

NATIONAL QUALITY FORUM

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MEASURE APPLICATION PARTNERSHIP
MEDICAID CHILD TASK FORCE

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THURSDAY
MAY 25, 2017

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

MEMBERS PRESENT:

RICHARD ANTONELLI, MD, Chair
TERRY ADIRIM, MD, MPH, Office of the Assistant Secretary of Defense for Health Affairs
ANDREA BENIN, MD, Children's Hospital Association
KATHRYN BEATTIE, MD, St. Luke's Children's Hospital
ANN GREINER, MUP, Patient-Centered Primary Care Collaborative
DEBORAH KILSTEIN, RN, MBA, JD, Association for Community Affiliated Plans
RACHEL LA CROIX, PhD, PMP, Florida Agency for Health Care Administration
ROANNE OSBORNE-GASKIN, MD, MBA, FAAFP, MDwise, Inc.
AMY POOLE-YAEGER, MD, Centene Corporation
AMY RICHARDSON, MD, MBA, Aetna Medical
CAROL SAKALA, PhD, MSPH, National Partnership for Women and Families

SUBJECT MATTER EXPERTS (VOTING)

KIM ELLIOTT, PhD, CPHQ, Health Services Advisory
Group

FEDERAL GOVERNMENT MEMBERS PRESENT (NON-VOTING):

SUMA NAIR, MS, RD, Office of Quality Improvement

MARSHA SMITH, MD, MPH, FAAP, Centers for
Medicare and Medicaid Services*

NQF STAFF:

HELEN BURSTIN, MD, Chief Scientific Officer

ELISA MUNTHALI, Vice President, Quality
Measurement

SHACONNA GORHAM, MS, PMP, Senior Project Manager

MIRANDA KUWAHARA, Policy Analyst

DEBJANI MUKHERJEE, MPH, Senior Director

MAY NACION, MPH, Project Manager

ALSO PRESENT:

SEPHEEN BYRON, MHS, National Committee for
Quality Assurance

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

RENEE FOX, MD, Division of Quality and
Health Outcomes, Centers for Medicare and
Medicaid Services

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

LAURIE NORRIS, JD, Division of Quality and
Health Outcomes, Centers for Medicare and
Medicaid Services

LAYLA PARAST, RAND Corporation*

KIMBERLY PERRAULT, Centers for Medicare and
Medicaid Services

GIGI RANEY, LCSW, Centers for Medicare and
Medicaid Services

SHIVANI SHAH, Children's Hospital of
Philadelphia*

JEFF SILBER, MD, Children's Hospital of
Philadelphia*

ANDREA STEWART, New Hampshire Department of
Health and Human Services*

* present by teleconference

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

2 9:08 a.m.

3 MS. MUKHERJEE: Hi, everybody.

4 Welcome back. Good morning.

5 My name is Debjani again, but, by now,
6 you all probably know me.

7 And so, without ado, we will get
8 started on our third and last day of the Medicaid
9 Adult and Child Task Forces, and today we are
10 Child Task Force only. So, hopefully, we'll
11 power on and we will get done early again.

12 With that, I will turn it over to our
13 Chair, Rich.

14 CHAIR ANTONELLI: Good morning,
15 everybody.

16 Thank you for the engagement
17 yesterday, and I'm really looking forward to the
18 work that is before us today.

19 We want to talk a little bit about
20 what is going to happen today, the structure of
21 the day, and then, we will review a little bit of
22 what we decided yesterday jointly with our Adult

1 Task Force partners.

2 In the morning we are going to review
3 the materials that we have received in
4 preparation coming to the Task Force. CMS is
5 going to weigh-in with their perspective. Our
6 colleague who joined us from New York State is
7 going to give us the view from the trenches, if
8 you will. And they are going to set the context
9 for an approach to strengthening the child core
10 set and prioritizing the gap areas.

11 In the afternoon, we are going to work
12 through these gap areas, make recommendations on
13 measures for consideration to add to the child
14 core set.

15 You should have all received the
16 discussion guide materials.

17 A word about parsimony. So, people
18 heard a lot of themes yesterday. I had the
19 privilege of actually acknowledging the CEO, and
20 Dr. Agrawal opened us yesterday. At the Annual
21 Meeting of the NQF, he actually called out that
22 the Standing Committee on Care Coordination

1 actually removed measures, and this notion of
2 let's not just promote measures because there are
3 measures.

4 I guess I want to channel Mary
5 Applegate yesterday. You know, there are
6 measures that she needs. And so, there's lot of
7 opportunity in that space. So, parsimony should
8 be top of mind for our work today. In the
9 strategic conversation this afternoon, Debjani is
10 going to talk specifically about moving forward
11 with additional pruning opportunities. And some
12 measures may actually be brought out today.

13 So, the highlights from day two: we
14 reviewed maternal and perinatal measures, the
15 recommendations for removal; 1391, frequency of
16 ongoing prenatal care, timeliness of prenatal
17 care, conditional support to remove, and the
18 behavioral risk assessment for pregnant women.

19 I'm just going to take the Chair's
20 prerogative and spend 30 seconds to talk about
21 why I think this was really important. The idea
22 that, yes, we're measuring. We heard some really

1 important things from the frontlines. Rachel, in
2 particular, your comment about a lot of work is
3 being done already in this space, resources have
4 been invested, we have to be respectful of that.

5 But, to where we need to get, some
6 decisions were made. And the optics, if you
7 will, the messaging that comes out of this Task
8 Force is really, really important. There isn't
9 anybody in this room that doesn't think that
10 timeliness of prenatal care isn't important or
11 frequency of prenatal care isn't important.

12 So, as Karen has assured us, and our
13 CMS colleagues have assured us, the commentary
14 that comes out of this body is going to be
15 critically important for advancement.

16 Carol, I particularly want to thank
17 you for bringing the Behavioral Health Risk
18 Assessments. What was really, for me, kind of
19 affirming was that it went back to 2012. It
20 initially was intended to an eMeasure and wasn't
21 gaining traction for whatever reason, some of
22 which has to do with were the EMRs capturing that

1 data. So, there's not a sense that asking those
2 questions of pregnant is not important; it is
3 vitally important, but was the measure able to
4 deliver, and I think coming up with that
5 recommendation.

6 Next, the contraceptive care with the
7 most moderately effective methods with the
8 conditional supports, we moved forward, and the
9 AMR as well.

10 Okay. I am going to hand it over to
11 May who is going to talk a little bit about staff
12 review experience of the core set. By the way,
13 do we have any Task Force members on the phone
14 today?

15 DR. SMITH: Hi. This is Marsha Smith.

16 CHAIR ANTONELLI: Who is that?

17 Marsha? Okay, good.

18 Good morning, Marsha.

19 And is it just Marsha on the phone
20 because I see Dr. Benin. Is here today. Yes,
21 good. Okay.

22 May?

1 DR. NACION: Hello. Okay? Okay.

2 So, here I will just do a quick
3 overview of CMS' goals for the child and adult
4 core set, again, which are to increase state
5 reporting, increase the number of measures
6 reported, and increase the number of states using
7 the core set measures.

8 This was also previously discussed
9 yesterday and gives us an idea of how CMS uses
10 their core set data. So, I won't really go over
11 this.

12 Here again is an overview of the
13 measure selection criteria, as presented in the
14 previous days. So, I will just go to the next
15 slide.

16 For 2016, the Task Force members
17 supported all but two of the 2016 child core set
18 measures and recommended five measures for phased
19 addition to the 2017 child core set.

20 Presented are the five measures for
21 phased addition. The measures outlined in red
22 were adopted in the 2017 core set. As an update,

1 the measures conditionally supported last year
2 actually have received NQF endorsement.

3 Here are the 2016 Task Force
4 recommended measures for removal. So, it was
5 frequency of ongoing prenatal care and, and was
6 voted on yesterday, it was also recommended for
7 removal by this Task Force, as well as the child
8 and adolescents access to primary care
9 practitioners. Last year's Task Force noted that
10 performance on this measure was very high overall
11 and with little opportunity for improvement.

12 For the 2017 core set, again, two
13 measures were added, but no recommended measures
14 for removal were removed. Do note that the
15 contraceptive care postpartum measure was also
16 added to the adult core set into an alignment of
17 these measures.

18 CMS did remove one measure, the HPV
19 vaccination for female adolescents measure. This
20 was retired by the measure steward and added to
21 the immunizations for adolescence measure, No.
22 1407, which is already in the child core set.

1 Again, the HPV measure was retired and
2 combined with the immunizations for adolescents
3 measure. These two measures will be combined to
4 reflect the Advisory Committee on Immunization
5 Practices recommendation that males and females,
6 starting at age 11 or 12, should receive routine
7 meningococcal, Tdap, and HPV vaccination. This
8 new specification has not submitted for NQF
9 endorsement yet. NCQA, which is the measure
10 steward, expects to make these updates during the
11 next annual update or endorsement maintenance
12 phase.

13 Here are the next few slides. We'll
14 just show the 2017 child core set measures
15 categorized by their topic areas. The measure
16 here outlined in red was the 2016 recommendation
17 that was added to the 2017 child core set. Here,
18 another 2016 recommendation added to the core
19 set.

20 And on this slide, again, to note the
21 endorsement for medication management for people
22 with asthma, No. 1799, has been removed, as

1 discussed yesterday.

2 Here's a breakdown of the measures in
3 the core set by endorsement status, measure type,
4 data collection method, and federal program
5 alignment. We have 17 endorsed measures. The
6 majority of measures are process measures and are
7 primarily administrative claims data. Here the
8 characteristics are not mutually-exclusive.

9 Here, I am just going to go give a
10 brief update on any endorsement updates. So,
11 three measures lost endorsements, so No. 1391,
12 1517, and 1799, and the reasons have been
13 outlined during the maternal, perinatal, and
14 asthma discussions yesterday.

15 This is an overview of the federal
16 fiscal year 2015 reporting. The 2015 child core
17 set includes 24 measures. Fiscal year 2015 is
18 the first year reporting of two new measures,
19 which are the dental sealants for 6- to 9-year-
20 old children at elevated Caries risk, as well as
21 the child and adolescent major depressive
22 disorder suicide risk assessment. One measure

1 was retired, the percentage of eligibles that
2 receive dental treatment services.

3 This slide illustrates the number of
4 states reporting on each measure in the core set
5 for fiscal year 2015. The central-line-
6 associated bloodstream infection measure is not
7 reflected in the data because, beginning in
8 fiscal year 2012, data for the CLABSI measure was
9 obtained from CDC's National Healthcare Safety
10 Network.

11 The measures most frequently reported
12 by states for fiscal year 2015: assess
13 children's access to primary care; percentage
14 with well-child visits; use of dental services;
15 receipt of childhood immunizations, and
16 satisfaction with care received.

17 Here, this slide illustrates the
18 number of states reporting on each measure in the
19 core set and changes in reporting from fiscal
20 year 2013 to 2015. The measure above the red
21 horizontal line highlights the measures that are
22 publicly reported by 25 or more states in 2015.

1 And for the purposes of illustration,
2 we bucketed the measures into high, medium, and
3 low. So, a closer look at the measures with high
4 levels of reporting, this graph shows measures
5 reported by greater than 40 states in fiscal year
6 2015. These tend to be claims-based measures and
7 primarily reflective of primary care encounters.

8 Here, these are measures that were
9 reported more frequently in 2015, which are
10 between 26 to 40 states reporting. All of the
11 measures experienced an increase in fiscal year
12 2015 except for the live births weighing less
13 than 2500 grams. This decreased from 29 states
14 in 2014 to 28 states in 2015.

15 Here, these four measures reflect the
16 number of recording by the fewest number of
17 states. So, this is between 1 to 22 states
18 reporting in fiscal year 2015. Reasons for low
19 reporting will be discussed later in the day.

20 Not surprisingly, the child and
21 adolescent major depressive disorder measure is
22 the lowest reported because it was new to the

1 2015 core set, with one state reporting this
2 measure.

3 The next few slides just present more
4 detailed information on which states reported
5 which measures. So, you should have a handout in
6 your seats, so you can see the information a
7 little bit better.

8 Okay. I'm just going to go quickly
9 through these. So, again, just another page of
10 the states and specific measures reported.

11 So, here, in conclusion, there is
12 always room for improvement, but, overall, the
13 child core set, participation is quite strong,
14 with 19 of the 24 core measures are reported by
15 25 or more of the states.

16 Okay.

17 CHAIR ANTONELLI: Thank you, May.

18 So, we have some time to open this up
19 for questions and comments from Task Force
20 members. Just a reminder to use your tent cards
21 to get into the queue.

22 Ann?

1 MEMBER GREINER: I'm wondering if the
2 staff has done any analysis to look at the most
3 frequently-reported measures and the performance
4 and how states fare.

5 MS. RANEY: Can you tell us if you're
6 asking a question about a specific measure or
7 just a general question about reporting?

8 MEMBER GREINER: Well, I recognize
9 that, given the number of measures, you couldn't
10 do it for all. So, the question was, has there
11 been any attempt to look at the most frequently-
12 reported measures and look across states to see
13 how they compare to each other?

14 MS. RANEY: We have recently just
15 received the 2015 chart pack, which you guys
16 received, and we are still actually in the
17 process of putting that up on medicaid.gov. So,
18 you guys have a little advanced preview of that.
19 So, we are in the process of doing that right
20 now.

21 MEMBER GREINER: Sure. Because I
22 don't know, but from my years at NQF, I know that

1 policymakers are very interested, as you know, in
2 how the states perform and they always want to
3 see how they perform vis-a-vis their neighbors
4 and other benchmark states.

5 MS. RANEY: Yes. So, we are in the
6 process of getting that information out there,
7 and I'm sure we will hear back where some of the
8 priorities are, for us to take a deeper dive with
9 the limited resources that we have to do so.
10 Sure.

11 MEMBER GREINER: Thank you.

12 DR. FOX: In the past we have looked
13 at sort of best-performing states and published
14 briefs about them. So, on our website there is
15 information. It's a little dated now, but that
16 is the kind of thing we do. But the maps will
17 tell you how states are doing in the chart packs.

18 MEMBER POOLE-YAEGER: I think they
19 asked this yesterday about the adult set, but
20 could you give us a little color on some of the
21 ones that you decided not to include or take off?

22 MS. RANEY: Sure. Any specific one

1 that you would like us to focus on?

2 MEMBER POOLE-YAEGER: Essentially, the
3 dental screening one. That one was removed? Is
4 that what I read, or no?

5 DR. FOX: That was actually, we
6 replaced that one with the sealant.

7 MEMBER POOLE-YAEGER: Okay.

8 MS. RANEY: We are going to bring our
9 dental expert up to address your question.

10 DR. FOX: Who will be speaking later.

11 MS. NORRIS: So, last year we took the
12 dental treatment measure off and we replaced it
13 with a sealant measure. And the reason why we
14 did that -- and you guys recommended it, I think
15 -- is because the dental treatment measure was
16 problematic. We could track utilization of
17 dental treatment, but we didn't know what that
18 meant. You know, are we doing a good job of
19 finding more kids who need care and addressing
20 their needs? Or are we doing a poor job with
21 prevention and more kids are -- we didn't know
22 whether it should be going up or down, because we

1 had no way of knowing what the need for dental
2 treatment was.

