 7 it specifically states what
16 the changes are.

17 Which include change in the name and
18 adding two submeasures of severe and moderate
19 within the measure. But the rest of it hasn't
20 really changed.

21 CO-CHAIR GESTEN: Okay, thanks.
22 Operator, any public -- I'm sorry, any other

1 public comments in the room?

2 OPERATOR: To make a comment, please
3 press star-one. And we have no comments at this
4 time.

5 CO-CHAIR GESTEN: Okay. So this is
6 the child task force voting on, let's see, did we
7 have a proposal yet?

8 I guess do we have a motion and a
9 second? I'm blocking. No. Okay, looking for a
10 motion to vote on the addition in the child core
11 set measures 0716.

12 This would be unexpected complications
13 in term newborns. The vote would be a
14 conditional support, thank you.

15 Do I have a motion? Do I have a
16 second? Second, okay. It is voting time. A yes
17 vote for this would be a recommendation to
18 include conditionally based on endorsement.

19 MS. GORHAM: We are now voting on
20 measure 0716. The voting is open.

21 CO-CHAIR GESTEN: Eleven votes?

22 MS. GORHAM: Yes.

1 CO-CHAIR GESTEN: Okay, so this did
2 not pass. Fifty-five percent yes, needed over 60
3 percent to be recommended.

4 So we are going to take a five minute
5 break and then we're going to come back and we
6 have some asthma measures in front of us. Not as
7 many as this, right, two?

8 MS. GORHAM: First we have to do the
9 adult, we have a couple of more measures on
10 adult.

11 CO-CHAIR GESTEN: Okay. I'm sorry,
12 what's the question? Harold?

13 CO-CHAIR PINCUS: I thought we were
14 told to --

15 CO-CHAIR GESTEN: Five minute break.

16 (Whereupon, the foregoing matter went
17 off the record at 2:26 p.m. and went back on the
18 record at 2:44 p.m.)

19 CO-CHAIR GESTEN: So, we have a
20 challenge, collectively, which is we have a
21 number of different -- several more votes we need
22 to get through. We have a couple of more

1 prenatal measures that were recommended. And
2 I'll turn things over to Kim in a second, who
3 recommended them to us, to explain those.

4 The recommendation is from an Adult
5 Task Force member, so they would be voted on the
6 by adult task force. And then we have, I
7 believe, two asthma measures to get to.

8 And then the Adult Task Force members,
9 who have planes, trains, and automobiles to catch
10 probably starting 3:30-4:00, need to, hopefully,
11 before they leave the room prioritize the votes
12 that have been made. Rank order towards the
13 recommendations to CMS. So we have a number of
14 things to go through.

15 We're going to try to encourage folks
16 to keep their comments as succinct as possible,
17 not repeat things if they can avoid that. And
18 we'll try to go swiftly through. So, do you want
19 to -- what's that?

20 MS. GORHAM: So, I just want to make a
21 comment acknowledging some of the feedback. So,
22 as staff we apologize. You know that we have

1 tried a new process this time, whereby we had
2 Task Force members recommend measures for
3 possible discussion and inclusion into the core
4 set. So, we received some of those measures as
5 late as last night. So we understand your
6 uneasiness, as we tried to pull the information
7 together last night. That's why you did not have
8 it in advance.

9 So, as we move forward, what we will
10 try to do is definitely have a cut-off date. So,
11 we initially started with the cut-off date of
12 April 22nd, but of course we had more Task Force
13 members recommend. And we tried to accommodate
14 all those recommendations, but moving forward we
15 will have a cut-off date. So that we will make
16 sure that you have the information in a timely
17 manner.

18 Okay. But as Foster said, we do have
19 a bit of a time crunch. So, we're going to do
20 discussions for the Adult Task Force, for the
21 maternal and perinatal measures. Then the asthma
22 and then we'll rank, so that we can be respectful

1 of your time.

2 CO-CHAIR GESTEN: So, Kim. These two
3 measures, that I understand were measures that
4 you recommended. Can you just -- do you want to
5 briefly just give a little background about the
6 measure? And why you're recommending them to the
7 staff?

8 DR. ELLIOT: Yes. I think the
9 elective delivery measure is really an important
10 one. It's a lot of focus from many different
11 organizations and different government programs.
12 And from a Medicaid perspective, I just think
13 it's really a critical measure on the adult side
14 to consider.

15 The adverse outcomes to the infant, of
16 course, are well-known. There are potentials for
17 developmental delays, et cetera, and it's often
18 very prevented -- preventable. So, even with
19 heart stops and hospitals and things like that,
20 for the elected deliveries before 37 weeks
21 gestation or 39 weeks gestation. It -- I just
22 thought it was a really important one for us to

1 consider.

2 CO-CHAIR PINUCS: Isn't this in process
3 in some way in NQF? For endorsement?

4 DR. ELLIOT: I don't know the answer
5 to that.

6 MS. GORHAM: Oops, sorry. This measure
7 was reviewed by the perinatal and was recommended
8 for endorsement. It has not been ratified by the
9 Board. I know you'll notice that this is the e-
10 measure version. 20469PC01 elected delivery, that
11 is already in the core set.

12 So, we have the paper version of this
13 measure already in the adult core set and this is
14 the e-measure version. So, what you're voting on
15 -- what you will be voting on if there is a
16 motion is the e-measure version.

17 CO-CHAIR PINUCS: And Kim, can you
18 just clarify? So, if the non e-version is
19 currently in the set, your feeling about the
20 importance of having an e-version?

21 DR. ELLIOT: Not as important, other
22 than that I would really like to see us move in

1 the direction of more e-measures being part of
2 the core measure set. So that it's more feasible
3 across the board, for providers, for health
4 plans, and for states.

5 CO-CHAIR PINUCS: So, can I channel
6 Susan for a second and just ask is there any
7 substantive difference that the group should know
8 of between the e-measure and the non e-measure?

9 DR. ELLIOT: Not that I'm aware of,
10 no. I couldn't see any.

11 CO-CHAIR PINUCS: Carol?

12 DR. SAKALA: So, this is a little bit
13 of a broader comment about this measure. Because
14 I think if we have the one, we should have the
15 other if they're the same measure. And offer the
16 options, as Karen mentioned, for collection. I
17 did the calculation on opportunity for
18 improvement here, looking at the fact that the
19 denominator is weeks 37 and 38, and right now the
20 average rate is 3.3% in that population. And
21 it's never expected to go to 0%. That means that
22 less than 1 percent of all babies right now are

1 being electively delivered, according to these
2 terms.

3 And so, the opportunity for
4 improvement overall is limited. And if we wanted
5 to reduce burden, this might be a place where we
6 would look. So, it's a little different
7 perspective, but I did want to share that.

8 CO-CHAIR PINUCS: Diane?

9 MEMBER. CALMUS: Well, and following
10 on that comment, I know a number of these births
11 do occur in rural areas where there are reasons
12 that these early elective procedures are
13 selected. You know, if you have a woman that
14 lives three hours away from the hospital and
15 there's a snowstorm coming. It may be a prudent
16 choice to electively deliver them sooner, rather
17 than sending them home. So, I know that's an
18 issue that fills in what some of that 1 percent
19 is.

20 DR. LACEY: I can't see the other one,
21 the one that's not the e-measure. But --
22 exclusion criteria. Same, do they not matter,

1 what's the status on that?

2 DR. SAKALA: I didn't see any
3 differences in the exclusion criteria in those
4 two measures.

5 DR. LACEY: And they are important?

6 DR. SAKALA: Yes.

7 MEMBER KENDIG: I just have a question
8 to follow up on what Carol said. With, you know,
9 with that small window for improvement. I'm just
10 wondering, because of all of the work around
11 driving the early elective deliveries down. Did
12 you all have any discussion in the perinatal
13 committee about is this a reflection of all of
14 that work? And if that measure goes away, is
15 there any danger of back sliding?

16 DR. SAKALA: This measure was strongly
17 supported for continued endorsement. I think
18 that is one possibility. The other thing is that
19 the calculation that I gave you is based both on
20 how many babies are born in those two weeks. But
21 the 3.3 percent is coming from Joint Commission
22 data on hospitals with 1,100 or more births. And

1 so, it definitely, I think, would behoove us at
2 least to wait until we get to 300 or more births.
3 And see how things are playing out in smaller
4 hospitals.

5 CO-CHAIR PINUCS: Jeff and then Cindy.
6 And then we're going to ask for a motion.

7 MR. SCHIFF: The Medicaid Medical
8 Directors did this calculation not with this
9 measure, but using the Sappenfield methodology.
10 And we had about, well, it was just under 9
11 percent of births that were elective and in this
12 age range. So, I think that this 1,100 -- I
13 think the type of hospital may make a difference.

14 And that measure certainly has,
15 perhaps, some weaknesses compared to this
16 measure. Because of the data, the way it's
17 calculated. But I think the question for the
18 committee is really, are we at a point yet where
19 we -- where it would be safe to retire this? And
20 I would think that we may not be there yet.

21 MS. PELLEGRINI: We did talk about
22 retirement in the perinatal committee as well.

1 And there was a strong consensus that this is
2 brand-spanking new practice change. And that if
3 we take our eye off the ball with this measure
4 right now, things will immediately revert right
5 back to the way they were before.

6 CO-CHAIR PINUCS: So, is there a
7 motion to recommend this measure? Second? Okay,
8 so are we ready to vote?

9 FEMALE PARTICIPANT: Yes, we are ready
10 to vote.

11 Adult Task Force member are voting on 2829PC01,

12 elective delivery

13 MS. GORHAM: So, the Adult Task Force
14 member are voting on 2829PC01, elective delivery.
15 This is not an endorsed measure. So, you will be
16 voting to support conditionally for
17 recommendation for addition to the core set.
18 One, you are voting conditionally you support it.
19 Two, you do not.

20 OPERATOR: Voting is open.

21 CO-CHAIR PINUCS: And also there's
22 somebody on line now.

1 MS. DUNN: I submitted my vote, thank
2 you.

3 MS. GORHAM: I have it, thank you.
4 So, the adult core set has voted to conditionally
5 support 2929PC01, elective delivery.

6 CO-CHAIR PINUCS: Okay. So, Kim you
7 had a second recommendation.

8 DR. ELLIOT: Yes.

9 CO-CHAIR PINUCS: Can you speak in the
10 microphone?

11 DR. ELLIOT: From a Medicaid
12 perspective, this is a continued area of focus --

13 CO-CHAIR PINUCS: Get a little bit
14 closer to the mic?

15 DR. ELLIOT: From a Medicaid
16 perspective is also a very high focus area for
17 us. Increasing -- or reducing the C-section rate
18 in first time births, first time pregnancies of
19 women. So, this is something that's very easily
20 movable and I thought it would be a really good
21 one to add to the adult core measure set.

22 CO-CHAIR PINUCS: So, it's my

1 understanding this is already in the child
2 measure set? And is it the same measure that's
3 in the child measure set?

4 MS. GORHAM: No.

5 CO-CHAIR GESTEN: Of course not.

6 MS. GORHAM: This is a different
7 measure. This measure is a PQNP measure. It has
8 not been submitted to NQF. So, there has not
9 been a standing committee that has reviewed this
10 measure. The measure that is in the child core
11 set is a different measure, and that measure is
12 0471 Cesarean rate for nulliparous singleton
13 vertex. And that is a joint commission measure
14 that is in the child core set.

15 DR. ELLIOT: With that said, and our
16 desire to really only include NQF endorsed
17 measures, I would like to withdraw my
18 recommendation on this measure. Until a
19 committee has time to review it as potential NQF
20 endorsed measure.

21 CO-CHAIR PINUCS: Okay, so you're
22 withdrawing that? Okay, so why don't we move on

1 to the asthma measures.

2 MS. GORHAM: Okay, so for the second
3 time I won't go through this bullet by bullet.
4 But this is just some background about the
5 asthma. And I just want to state that measure
6 1799 was recommended for addition to the adult
7 core set in 2014 and 2015. It is currently a
8 measure in the child core set. Next slide.

9 So, on your spreadsheet, again, you
10 had a number of different measures for potential
11 addition. Some of them were recommended by the
12 task force members. And let's go into some of
13 those measures. Before we move on to the actual
14 recommendations for task force members, I would
15 like to bring to your attention the themes from
16 public comment on 1799.

17 Again, that measure was recommended by
18 the Adult Task Force members. We received public
19 comment on that measure. And as a result of that
20 the coordinating committee asked us to bring that
21 measure back. So that both the core sets would
22 have time to discuss the measure is in the child

1 core set. We received a comment that measure
2 1800, the asthma medication ratio, and then also
3 on measure 0548, the sub-optimal asthma control,
4 may be superior over the 1799.

5 So we wanted to bring that back to
6 your attention. On the next slide, we have the
7 description and enumerated specifications for
8 1799. And that measure was recently reviewed by
9 the Pulmonary Critical Care Standing Committee.
10 And overall, the Committee did not reach
11 consensus on this measure. On the overall
12 suitability of the measure. The Committee had
13 robust discussion. They had conversation about
14 the evidence of the measure and they could not
15 reach consensus on evidence.

16 The Committee felt the measure did
17 meet the performance guide, as well as
18 reliability, ability, and feasibility criteria.
19 But the Committee raised the concern about the
20 potential for unintended consequences of
21 increasing cost and medication use within
22 improving patient outcomes. So, the next slide

1 you will see just the reporting for 2014 on 1799.

2 Again, this measure is recorded in the
3 child core set and in 2014, 27 states reported on
4 this measure. And the most common reason was
5 data not available from not reporting.

6 CO-CHAIR PINUCS: To clarify, it's in
7 the child set, but not in the adult set?

8 MS. GORHAM: 1799 is currently in the
9 child core set, it was recommended for the adult
10 core set in 2014 as well as 2015.

11 CO-CHAIR GESTEN: CMS didn't include
12 it?

13 MS. GORHAM: CMS did not accept that
14 as a recommendation, yes.

15 CO-CHAIR GESTEN: Do we know if CMS
16 didn't include it because of issues and comments
17 related to 1800? Or is it just a black box?

18 MS. GORHAM: So, the Standing
19 Committee met after CMS decided their
20 recommendations. I'll let them speak on why they
21 didn't choose it. But I know that the Pulmonary
22 Committee just met in April.

1 DR. MATSUOKA: This predates me, so
2 I'm going to turn it over to Gigi.

3 MS. RANEY: From what I recall of our
4 discussions last year, there were a couple of
5 factors that went into our decision not to add
6 this to the adult core set measure. One of them
7 was that we were trying to be very parsimonious
8 in the measures that we added. And there were a
9 couple of other high priority topic areas that we
10 did want to address, such as the opioid addiction
11 epidemic.