3 So, that measure didn't feel
4 productive to us; whereas, the sealant measure,
5 we know sealants is the most evidence-based
6 intervention that can happen for kids in the
7 dentist office. And so, we were thrilled to have
8 that measure on instead of the dental treatment
9 measure.

10 MEMBER POOLE-YAEGER: Great. Thank
11 you.

12 And I'm only asking because the
13 sealant, I agree, is a great measure, but it is
14 only the 3-, 4-, 5-, 6-year-olds, right? So, it
15 doesn't --

16 MS. NORRIS: It's 6 to 9.

17 MEMBER POOLE-YAEGER: Or 6 to 9, yes.
18 And just from, again, our experience, access to
19 dental care is a huge issue. For Medicaid
20 patients finding dentists that will take Medicaid
21 patients is a struggle. From a perspective of
22 getting an all-encompassing look at whether

1 Medicaid kids are getting dental care, I just was
2 interested.

3 MS. NORRIS: So, we have another
4 measure, our most reported measure, and I will
5 not give you the whole thing because I am
6 presenting in a few minutes about it.

7 MEMBER POOLE-YAEGER: Yes.

8 MS. NORRIS: But you'll see that we
9 still have PDENT, which is preventive dental
10 services.

11 MEMBER POOLE-YAEGER: Got it. Got it.

12 MS. NORRIS: With that, we are
13 tracking, and that gives us a picture of all ages
14 and levels of access.

15 MEMBER POOLE-YAEGER: Okay.

16 MS. NORRIS: So, I will give you the
17 results on that.

18 MEMBER POOLE-YAEGER: That's awesome.
19 Perfect. Thank you.

20 MS. RANEY: And I think some of those
21 thoughts or one of the other measures that had
22 been recommended for removal last year was the

1 child and adolescents access to primary care
2 practitioners. And there was lively discussion
3 last year about this. We actually decided to
4 keep that as part of our measure set for several
5 reasons, one being that there was some
6 variability and there were some states that had a
7 lot of room for improvement on that measure,
8 particularly in regard to adolescents. And
9 another reason was we wanted to maintain it for
10 potential use with states' new access monitoring
11 review plans, and just kind of keeping it on
12 there. So, it lines up similar with what Laurie
13 was saying about the dental care and access.

14 MEMBER POOLE-YAEGER: Yes, and I'm
15 sorry to keep asking those questions. I'm sort
16 of new. I wasn't at the last ones.

17 I'm just curious about --

18 CHAIR ANTONELLI: As long as it's not
19 about dental because --

20 MEMBER POOLE-YAEGER: As long as it's
21 not about dental?

22 CHAIR ANTONELLI: -- because the next

1 item is dental.

2 (Laughter.)

3 MEMBER POOLE-YAEGER: No, this is
4 about well-child visits now. So, I'm just
5 curious of your thought about EPSDT versus
6 reporting on the well-child visits, which are
7 just several -- you know, looking at those
8 separate age groups and how you look at that.

9 DR. FOX: Well, they are really
10 separate. There are overlapping things, but, of
11 course, EPSDT is what happens in the office, and
12 physicians are --- people are required to report
13 that for Medicaid. Some of the other, this is
14 not mandatory. So, it gives us a way to compare
15 and contrast what is happening. There are gaps
16 in both. Neither is perfect.

17 MEMBER POOLE-YAEGER: And I'm just
18 asking, you know, with the discussion about
19 reporting burden, it is two sets of reporting
20 that has to go on to get the similar measures
21 with slightly different specs, and sort of, kind
22 of telling you sort of the same thing, but not

1 exactly. And I would love to have some ability
2 to say, okay, can we come up with something that
3 is going to address all of it?

4 CHAIR ANTONELLI: So, actually, since
5 you made that statement -- we would, too -- can
6 we talk a little bit about that, thinking from
7 the perspective of data flows and performance.
8 So, those of us that care for patients with
9 Medicaid, we know EPSDT. It has limitations.
10 But, then, we are looking at some of the other
11 measures.

12 And I was actually going to bring this
13 up later on today when we talk about the
14 sunseting of the measure on developmental
15 screening, which nobody in this room at its heart
16 says that's not important, similar to prenatal
17 care.

18 But talk a little bit about what are
19 the opportunities. Renee, you mentioned that
20 there is a little bit of overlap. But is that
21 overlap leverageable or are they disparate enough
22 so that the ability to squeeze some parsimony out

1 would actually be worth pursuing going forward?

2 DR. FOX: We're going to invite our
3 colleague to come up. This is Kimberly Perrault.

4 MS. PERRAULT: Just to address some of
5 the questions in terms of data, we do have
6 various sources that we use to try to paint the
7 picture of what we're seeing in terms of core set
8 measure reporting, and specifically looking at,
9 let's say, comparing EPSDT data. We have a
10 longstanding process for that. And states are
11 very familiar with the technical assistance that
12 we can provide to try to iron out some of the
13 data.

14 One of our focuses, I think, going
15 forward is definitely trying to streamline the
16 data that we are receiving and working with
17 states to make sure that, you know, across the
18 board we're looking at apples to apples for each
19 of the measures. We are recognizing that states
20 are unique and all have individual challenges.

21 So, going forward, I think the
22 questions, as we provide technical assistance,

1 are just kind of asking what are the types of
2 databases that you're using; what are the data
3 sources; where can we find that overlap. And
4 those discussions can vary from state to state.

5 But we do recognize that, where we can
6 make contributions and use data and move towards
7 other data sources that are more conformed, it is
8 helpful, and we do tend to get better reporting.
9 We are also recognizing that, if we can do things
10 like develop stats codes that work with a state's
11 database system and to provide TA, that we are
12 also having some uniformity there, as well as,
13 ideally, looking internally at our own CMS
14 systems where we are receiving data to see how we
15 can improve that and have a more robust and
16 better look at what is being presented.

17 CHAIR ANTONELLI: So, to get really
18 tactical about this, if we decide let's take
19 developmental screening from zero to 3 out of the
20 core set, does that mean that we will know the
21 performance based on the EPSDT data?

22 DR. FOX: Yes, we have really

1 struggled this year about the developmental
2 screening. We got close last year in the 2015
3 data, and we knew that the endorsement had been
4 withdrawn or was withdrawing. And we decided it
5 was just like access. It was something that we
6 did not want to take off because we didn't want a
7 signal to anybody that that wasn't important.

8 We would love -- and I know Lindsay
9 and I had a conversation a couple of months ago
10 about developmental screening -- we would love a
11 better measure. We would love somebody to
12 develop a better measure. There just aren't any
13 measures out there, and this side of CMS does not
14 develop measures.

15 MEMBER POOLE-YAEGER: Did you say that
16 the endorsement status was removed from the
17 screening measure? And if that's true, can you
18 say why?

19 DR. FOX: I can explain why. It was
20 given provisional or conditional endorsement
21 based on further data, and the measure developer
22 was unable -- you know, the cycle this year, we

1 had another pediatric measure committee and we
2 encouraged -- so, the measure developer was
3 unable to give us any more data. So, wasn't able
4 to submit for re-endorsement. And so, that makes
5 it, by NQF rules, no longer endorsed.

6 MEMBER POOLE-YAEGER: It's a
7 challenging measure.

8 CHAIR ANTONELLI: Microphone, please.

9 MEMBER ADIRIM: What I'm saying is, it
10 wasn't because now we have found it to be a bad
11 measure. It is just that there wasn't any
12 further research or evidence or data to
13 support --

14 DR. FOX: Right.

15 MEMBER POOLE-YAEGER: Okay.

16 DR. FOX: They were unable to perform
17 the data analysis that they needed to submit it.

18 MS. RANEY: And just a key reminder,
19 CMS is not required to have measures that are
20 NQF-endorsed on our core set. So, if you'll
21 notice the slide that May had earlier, I believe
22 there are 10 measures that are currently on the

1 child core set that are not NQF-endorsed for one
2 reason or another. So, losing endorsement is not
3 reason itself for removing a measure or measure
4 not having it, period. You know, there are other
5 things to take into consideration.

6 MEMBER ADIRIM: Thanks for that
7 clarification. I think both points are
8 important. Thanks.

9 DR. FOX: And that's different, those
10 of you who cross over into like adult world,
11 that's different from Medicare, where the MAP
12 actually can direct what they adopt on the
13 Medicare side. The Medicare, CMS has to accept
14 the MAP recommendations.

15 MEMBER POOLE-YAEGER: Sorry to keep
16 asking questions. I'm trying to get it to pull
17 up, but the slide that you showed where you don't
18 have it on the core set where it was recommended
19 by MAP, I think the sickle cell measure was on
20 there. Yes. Can you talk a little bit why you
21 didn't --

22 DR. FOX: Well, the word

1 "parsimony" --

2 MEMBER POOLE-YAEGER: Yes.

3 DR. FOX: -- comes up again. We
4 recognize that, clearly, sickle cell disease is
5 disproportionately represented in the Medicaid
6 population, just by who's covered in Medicaid.
7 We just really thought that many of our other
8 measures also addressed disparities, just by the
9 basis of measuring access.

10 CHAIR ANTONELLI: Roanne?

11 MEMBER OSBORNE-GASKIN: Hi. I just
12 had a quick question about -- and I don't know if
13 this is the time to ask about it -- about the
14 childhood immunization status measure. Do you
15 have just the specs on that? Is there an age
16 range for that one, specific one? Okay. I was
17 trying to look for it, and I couldn't find it.

18 DR. FOX: There's two --

19 MEMBER OSBORNE-GASKIN: Yes, up to a
20 specific age?

21 DR. FOX: It's 0038.

22 Yes, it's getting all of your

1 organizations. There's several sets of COBL 1,
2 2, 3, 4, 5 which have different sets of
3 immunizations, but it is also that childhood
4 immunization schedule, but by age 2. So, you
5 know, whether you get your three DTPs and your
6 Tdaps, yes, those also. But you have to get them
7 all by the age of 2 to meet that measure.

8 MEMBER POOLE-YAEGER: Right, it's
9 assessed at age 2.

10 DR. FOX: Yes.

11 MEMBER POOLE-YAEGER: Can I just give
12 a comment on that one, since I know this measure
13 very well? The other spec problem, in my mind,
14 the spec -- and again, this is managed care kind
15 of talk here. So, we pulled this measure, and
16 the specs say that you have to have a continuous
17 eligibility for at least one year.

18 And for pediatricians in the room, you
19 know that most of your immunizations are given in
20 the first year of life, not in the second. This
21 is a two-year measure, right? So, we have people
22 that get eligible when they turn 1 to 2, and they

1 all look non-compliant because we don't have the
2 data from when they were born to when they were
3 1.

4 And so, unless there is a good
5 immunization registry in the market, which is not
6 -- you know, I've got 23 states and varying,
7 varying degrees of good immunization registry
8 data. So, it will look to me like none of my
9 kids are vaccinated, even though a lot of them
10 are.

11 So, when you're trying to do an
12 intervention to say, "Hey, you're behind," it's
13 virtually impossible to do if we don't have the
14 data. So, I'm just kind of bringing that up as a
15 barrier in the real world.

16 CHAIR ANTONELLI: All right. I think
17 we'll call up Laurie Norris, make up some time
18 here on the schedule. Are you ready?

19 MS. NORRIS: I'm ready.

20 CHAIR ANTONELLI: Yes. We are going
21 to talk a little bit --- Laurie, if you could
22 introduce yourself? And we're going to dive into

1 the Oral Health Initiative, please.

2 MS. NORRIS: So, thank you, and good
3 morning.

4 And I want to say a special hi to
5 Rachel. I don't think -- have we ever met
6 before? We've been talking on the phone for
7 three years.

8 MEMBER LA CROIX: Thank you. It's
9 great to be here in person.

10 MS. NORRIS: Thank you. What a nice
11 surprise.

12 CHAIR ANTONELLI: Let's really get to
13 your slides, right? Yes.

14 (Laughter.)

15 MS. NORRIS: Yes. Okay, here we go.

16 So, I'm here to talk about, I guess
17 I'm supposed to give the perspective on how CMS
18 uses the measures and maybe a little bit on how
19 we observe states using the measures. And I'm
20 going to do that in the context of the oral
21 health measures in the child core set.

22 So, how does CMS use the measures to

1 begin with? We use it to understand how states
2 are doing in the first instance. We do
3 religiously compare across states to track who's
4 going up, who's going down, who's at the head of
5 the line, who's at the tail of the line, that
6 kind of thing.

7 And then, we also use the measures to
8 support states to improve. And I know that is
9 the ultimate goal. That is a sort of selective
10 effort. We don't have the resources to work with
11 every single state. We hope that our publication
12 of who's at the head of the line and who's at the
13 tail of the line will, like, self-motivate states
14 to do their own improvement efforts. And it
15 does in some instances. But we also work sort of
16 hands-on with a small number of states to support
17 their improvement.

18 So, how do states use the measures?
19 They use it to monitor their plans --- their
20 health plans. So, they use the measures at the
21 next level down and, also, to encourage
22 improvement. So, it is a similar sort of

1 parallel process, and I'll tell you in a little
2 bit more in detail about what we've observed
3 states doing with the oral health measures in a
4 few slides.

5 I'm also going to end today with a
6 little bit of, like, the next steps of what we
7 see in the oral health measures, where we would
8 like to go next if we have the opportunity to do
9 that.

10 Next slide.

11 All right. So, I think I shared this
12 slide with you last year, and we now have one
13 more data point. It remains my good news/bad
14 news slide. The good news is that the line is
15 continuing to slope upward for any dental
16 service.

17 And this goes to the original point.
18 You know, we do track whether a child between the
19 ages of 1 to 20 got a dental service, and that is
20 the blue line at the top. That is any kind of --
21 they were at the dentist's office, regardless of
22 what happened there.

1 It is sort of a milestone for us that
2 in 2015 we reached the 50-percent mark. So, half
3 of our kids are using the benefit, which is
4 terrific. But the bad news is the other half
5 aren't, right? So, we still have a long way to
6 go.

7 The red line is our preventive dental
8 services measure specifically. And that is very
9 narrowly-defined. There are really only three
10 things that are in that line: a cleaning, a
11 fluoride treatment, or a sealant. That's it. We
12 don't count exams or x-rays or, you know, just
13 your checkup stuff that you might think would be
14 in there. We only check if there was an actual
15 intervention that has a preventive effect.

16 And then, that bottom line, the green
17 one is the treatment services. We do track that.
18 It's not in the core set, but it comes in through
19 our EPSDT data.

20 Like I said earlier, we have no idea
21 whether we are happy this line is staying steady
22 or whether we wish it was going up or whether we

1 wish it was going down, because we don't have a
2 way of measuring what the need for dental
3 treatment is. So, that measure is kind of a
4 mystery to us.

5 Okay, next slide.

6 So, these are all the measures in the
7 core set. You've seen this slide a million
8 times. But what we are showing here are the two
9 oral health measures by rate of report by states.

10 So, the most frequently reported
11 measure is the preventive dental services
12 measure. And there is no mystery behind why that
13 is the most frequently reported measure. It is
14 because all states are required by law to send us
15 their dental data through EPSDT reporting
16 process, and we just take the data and number-
17 crunch it and dump it into the core set. So, the
18 states aren't actually reporting this into the
19 core set. They're reporting it elsewhere, and we
20 do the transfer. So, we win every year, but, you
21 know, there is really no magic to it. And that
22 measure has been in the core set since the

1 beginning.

2 Way further down is that sealant
3 measure for children 6 to 9 at risk of caries.
4 That measure was added last year. But we are
5 super proud that we got 26 states to report the
6 very first year, which means that we can report
7 it out publicly right away. So, we now have our
8 baseline and it can become public.

9 We are not using it for improvement
10 yet because it is just our baseline. But, unlike
11 the other new measure that was added last year
12 that I think had one or two states report, we are
13 really, really pleased with this reporting.

14 Next slide.

15 So, the PDENT measure is the one that
16 we most actively and have been using since before
17 it was even PDENT, through the EPSDT reporting.
18 It is the core measure that we use in our Oral
19 Health Initiative.

20 And I previewed this for you last
21 year. Our aim is to increase by 10 percentage
22 points the proportion of children who receive a

1 preventive dental service.

2 We set our baseline in 2011.
3 Nationally, we were at 42 percent in 2011. So,
4 our goal is to get it to 52 percent. We had
5 improved by 4 percentage points as of 2015. That
6 was our original deadline for ourselves. We
7 didn't quite make it. So, we have given
8 ourselves a three year extension out to 2018 to
9 continue to make progress.

10 Of course, we have the national goal,
11 but every single state has their own baseline and
12 their own 10-percentage-point improvement goal.
13 And I get to call out Florida here, is one of the
14 four states that made their 10-percentage-point
15 improvement goal by 2015. So, we had a few that
16 made it. Florida was very motivated. I will
17 show you the graph in a minute. So, we are still
18 working on this.

19 Next slide.

20 So, here's our, you know, who's at the
21 head of the line, who's at the tail of the line
22 slide. As of 2015, we had a new winner in 2015.

1 Texas moved to the head of the line for the first
2 time. So, they are really, really up there.

3 Connecticut, Washington, New
4 Hampshire, Vermont have been good performers,
5 really strong performers, and continue to be
6 strong performers. Those little New England
7 states seem to have a handle on how to address
8 dental access for kids.

9 But, then, sadly, down at the tail of
10 the line, on the righthand side, Florida is no
11 longer the lowest-performing state in the nation.

12 (Laughter.)

13 They held that place of honor for many
14 years, but now they have moved up to the third
15 from the bottom, and Wisconsin is now our lowest-
16 performing state, and North Dakota, South Dakota,
17 and Ohio also hanging out there in the bottom.

18 I mentioned earlier that we are
19 focusing on a small number of states in our
20 improvement efforts, our sort of hands-on
21 improvement efforts. We are focusing on those
22 low-performing states to try to engage them in

1 improvement efforts.

2 Next slide.

3 All right. So, that's how CMS uses
4 the measures. So, I wanted to just spend a
5 little bit more time on how states use the oral
6 health quality measures. Some states have
7 started using SEAL. So, that is not just about
8 PDENT. It is also about SEAL.

9 The sealant measure has been out in
10 the world before we put it into our core set.
11 So, states, you know, some states got a headstart
12 on adopting its use.

13 So, states with managed care use it in
14 their health plan contracting. This is a super
15 strong way to motivate health plans to pay
16 attention to oral health services. They set
17 improvement goals. They set specific improvement
18 goals. Florida did that. They tie incentives or
19 penalties to the achievement of those improvement
20 goals. So, that is probably the most frequently
21 used way.

22 And we have about 36 states now, I

1 think, that use managed care for dental services.
2 So, this is a really good tool for states.

3 Also, as you may be aware, states with
4 managed care are required to do performance
5 improvement projects with their plans, or their
6 plans are required to do performance improvement
7 projects. That is another way that states can
8 use these measures, as building them in, building
9 a performance improvement project around the
10 measures. They also include the measures as part
11 of their quality strategies.

12 We have also seen some states and some
13 managed care plans, depending on what level is
14 actively working on improvement, use the measures
15 to motivate provider improvement, so one level
16 down, paying providers incentives for reaching
17 certain goals or just improving the number of
18 services they provide; using some kind of a pay-
19 for-performance approach. Or we have one state,
20 Oregon, that is actually starting to experiment
21 with a shared savings approach, and they are
22 using SEAL, maybe with a slight modification in

1 the measure specification, to do that.

2 There's also at least one state,
3 Tennessee, that is really effectively using the
4 measures for provider motivation. There's no
5 money attached to it, but every quarter they send
6 out these beautiful dashboards to all their
7 providers and they tell the providers how they
8 are performing relative to the last quarter
9 themselves and relative to their peers in the
10 state on a variety of measures, including our
11 measures. And it just sort of juices up the
12 competitive sense of the dentists and it helps
13 them improve that way. So, we are seeing some
14 pretty robust use of the measures by states.

15 Next slide.

16 So, this is another sort of good news
17 slide. As we've seen coverage and enrollment
18 increase over the last few years, we've seen
19 access to care increase. And this, the
20 information that is displayed on this slide, on
21 the lefthand side it is broken down by racial and
22 ethnic groups. We're seeing improvements across

1 all racial and ethnic groups. We are seeing the
2 gaps in access between racial and ethnic groups
3 actually shrink almost to closing. So, this is
4 just really super good news. You can see the
5 2014 numbers are very close to being the same.

6 The same is true by source of
7 insurance. Whether a kid has commercial
8 insurance, employer-based insurance, or Medicaid
9 or CHIP, we're seeing that use of dental
10 services, at least in one study, showed that
11 there was essentially no difference between the
12 two, based on parent-report, after adjusting for
13 certain demographic and parent characteristics.
14 So, we are doing a good job at closing some of
15 those gaps.

16 However -- next slide -- what we're
17 not necessarily seeing is that more access to
18 care is leading to better care. And here, we are
19 sort of moving from the utilization and access
20 space to the outcome space, right? And these
21 are, what I'm showing you on this slide are just
22 some sort of scattered studies that looked at

1 various aspects of the care we're delivering and
2 what we're spending on it and what we're getting
3 for it.

4 And so, I'm just going to call your
5 attention to the third bullet on the slide just
6 as one example. We looked at our preventive, our
7 PDENT measure compared to our sealant measure in
8 2015 and the 6-to-9 age group. And what we saw
9 was that 57 percent of children in the 6-to-9 age
10 group had a preventive dental service. That's
11 not bad, you know. And as I said before, that is
12 either a cleaning or a sealant or a fluoride
13 treatment.

14 Only 16 percent of those kids got a
15 sealant. So, almost all of those kids needed a
16 sealant. And we know they were in the dentist's
17 chair. So, we're not talking about the heavier
18 lift of getting the kid into the office. These
19 kids were in the office, but they didn't get the
20 most evidence-based intervention while they were
21 in the office. So, that is just an example of
22 how we are doing a good job of driving more care,

1 but we are not necessarily doing a good job of
2 driving the best care.

3 Next slide.

4 So, to begin to address that issue, we
5 have launched a value-based payment project in
6 collaboration with our Innovation Accelerator
7 Program. We have designed a project to work with
8 states to just do very small pilot projects, to
9 look at driving value and outcomes through a
10 different way of paying for care.

11 And I'll just say that this project is
12 designed in a kind of unusual way for a reason.
13 We have observed that there are dental clinicians
14 out there who were self-motivated to figure out
15 how to get better outcomes for their kids. And
16 so, they have turned on its head the normal way
17 of thinking about dental care for kids. They're
18 doing intensive prevention. They're doing
19 evidence-based prevention. They're doing more
20 frequent visits. They're doing more family
21 engagement. They're doing some sort of new
22 treatment interventions, something called interim

1 therapeutic restorations, something called silver
2 diamine fluoride. These are all very low-cost,
3 low-impact, no-surgery ways of dealing with the
4 disease and halting the progress of the disease
5 in a child's mouth. And they're getting some
6 really good results.

7 So, what we have asked for in this
8 project is that states that want to experiment in
9 this space partner with a clinical site that has
10 already figured out how to get better outcomes
11 and, then, work with the state Medicaid agency to
12 figure out how to develop a value-based payment
13 approach that will make that clinical approach
14 sustainable.

15 What we are finding is that the
16 clinicians who have revised and reformed the way
17 they deliver care, dental care, to kids are
18 having to -- you know, they are just not getting
19 reimbursed for a lot of stuff and they are having
20 to go to foundations to backfill.

21 It just seemed logical to us, if they
22 are producing the health outcomes that we want,

1 we should be paying for it in a way that makes it
2 feasible for them to continue to provide care
3 that way and, then, ultimately, to spread those
4 models beyond those initial sites.

5 So, that is the theory. That is our
6 theory of change. We are pleased to be able to
7 test it with just a few states over the next two
8 years to select, design, and test a value-based
9 payment approach in partnership with their
10 clinical site to see whether we can figure out
11 how to sustain those outcomes.

12 A challenge, getting back to the
13 measures space, a challenge we expect to face in
14 this work is the dearth of outcomes measures in
15 the children's oral health space, to be able to
16 measure whether the value is being produced or
17 not. So, that is something that we will just
18 have to tackle in the context of this project,
19 but we see that as really a next step in measure
20 development in this area.

21 I think that's my last slide. Yes.

22 Thank you.

1 CHAIR ANTONELLI: Thank you, Laurie.

2 And while people are getting ready to
3 put their cards up, I have a question. Can you
4 speak a little bit about the reporting at the
5 state level? So, for either the sealant and/or
6 PDENT, those are dental codes, obviously. But
7 are there states that are using non-dental
8 personnel for any of those services, but bundled
9 into a primary care service, for example?

10 MS. NORRIS: Yes. Yes. Every state
11 in the country now -- Indiana was the last one to
12 join us last year -- but every state in the
13 country now does reimburse medical providers,
14 primary care providers, for providing the oral
15 health interventions for kids that are within
16 their scope of practice.

17 We do collect that data as well. It
18 is part of our EPSDT reporting. It is not in the
19 core set. So, we do track that.

20 The numbers are not encouraging. I
21 would say the latest numbers are hovering around
22 10 percent. That is of children ages 1 to 5.

1 And I think that is the best-performing age group
2 for interventions in the primary care office.

3 So, we are tracking it, but it is a
4 definitely a place where there are huge
5 opportunities for improvement.

6 MEMBER BENIN: Hi. Thanks. That was
7 really interesting.

8 Is there a data that looks at what is
9 covered by state, like what folks get reimbursed
10 for by the performance on the metrics? That has
11 always been the urban myth, anyway --

12 MS. NORRIS: Yes.

13 MEMBER BENIN: -- that the reason why
14 you can't get anybody into a dentist is because
15 the dentists don't get paid for it, so they won't
16 take the patients.

17 MS. NORRIS: Well, I'm going to
18 interpret your question as having two dimensions.
19 One dimension is it's covered, but how much does
20 a provider get paid, right? So, what are the
21 reimbursement rates? And that is a challenge.

22 We do, thanks to the American Dental

1 Association's Health Policy Institute, we do have
2 data on that. So, we know what states pay, at
3 least in their fee-for-service fee schedules.
4 And there is a wide range from something like 26
5 percent of the usual and customary all the way up
6 to 80 percent of usual and customary, depending
7 on the state. So, we do keep track of that. CMS
8 doesn't track it, but we have access to it and we
9 do pay attention to that. And when we engage
10 with states about their performance, we talk
11 about that if it is an issue.

12 In terms of what is covered -- so you
13 have to give a service away -- children's oral
14 health services are mandatory and it is part of
15 EPSDT. So, theoretically, all services that a
16 child needs are supposed to be covered, right?
17 And that tends to be the case, like sort of no
18 questions asked in the treatment space. If
19 somebody says, "This kid needs a root canal," the
20 kid is going to get a root canal. He needs an
21 extraction; no problem.

22 Where it is more challenging is in the

1 prevention space, which is where we are trying to
2 focus more attention. There is a periodicity
3 schedule for dental care. And unlike maybe how
4 it operates in the primary care space -- I'm not
5 really as familiar with that -- but, you know,
6 it's sort of the recommended frequencies for
7 checkups. But how it tends to be implemented by
8 states is the ceiling of frequencies and not the
9 floor of frequencies.

10 So, what a typical periodicity is, is
11 two dental checkups a year with two cleanings a
12 year and two fluoride treatments a year, et
13 cetera. And some states have implemented that as
14 you can't get any more than that; you can't get
15 paid for any more than that.

16 And so, there becomes a challenge
17 that, well, hypothetically, you could if you
18 submitted a justification as to why this child
19 needs to come four times a year, why they need
20 more fluoride treatments, et cetera. But that
21 becomes a big burden on the provider to do that
22 for every single kid that they need more frequent

1 care.

2 Some states are beginning to -- and
3 Texas is an example -- to allow kids at high risk
4 or even kids below the age of 5, or some kind of
5 a limiter like that, to allow -- they pay four
6 times a year. So, it is starting to loosen up,
7 as I think states are learning that the higher
8 frequencies can be impactful on children's oral
9 health, but it is not the standard yet.

10 And so, that is where people run into
11 it. Like there is no reimbursement for oral
12 health education. And so, providers are
13 reluctant to do the family engagement piece. Or
14 there is no reimbursement for silver diamine
15 fluoride. So, they can't do that simple
16 intervention that will halt the disease. So,
17 those things are starting to get traction, but
18 they are not in every state yet.

19 MEMBER BENIN: It just does seem to me
20 that, as we are potentially in a situation where
21 those states will have less money for Medicaid,
22 that these things will get more complicated and

1 these kinds of programs will be at risk. It will
2 be interesting to see that --

3 MS. NORRIS: Yes.

4 MEMBER BENIN: -- in each of the
5 states and how that impacts the metrics and how
6 we think about the need for the metrics. To me,
7 that ties together.

8 CHAIR ANTONELLI: Yes. Thank you.

9 MS. NORRIS: Yes, and I think, also,
10 one of the --

11 CHAIR ANTONELLI: Actually, Laurie, I
12 am going to cut that off because I want to do
13 this.

14 Deborah, Kim, and, then, Lindsay. And
15 then, we're going to move into Lindsay's
16 presentation. So, we can do that later, but I
17 want to make sure that we have enough time for
18 the New York presentation.

19 Okay. So, Deborah?

20 MEMBER KILSTEIN: Question: when you
21 talked about 36 states with managed care for
22 dental, I assume that includes states where it is

1 carved out of the health plan and is part of DPO?
2 And do you see any issues in terms of the
3 carveout where a physician service might be
4 covered under the managed care plan, but the
5 dental service, when it is done by the dentist,
6 is done by the DPO?

7 MS. NORRIS: Yes. Yes, we are -- I am
8 including carveouts in that number, but only for
9 carveouts that are managed care dental carveouts.
10 Some states carve it out to like an
11 administrative services organization. So, it is
12 fee-for-service. So, yes, and it does complicate
13 the tracking of expenses and potential
14 motivations for savings when you separate the
15 dental from the medical, because on the medical
16 side is where you are still paying for the
17 operatory -- like if kids have to go to the
18 operating room. But where you are going to
19 impact that is by doing a better job over on the
20 dental side. So, yes, it complicates it.

21 DR. ELLIOTT: Have you found a way now
22 to capture all of the other provider types in the

1 CMS 416 for doing the preventative services, like
2 the PCP and other providers in the PCP's office?

3 MS. NORRIS: Yes, we have a line in
4 our EPSDT reporting that is not by a dentist and
5 not under the supervision of a dentist. So, you
6 know, the typical, the dentist and under the
7 supervision of, that gets you all the dental
8 hygiene and dentist services. And then, we have
9 this other line which is the primary care folks,
10 and that's the one I was talking at the
11 beginning, where we are around 10 percent of kids
12 in ages 1 to 5 that are getting those services.