12 So, we focused on that and the second
13 was we knew this was in the child set measure.
14 And the number of adults with asthma as compared
15 to these other priority areas was not as
16 significant. So, those were the two elements
17 that we did look at.

18 CO-CHAIR GESTEN: Yes, what -- I know
19 that the measure developer -- I think we may have
20 somebody on the phone. Right? Children's
21 hospitals? I thought these were both NQF
22 measures, I guess I'm confused. NCQA measures.

1 Ben, if you're on the phone, I don't
2 know if you need to be unmuted. Did you -- I
3 wonder if you want to just, if there's any light
4 to be shed about why these two measures? How the
5 folks have viewed these two measures that might
6 help us before we start deliberating?

7 MR. HAMLIN: Yes, sure. Hi, this is
8 Ben Hamlin from NCQA. You know, the two measures
9 were developed simultaneously. They address
10 slightly different aspects of asthma care. The
11 MAM in the 1799, the Medication Adherence
12 Measure. You know, just basically uses a simple
13 medication persistence of days covered to, sort
14 of, define, you know, adherence to the
15 medications.

16 The thought being that people who are
17 adherent, generally are going to, you know, have
18 lower overall cost. Due to, you know, fewer
19 exacerbations, and exacerbations of the condition
20 itself. The asthma medication ratio is a little
21 more sophisticated. A little more sensitive. It
22 uses medications as a proxy to help define asthma

1 control.

2 It's a really well-validated numbers
3 study that works. It can work at the provider
4 level and at the system level. It tends to be a
5 little complicated and a little obscure, so some
6 people have different opinions of it. But again,
7 they're both addressing two different issues.
8 There have been some questions about the
9 adherence measure, why there are multiple
10 thresholds.

11 And again, those were sort of
12 developed on a consensus-based process from our
13 Pulmonary Advisory Committee, that was, you know,
14 thinking about quality improvement opportunities.
15 And how you, sort of, define the population by,
16 you know, well-adherent and probably not needing
17 much attention to those who are not very
18 adherent. And perhaps, you know, probably do
19 require some additional focus with regard to
20 asthma care or asthma management.

21 CHAIR PINUCS: Thank you, Ben. So,
22 let me just -- the vote will be on for the adult

1 group, but joint discussion right now?

2 MS. GORHAM: Yes, we can have a joint
3 discussion right now. We'll say for measure 1800
4 that, again, the Pulmonary Committee reviewed
5 this measure, which is also a maintenance measure
6 for continued endorsement. And they recommended
7 continued endorsement without -- consensus was
8 reached on all of the criteria for 1800.

9 CO-CHAIR PINUCS: Let me just clarify.
10 I'm trying to understand. So, this was proposed,
11 Marissa, by you?

12 MEMBER SCHLAIFER: Well, yes.
13 Although, I may elaborate slightly on that.

14 CO-CHAIR PINUCS: Yes, so. But just
15 assisting with the process, so it's proposed by
16 somebody from the adult measure group, but it's -
17 - but a version of this is already in the child -
18 -

19 MEMBER SCHLAIFER: Right.

20 CO-CHAIR PINUCS: -- measure group,
21 so.

22 CO-CHAIR GESTEN: That'd be the 1800,

1 or 1799.

2 MS. GORHAM: So, Marissa recommended
3 -- if I may speak for you -- recommended 1799 for
4 addition for the adult core set. And that is the
5 measure that is in the child core set. 1800 is
6 nowhere on either core set --

7 CO-CHAIR PINUCS: Right. No, I
8 understand that.

9 MS. GORHAM: So, this -- so, you're
10 right. We're not staff, we are not recommending
11 any --

12 FEMALE PARTICIPANT: You sound like
13 you're giving a staff recommendation.

14 MS. GORHAM: So, that measure was
15 brought as comment from last year's
16 recommendation to 1799. A public comment was
17 received as a result of the recommendation for
18 1799. Once we put the report out for comment,
19 the public made a public comment. And the
20 coordinating committee asked staff to bring that
21 measure back. Both measures back, so that both
22 of the task forces can look at the measure. And

1 you all can think about the measure again.

2 CO-CHAIR PINUCS: So, let me clear.

3 So, I think, for the purpose this is not just

4 adult, it involves child as well. And so, I

5 think we should be thinking about this in terms

6 of a joint discussion now, you know, among the

7 two task forces. For determination of -- and

8 have votes from both task forces, discussion

9 simultaneously. And then sequential votes from

10 each of the task forces. Okay? So, Marissa do

11 you want to say some more? About your rationale?

12 MEMBER SCHLAIFER: Sorry?

13 CO-CHAIR PINUCS: And also whether

14 you're withdrawing the 1799 and proposing the

15 1800?

16 MEMBER SCHLAIFER: I am not. No, I'm

17 not withdrawing 1799 and recommending the 1800.

18 I think, number one, I think in the future it

19 might help us to know if it's a staff

20 recommendation or a staff recommending. Just

21 because it was in the comments. Just because

22 that would probably change what -- it changes

1 what I was thinking.

2 Because part of what I was going to
3 mention is that I somewhat disagreed with the
4 staff recommendation. Because if we are going to
5 add another asthma measure, it seems like the
6 child measure and the adult measure should be the
7 same, which would be 1799 rather than 1800. But
8 I was going to defer to staff, but if it's not
9 really staff I may not defer.

10 So, just to clarify the difference
11 between the two, which I think was just said on
12 the phone but just to make sure everyone
13 understands. 1799 looks at the percentage of --
14 once you are diagnosed with asthma through
15 various measures in the denominator, through
16 various conditions in the denominator. Then it's
17 just seeing are -- do you take your medication
18 for -- to prevent -- your asthma 50 percent of
19 the time or 75 percent of the time?

20 And I think the question, really the
21 only question, for this group is -- it's been
22 accepted as a -- it was recommended by this group

1 to CMS for both. Do we want it just as a child
2 measure, or should it be a child and an adult
3 measure? My assumption was that CMS had not
4 accepted it because they were trying to, you
5 know, just add a couple measures during the year.
6 And that this, as we were thinking about
7 additional measures for this year, it was worth
8 reconsidering it.

9 If it truly is and if we agree that,
10 you know, asthma isn't an issue in adult, which
11 I'm not sure that I do. But I'll leave that to
12 the group. Then that's a good reason not to add
13 it. But I think we just need to decide do we
14 want to worry about asthma in adults. And if so,
15 then I think rather than 1800, 1799 is the best
16 measure. Both because -- I think they're both
17 good measures -- but because I think we would
18 want to keep harmonization between -- it does not
19 make any sense to have one measure on the child
20 side and a different measure on the adult side.

21 So, if we add one I would definitely
22 advocate for 1799. I guess the question is just

1 do we add an asthma measure for adults.

2 CO-CHAIR PINUCS: Well, I guess for
3 the child side I guess there's also a question.
4 Do we change the asthma measure for the child
5 side or do we not?

6 MEMBER SCHLAIFER: So, to go back.
7 What the measure 1800 looks at, you know, the
8 ratio of if you're using asthma medications.
9 Both the controller medications and the rescue
10 medications, to make sure that the one that's
11 predominately used is the controller medication.
12 Now, what I didn't know. I didn't realize in
13 advance is that there is also measure 548, which
14 could also be thrown into the mix. But that
15 probably would just -- so, I have pulled it up
16 and I can answer any questions about it. But
17 that would probably confuse things more at this
18 point.