13 DR. ELLIOTT: And then, that rolls up
14 into the actual reported rates, so like the 50-
15 some percent?

16 MS. NORRIS: Actually, it doesn't.

17 DR. ELLIOTT: Okay. So, I think that
18 has been some of the challenges that states have
19 had.

20 MS. NORRIS: Yes. In our PDENT
21 measure we are not counting the contribution of
22 the primary care folks because of denominator

1 issues.

2 CHAIR ANTONELLI: Lindsay?

3 MS. COGAN: So, I'm pretty sure Rachel
4 just walked out.

5 My question was -- and maybe it could
6 be more of just a global statement -- was, so
7 what did Florida do to bring up their rates? And
8 that's something I think that, as other states, I
9 think it is great when you highlight briefs where
10 there's high-performers, but I think it would be
11 just as interesting to highlight states that are
12 maybe low-performers that are managing to pull
13 themselves up a little bit. So, what are they
14 doing? What's working for them and how can we
15 spread that to other states?

16 MS. NORRIS: So, I had a slide on
17 Florida which didn't make it into this deck. So,
18 very quickly, Florida put a requirement of a 10-
19 percentage-point improvement in -- well, to meet
20 the 10-percentage-point improvement rate for each
21 of their health plans in the contract, and they
22 had a disincentive attached to it. And all but

1 one plan met the goal.

2 They also mandated an oral health PIP
3 across all their health plans, which I suppose
4 the plans used to help them meet their goal.
5 They also really ratched-up their stakeholder
6 engagement, and through that process, they did a
7 statewide -- they designed and deployed a
8 statewide oral health education campaign that
9 involved community-based organizations and
10 started to do a much better job of getting the
11 message to families that this benefit was
12 available and they should use it. So, those are
13 the top three things they did.

14 CHAIR ANTONELLI: Thank you very much,
15 and thank you for a strengths-based approach to
16 reporting that data.

17 All right. We are going to invite
18 Lindsay Cogan to come and present the New York
19 State perspective with respect to the child core
20 set.

21 Lindsay, if you could just take 30
22 seconds to introduce yourself, your role, and

1 then, launch into the discussion?

2 MS. COGAN: Sure. Thank you very much
3 for having me today.

4 My name is Lindsay Cogan. I'm with
5 the New York State Department of Health, and I
6 work in the space of quality measurement. I'm
7 the Director of the Division of Quality
8 Measurement, and our area handles quality
9 measurement across multiple levels.

10 So, we look at quality measurement
11 across payers. We look at it specifically for
12 Medicaid. And my area handles a lot of the
13 reporting for both the adult and child core set
14 to CMS.

15 As of late, we have been doing quality
16 measurement in all different kinds of spaces as
17 well. As part of our 1115 waiver, we have been
18 looking at more health systems. And as part of
19 our work with our SIM grant, we have even been
20 getting down to more provider practice-based
21 quality measurement.

22 So, I'm excited to be here. I'm

1 excited to talk about the child core set.

2 Usually, I talk about the adult core set. So,
3 this is a great opportunity to move into this
4 space, which I think is exciting and a little bit
5 more challenging.

6 So, next slide.

7 So, here is just a brief overview of
8 what I am going to talk about. I'm going to say
9 that I aimed high. You know, go big or go home.
10 I've got some aspirational goals in here, and not
11 always a clear path on how to get there. So, I
12 just want to acknowledge that right upfront,
13 that, you know, some of the asks are things that
14 we would want as a state may be unobtainable for
15 now, but I want us to really think about stretch
16 goals here.

17 And so, I'm going to give you an
18 overview and, then, some recommendations and,
19 then, sort of where we would like to see the
20 future of the core set go.

21 Next slide.

22 So, here's just a brief snapshot of

1 New York State Medicaid and children, right? So,
2 children account for about 43 percent of all
3 Medicaid enrollees. You can see I've given you
4 some distributions by age and by race. So, about
5 60 percent of our population is in New York City,
6 which is an extremely diverse population.

7 In this space, most of our children
8 are enrolled in managed care. You can see about
9 a 90/10 split fee-for-service.

10 We have a small proportion of children
11 in the State who are SSI. It's about 5 percent
12 in 2015.

13 And if you go to the next slide, I
14 have given sort of complement to the population
15 now and shifted over to cost. So, our colleagues
16 at the United Hospital Fund did a great study in
17 2014 looking at continuously-enrolled children,
18 and I have given a link at the bottom, if you are
19 interested in looking more at this.

20 You can see that average cost per
21 child is about a third, maybe 37 percent, of what
22 we spend on adults. Children are mostly healthy

1 and low-cost. There is a small proportion of
2 children, however, that are very costly. And you
3 can see down in the bottom slides there some of
4 our cost per child enrollee for the year for a
5 child, say, with SSI compared to not. And even
6 within SSI, there are certain populations that
7 are those drivers of high cost, high need.

8 And again, I don't think that this is
9 a story really that differs much on the national
10 picture as well, but I kind of wanted to give
11 some relevance here. We do see that children
12 with one or more chronic conditions is quite a
13 bit higher in New York State than we see on the
14 national front. It could speak to more of our
15 benefit package waivers where we cover more
16 children perhaps than other states, but I just
17 thought it worth noting.

18 Next slide.

19 So, here's a little bit about the
20 history of the Medicaid managed care program in
21 New York State. As I said, we are a managed-
22 care-for-all state and have been since our first

1 Medicaid waiver, known as the Partnership Plan in
2 the nineties. And each year since, we have
3 really been looking to expand and bring in those
4 excluded populations into managed care, keeping a
5 close eye on the quality. But we have continued
6 to roll out managed care in more and more of our
7 population. We are a Medicaid expansion state as
8 well.

9 Next slide.

10 So, with that background, this gets
11 into really the meat of what I want to talk about
12 here today. So, in New York we've been reporting
13 on the child core set since 2013. In the most
14 recent reporting cycle, we were able to report on
15 23 of the 26 measures. We didn't report on the
16 following three measures that I have listed here.
17 No surprise; these are ones that sort of showed
18 up in the slides earlier as being sort of low-
19 reporters from other states as well.

20 Next slide.

21 And so, one of the main reasons as a
22 state we're able to report all that we are able

1 to report to is because we leverage our strong
2 outpatient reporting system that's largely
3 comprised of HEDIS measures collected through our
4 managed care plans. And I think this is a
5 similar story for other states that you have
6 heard before.

7 We are able to report some information
8 to both the child and adult core set from
9 existing projects, one of which I've listed here.
10 And I'll get into that a little bit later.

11 And then, I have given you a flavor of
12 some of the types of measures that are difficult
13 at a state level to report. Since we are managed
14 care for all state, anything non-HEDIS gets
15 tricky. Anything provider-based or coming from
16 electronic data sources is also really
17 challenging.

18 We are looking for a statewide
19 solution for electronic data collection. We are
20 just not there yet.

21 And we really weigh the additional
22 cost versus the new information that we would be

1 able to yield before deciding to add resources to
2 really collect a measure for one of these core
3 sets.

4 Next slide.

5 So, now that I have told you what we
6 report and how we do it, let's talk a little bit
7 about the uses of quality measures. I don't need
8 to tell you all sort of the three main uses of
9 quality measures. We do all three in some
10 capacity. We publicly report all of our data.
11 We feel very strongly about data transparency.
12 We offer financial incentives to our Medicaid
13 managed care plans that tie back to a lot of the
14 quality measures in the core set.

15 I get asked a lot -- in fact, in
16 preparation for this presentation -- how we use
17 this data in the core set for quality
18 improvement. So, since we are a managed care
19 state, a lot of our quality improvement work goes
20 through the managed care plans in either a
21 performance improvement project or a targeted
22 study.

1 And then, we talked a little bit about
2 stratification yesterday. So, I'm not going to
3 get too much into it other than to really hammer
4 home how important we think stratifying our
5 measures not only by age, gender, or race, but by
6 looking at some of these other conditions, other
7 vulnerable populations. We call them priority
8 populations.

9 And we do this regularly because we
10 want to understand the quality of care for these
11 populations, and we want to best use the
12 information that we have available.

13 So, we use this in our quality
14 improvement space to sort of drill in and help
15 people understand where best to target some
16 populations, as well as to understand perhaps
17 where other gaps are. And we would put that
18 under research as well. So, sort of understanding
19 the need, evaluating different programs and
20 populations, and tying process to outcomes, we
21 think is incredible important.

22 Next slide.

1 So, I mentions this, and I apologize
2 for not a good transition, but I put this in here
3 because I wanted to mention this. This is one
4 example where we are working directly with
5 providers on quality improvement as it relates to
6 our prenatal care standards that were updated in
7 2009.

8 So, what we have done is we are
9 working with high-volume providers. We are going
10 in; we are having them take a sample of medical
11 records from those who had a live birth, and we
12 are asking them to go through the entire medical
13 record and answer some questions.

14 And we've had to develop this portal
15 for providers to actually extract information
16 from the medical record and bring it to us. So,
17 we have a portal.

18 And I'm sorry, I missed Mary's
19 presentation yesterday. I'm guessing she
20 probably got into this, too. So, a lot of the
21 information that we want to gather is in the
22 notes section of an electronic health record,

1 right? So, there's no standardized way for us to
2 get that information. So, it is incredibly
3 labor-intensive. It is on a small sample of
4 records because of that.

5 It has really been a rich project
6 where we have gotten a lot of great information,
7 but it has also been rich in the sense that it is
8 incredibly costly. We have gone way, way over
9 budget. So, the sustainability of this project
10 is really coming into question.

11 And I bring that up because -- next
12 slide -- this is one place where we were able to
13 gather some information to put into our core set
14 reporting. So, we are able to report on this
15 behavioral health risk assessment for pregnant
16 women measure using the small sample of records.

17 And if we didn't have this project, we
18 would never have been able to put the resources
19 into collecting it. So, we are able to use it,
20 and it is expected in our prenatal care centers
21 that women receive the psychosocial risk
22 assessment screening, counseling, and referral

1 for care.

2 We do adapt this measure a little bit
3 in how we report it. We don't report it the way
4 the specs do. So, we do not on the first visit,
5 but we count anything over the initial two
6 visits.

7 And the reason why we do that is
8 because we've found that in the medical record
9 reviews it is common for the risk assessment to
10 be conducted by a social worker or other non-
11 physician provider and, then, followed up with a
12 provider in the next subsequent visit.

13 So, we're not going to go back and
14 say, "Don't do that. That's not compliant,"
15 because that is the reality of the care and how
16 it is being delivered. And it is a good thing.

17 So, we do adapt that measure a little
18 bit. And we don't stop with just the screen,
19 right? So, the screen, we are doing all of it.
20 We are at 81 percent. You know, we don't just
21 like, good, we're good to go. We don't, because
22 you can see that the counseling and referral from

1 those people who are identified as positive
2 ranges quite a bit. It goes down to 69 and,
3 then, up to 100 and, then again, even those who
4 were referred, asking if they followed up and
5 actually either went to another appointment or
6 got the service, or something else. You see it
7 drops even lower. We get down to like the
8 fifties.

9 So, we just really wanted to make the
10 point that it is highly labor-intensive to
11 collect this information. I don't know that you
12 need every state in the country to invest the
13 resources to know that we fall down on followup.
14 And I think we fall down on followup not just
15 here, but in other spaces as well.

16 So, the next slide I want to talk
17 about is really kind of what brought me here
18 today and really what motivated me to come and
19 speak to you. Getting back to counting what
20 counts, and I apologize for not being here for
21 the whole meeting, but I'm assuming that this has
22 been brought up in some way or another.

1 And I took this line from the Vital
2 Signs Core Metrics for Health and Healthcare
3 Progress Report that I am sure some of you wrote.
4 I know Helen was the Chair. Many of you probably
5 participated or put forth this information.

6 But I think this paper is incredibly
7 relevant to the main points of developing a core
8 set. And it has become my guiding principle as I
9 come out of my first tenure in the field of
10 quality measurement. I'm not here to talk about
11 gaps in measures. In fact, I think we have a lot
12 of measures; sometimes we have too many measures.

13 The gap comes in how we're using and
14 applying these measures. So, that is really what
15 I kind of want to hammer home here today. What
16 we have done is we have taken measures that were
17 never intended to be used to describe a
18 healthcare system, a state, the care of children
19 in Medicaid, and we are applying them in this way
20 and putting it into a core set.

21 If you are not familiar with this
22 report, they outline sort of domains and key

1 elements and core measure focus. And then, they
2 say, you know, "And here's the best measures we
3 have that are selected that are the most
4 representative and could fit into these
5 particular areas."

6 And I did this mapping of your core
7 set measures into these domains. This didn't
8 come necessarily out of the report. This was
9 just me, in preparation for this presentation, to
10 kind of demonstrate that, for the most part, your
11 core set seems to follow the same framework.

12 And I have, again, backed in the best
13 current measures you have in the core set to
14 these measure-focused areas like preventive
15 services, access to care, patient safety. I have
16 sort of called out a challenge. You don't have a
17 preventable hospitalization rate in your core
18 set. I am not necessarily advocating that you
19 need to include something like the PDIs. Oh, you
20 recommend it? Okay. I am not necessarily going
21 out on that limb and saying that you need to put
22 one in there. I am just calling out that I think

1 this particular area is a real challenge for
2 ensuring that we have measures that address
3 evidence-based care.

4 And in the next slide, you know, the
5 phase 1 of your core set really was taking these
6 measures and kind of backing in what we have
7 currently available to us. And I think the theme
8 I have gotten from just the little that I have
9 been here is that we want more outcome measures,
10 less process. And this is children. Most are
11 healthy; most are low-cost. That is a challenge
12 in the child space; whereas, I think you get more
13 traction in the adult space. We've got really
14 small numbers.

15 Outcomes in children may not be known
16 for many, many years. And so, while I totally
17 agree that outcome measures are great, we support
18 outcome measures. You just heard a dental
19 presentation where you want to move towards
20 outcome.

21 It is important not to abandon
22 evidence-based process-of-care measures. If you

1 do, and you only look at the outcome, you won't
2 know what's not working along that path. You
3 won't know until it's too late to go back and do
4 something.

5 So, just proceed with caution. As you
6 look to sort of throw out process and replace
7 with outcome, just don't throw them all out. We
8 think it is important to have some in there.

9 And again, just to get back to most of
10 these measures were developed for very specific
11 purposes. As we get through this first phase of
12 the core measurement set, is using the best
13 measures available, is that really good enough?

14 And so, on the next slide, I have
15 given you sort of a flavor of some of the
16 measures that were designed to do something
17 really specific, right? And I agree with all of
18 these measures. I agree with measures for
19 specific populations. I agree with it is
20 important for us to know that adolescent women
21 were screened for chlamydia. It is important to
22 know that we screen women for all kinds of

1 things. I'm not saying that, but is that really
2 driving us towards where we need to go?

3 And if you just hit down once, there
4 is an animation in the slide. So, are you really
5 ready today to give us additional screening
6 measures to track when it is the followup that we
7 seem to fall down on time and time again?

8 Caveat: I didn't look ahead at the measures that
9 you propose today.

10 But, again, are the best measures we
11 have the best we can do? Are we really counting
12 what counts or just measuring something for the
13 sake of measuring something. Time and time
14 again, I think this has really started to come up
15 and percolate in our State.

16 And the next slide, this isn't
17 something I hear a lot about at the measures I
18 attend. It is often getting to measures that are
19 designed to measure system performance, and this
20 is really where we need to go. After all, we're
21 here today because you want to say something
22 about the quality of care of children in

1 Medicaid, right? You want to say something about
2 the Medicaid system as a whole.

3 Instead, when we stick with these
4 individual fragmented measures, none of which
5 were actually designed to be put together, and
6 come up with a patchwork of care, we may miss the
7 bigger picture. And I struggle with some of the
8 data that comes out on the core set because it is
9 up and down; it is all over the place. I do good
10 on access. I'm not good on this. I'm good at
11 followup for ADHD. I'm not good at behavioral
12 risk assessment screening. It's kind of up/down,
13 all over.

14 And I think what we really want is
15 either some intelligence to those measures, put
16 them together and tell me something, add
17 something on top of just pushing out the results,
18 or -- and this is like the huge aspirational ask
19 -- do we need to change how we think about
20 measurement, so that we're thinking more at this
21 whole spectrum of care?

22 Are people getting to the care? Do

1 they have the access to care they need? When
2 they get there, are they getting the evidence-
3 based care that is required or needed? And then,
4 if they need something additional, are they able
5 to follow up, right?

6 And so, that is the big picture. I
7 think that is all where we want to go. And I do
8 acknowledge that that is a huge ask.

9 And Vital Signs really stopped just
10 short of taking this next step. They said, you
11 know, "We're not going to go to that composite
12 level. We're not going to go to that next
13 level." And I'm here today to tell you the time
14 is now. We really need to take that next step.

15 And this is why, in the next slide.
16 So, we are changing the way we pay for care. And
17 New York, we have big goals and in short order.
18 By 2020, we are pushing to have 80 percent of all
19 payments be value-based arrangements.

20 So, the way we are doing this is
21 through a couple of different initiatives. We
22 have so many. These are just the big ones,

1 right?

2 So, we are looking to advance primary
3 care as well as our Medicaid 1115 waiver, our
4 disparate program. And this is where I, as
5 quality is the gateway to the shared savings, I
6 spend almost all of my time now talking about
7 quality measures and their application in value-
8 based payment.

9 And while I appreciate the core set
10 has not been designed to be used for payment, I
11 will tell you that we are trying to align, align,
12 align. So, those measures that you signal that
13 are important in the core set, we are trying to
14 say that is a starting place for sort of
15 alignment as we move down and across payers.

16 So, while you didn't intend for these
17 measures to be used for payment, they are being
18 used for payment, and because we do want that
19 alignment, that parsimony across sets.

20 And a few years ago, where it seemed
21 like we were looking hard at cutting back on the
22 number and type of measures, this introduction of

1 EBP has created a mania. It's mania. It's manic
2 around measures again. It has exploded all over.

3 And for ours, in our State, we are
4 taking an incremental phased-in quality
5 measurement approach, not unlike what I described
6 in phase 1 of the core measurement set. We are
7 leveraging in 16 measures to get off the ground.
8 We are looking to sort of come to a core set of
9 measures. We're doing our best to push for
10 alignment across sets, like the core set, and
11 then, across payers, too. So, let's not forget
12 that, right?

13 So, providers don't just provide care
14 to Medicaid enrollees. We do have some safety-
15 net providers that may provide the bulk of their
16 care to Medicaid, but that is few and far in
17 between in a state as large as New York. We want
18 all providers and payers to come to some sort of
19 quality measurement alignment.

20 And we're trying to reduce duplicative
21 effort, measurement burden, and cost, but,
22 eventually, we need to get to the measures we

1 really need. And I ask you, when are we going to
2 the measures we really need? We don't want to
3 be, as a state, going at it alone and going off
4 on a tangent.

5 I constantly say that to people who
6 are within our State's interest groups that come
7 in and say, "You don't need NQF endorsement. We
8 need to just do it our self." And I say, "Whoa,
9 whoa. Bring it back. Like let's think about
10 that and the implications of us sort of going off
11 on our own."

12 But I do feel the challenges. We're
13 really pushing providers to take on risk. And in
14 some of these measurement spaces, I'm losing it,
15 getting up there and saying, "Well, we can just
16 use what we have. It will be fine."

17 Because we are talking about keeping
18 the lights on and closing providers. They are
19 taking on huge risk here. So, I'm losing that
20 ability to say what we have is good enough
21 anymore.

22 And that's tricky. I have been doing

1 that for a long time. I was the one they sent
2 out to say, "No, we don't need anything new.
3 Just use what we have. It will be fine." And
4 so, for me to lose that really has sort of pushed
5 us to look further.

6 So, next slide.

7 I'm not sure if this measure is what
8 we are really looking for. And I don't know if
9 it is necessarily an example of what we are
10 thinking, but I did want to pull in a very real
11 example of where we are launching a small pilot,
12 leveraging a healthcare value-based payment model
13 to engage the healthcare sector in school
14 readiness.

15 So, I caveat that with the fact that
16 school readiness is hard to measure. There is
17 not currently a uniform way to do it. But we
18 feel very strongly that the healthcare sectors
19 plays a critical role in ensuring school
20 readiness. So, we're going to give it a shot.

21 Next slide.

22 We're fostering a cross-sector

1 collaboration between several managed care plans,
2 some high-volume pediatric providers in the city
3 of Albany, early intervention, schools and
4 parents. And we're incentivizing things like
5 developmental screening in the first three years
6 of life, referrals, positive identification
7 services, and eventually kindergarten readiness.

8 More to come on this, as we continue
9 to build up this project. But the point being
10 here that we are looking towards the whole
11 spectrum of care for children and not just paying
12 for the individual pieces.

13 And I know anyone who has talked to me
14 about sort of developmental screening in the
15 first three years of life, when I put on my data,
16 my measurement hat, that is an incredibly hard
17 measure to gather and collect and report out on.
18 But, when I put on my policy hat, it is a really
19 important measure. It's population-based. It's
20 sort of a way to get children the services they
21 may need.

22 So, I struggle, constantly going back

1 and forth on this particular measure. And we
2 don't have a statewide solution for it, and we're
3 pushed. Every day I get more and more questions
4 about, when are we going to have a statewide
5 solution for this measure?

6 So, we are going to look at, through
7 this pilot, trying to see if maybe kindergarten
8 readiness is not the right outcome to be pushing.
9 Maybe it is the screening that we do want to
10 push. So, hopefully, I will be able to come back
11 to you and talk to you a little bit more about
12 what we learn there.

13 But, next. The last slide is really
14 what I leave you with here today. It is that
15 more is not better. Continuing to propagate a
16 core set made up of fragmented measures that
17 represent our fragmented system of care or
18 feeding the beast, as I like to call it, you
19 know, looking for more measures for specialized
20 populations, of which you will never have enough.
21 You will never reach all the populations that you
22 need to.

1 Will that really get us any closer to
2 measuring system performance? Are you ready to
3 count what counts or just measure something for
4 the sake of measuring something?

5 So, with that, I will take all kinds
6 of questions, and you can feel free to hit me
7 with them. I love questions.

8 And I have left my contact information
9 here, too. So, please do feel free to follow up
10 with me at any point if we don't get to all of
11 the questions today.

12 CHAIR ANTONELLI: Bravo, and thank you
13 so much.

14 Can we advance to the group discussion
15 thing? So, again, for the sake of time
16 management, I would appreciate it if the
17 questions and comments from the Task Force for
18 Lindsay and the New York experience can anchor to
19 these themes.

20 So, most significant challenges and
21 how changes to the core set help facilitate that,
22 I think you did a marvelous job of articulating

1 your frustrations, where your successes may lie,
2 and your needs going forward.

3 Any of the points of feedback for the
4 states to influence the decision process around
5 our recommendation of either removing or putting
6 forward specific measurements. And most notable
7 successes related to quality measurement.

8 And so, again, try to keep our
9 comments and questions anchored to these themes.

10 So, I think we had Deborah first and,
11 then, Terry.

12 MEMBER KILSTEIN: Question for you.
13 Besides this kindergarten readiness, are you
14 doing anything where you are looking at multiple
15 measures for an individual child and looking
16 across all kids? Like how many kids are getting
17 their EPSDT, their dental screening, their
18 developmental screening, and looking for the
19 child and looking at all these measures, rather
20 than looking at the service across all kids?

21 MS. COGAN: So, we have done a lot of
22 work in that space, trying to take what we do at

1 a sort of health plan quality rating. We do a
2 five-star rating for health plans, taking these
3 measures and rolling them up into like domains or
4 families. So, we are starting to look in that
5 space to say, you know, what if we look at this
6 as more of a domain approach? But, then, you get
7 into all kinds of questions about what weighs
8 heavier than others. Do they all equally weight-
9 in?

10 So, we are playing around with that a
11 little bit and trying to think about more of
12 composites. So, if you get all of the above or
13 none of the above, we are kind of looking at that
14 does response. If you get some of it, but not
15 all of it, and then, again, trying to tie that to
16 outcome. So, we are dabbling in that space a
17 little bit. Again, I don't have all the answers,
18 but it is something to start with at least.

19 MEMBER ADIRIM: Great presentation.
20 I think it is really helpful to hear from states
21 how they are really using the measures and what
22 you talk about with regard to how you are trying

1 to achieve improvement around some of those
2 measures.

3 I have a brief comment and, then, a
4 question. The comment is around the kindergarten
5 pilot that you are going to do. Are you working
6 with your home visiting program? Because I know
7 that the home visiting programs have measures
8 around certain domains. And we don't have
9 quality measures for kindergarten readiness that
10 I know of and that kind of education domain, but
11 there may be, if you work with your home visiting
12 program. So, that was just a comment.

13 The second, the question is with
14 regard -- at the beginning of your presentation
15 you talked about your higher-cost populations.
16 Do you find that there's a gap in measurement
17 around that particular population? And if you
18 could speak a little bit about what your needs
19 may be around that?

20 MS. COGAN: So, the issue with getting
21 at measuring that population is it is so small.
22 So, you lose power very quickly.

1 So, we do a lot with stratification
2 and we try to really hone-in on, like I
3 mentioned, you know, children with special
4 healthcare needs, but that is an incredibly wide
5 and diverse group of children.

6 So, then, diving a little bit deeper,
7 who is it in that group that really needs
8 something? So, we haven't gone as far as to say
9 we know we need a measure for -- I don't know;
10 I'm going to make it up -- this one segment of
11 the population. We have looked a little bit at
12 sickle cell, and I do work with Michigan who I
13 think is the recipient of a grant that is looking
14 at sickle cell a little bit. One of our medical
15 directors is very interested in sickle cell. So,
16 we are trying to dive a little bit deeper into
17 sickle cell.

18 And then, again, look at, is it that
19 it is a gap -- do we need a gap? Is there a gap
20 because we need a new measure or do we need a way
21 to measure if children get what they get? So,
22 that has kind of been our struggle going back and

1 forth.

2 MEMBER BEATTIE: Hi. So, I am an
3 administrator for a children's hospital and a
4 pediatrician working as a hospitalist, but I am
5 here representing America's Essential Hospitals.

6 And one of the things that I didn't
7 see you talk about, but I am going to link to
8 your request for prevental hospitalizations, is
9 the issue of psychiatric care for kids. And even
10 in looking at -- like we currently have in the
11 core set, it addresses more of the after-the-fact
12 as opposed to preventative and the continuum of
13 care.

14 And I'm not sure what the situation is
15 in New York, but we really don't have continuum
16 of care to even offer to kids in my State, in
17 many states, where you have got outpatient with
18 poor access and you have got inpatient with not
19 enough beds, and nothing in between.

20 So, is that something that we should
21 be looking at to help drive for states to be
22 supporting development of continuity of care to

1 prevent the incorrect hospitalizations? Because
2 what happens is these kids end up in our medical
3 hospitals because there's no place for them in
4 psych beds.

5 And when I was at the CHA conference
6 last year, I noted that something like 30 percent
7 of the presentations were all about this
8 challenge that all of our children's hospitals
9 are having. And I know it is true in the
10 community hospitals as well.

11 So, can you talk a little bit about
12 what Medicaid in your State is doing and how we
13 might be to even begin to address that in some
14 sort of an element within our quality core sets?

15 MS. COGAN: Absolutely. So, that is
16 a huge challenge. And I think we have started in
17 the adult space with our Health Home Initiative
18 and sort of carving our behavioral health
19 services back into managed care. So, I think we
20 have started with adults.

21 Children's health homes, in looking at
22 more complex conditions for children, is sort of

1 just coming up to the forefront for us. So, I
2 will be pulled into those conversations next
3 about, you know, what is the right measure? How
4 do we want to look at kids?

5 And I agree with you, that is a huge
6 issue. There's that integrating physical and
7 behavioral health. So, it is something we are
8 starting to try and tackle, and kids are ending
9 up in the emergency room, right? So, that is how
10 they are getting into the hospital, because they
11 can't get any outpatient care. So, they are
12 showing up in crisis in the emergency room, and
13 we hear that often a lot in New York.

14 So, it is an area that I think is
15 ripe, and we would welcome some more work in that
16 space. And I agree, again, if we can keep the
17 measure that looks sort of across -- what you've
18 given us in this space in the core set is a very
19 specific measure on screening for suicide
20 assessment for children diagnosed with
21 depression. So, you've gone way down. And so,
22 if we could just sort of back up a little bit and

1 talk more about accessing mental health care or
2 take a step back. And that is, I think, where
3 we would welcome some health and support.

4 MEMBER BEATTIE: So, the AAP, of
5 course, has a recommendation of depression
6 screening for all from 12 and older. And we
7 don't really have anything like that in here.
8 So, I'm just thinking, as I'm listening to her,
9 that that might be something.

10 And I know in the adult core set there
11 is some generalized use of the depression
12 screening and, then, follow up if you are scoring
13 over a 6. So, that might be something to
14 consider for the future.

15 MS. COGAN: Are you going to talk
16 about that measure today? Because it does go
17 down to age 12. So, they've cut it at adults for
18 the adult core set, but the actual measure was
19 endorsed for 12 and above. So, I didn't know if
20 that was on the docket for today. No? Okay.

21 CHAIR ANTONELLI: We don't think so,
22 but if you can confirm that while we continue the

1 conversation?

2 So, you're making eye contact, but I'm
3 looking at her name. Okay. It is hard enough
4 being middle-aged.

5 (Laughter.)

6 All right, go ahead, Kim.

7 DR. ELLIOTT: You were talking a
8 little bit about not throwing away the process
9 measures because we are moving more and more
10 towards outcomes measures. I would like to hear
11 you talk a little bit more about that, because I
12 see outcomes measures as being driven by
13 processes. So, if you are measuring the outcomes
14 and you are having some issues or concerns with
15 the rates you are receiving, you would go back
16 and look at the processes that drive that
17 outcome. So, I'm a little curious as to your
18 thoughts on that.

19 MS. COGAN: Yes. So, you will always
20 have the process measures, right? So, we are not
21 going to get rid of the process measures.
22 Sometimes we don't have good outcomes. So, I

1 don't know that I can measure kindergarten
2 readiness. You know, we have something. We have
3 a tool. We are going to use it. We are going to
4 try. I may never be able to accurately and
5 consistently report something for kindergarten
6 readiness, but I may have really strong evidence
7 that something else, a process measure, really
8 ties very closely to that outcome.