19 CO-CHAIR GESTEN: 1799 for the child
20 has an age range, as it's specified, that goes up
21 beyond children. Is that not, is it not being
22 reported as such?

1 HAMLIN: It's currently stratified for
2 both treatments. So, there's a 5 to 12
3 stratification and there's a 13-18
4 stratification, so they can be used for a child
5 core set. It's also stratified, you know, the
6 adult stratifications also exist too. So,
7 there's a wide age range but it is broken down
8 into different cohorts. And that holds true for
9 both measures, they both have the same age
10 strats.

11 MEMBER SCHLAIFER: What's listed here
12 is ages 5 to 64.

13 CO-CHAIR GESTEN: So, what we have is
14 1799 here is -- this is what was confusing me
15 before -- is it says it's the Children's
16 Hospital at Philadelphia measure. And not NCQA's
17 measure. And in the numerator I don't see where
18 it, I don't see those stratifications that Ben
19 just mentioned. So, are we looking at the wrong
20 measure, wrong name?

21 MEMBER SCHLAIFER: At least what's in
22 the spreadsheet is that there's no numerator -- I

1 mean, there's no stratification. The denominator
2 is all patients 5-64 years of age as of December
3 31st, and there's no ages in the numerator.

4 MR. HAMLIN: This measure should be
5 stratified. It may be done so to have the child
6 age range as one cohort, so it could it be used
7 in of the, you know, child core sets. So the
8 current strata are 5-11, 12-18, 19-50, 51-64 of
9 the total we're reporting.

10 MEMBER SCHLAIFER: I'm going back to
11 the NCQA measure specifications. I'm not sure.
12 That's probably right.

13 CO-CHAIR PINUCS: So, just, the vote
14 on the table would be whether to include 1799 in
15 the adult set. And then, also whether to include
16 1800 in the adult set. And you said you might
17 want to vote this, 1799's already in the child
18 set. So, I don't if you were proposing that we
19 vote, the child task force, vote on 1800. I
20 might suggest we could do that just in terms of
21 time. We might want to take advantage of the
22 adult members right now and do votes if that's

1 what we're going to do.

2 MEMBER SCHLAIFER: Yes, on the NCQA
3 specs, there's no age stratification.

4 DR. SULLIVAN: Can I just ask a
5 clarification? If it's already in the child set
6 going up to age 64, then what's the value of
7 putting it in the adult set? Why do we do that?
8 Are we gathering it across all the adults
9 already? Is it just a -- I mean, what's the
10 purpose of -- ?

11 MEMBER SCHLAIFER: That's my CMS
12 question.

13 DR. SULLIVAN: But you're already
14 reporting it in the child, so.

15 FEMALE PARTICIPANT: It's 520 in the
16 child core set.

17 DR. SULLIVAN: Okay, so we would be
18 voting just to cut -- I mean, it's not reported
19 as it is already?

20 CO-CHAIR GESTEN: It's reported up to
21 age 20 in the child.

22 DR. SULLIVAN: No, but the measure --

1 I'm sorry, I thought they were saying that it did
2 already go to 64? No. Then I'm
3 misunderstanding, I'm sorry.

4 MEMBER SCHLAIFER: What the NQF
5 measure does, whether it's used that way to see -
6 - NQF measure goes to 64.

7 DR. SULLIVAN: Okay, I've got you.

8 MEMBER SCHLAIFER: But whether or not
9 CMS is using that way is --

10 DR. SULLIVAN: So, is CMS just using
11 it for children then?

12 MEMBER SCHLAIFER: At times.

13 CO-CHAIR PINUCS: The measure has
14 stratifications, right Bob? And I don't know if
15 you or Ben want to clarify, but the measure
16 itself has eight stratifications. And so for
17 purposes of child core set measures, I believe
18 although I don't have the information, that we
19 for example in New York are reporting the eight
20 stratifications that go up to age 20. They do
21 not --

22 DR. SULLIVAN: They don't include

1 adults?

2 CO-CHAIR PINUCS: And not including
3 the adults.

4 DR. SULLIVAN: Okay, thank you.

5 MR. HAMLIN: Yes, the measure was
6 specifically -- there was a specific age strata
7 cut-off of 18 years. So that 5-11 is the first
8 strata, 12-18 was the second. So, that's 5-18
9 combination to be used for child reporting. And
10 that strata was added just for that reason.

11 The 5-11 versus the 12-18 are
12 different because of the different clinical
13 approaches to treating the patients of those
14 different ages. But we did add that cut-off so
15 that those two could be used consistently across
16 child core programs.

17 CO-CHAIR PINUCS: Well, so I think
18 what we're asking for is, is there a motion to
19 propose to add this to the adult measure set? So
20 that in a harmonized way, there would be an --
21 this measure, in a harmonized way would be
22 reported in both the adult and child set. And

1 allow the population to be extended to the full
2 range.

3 FEMALE PARTICIPANT: What he said.

4 MEMBER SCHLAIFER: That's the motion.
5 The motion would be to add it to the adult core
6 measure set, so that there's harmonization
7 between the adult and child.

8 CO-CHAIR PINUCS: So, is that a
9 motion?

10 MEMBER SCHLAIFER: Yes.

11 CO-CHAIR PINUCS: Is there a second?

12 MEMBER SHA: I'll second it but do we
13 want to hear --

14 MEMBER SCHLAIFER: Microphone.

15 MEMBER SHA: I second it. But do we
16 want to hear from the child task force side to
17 see if they want to change 1799? Add 1800?
18 Because I think, from the Adult Task Force side,
19 we're happy to align with the child set. But I'd
20 be interested to hear if the child set, Child's
21 Task Force, would want to make any changes first.

22 MR. GERSTEN: It's sort of like after

1 you get stoned, kind of thing?

2 MEMBER SHA: What?

3 CO-CHAIR GESTEN: So.

4 MALE PARTICIPANT: Chip and Dale, don't
5 you remember that?

6 MR. GERSTEN: Okay. So, speaking on
7 as a Chair. So, I would say that I don't have
8 enough information to know if 1800 is a better
9 measure than 1799. I think they're different.
10 And so, my lens is really around parsimony. So,
11 if there's going to be one asthma medication
12 measure, which is a value.

13 The same CMS talked about, wanting to
14 have other things. Which is the better measure?
15 I mean, it feels like it's an -- they're
16 different. I don't know which is better. I'm
17 compelled to some degree by persistent comments
18 from the Academy for Allergy, Asthma, and
19 Immunology that says pointedly 1800. You should
20 drop 1799, 1800's better.

21 They give a list of references and
22 reasons why. There's not a lot, I mean there's

1 maybe one other. I think there's a drug
2 manufacturer that also suggests that we do 1800.
3 There's not a critical mass, if you will, of
4 folks saying 1800 is much better than 1799. My
5 understanding is that they're really getting a
6 different concept, so it's kind of a challenge.

7 For me, there isn't anything that says
8 we've made a terrible mistake with 1799 we need
9 to go to 1800. But I would defer to other folks
10 on the task force to see if you have any insights
11 or feelings about one versus the other. And
12 again, it doesn't have to be one or the other.
13 You could certainly add both. But my value would
14 be to try to pick one.