9 So, I may want to keep and hang onto
10 that process measure because it really does
11 correlate very closely with an outcome. So, it
12 gives us the best opportunity to measure what we
13 are trying to get to. So, I think that is more
14 of what I am talking about.

15 I am all about for shrinking. So,
16 don't keep it all in for me. You know, I am
17 about sort of limiting your set. And we will
18 always have those individual measures to go back
19 to and sort of drill in deeper at a state level,
20 and understand where the gaps are. But I think
21 sometimes with children, I think outcomes are a
22 challenge.

1 MS. GORHAM: So, just to answer your
2 question, we do have a slide already prepared for
3 discussion for the child and adolescent major
4 depressant disorder, suicide risk assessment.
5 So, we do have that slated for discussion.

6 CHAIR ANTONELLI: Terry, are you in
7 the queue again or is that an artifact? All
8 right. Do you have a new one?

9 MEMBER BEATTIE: Yes. Just I think
10 what we are referring to is to add the depression
11 screening for all adolescents. It is not about
12 suicide screening for adolescents who were
13 previously identified and known to have a
14 depressive disorder. It is, are you screening in
15 primary care for a psychiatric condition?

16 CHAIR ANTONELLI: So, where you are
17 going will actually be for later today. So,
18 absolutely keep that. I asked the staff to
19 comment specific to this question. If you would
20 like to raise that later on, we could absolutely
21 take it on. But I guess I will charge you with
22 doing that. Okay? Okay.

1 Andrea?

2 MEMBER BENIN: Lindsay, I think given
3 the fact that you expanded a little bit on how
4 these metrics do get used for payment purposes,
5 which is something I think we all know, although
6 there is always sort of this discussion as though
7 that is not true, but we know that it is. Could
8 you expand a little bit on the concepts that were
9 discussed a little bit yesterday around how, when
10 you have metrics where the ideal performance
11 isn't known, how that plays out in your world
12 where you are using them for pay, and sort of how
13 we think about including metrics that may or may
14 not -- you know, that aren't 100 percent or zero
15 percent goal target, easily set. Everybody needs
16 PDENT, or whatever, but some of these other
17 metrics where we've said, "Oh, it's okay to hit"
18 X -- fill in the blank; choose your target. If
19 you could speak a little bit about how that plays
20 out, I think it would be helpful.

21 MS. COGAN: So, what we do in a lot of
22 those situations is we have sort of a pay-for-

1 performance and, then, a pay-for-reporting. And
2 that has been kind of a recommendation we have
3 delineated. In particular, with the
4 contraception care measure, I have been pretty
5 close to that measure. I work very closely with
6 Lucretia. We are a recipient of a grant to help
7 develop that measure.

8 So, I have been very close to that.
9 So, I have been able to bring back to my State
10 the recommendation that we don't use that for
11 pay-for-performance; that really it not been
12 endorsed that way; it has not been put forth that
13 way. You know, the conditional requirement.

14 So, I am able to make those types of
15 policy recommendations. I don't know that every
16 state sort of has that closeness to either CMS or
17 a measure developer or NQF, to even know enough
18 that, when you look at a measure endorsement,
19 that you have provided recommendations about what
20 it should be used for.

21 And I do get some pushback when I say,
22 "Hey, you know, this measure wasn't really

1 intended to be used for payment." And I
2 sometimes get overridden and they say, "I don't
3 really care. We're using it for payment."

4 So, it is a struggle that we face time
5 and time again. But one of our strategies is we
6 will do sort of a recommendation that this be a
7 pay-for-performance because it is clear that we
8 want to get to higher is better, as close to 100
9 percent as we can. And then, for those that we
10 are not as certain about, we will maybe put in a
11 pay-for-reporting. So, we just want you to keep
12 an eye on it. It is important enough that we
13 want you to report on it, but we are not going to
14 include that in any kind of shared savings
15 arrangement.

16 CHAIR ANTONELLI: Amy, I will let you
17 ask the last question for this segment.

18 MEMBER RICHARDSON: Your slide about
19 fortune is in the followup, to make sure I
20 understand, are you arguing for sort of fewer
21 domains. But, for example, you have chlamydia
22 screening. We can screen a zillion things and

1 they are good, but if the screening wasn't
2 followed by treatment and a followup visit,
3 right, the screening isn't worth much.

4 So, are you arguing for fewer
5 measures, but that include the screening and the
6 outcome? What is the argument here?

7 MS. COGAN: So, I am kind of posing
8 that as a real question. So, I think you're
9 right on, right? We can screen, and as a part of
10 my dissertation work, I looked at whether or not
11 women in Medicaid were actually screened, not
12 only screened for chlamydia, but those who tested
13 positive were treated. And I've got to tell you,
14 it wasn't good. And I am sure it is not good in
15 the commercial space, either.

16 So, I am throwing that out there as a
17 possibility. I think, ideally, we would want to
18 look at the whole picture, right? So, you don't
19 want to just stop with the screening. You want
20 to know that not only was someone screened, but
21 if they needed followup care, did they get that
22 followup care? And then, what happened after,

1 right?

2 But I know I am asking something
3 really big here and sort of changing the way that
4 we are thinking about measurement. I am also
5 saying, "Don't give me something about screening
6 for chlamydia and, then, suicide assessment and,
7 then, something else."

8 Just we are getting to this realm of
9 I don't need to know necessarily -- it would be
10 nice to have this, all the underneath and, then,
11 the specifics, again, to be able to dig into it
12 deeper if we don't know. But, at a state level
13 or at that higher level, just: did you get in?
14 Were you screened for what you needed to be
15 screened for, whether it be depression,
16 chlamydia, counseling on your weight, nutrition,
17 physical activity? And then, if you were found
18 to be positive, did you have the necessary
19 followup care?

20 And I realize that is a big
21 aspirational ask, right? Because that is not how
22 we think about measurement. Right now, we look

1 at chlamydia screening; we look at weight
2 counseling; we look at physical counseling; we
3 look at counseling for nutrition. But we are not
4 putting it all together and saying, for children,
5 I don't care what age you're at, were you able to
6 get in; were you able to get what you need, and
7 did you have followup if you needed it? So, I do
8 realize it is a huge ask.

9 CHAIR ANTONELLI: So, there are some
10 measures that actually look at -- sort of the
11 jargon and care coordination measurement is with
12 closing the loop, which includes some of the
13 remission measures for behavioral health
14 diagnoses. But it is early.

15 All right. So, we have two minutes
16 until the break. I would be happy to let you
17 now, assuming that Kim didn't usurp your card
18 again, go ahead, Roanne.

19 MEMBER OSBORNE-GASKIN: Yes, so I just
20 had an observation point. I noticed that you
21 said that New York did not report on the
22 developmental screening in the first few years of

1 life. But in your pilot that you are talking
2 about for kindergarten readiness, it is part of
3 what they are going to be using.

4 So, is it that you are going to move
5 to what is reporting on it because you are going
6 to actually have that as a way to sort of
7 standardize how you assess for kindergarten
8 readiness in New York?

9 MS. COGAN: Well, it is such a small
10 pilot. We could provide you some results. We
11 also did another sort of -- we cracked open some
12 medical records, about 400, a couple of years ago
13 and looked at whether or not we could come up
14 with a statewide solution for this measure, and
15 it wasn't good.

16 It just wasn't something we
17 could implement that we felt actually reflected
18 the care that was happening in the State because
19 of just the measure, how it is built, and how you
20 extract that information with the instructions
21 that is given in the specs. It is tough. It is
22 tricky.

1 The interpretation varied, and that is
2 what worried us about putting forward results for
3 something when we are not clear about what we are
4 measuring and if we are actually capturing the
5 right thing. So, we were trying to do it
6 administratively. The code was picking up oxygen
7 screening. It doesn't count. If you read the
8 measure, it doesn't count, but the code is there.

9 So, we just got into all kinds of
10 implementation issues. We are going to try to
11 figure it out, though. In this very small pilot
12 we are going to try to figure out, you know, how
13 can we measure this in a very small, controlled
14 situation with just a couple of thousand
15 children. And then, hopefully, we will be able
16 to build that out and come up with a statewide
17 solution that would allow us to measure that.

18 Because I don't care if you unendorse
19 it or don't put it in the core set. I have got a
20 whole State full of people that say, "You need to
21 measure this for me and I want results at a
22 statewide level." So, I do have to answer to

1 them as well. So, we are going to be coming up
2 with a statewide solution for this measure, more
3 than likely, and we will report it if we can.

4 CHAIR ANTONELLI: So, thank you so
5 much. What you contributed yesterday and today
6 was wonderful.

7 So, we are going to take a break. We
8 will start promptly at the top of the hour. We
9 have got a lot of work ahead of us.

10 But thanks to CMS and thanks to the
11 State of New York.

12 (Whereupon, the foregoing matter went
13 off the record at 10:46 a.m. and went back on the
14 record at 11:02 a.m.)

15 CHAIR ANTONELLI: All right, let's get
16 started on the next section.

17 Can you move us to the next slide,
18 May, please?

19 All right. So, measure-by-measure
20 review of the child core set. Shaconna is going
21 to step in to do a presentation for us.

22 I just want to make sure we still have

1 Dr. Smith on the phone.

2 DR. SMITH: Yes, I'm on the phone.

3 CHAIR ANTONELLI: Great. Okay, thank
4 you.

5 (Pause.)

6 We're solving a technical issue.

7 MS. GORHAM: Okay. We are going to
8 get started in the room. We realize that, if you
9 are streaming, you are having a bit of difficult.
10 Our screen is frozen. So, we do acknowledge that
11 you may not be able to follow along as we advance
12 through the slides because we cannot advance, but
13 we are working. But, for the sake of time, we
14 want to stay on time. So, we are going to
15 continue in the room. So, please listen to the
16 conversation. Thank you.

17 So, please move to the next slide.

18 So, right now, we're on slide 307.

19 And I won't spend a lot of time on
20 this. Some of the slides, we actually reviewed
21 yesterday. We stuck them in the slide deck for
22 sake of organization.

1 But this, again, is our measure-to-
2 measure review, and the measures reported in
3 FY2015 appear to be functioning pretty well.
4 Over the next few slides, we will discuss the
5 four measures that 22 or fewer states reported
6 on.

7 So, we can go to the next slide.

8 This slide shows the potential reasons
9 for removal from the core set. And again, we
10 discussed that yesterday. So, unless we have
11 questions, I will move on. Okay.

12 This shows exactly what is on your
13 handout and what we discussed yesterday as far as
14 the decision categories. So, you have support,
15 conditional support, and do not support. And
16 again, if we decide to support a measure
17 conditionally, we just need to state the reason
18 for that condition.

19 Okay. Slide 310.

20 So, these are the four measures with
21 low levels or the lowest levels of reporting in
22 the child core set for FY2015.

1 Next slide.

2 So, we talked a little bit about 1448
3 earlier, and that is the developmental screening
4 in the first three years of life. This measure
5 is no longer endorsed and, as stated earlier, the
6 developer didn't have the resources to test or
7 maintain this measure. The endorsed or the
8 previously endorsed, the measure you have in
9 front of you, the specs you have in front of you
10 did not -- the current standards have been
11 updated, and this measure does not reflect that.

12 This measure, on the 2015 core set 22
13 states reported the measure, which is an increase
14 from the 20 states that reported the measure in
15 both 2013 and 2014. Twenty-seven states did not
16 report this measure in FY2015, for a number of
17 reasons. Again, I refer you back to the resource
18 that CMS provided and that we sent before the
19 meeting.

20 So, some of those reasons include --
21 and again, I won't read all of them -- but,
22 again, some of the reasons, the same as we have

1 discussed so far: budget constraints. Data
2 elements necessary for calculation are only
3 available via medical records review. Providers
4 are using the CPT code for this measure.
5 However, guidance has not been provided yet to
6 providers to ensure the tools used for the screen
7 are consistent with the specification. The state
8 does not calculate this measure, nor require our
9 health plans to calculate it. So, those are a
10 few. Inconsistencies made the data unavailable,
11 and so forth.

12 The next measure, 0471, is a PC-02
13 Caesarian birth measure. The number of states
14 reporting the measure increased from 12 states in
15 FY2012 to 17 states in FY2013 and, then,
16 decreased to 16 states in 2014, and 15 states in
17 2015.

18 So, 34 states did not report this
19 measure. Reasons include data requires
20 information from the Division of Public Health
21 Vital Statistics Office. The state has not been
22 able to validate the rates yet with hospitals.

1 Birth certificate data have been not to
2 specification logic. However, states would like
3 to verify the data with some hospitals. MCOs are
4 not required to submit this HEDIS measure, and so
5 forth. Again, you have a comprehensive list in
6 your reference material.

7 We voted on this measure yesterday.
8 You all voted not to have the measure continue in
9 the core set, so to have the measure removed.
10 So, I won't go into this measure, as it was
11 discussed yesterday.

12 If we advance the slide, please?
13 Thank you.

14 So, the behavioral health risk
15 assessment is the one that you all voted to
16 remove from the core set. So, I won't go into
17 the particulars about this measure.

18 Next slide. Okay.

19 And then, the child and adolescent
20 major depressive disorder, the suicide risk
21 assessment, we had a little discussion about this
22 earlier today. Forty-eight states did not report

1 this measure. I will say that the measure was
2 just added in FY2015. So, that could also be a
3 reason for low reporting.

4 Some of the reasons stated state: it
5 is focusing on trying to improve the quality of
6 reporting all measures that have been reported
7 consistently over the last few years, and prefer
8 to work on quality over quantity.

9 Data element from electronic health
10 records are necessary for calculation, but are
11 not available. MCOs are not required to submit
12 this measure, and so forth.

13 Next measure, next slide.

14 Okay. So, I'll turn it over to Rich.
15 But, again, as we do all of the days, we just
16 highlight some of those measures that have low
17 reporting by the states. You all definitely can
18 discuss again. You have already discussed the
19 behavioral health risk assessment and decided to
20 remove that measure.

21 Rich?

22 CHAIR ANTONELLI: Okay. Thank you.

1 So, we want to think about the process
2 of consideration for removal from the set. I
3 really liked the interaction there at the end of
4 the last session where Lindsay said, "It's a
5 heavy lift, but we're going to do the behavioral
6 health screening inside our Albany demonstration
7 project because it's important." And that wasn't
8 because it's in the core set. And so, I think we
9 need to be mindful of that, as we deliberate
10 keeping measures in or putting them forward for
11 inclusion. You know, are they meeting criteria
12 around parsimony and is it moving us
13 directionally where we want to go?

14 So, the reason, we have already talked
15 about 1448. So, I won't spend any more time with
16 that.

17 And I think, in general, why don't we
18 just go ahead and proceed to open up to the Task
19 Force, if anybody would like to raise any --
20 Karen, do you want to add something at this
21 point?

22 DR. MATSUOKA: Yes. I just wanted to

1 note that a measure does not have to be a low-
2 reported measure in order to be a candidate for
3 removal. So, I know this was a point of
4 confusion that Roanne asked about yesterday. So,
5 I just want to clarify.

6 That is certainly one of the reasons
7 why you might consider removing a measure, is
8 because states aren't reporting it, but that
9 doesn't have to be the reason why.

10 CHAIR ANTONELLI: Really important.
11 Thank you very much.

12 Okay. So, we have Roanne and, then,
13 Rachel. Go ahead.

14 MEMBER OSBORNE-GASKIN: So, I just
15 wanted to refer to slide 252. Is that one of the
16 ones that is also being recommended for removal,
17 the child and adolescence access to primary care
18 practitioners? Or is that also -- slide 252.
19 Are we considering that one as well? Or that's
20 not for discussion right now?

21 MS. GORHAM: So, that measure was
22 recommended last year, but you certainly can

1 recommend that measure, have discussion, and if
2 it is seconded, someone motions to second, you
3 definitely can recommend it again. Just because
4 it was recommended last year does not mean you
5 cannot recommend it again.

6 So, Karen made a really good point,
7 that we, as staff, just organized our deck where
8 we have like the low-reported measures. But you
9 can look at any measure from the core set. And
10 if you want to have discussion about removal and
11 recommend to CMS, you can.

12 So, again, that was a recommendation
13 made last year, and you can, again, have
14 discussion and make the recommendations to CMS.

15 MEMBER OSBORNE-GASKIN: So, it was
16 recommended last year, but it was cut? It did
17 not --

18 MS. GORHAM: Exactly.

19 MEMBER OSBORNE-GASKIN: Okay.

20 MS. GORHAM: It was recommended by the
21 Task Force last year, but CMS did not elect to
22 have that measure removed. And now, Karen may

1 want to speak about the reason, but --

2 DR. MATSUOKA: Yes. So, I think the
3 main reason that we wanted to keep this in here,
4 because, first, we thought it was an important
5 complement to well child visit. I know that a
6 lot of the discussion last year -- I'm trying to
7 jog my memory -- was around, you know, if we have
8 a well child visit, do we really need this one.
9 And I think part of the answer that we heard from
10 our interaction with states, but also internally
11 at CMS, was that having a measure of access to
12 any kind of care at all is measuring something
13 slightly different than well child visit, which
14 is measuring some of the content at what you're
15 getting at the PCP visit. So, for that reason,
16 we thought we wouldn't want to remove it just
17 because we had well child visit in there.

18 The other main reason why we decided
19 to keep it in was because, although, by and
20 large, in the aggregate we are doing very well,
21 states are doing very well on that measure, we
22 saw a noticeable gap with regard to adolescents.

1 And we didn't want to -- I don't know that we
2 thought about just kind of keeping the adolescent
3 piece of it in the core set and getting rid of
4 the other age groupings. But, in order to be
5 able to keep tabs on how we are doing with
6 adolescent care, we decided to keep the whole
7 measure in.

8 MEMBER OSBORNE-GASKIN: So, I guess my
9 other question to that would be that, even with
10 adolescent well care visit and the immunizations
11 for adolescents, you have two other measures
12 there that look at adolescents, you know, if
13 that's a population that you want to look at
14 specifically. So, maybe I should just look at
15 it, but where there are significant differences
16 between, so you kind of capture the well car and
17 the immunizations for adolescents. Was there
18 some difference that was seen that made you still
19 want to keep that there?

20 DR. MATSUOKA: So, you bring up an
21 interesting point, which is that some of these
22 measures become very interesting when they are

1 looked at in conjunction with each other. So,
2 this is a good example of, you know, if you have
3 a state who has a relatively good access to care
4 measure, but is slightly doing less well on well
5 child visits for adolescents, and doing slightly
6 less well in terms of immunizations for
7 adolescents, each of those measures taken
8 together tell you a slightly different story
9 about what a state might think about as an
10 intervention point with regard to the delivery of
11 care for adolescents in their state overall.

12 So, they are very related and they are
13 all getting to access to and quality of
14 preventive care, but measuring a slightly
15 different dimension of it.

16 Another example would be asthma. So,
17 we have an asthma measure that we talked about
18 yesterday. That is looking at sort of medical
19 adherence and the extent to which the clinical
20 side of delivery of care for kids with asthma are
21 evidence-based.

22 But we also have the PQI-15 measure

1 for the extent to which there are avoidable
2 admissions to the hospital for asthma. And you
3 could say, well, those are both kind of looking
4 at quality of care for asthma, but they are
5 measuring something slightly different. And they
6 become very interesting in states where maybe
7 medication adherence is actually doing quite
8 well, but you are, nevertheless, seeing a fairly
9 elevated level of admissions to the hospital for
10 avoidable asthma care. It tells you something
11 slightly different.

12 And so, I don't know that we
13 necessarily think of all asthma measures as being
14 one and the same, and so, as long as we have one,
15 we're okay. So, I don't know if that answers
16 your question, but we do kind of, at least at the
17 federal level, we do, then, take that information
18 to think about, you know, what kind of affinity
19 groups do we want to offer.

20 So, we know that the HPV adolescent
21 vaccination rate was quite low. So, looking at
22 that, if we didn't have that apart from

1 information about the well child visits for
2 adolescents, we wouldn't know that there might be
3 a need for having some targeted technical
4 assistance to states on how to boost immunization
5 rates for adolescents.

6 So, I think a long answer, but I will
7 stop there and see if that answered your
8 question. Okay.

9 CHAIR ANTONELLI: And so, I want to
10 ask another question. Was that sufficient for
11 you or do you want to entertain proposing it for
12 consideration? Because we kind of moved into the
13 consideration phase, but because it was CMS
14 leadership speaking, I didn't want to cut it off.
15 But I don't mind burning clock time, but I want
16 to make sure that we are burning clock time for
17 things that rise to the level of a motion that
18 gets seconded.

19 So, would you like to proceed or was
20 that sufficient and you don't want to consider
21 raising a motion?

22 MS. GORHAM: I can also, Roanne, if it

1 would help, just tell you some of the reasoning
2 behind the recommendation last year, as far as
3 the Task Force is concerned, if that would at all
4 help you.

5 MEMBER KILSTEIN: Yes. And I just
6 want to kind of leave -- I just wanted to bring
7 it back to the floor. I don't know if anybody
8 else has any strong feelings about it. And then,
9 I know we have to leave the time for discussion
10 for the others. So, I mean, it is fine to swing
11 back and, you know, if it comes up again, then --

12 CHAIR ANTONELLI: Okay. Okay. Thank
13 you. Thank you.

14 Amy?

15 MEMBER RICHARDSON: Thank you.

16 I think there's one on this list that
17 sort of falls pretty quickly into some of the
18 discussion we had yesterday and here today. And
19 that is the Caesarian birth one that is on slide
20 312, yes, the Joint Commission.

21 So, I have no doubt that our Medicaid
22 moms are having higher rates of unnecessary

1 C-sections for term babies. But I'm not sure --
2 if we think about the downstream of measure
3 intervention, that the Joint Commission is in far
4 better position to (a) measure this and (b) do
5 something about it through their management of
6 quality at the hospital level.

7 So, I would like to move that this be
8 removed.

9 MEMBER BENIN: Second.

10 CHAIR ANTONELLI: Okay. And guidance
11 from the staff: do we want anything to finish
12 the conversation ending in a vote? Or do we want
13 to collect the measures and, then, adjudicate
14 them? Okay.

15 So, if it is up to me, what I would
16 like to do is let's note that, with a seconded
17 motion. Let's spend the time seeing if there are
18 other measures that people would like to bring
19 forward. And then, we will do the discussion
20 with a group of the measures or the measure.
21 Okay.

22 Rachel?

1 MEMBER LA CROIX: I have comments on
2 just a couple of the measures. First, I agree
3 with the recommendation for the Caesarian birth.
4 That is a measure we think is really important,
5 but, again, those data are often housed with our
6 vital statistics data, which sometimes has a lag
7 and is sometimes hard to match up with our
8 Medicaid data, and it is difficult to look at at
9 a health plan level sometimes.

10 I think there have been some
11 improvements with ICD-10 of being able to pick up
12 some of these other information and codes that
13 you might have in claims and encounters, but
14 maybe that would be a new measure down the line
15 that someone could come up with using some of
16 those codes.

17 My other comment was related to the
18 developmental screening measure. We do think
19 that is a really important measure, but, like New
20 York, we have had difficulties pulling data for
21 that measure. And we did have a couple of plans
22 try to use the administrative method for that,

1 but the code that is available for that is not a
2 valid code to use for the instruments required
3 for that measure. And so, we found that to not
4 be meaningful to pull it that way.

5 And we did report it this past year,
6 but it did require medical record review and
7 looking at just a sample of records. So, it is a
8 harder one for us to look at as well.

9 CHAIR ANTONELLI: Thank you.

10 Task Force Members, are there any
11 other measures that you would like to consider
12 suggesting for removal?

13 Terry?

14 MEMBER ADIRIM: No, I just wanted to
15 follow up on your comment about the developmental
16 screening. I think where feasibility for
17 implementation should be a consideration, this is
18 a really critical measure domain. So, I would
19 not recommend taking it off the core set, but I
20 think we should maybe think about, you know, how
21 we can facilitate its implementation in the
22 states.

1 CHAIR ANTONELLI: Go ahead.

2 MS. GORHAM: So, I usually don't ask
3 these questions of staff. But, just for my
4 curiosity, the note that I have for this
5 particular measure is that the developer didn't
6 have the resources to test or maintain. And so,
7 the current standards, the measure as it stands,
8 the current standards, they don't have the
9 ability to test. So, they withdrew from
10 consideration.

11 So, if the developer is saying that
12 they aren't maintaining this measure, but
13 guidelines and standards, and so forth, are
14 changing, how do you, then, know that this is
15 still a good measure?

16 MEMBER ADIRIM: Well, obviously, we
17 don't because it hasn't been tested. But, you
18 know, if there isn't another measure that
19 measures development in the first three years,
20 this is such a critical piece to this population,
21 then I think we need to look at how we can
22 implement and maybe -- hint, hint -- CMS might

1 pay for some field testing or something to help
2 support this measure and states' implementation
3 of the measure.

4 MS. GORHAM: Do you keep the measure
5 up, not knowing that it is like a valid measure?

6 CHAIR ANTONELLI: Well, the issue,
7 though, that it is going to lose its NQF
8 endorsement.

9 DR. MATSUOKA: That doesn't mean it is
10 not a valid --

11 CHAIR ANTONELLI: Exactly. So, I
12 guess I just sort of want to define the issue
13 here. So, we are not going to argue that, you
14 know, NQF, please find it in your heart to break
15 your rules. That's not the issue.

16 I think it actually gets down to the
17 dynamic, and Karen's point before rings true yet
18 again. There are other reasons to think about
19 removal, but, also, they don't have to have NQF
20 endorsement to keep measures in.

21 So, I think what you're saying -- and
22 I'm not going to make a motion for you -- but

1 what I think you are saying is you want to talk
2 about the value of this measure and maintaining
3 it in the core set, in spite of the fact that,
4 for technical reasons, it lost its NQF
5 endorsement. Is that correct?

6 MS. GORHAM: Yes.

7 CHAIR ANTONELLI: Okay. But, again,
8 I'm not making a motion for you, yes.

9 Karen, did you want to weigh-in?

10 DR. MATSUOKA: Not to necessarily
11 weigh-in, but to just ask and kind of repeat what
12 we said for the first two days. But just to
13 underscore here, too, that beyond the actual
14 yes/no vote, it is this discussion that is
15 actually the most helpful for CMS in terms of
16 deliberating ultimately what makes it in or out.

17 And so, as we are discussing these
18 measures, if we could be very clear about when
19 you are advocating for removal or addition, I
20 think we definitely want to hear about the
21 feasibility issues, but if we can just note that.

22 So, just as an example for Caesarian

1 section, definitely heard that it is hard to
2 measure because it is a hospital measure and
3 requires some linkage to vital records. But,
4 then, to Terry's point, it would be helpful for
5 us to know whether, beyond feasibility, you know,
6 if there were some way that we could think about
7 finding a way to slice data and report it at a
8 Medicaid-specific number for the states, would it
9 be important?

10 So, in your discussions, just kind of
11 carefully teasing out, you know, and separating
12 feasibility from importance. We want to know
13 about both. But, if we can just kind of make
14 sure we differentiate in the discussion?

15 MEMBER POOLE-YAEGER: Thanks. I'm
16 going to just speak with the managed care hat
17 here and say, you know, when I read a lot of the
18 comments about why states weren't reporting, it
19 was because the MCOs aren't reporting it and
20 don't report it. And we are held to NCQA
21 accreditation standards. There is a set of NCQA
22 accreditation measures, HEDIS. Every

1 administrative company has software and auditing
2 and hybrid specifications, and all the things to
3 do that in managed care.

4 So, as much as we could align this set
5 with those or get that set to align with these,
6 it would really help all of us, I think, to say,
7 okay, we can all, then, roll in the same
8 direction. Because what happens is we have some
9 states that say, okay, we want to measure this,
10 so we are going to do some offline HEDIS admin,
11 you know, hybrid chase, versus the ones that are
12 in HEDIS, and it gets really kind of complicated.
13 So, I just bring that up as a point.

14 CHAIR ANTONELLI: Amy? Then, Carol
15 and, then, Terry, you just raised again, yes?

16 MEMBER ADIRIM: Yes.

17 CHAIR ANTONELLI: Okay.

18 MEMBER RICHARDSON: Thank you.

19 So, with my pediatric hat on, I
20 completely agree with the AAP's guidelines about
21 developmental screening.

22 CHAIR ANTONELLI: Could you lean into

1 the microphone, please?

2 MEMBER RICHARDSON: Sorry.

3 I completely agree with the AAP's
4 recommendation for developmental screening.

5 Now I am going to take off that hat
6 and put on my hat as a certified coder and a
7 managed care executive, which is these two codes
8 that drive the measurement are amuck and a mess.
9 So, they are adjacent. They are 96110 and 96111.

10 Primary care providers haven't got a
11 clue what distinguishes those two, which one is
12 appropriate, who should be doing it, what
13 documentation is required. I can't tell you how
14 many potential fraud cases have been sent to me
15 to review, and it wasn't fraud. It was somebody
16 in the doctor's billing office who didn't know
17 which code to use.

18 And so, until we educate the provider
19 community about the guidelines, about how to code
20 and bill for them correctly, the data that
21 underlies your measure isn't reliable.

22 So, I agree that it is important. I

1 don't think we are at a place where it is being
2 properly done or properly documented or properly
3 coded. And so, do we want to make state-level
4 decisions about where we are going to spend our
5 money, promoting quality on something whose
6 foundation is not yet solid?

7 CHAIR ANTONELLI: Carol?

8 MEMBER SAKALA: So, you will not be
9 surprised that I strongly feel that we should
10 keep the Caesarian measure. There are three
11 different kind of Caesarian-related -- well, one
12 woman in three is having a Caesarian. We stopped
13 the steep rise, but it has plateaued.

14 When Pacific Business Group did a
15 pilot tying it to payment reform, boy, did it
16 drop really fast and, also, the VDAC rose, even
17 though that wasn't even a part of it. And it
18 rose across all covered women, even though some
19 of them fell under the contracts that led to the
20 changes.

21 So, I think there is a lot we can do
22 with improvement, and I think the value-based

1 world is coming. And this is widely recognized
2 as a huge issue around cost and outcomes for
3 mothers and for babies.

4 This rate is viewed as the fairest
5 rate in comparison with the total Caesarian or
6 primary Caesarian. So, I think that is really
7 important for our service providers.