15 CO-CHAIR PINUCS: Any thoughts from
16 the child task force?

17 MEMBER SHA: So, I think in the
18 absence of any sort of motions from the child
19 side, I think the adult side can proceed with the
20 motion.

21 CO-CHAIR PINUCS: Okay. So, can we
22 prepare a vote on 1799 for the adult set? So,

1 this would be to add 1799 to the adult set, which
2 would have states reporting on the full age range
3 on this measure. Okay? Are we ready to vote?

4 MS. OGUNGBEMI: Yes, voting is open.

5 MS. GORHAM: Katie, can you please
6 send your vote for 1799, medication management
7 for people with asthma? This is a vote to
8 support addition of this measure.

9 MS. DUNN: Yes, it will be right there
10 in just a moment.

11 CO-CHAIR GESTEN: What's the number
12 I'm looking for, nine?

13 CO-CHAIR PINUCS: It should be nine.

14 MS. OGUNGBEMI: We are at eight
15 because George Andrews has left us.

16 CO-CHAIR GESTEN: Eight, okay, just
17 like the Supreme Court.

18 CO-CHAIR PINUCS: One, two, three,
19 four, five, six, seven, eight. Shouldn't there
20 be nine? So, are there any other adult measures,
21 recommendations to be considered?

22 CO-CHAIR GESTEN: 1800, I think.

1 MR. GORHAM: Hold on for one minute.
2 There are nine Task Force members. There are
3 eight in the room and one on the phone, so we
4 should actually have nine votes. Even with the
5 absence of George. Jeff is a State Panelist.

6 WOMAN: There is nine.

7 CO-CHAIR PINUCS: Either way it would
8 pass, I think.

9 MS. GORHAM: We're going to re-vote
10 just so we can have an accurate count.

11 MS. OGUNGBEMI: Voting is open.

12 MS. GORHAM: Okay, so the Adult Task
13 Force has voted to recommend to CMS inclusion of
14 1799, medication management for people with
15 asthma, into the core set.

16 CO-CHAIR GESTEN: So, do we have to
17 vote on 1800 since it was recommended? If
18 there's a motion. And this would be for either,
19 or for anyone Kim? Or just adult, adult or
20 child? Anyone want to make a motion to include
21 1800 on, in the core set? Moving on.

22 MALE PARTICIPANT: What was the other

1 one?

2 MS. GORHAM: The other measure was
3 0725. But the Task Force member who recommended
4 that measure withdrew her recommendation. Okay,
5 so the fun part. The Adult Task Force members
6 need to prioritize the measures that they voted
7 on yesterday. The maternity neonatal and the
8 asthma measures. So, give us one minute so we
9 can put those measures on the voting slide so
10 that you all can prioritize.

11 CO-CHAIR PINUCS: So, can you explain
12 how we do the voting for prioritization?

13 MS. GORHAM: So, as we did last year
14 we wanted to rank the measures. So, the top five
15 measures would our recommendation to CMS. Last
16 year, we did maybe nine measures. We want to
17 kind of narrow that down because we know that CMS
18 will make incremental changes.

19 And so this year, we are going to take
20 the top five measures. So, we will put all of
21 the measures on the screen, the measures from
22 yesterday. And they'll show you those, refresh

1 your memory. And the measures that we voted for
2 today for inclusion on the core set. And we'll
3 take the top five. So, if you see on your screen
4 we have 2152, preventive care and screening,
5 unhealthy alcohol. We have the 0541
6 proportionate base covered, three rates by
7 therapeutic category.

8 We also have 2607, diabetes care for
9 people with serious mental illness, hemoglobin
10 A1C, poor control. We have 2605, follow up after
11 discharge from the Emergency Department for
12 mental health or alcohol or drug dependencies.

13 We voted today to include 2829 for
14 conditional support and we also voted 1799. So,
15 we will vote on those measures and we will rank.
16 And the top five measures will be included in the
17 report for recommendation.

18 MEMBER SCHLAIFER: Just repeat which
19 ones are conditional support?

20 MS. GORHAM: Yes.

21 MEMBER SCHLAIFER: Is it just the
22 elective delivery? Or is there more than one?

1 MS. GORHAM: Give me one minute to pull
2 it up. Okay, so the measures in bold on your
3 screen. The 2152, 0541, 2607, 2605 are all
4 measures with support. Because those measures
5 are NQF endorsed. Measure 1799 is also NQF
6 endorsed. The 2829 is not endorsed, so that is
7 conditional support.

8 MEMBER SCHLAIFER: And we're going to
9 rank five -- ?

10 CO-CHAIR GESTEN: Michael, do you have
11 a question? Harold, do you have a question?

12 MEMBER SHA: So, I guess, if we are
13 thinking about recommending five to move forward.
14 So, we're deciding which one to vote off the
15 island. 2829 seems to just be, I mean, from a
16 pharmacy side we call it a line extension. It's
17 just the electronic version of an approved
18 measure and a measure already in the adult core
19 set. It just seems to be a natural extension of
20 something that already exists.

21 MS. GORHAM: Let me confirm with CMS.

22 DR. SAKALA: So, that was my comment

1 as well, or question. That we were presented
2 with new e-measures, and told these are
3 identical, fully aligned with the existing
4 measures. And it's really another way of
5 collecting them, providing more flexibility. So,
6 my gut feeling is that they could just be, like,
7 slid in. Rather than considered to be a whole
8 separate measure. Because you wouldn't collect,
9 you would never collect both of them.

10 CO-CHAIR PINUCS: So, just from my
11 prerogative. It seems that to make things
12 simpler, since five is arbitrary anyway, that we
13 could simply endorse the five. And say that we
14 also recommend adding this one without, you know,
15 further adieu.

16 MS. GORHAM: So, I just spoke with
17 Karen and she also agreed that they would -- CMS
18 would give the states the option. So that would
19 give them flexibility on reporting which measure
20 depending on their source. The data source that
21 they choose. So we can actually just, like you
22 said Michael, keep the measures.

1 CO-CHAIR PINUCS: Terrific. So,
2 what's next?

3 MS. GORHAM: So, just -- it's a matter
4 of process. So these measures would be the
5 measures that the Adult Task Force members would
6 recommend to CMS. We would include these
7 measures in the report as such. The report will
8 go out for public comment and then CMS will have
9 the report.

10 August 31 is when we send the
11 deliverable to CMS. And then they have will have
12 the option -- they will deliberate -- have the
13 option to choose whichever measure. If so, if
14 they decide to choose one of the measures or
15 however many. And they will put a report out,
16 usually in November or December. And we will
17 know what recommendations they decided to accept.

18 CO-CHAIR PINUCS: Why don't we go to
19 public comment? First on the phone?

20 Public Comment

21 OPERATOR: If you'd like to make a
22 public comment, please press Star and then the

1 Number One. There are no public comments at this
2 time.

3 CO-CHAIR PINUCS: Public comment in
4 the room?

5 CO-CHAIR GESTEN: Okay. So, I think
6 we're done.

7 CO-CHAIR PINUCS: Could I just take a
8 -- sorry, I spaced out a little bit. There was a
9 list of measures for adults that included the
10 bold ones and then the non-bold ones? They
11 didn't get 60%?

12 CO-CHAIR GESTEN: Yes. They didn't get
13 --

14 CO-CHAIR PINUCS: But those are the
15 measures that you considered, is that what this
16 was? Got it, sorry. So, I know we had a slew of
17 other things that we were trying to get to. Do
18 you want to prioritize which slides you want to
19 through? Which is particularly important to have
20 as a together?

21 MAN: So, we're at lunch.

22 MS. MUKHERJEE: So, what I can do is

1 just, like, quickly flip through the slides like
2 this one. The IOM Vital Signs, we have talked
3 about it before. And this was where, this was
4 the genesis of our policy discussion. So, what
5 I'll do is just flip through slides that have
6 either been presented before or just cover one
7 point. And then go to the slides that have more
8 of the discussion points.

9 So, we have looked at the IOM Vital
10 Signs and done a cross walk with our core sets.
11 Just looking at domains, and key elements, and
12 where our core sets match up with IOM. And as
13 Marsha had mentioned earlier today, our measures
14 fall into many different buckets. And are not
15 exclusive to a few domains or key elements. And
16 just a quick, swat analysis, some of the things,
17 the strengths were the type of measures we had.
18 Looking at immunization, perinatal care, asthma,
19 and behavioral health.

20 Some of the weaknesses were a lack of
21 outcome measures threats, burden, resource
22 issues. And opportunities were a meeting such as

1 this to revisit the gaps. So, some of the
2 resident themes that were in the IOM key elements
3 and domain, as well as the core sets. Were
4 healthy people and engaged people, so the
5 beneficiary, patient-centeredness.

6 Care coordination and access to care,
7 two things we have talked about these past couple
8 days. Resource, data collection and recording,
9 as well as measurement alignment and data burden
10 that comes from misalignment. So, when it came
11 to alignment, the homework talked about alignment
12 in different perspectives. Alignment of
13 concepts, alignment of measurements, how you're
14 measuring exactly. Alignment across multiple
15 programs, and alignment through standardization
16 of definitions. And then across pairs.

17 So, these were the two definitions of
18 alignment that were provided before. And the
19 important, just to note, is they talk about same
20 or related measures. And the goal is to reduce
21 duplicate of data collection, and enhance
22 comparability and transparency. And this is

1 taken from the Map Coordinating Committee report.

2 And they do say that in some cases there will be
3 a need and compelling reason for multiple,
4 similar and/or narrowly focused measures. And
5 they realize that.

6 So, the homework was what do we mean
7 by alignment and how do we operationalize the
8 concept? Is it, you know, same concept being
9 measured the same way? Same concept being
10 measured across different programs? And this is
11 a collation and summation of all the response
12 that we had gotten to the homework. So,
13 alignment was defined by looking at some of the
14 benefits of alignment, as well as some of the
15 challenges.

16 And the benefits were comparability
17 and being able to look across states. And
18 reducing burden, and simplifying and improving
19 reporting. And another one was alignment across
20 measure, measure programs, and payment models.
21 Some of the challenges were the voluntary nature
22 of Medicaid reporting, aligning with commercial

1 and private pairs, and innovation and variation
2 in the field. Some of the considerations on the
3 operational side were mandates. You know, would
4 it be worthwhile thinking about a measure
5 mandate? Maybe a methodology mandate of how
6 you're implementing the measure. But also
7 balancing the goal of measurement with
8 implementation flexibility.

9 Some temporal considerations come up,
10 as far as data -- longitudinal data. How long
11 it's been followed -- infancy, childhood,
12 adulthood. Completeness of data, and the other
13 thing mentioned was also the appearance of
14 comparability versus actual comparability. So,
15 saying HVA1C was measured, yes/no. Versus the
16 levels of measurement and the ranges captured.

17 And that was provided more as a
18 caution when you're operationalizing a measure.
19 And this is a quote that was provided which was,
20 "measures are only as good as their design".
21 And some of the discussion yesterday was around
22 the difficulty in understanding measures. And

1 especially in an environment where measures are
2 getting more complex and composite. And some of
3 the elements that were mentioned for discussion
4 for exclusions. Risk adjustment, the nature of
5 the population, the transient nature. Resources,
6 as well as data.

7 And then the next set of questions was
8 claims data. How can we move beyond what is
9 feasible beyond claims data. And when looking at
10 data collection, also looking at appropriateness
11 of data stratification. So, some of the things
12 that were discussed was claims data as being the
13 limit of feasibility. It's basic, but it's easy
14 to capture and however, it doesn't provide a lot
15 of granularity. There are resource limitations
16 in broadening it to other types of data. Also,
17 alignment versus other values such as purpose of
18 measurement, comprehensiveness. There was some
19 discussion about annotating the amount of
20 alignment.

21 So fully-aligned, partially-aligned.
22 And, sort of, annotating the variation in a way.

1 Also, stream lining data acquisition and
2 collection. And identifying and developing
3 outcome measures and patient reported outcome
4 measures. Identifying measures that would make
5 data collection more feasible and easier. So,
6 some of the other considerations were ability to
7 track system and population level health
8 improvements. And that's something that came up
9 in the discussion yesterday. Being able to look
10 at the individual person's data, but then
11 aggregate it up to look at population level data.

12 Interoperability, as far as data
13 capabilities goes, and collecting data in a data
14 warehouse. Measure design and exclusions,
15 simplifying measures. Being able to make the
16 measure something that a policy maker can
17 understand, and they can understand the impact of
18 the measure. And also, survey data came up, and
19 it was something also discussed today when
20 talking about care coordination and experience.
21 Provider reporting systems, and using them as
22 much as possible.

1 Too, data mine came up, as well as
2 following the NQF SDF project to track data
3 stratification. And, sort of, the pros and cons.
4 And some of the factors influencing state
5 participation were clarity of measure
6 specifications, the feasibility of data
7 collection, infrastructure, budgetary
8 environment, perceived importance, political
9 will. And this is where we paused to have a
10 discussion among the Committee, the Task Force
11 members. And we can do that, or we can sort of
12 go through the stratification issues and then
13 pause for discussion.

14 CO-CHAIR GESTEN: Well, does anyone
15 have a comment or question? Or clarifying
16 question? I mean, maybe we can go on just in the
17 interest of time. What time do we have until?
18 When are we supposed to end, 4:00? 3:45, okay.
19 So, we have a grand total of ten minutes. So,
20 why don't you keep going with it, Jani?

21 MS. MUKHERJEE: Okay, so some of the
22 data stratification issues were to assess

1 disparities, and care in looking at data. And
2 that was mentioned in even our state presentation
3 yesterday to show how data can be parted and
4 stratified to look at disparities. There was a
5 caution not to penalize safety net providers when
6 stratifying and having small N's. Various
7 parameters were thrown out there for stratifying.
8 And then, again, tracking the NQF stratification
9 SDF project. And then care coordination was the
10 other policy issue that was in the homework.

11 And one of the things mentioned was
12 that Medicaid regulations do not define care
13 coordination. And however, some of the
14 components that are important for care
15 coordination are comprehensive assessment and
16 periodic assessment of needs. Development and
17 periodic reassessment of care plan, based on
18 changes in needs, referrals, regular monitoring
19 and follow up. Just another way of defining care
20 coordination. And then the other thing to
21 consider is for Medicaid adults care coordination
22 might mean chronic health condition management.

1 Versus for Medicaid children, care coordination
2 services might be markedly different. Especially
3 for kids with disabilities, especially physical,
4 developmental, and mental. IOM also noted a
5 connection to community and integration with
6 community. So, that was the other part.
7 Community linkage, linking clinical providers
8 with community services, social workers.
9 Clinical -- other support services in the
10 community, and referral and referral follow up.

11 Also addressing availability,
12 affordability, and accessibility of these
13 resources in the community. And not burdening
14 the grassroots organizations. I provided a
15 couple of diagrams that showed community
16 integration from the literature. And it's
17 basically going from the individual in the
18 clinical setting to their native community
19 setting. Bringing the two together and then
20 moving it up to population health. So, then
21 there are some questions. But we can just sort
22 of move on to shared importance, and sort of lump

1 everything together. So, for shared importance
2 data collection challenges. Sort of, issues with
3 data availability and infrastructure, along with
4 workforce issues.

5 How do we move beyond that balancing
6 process? Versus outcome measurement. Also,
7 quality improvement action, motivating factors.
8 Some of the tipping points that move states to
9 embrace quality improvements. Some of the
10 regulatory actions. And then manage care versus
11 fee for service, and other related data
12 implications with alternate payment models. And
13 then, we have some questions for discussion.

14 CO-CHAIR GESTEN: Thanks. So, you
15 recognize we just threw the kitchen sink at you
16 all at the end of a really long day. Sliding the
17 jungle, or the weeds, or whatever. The swamp,
18 the nitty gritty of measures. And by the way,
19 thank everybody for going through that. So, it's
20 an opportunity, I know time is short and folks
21 are tired, but it's an opportunity to make some -
22 - get out of the weeds. You know, go up 10,000

1 feet and make some comments, observations, or
2 suggestions. In terms of, along these lines.
3 What we see in terms of the opportunities,
4 comments that folks might want to make about
5 alignment.

6 And how we can -- what recommendations
7 we can make to try to deal with some of these
8 issues. And facilitate alignment and so on and
9 so. There are a lot of different issues thrown
10 out there, but if anyone has comments they want
11 to make along the lines of any these topics. Now
12 is the time, and we're happy to start discussion.
13 Sue, looks like you're equivocating. Go ahead,
14 go for it.

15 DR. SULLIVAN: Okay, well I don't want
16 to keep everybody. But maybe this will be a
17 close to ending comment. Opportunities for
18 change, and how can CMS and HHS facilitate
19 alignment at the state level? Many of the things
20 that we just went through in the past ten minutes
21 that should have been a day long discussion.
22 Really center on engaging patients and engaging

1 our communities.

2 And I would argue that if we want to
3 move quality metrics and improve patient
4 outcomes, those two are exceptionally important.
5 As we look at alternate payment mechanisms and
6 clinical integration models, we're still stuck in
7 a medical hospital centric model. We cannot move
8 these metrics and population health metrics,
9 unless we are engaging our community resources.
10 Our community resources are most of the time on
11 soft money.

12 So, I would challenge us to really
13 look at, if we are truly trying to innovate how
14 can we set up these models? That truly leverage
15 the community resources that will help patients
16 access what they need. And importantly, put that
17 into action where they live and work. So, I
18 think would be my challenge. I always wrestle
19 with that when we have these discussions.
20 Because the words are there, the challenge is how
21 do we implement it? And how do we move those
22 resources, that we know will help to support

1 moving the needle, into a sustainable framework
2 as part of our care system?

3 CO-CHAIR GESTEN: Good question. I
4 mean, I think that there's probably a lot of
5 support for the things you just said. I'm
6 wondering whether you're also saying that you
7 think the ability of states to do that is a
8 measurement area? Again, we're measure people
9 here. We're measurement. Yes, improvement and
10 system change. But I just want to -- I don't
11 want to jump. But as we're talking about that I
12 was wondering whether part of what you were
13 saying, in addition to making those investments.
14 Is this something you think is a measurement
15 area? Not putting words in your mouth, but just
16 asking you a question.

17 DR. SULLIVAN: I think we have to
18 maybe think about how we can measure that. But I
19 also think it is important as we are looking at
20 improving the metrics. How we can leverage those
21 opportunities. So, I think it's two prongs of
22 getting to the measurement issue.

1 MR. GESTEN: Thanks. Rich?

2 DR. ANTONELLI: I'm going to be very
3 timely, although I could take six months to flesh
4 this out. I actually want to tip my hat to the
5 opportunities presented by chapter 2703 of the so
6 called Health Home. It's going to force
7 entities, however you want to define an entity.
8 A hospital, an ACO, an accountable community.
9 It'll force them to think integratively. And I
10 think there are opportunities to measure that.
11 So, it's something that I would like to politely
12 push back on.

13 If you think about -- in fact, I love
14 the NQF definition of care coordination. Gerri
15 Lamb, who co-chairs a Standing Committee
16 coordination once said that she counted 68
17 definitions of care coordination. I think we
18 need to get beyond the definition, and I think we
19 need to look at frameworks, which do exist by the
20 way. And we need to start doing some
21 implementation testing. So, this is really more
22 of an observation. But it's an incredibly, an

1 exciting time. I think your dental example,
2 Karen, was exciting.

3 But it was really, if you will, a baby
4 step. I think we start pushing together
5 behavioral, health, and medical, there's an awful
6 lot of span in that space. A lot of wasted span,
7 and if we could move things forward. So, I'd
8 like to politely say that care coordination is
9 agnostic of age, and it's agnostic to a body
10 organ system. You can have care coordination
11 activities that get a family housing. You can
12 get care coordination activities that makes them
13 food secure. They work for NICU graduates, they
14 work for elderly.

15 So, we need to start operationalizing
16 the activities of care coordination and measuring
17 them. But sticking with outcomes. I'm all about
18 outcomes, but I think, Foster, my point is I
19 would love to partner with CMS in that
20 health/home space. That's the only way we're
21 going to win the game, right there.

22 CO-CHAIR GESTEN: Ann?

1 DR. SULLIVAN: I agree with everything
2 that's been said. But just to add something, I
3 think, on the issue of measuring for disparities.
4 You know, one of the things that we talked about
5 a lot yesterday was, kind of like, pulling out
6 certain data for those who have schizophrenia and
7 bipolar. And looking at all the disparities,
8 perhaps, in care for them. But disparity is much
9 bigger, it involves all the race, ethnicity,
10 cultural issues. And I think if we're going to
11 be moving, in terms of measuring, some day to the
12 managed care quality spectrum.

13 That was talked about by, the manage
14 care rule by CMS. That we begin now about how to
15 talk to states about how to gather some of that
16 data better. I think part of the problem with
17 doing the real disparities in communities is
18 often that what appears in the administrative
19 databases is very thin on these areas. And also
20 in medical records. So, to think about that and
21 having a push that the gathering of that data is
22 better. So that we can really shine the light on

1 disparities.

2 Because there are groups, especially
3 smaller ethnic and racial, in communities that
4 can get lost in big numbers. You'll think you're
5 doing well with 60 percent or 70 percent, but you
6 could have maybe only 20 percent of that group.
7 Getting the kind of service you need. So, to
8 kind of really get try to see to get ready to do
9 that better. I know that right now we're not at
10 a point where you can do a lot of it very well,
11 but I think it might be something to talk about.
12 In terms of the databases that we're gathering.

13 MR GESTEN: Good point, so I would
14 point out I don't think that any instructions for
15 states to do these measures -- that there's any
16 instructions relative to doing any kind of
17 stratifications currently. Although, I do think
18 there's conversation about the value of doing
19 that. I could be wrong, I don't think that I am.
20 Karen, am I wrong?

21 MS. MATSUOKA: We do encourage
22 stratification, it's not quite --

1 CO-CHAIR GESTEN: Do you define it in
2 terms, in particular categories?

3 MS. MATSUOKA: I want to say race and
4 ethnicity for sure.

5 CO-CHAIR GESTEN: I stand corrected.
6 And Karen, do you have a sense of how many states
7 are reporting the data by stratified fashion?

8 MS. MATSUOKA: Megan, do you know
9 numbers? Use your microphone.

10 MEMBER MURRAY: I know that as part of
11 the adult quality grant it was a requirement as
12 part of reporting. States had to stratify I
13 think at least three of four site measures by any
14 one of those demographic categories. And lots of
15 states have continued doing that after that time.
16 After the grant ended. But I don't have specific
17 numbers right now.

18 CO-CHAIR GESTEN: I'm just picking up
19 on your comment I think it would be an
20 interesting thing for us to have some data.

21 DR. SAKALA: You could see it. I
22 think that would be helpful to see and that could

1 be shared in some way.

2 CO-CHAIR GESTEN: Yes, it's a great
3 idea.

4 DR. SAKALA: I think that would be
5 great.

6 CO-CHAIR GESTEN: Sue, you put your
7 card down. Rich, are you? No? Katherine.

8 MS. PELLEGRINI: I just have a
9 question. Is there any --

10 CO-CHAIR GESTEN: Have we voted? I'm
11 just kidding.

12 MS. PELLEGRINI: Any existing time
13 line to requiring reporting? Any existing time
14 line to requiring reporting?

15 DR. MATSUOKA: You mean making it
16 mandatory that states do these measures?

17 MS. PELLEGRINI: That's another word
18 for it.

19 MS. MATSUOKA: Okay, I think that
20 would require a legislative fix. So, that's not
21 something that CMS would be able to decide. That
22 would be something that Congress would have

1 authorize.

2 DR. ANTONELLI: But the conversation
3 this morning was around within the manage care
4 role. That there's a, that it moved to a
5 requirement of -- either of framework or set of
6 measures. You know, stay tuned news at 11. Not
7 sure now detailed that's going to be, but they're
8 on a separate train. I think your question was
9 about this enterprise core measures. But there's
10 this -- right? I heard Marsha correctly? That
11 relative to managed care rules, there was coming
12 a set of requirements?

13 CO-CHAIR GESTEN: Requirements?

14 MS. MATSUOKA: That's managed care,
15 and that would be at the plan level. And that's
16 separate from this core measure set. But we
17 would want to ensure alignment, yes. Getting
18 back to Debjani's, like what is alignment? But
19 that is the goal.

20 CO-CHAIR GESTEN: Meg?

21 MEMBER MURRAY: There is a bill though
22 in Congress, just FYI, Senator Sherry Brown

1 introduced it, which would make the core measures
2 mandatory.

3 MS. MUKHERJEE: Based on the expansion
4 right now that's gone on, like, how relevant is
5 this discussion based on sort of that lens of
6 view? Of the population growing, and the needs
7 growing, and some of them coming in not having
8 had much care before?

9 CO-CHAIR PINUCS: So, Sue -- Katherine
10 you're -- So, why don't we before we do the
11 thank yous and benediction and all that, and
12 summary. Can we pull up the time line slide? So
13 folks know kind of where we are and what happens
14 next? In case you didn't know, the Child Task
15 Force you're not done yet. Tomorrow's the main
16 event. This was fun, but it was basically an
17 appetizer.

18 Tomorrow's the main meal. So, I'll
19 come back to that. So, tomorrow is the
20 discussion of the child core set. Similar
21 conversation to what we had today, and what the
22 Adult Task Force talked about yesterday. Looking

1 at potential removal or addition, and some over-
2 arching questions. At the end of this, between
3 July 6 and August 5, there's public comment on a
4 draft report that NQF develops on the
5 recommendations.

6 There's a review of both the comments
7 and recommendations from the two task force that
8 the Map Coordinating Committee does. That
9 happens via a web meeting, and some time in
10 August they get to be sent. And then we have our
11 deadline of August 31, by which the final report
12 is due to CMS and made available to the public.
13 And then, I'm a little -- Karen, you may help me
14 out about the time frame of what happens then.
15 Relative to CMS decision making about which ones
16 are going to the core set. It's before the end
17 of the year as I recall.

18 MS. MATSUOKA: Yes. Late fall, early
19 winter. Yes.

20 CO-CHAIR PINUCS: Okay. Any questions
21 around the time line, around the process? So, do
22 you want to go back to the previous slide about

1 summarizing something or other? I'll make
2 something up, summarize progress. We made a lot
3 of progress. So, the adult group was busy
4 yesterday.

5 And today, you know, we obviously went
6 through a number of different measures.
7 Discussed lots of over-arching and overlapping
8 issues. I don't know that we settled on a
9 comfortable way of thinking about perinatal
10 health quite yet in the ages. But at least, you
11 know, we've had the opportunity to think about
12 how to piece those things together. And think
13 about how they relate to one another.

14 I apologize that we had to skip so
15 quickly through a number of really interesting
16 issues that were, kind of, woven in our
17 conversations. Tomorrow, again, the Child Task
18 Force will meet and go through those measures.
19 And, you know, I just want to say -- Harold had
20 to step out, but I want to thank the Adult Task
21 Force for all their work over the past day and a
22 half. We certainly appreciate it.

1 And I'll thank in advance the folks on
2 the Child Task Force for today and also for
3 tomorrow. And as well, for the fantastic staff
4 that, you know, tried to accumulate a lot of
5 material and put it together in a relatively
6 short period of time.

7 I think that, you know, we tried to
8 balance the issue of being responsive to new
9 ideas for measures even until the last minute,
10 with the desire to have everything kind of in
11 front of you. Weeks ahead of time, for review.
12 I'm not sure, it will probably be a lively
13 conversation about whether we got that balance
14 right today or not. But I think that that was
15 the spirit of it, and the desire was to really be
16 responsive to this group and to others who made
17 recommendations for measures.

18 I know I really appreciated the
19 electronic format ahead of time. In which not
20 only did you invite us to do homework, but also
21 invited folks to list and describe measures. So,
22 I think that was responsive to comments that

1 we've had. I don't have any -- do you guys have
2 some comments? Yes, Debjani.

3 MS. MUKHERJEE: I would like to thank
4 our co-chairs. There's a lot of work getting to
5 this point and, sort of, they've been on call and
6 email and responding. Also, for anybody who's
7 submitted measures, thank you for being
8 responsive.

9 Next year, we will definitely have a
10 cut-off point. And we will hold you to that cut-
11 off point. But thank you for all your hard work
12 and coming here, and especially the team. It's a
13 fairly tight team that's not fully staffed. So,
14 we've all been, especially Shaconna and Nadine.
15 Thank you for their, you know, working with sort
16 of less than optimal staffing. And hopefully
17 we'll see you back tomorrow at the child side.

18 CO-CHAIR GESTEN: And one on that
19 side. Thank you all, safe travels.

20 MS. GORHAM: Thank you.

21 (Whereby, the above entitled matter
22 went off the record at 3:53 p.m.)

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This is to certify that the foregoing transcript

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Medicaid Adult/Child Task Forces

Before: NQF

Date: 05-25-16

Place: Washington, DC

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