8 You know, the early elective delivery
9 was kind of our test case in maternity care. We
10 came a little late to QI, but now everybody knows
11 we can do better. And to a great extent, this is
12 the new kind of focus now in the field.

13 So, we have had the AIM project of
14 Alliance for Innovation in Maternal Health that
15 has a bundle for intended vaginal birth that is
16 being implemented by all the leading national
17 clinical professional societies that are behind
18 this. The ACOG and the Society for Maternal-
19 Fetal Medicine, after being silent since 2000, on
20 what's going on with Caesarians, said this is
21 overused; we need to do something about it. They
22 issued a lot of recommendations in 2014 and have

1 reaffirmed that.

2 There is a Committee Opinion this year
3 from ACOG suddenly really getting with the
4 program around evidence-based practices that are
5 highly related to this. So, the field is really
6 going in this direction.

7 It is a part of the Joint Commission
8 measure set, and they are developing an eMeasure
9 to have multiple ways of collecting it. It is in
10 the CMS-AHIP Core Set.

11 And I feel that we also -- first, I
12 was like, why is this in the child and not the
13 adult? But, since then, I feel it is really
14 important for the child because we don't go by
15 individual studies, but we really want to see a
16 well-conducted, systematic review of the best
17 available studies.

18 And there are now systematic reviews
19 showing about a 20-percent increase in the
20 likelihood of Caesarian-born children developing
21 a whole series of chronic conditions. And that
22 includes asthma, allergy, Type 1 diabetes,

1 Crohn's disease, autism spectrum disorder. And
2 the theory is that this is related to the human
3 microbiome. And so, it is very foundational for
4 lifelong health.

5 And there is broad variation as well.
6 And we have real high-performers. So, I think
7 that the core set should be aligning with these
8 other programs that are focusing on this as a
9 huge opportunity for improvement in health and
10 cost.

11 CHAIR ANTONELLI: So, I am going to
12 pause us for a second.

13 So, 0471, there is a motion. Because,
14 remember, my goal was let's get the measures out
15 that people want to be considered for removal.
16 Then, we will sequentially bring conversation.
17 And then, we will actually vote. We would like
18 to get that done before the midday break.

19 So, do we want to put any other
20 motions on the floor for other measures? I
21 promise we will come back to the one that has
22 already had a motion in a second.

1 Deborah?

2 MEMBER KILSTEIN: Yes, I am concerned
3 about the developmental screening. While I think
4 it is a very important measure, the fact that the
5 measure is not being supported anymore, it is not
6 NQF-endorsed, you know, I think it calls it into
7 question.

8 And in terms of removal, I mean, at
9 best, I could support this being on conditionally
10 until something else is developed. But to just
11 say we should go continue with this without
12 calling it into question I think is an issue.

13 CHAIR ANTONELLI: Okay. So, is there
14 a motion embedded in what you just said?

15 MEMBER KILSTEIN: Yes, I'll make a
16 motion that this one should be either removed or
17 -- you know, I don't know of that -- yes, I would
18 make a motion it should be removed.

19 CHAIR ANTONELLI: 1448.

20 MEMBER KILSTEIN: Yes.

21 CHAIR ANTONELLI: The motion on the
22 floor is to remove 1448. Is there a second?

1 DR. ELLIOTT: I'll second that.

2 CHAIR ANTONELLI: There's a second.

3 Okay. Okay.

4 So, we have two measures to consider,
5 and we will get there next. Are there any other
6 measures that people would like to bring out to
7 discuss besides the two that have motions on the
8 floor?

9 Terry? If it is related to the two
10 motions on the floor, I want you to hold it,
11 please. I want to do the housekeeping. If you
12 could put your card down, please?

13 All right. People be thoughtful. Any
14 other potential measures for consideration for
15 removal?

16 I would err on the side of sharing
17 your ideas. Go ahead.

18 MEMBER OSBORNE-GASKIN: So, back to my
19 original question on child and adolescent access
20 to primary care practitioners, I think I would
21 make a motion to remove. And my rationale is
22 that it talks about access, but coming from the

1 managed care world, true access is something that
2 health plans do. And I am just curious about how
3 this is measuring quality, and I am not quite
4 sure how it is measuring quality.

5 And I understand what you said, Karen,
6 about the fact that you do see variations between
7 not so much a child, but the adolescent well
8 child visit and adolescent immunizations, but
9 this is something that is tracked by health
10 plans, that there are certain standards that the
11 health plans have to use to make sure that
12 there's a primary care provider within a certain
13 number of miles for the population that they
14 serve. And I am just having a little difficulty
15 trying to figure out how that -- if there needs
16 to be an additional measure to track that and how
17 that will actually affect quality.

18 So, that would be my motion.

19 CHAIR ANTONELLI: Okay. So, could you
20 maybe more succinctly state the motion, please?

21 MEMBER OSBORNE-GASKIN: The child and
22 adolescent access to primary care practitioners,

1 I don't see a number here. Oh, okay, it is not.
2 Okay. But it is part of the child care. Okay.

3 So, just a motion to remove the child
4 and adolescent access to primary care
5 practitioners from the core set.

6 CHAIR ANTONELLI: Okay. Okay. Thank
7 you.

8 Any seconds?

9 MEMBER POOLE-YAEGER: I'll second
10 that.

11 CHAIR ANTONELLI: Okay. So, we have
12 three measures to consider, and I will give folks
13 another minute or so. We are not talking about
14 these three measures. We are just collecting
15 candidates right now.

16 Any other measures that people would
17 like to put forward for consideration of removal?

18 (No response.)

19 Okay. So, what order should we go in?

20 MEMBER OSBORNE-GASKIN: So, I have a
21 quick question. I'm sorry. The one, 1365, are
22 we not removing? It is on the list of low-

1 reporting measures, but we are not going to --
2 you are not making a motion to remove that one,
3 that child and adolescent measure, major
4 depressive disorder, suicide risk assessment?

5 MS. GORHAM: So, again, just because
6 it is on the list of low-reported measures does
7 not necessarily mean that you have to remove it
8 or make a motion to remove it. It is up to you
9 whether or not you think the measure should
10 remain in the core set. If not, then why would
11 you want it removed?

12 We simply, when we did our bucketing
13 of measures, we just put high-reported, medium-
14 reported, and low-reporting. And so, these four
15 measures are the measures that are least reported
16 by the states, but we are in no way suggesting --
17 it is definitely up to the Task Force and your
18 expertise and your work with the core set
19 measures, if you think they should be removed.
20 That is just a way to guide the discussion.

21 CHAIR ANTONELLI: Okay. You have a
22 motion? Okay. Put your microphone on, please.

1 MEMBER POOLE-YAEGER: I'm going to
2 move for this child and adolescent major
3 depressive disorder, suicide risk assessment
4 measure to be removed, with the thought of
5 replacing it with the one that we were talking
6 about that is overall depression screening in
7 adolescents down to the age of 12.

8 CHAIR ANTONELLI: So, that sounds like
9 a conditional motion.

10 Is there a second for 1365?

11 MEMBER OSBORNE-GASKIN: Second.

12 CHAIR ANTONELLI: Second. Okay. All
13 right.

14 So, May, why don't you move us to the
15 first one? So, we have four to consider for
16 removal. I am very respectful that we have had
17 conversations tied to each of these things, and I
18 am very comfortable revisiting that, so that we
19 can actually surround each of these big decisions
20 with the appropriate content and context.

21 Okay. Terry?

22 MEMBER ADIRIM: Thank you.

1 I have just a general comment with
2 regard to removal of measures and, then, a
3 specific one about the developmental screening.

4 I think we need to be really careful
5 with regard to the measures that we want to add
6 or take off, in not allowing the technical or
7 necessarily the implementation pieces to drive
8 the whole conversation. Because I think what
9 happens is we have a lot of managed care people
10 here, and they may not want to add something
11 because it may cost too much, be hard, or
12 whatever.

13 We are supposed to be leading the
14 country in what we think should be measured. It
15 shouldn't be what the end-users want to be
16 measured. So, I think we need to be really
17 careful in teasing out those particular issues.

18 And so, with regard to the
19 developmental screening, I hear you. It may need
20 some work. I may need some technical assistance
21 for implementation, which I think that's what it
22 is.

1 It sounds to me, from what the NQF
2 staff have said, that the NQF endorsement is
3 being removed, not because it is a bad measure,
4 but because the measure steward or developer
5 didn't have the resources, or whatever it was, to
6 do further testing. That is not the same as
7 saying it is a bad measure. So, I think we need
8 to be really, really careful here because we
9 don't have another measure to supplant this.

10 And in childhood -- I'm an emergency
11 physician; I am not a general pediatrician --
12 but, in childhood, developmental screening is
13 critical. It is not being done. And I think we
14 need to, as the guiding light for quality
15 improvement, send out that message that this is
16 an important measure, an important concept. So,
17 that is my little piece on that.

18 CHAIR ANTONELLI: Okay. Thank you.

19 Deborah?

20 MEMBER KILSTEIN: Is the vote to
21 remove, does it have to be a yes or no? There
22 can't be a conditional like --

1 MS. MUKHERJEE: So, that would be in
2 the discussion. So, when we put in the measure
3 in the report, we will say, Measure So-and-So was
4 voted to remove. And then, we will say the
5 discussion included, you know, these caveats or
6 sort of considerations. So, it will be in there
7 and we also have CMS --

8 CHAIR ANTONELLI: And my intention was
9 to follow the paradigm we did yesterday, which
10 is, prior to going to the dichotomous yes/no, was
11 to give the Task Force a chance to actually
12 suggest a condition, which, then, makes it a
13 three-way vote selection, right?

14 MEMBER KILSTEIN: Okay. Thank you.

15 CHAIR ANTONELLI: So, I will do that
16 for each one of these measures. Okay?

17 MEMBER KILSTEIN: Thank you.

18 CHAIR ANTONELLI: All right. So,
19 focusing on 1448.

20 Yes?

21 MEMBER POOLE-YAEGER: So, I totally
22 agree that this is an important one. I am not

1 sure that we have got the coding stuff worked out
2 in order to do it. So, it would be a medical
3 record review.

4 I think my main concern with that is
5 not always effort, but, you know, what are the
6 specs for that? How do we make sure that is done
7 well? This is not a typical HEDIS measure. This
8 is a now not-endorsed NQF measure.

9 So, maybe I would propose some, you
10 know, a removal conditional on it becoming a more
11 standard, if it is going to have to be a medical
12 record review for the short-term until we get the
13 coding worked out. That is a long-winded way of
14 saying that, but, you know, conditional on work
15 toward getting some better specs on how to get to
16 that measure.

17 CHAIR ANTONELLI: Okay. Thank you.

18 It doesn't seem there is any more
19 discussion on 1448. So, let me actually come and
20 build off that.

21 So, would you like to -- I don't know,
22 and forgive me if this is reading something that

1 you didn't intend. Are you formulating a
2 condition that we would want to attach to a vote
3 for 1448? And if so, would you like to
4 articulate it?

5 MEMBER POOLE-YAEGER: Correct. Yes,
6 I would probably say we would move to
7 conditionally approve it with the condition that,
8 knowing that it is no longer NQF-endorsed, we do
9 need to work toward getting a standardization and
10 a way to measure it in short order.

11 CHAIR ANTONELLI: Okay. So, I am
12 allowed to take that as a motion and, then, to
13 solicit a second one and, then, combine them into
14 a vote. Yes.

15 So, Amy just formulated a condition
16 for 1448. I am mindful, because I would rather
17 not vote the other down. I would rather just
18 append this one to that. Is that okay if I do
19 that?

20 Could you restate the condition,
21 please?

22 MEMBER POOLE-YAEGER: Oh, sure. That

1 there would be -- again, it is conditional
2 because of the pending NQF endorsement or at
3 least a specification of a measure steward who is
4 going to take it on as somebody that is going to
5 keep the specs up-to-date and will be allowing us
6 to know how best to capture it.

7 CHAIR ANTONELLI: Yes. I hope we
8 don't have to vote up/down and, then, come back.
9 Can we just do this one as an amendment to the
10 vote on 1448?

11 MS. GORHAM: I actually need to check
12 with my leadership. But the measure is already
13 -- the endorsement has been removed. So, whether
14 the measure will ever be submitted again, we have
15 no control; we don't know that. So, that
16 condition, just I need to check because the
17 measure has been submitted. It has been, the
18 endorsement has been removed. The developer has
19 already said he cannot maintain it.

20 Whether or not another developer picks
21 this measure up, and whether or not it is
22 submitted to NQF, I can't see the future. So,

1 for that to be a condition --

2 MEMBER KILSTEIN: But couldn't the
3 condition, because, again, going back to the
4 chart with the three potentials, couldn't the
5 condition be for CMS to support that activity in
6 terms of coming up with the specifications that
7 take into account everything that was said here,
8 regardless of whether it gets NQF endorsed?

9 MS. MUKHERJEE: So, just to talk a
10 little bit about this conditional voting, the way
11 it is going to happen, I mean, at this point this
12 measure is an orphan measure. It doesn't have a
13 steward. I mean, it truly is an orphan measure.
14 And it is already in the core set.

15 So, what we can do is we can do an
16 up/down vote. And then, it is not necessarily
17 voting on a condition, but it is saying we are
18 doing a remove because this is our condition.
19 And the condition is more like a thought process
20 and our suggestion to CMS. And I think calling
21 it like a condition almost makes it sound more
22 constructive than it is. It is basically we are

1 voting up or down, so, yes, remove, or, no,
2 remove. And then, our condition, our sort of
3 thought around this vote is, you know, the intent
4 is great; it is not feasible to implement, and we
5 are looking for a better, newer measure.

6 So, the way our reports are sort of
7 structured is that it is not as if you are voting
8 with a condition, but you are voting yes or no.
9 And your gestalt, your sort of thought process is
10 that this is sort of what your thinking is around
11 this measure.

12 I just want to clarify that because I
13 feel like a lot of removals are conditional
14 removals. I mean, they are already in the core,
15 so it is not a conditional removal. Either you
16 are removing it or not. But your thought process
17 around that is you are removing it with a caution
18 or with a suggestion or with a recommendation.

19 CHAIR ANTONELLI: Has the issue been
20 framed for the esteemed Dr. Burstin? All right.
21 So, we are calling you in as our line of support
22 with your white cavalry hat.

1 DR. BURSTIN: I don't know what kind
2 of hat that is, but that's okay.

3 So, this is an interesting measure.
4 These are a set of questions, essentially, that
5 come out of a national survey of children's
6 health.

7 So, the developer here moved from
8 Oregon, now at Johns Hopkins, developed the
9 survey for HRSA as part of this HRSA survey. It
10 is administered, I think, every four years.
11 Correct me if I'm wrong.

12 And so, these questions came in to us,
13 but it was never very clear what the actual path
14 was to collect the data, particularly at the
15 state level for Medicaid. Have you guys figured
16 out a different pathway?

17 DR. FOX: I don't believe -- that is
18 another measure that came to the pediatric that
19 wasn't renewed. That is through the -- I'm
20 forgetting her name who moved from Oregon. No,
21 this is the measure that comes from coding for
22 developmental screening. And then, it is hybrid

1 measure. So, you either measure the 96110, or it
2 is done by chart review. And it was originally,
3 it is Oregon but a different group at Oregon. It
4 is not CAMI.

5 DR. BURSTIN: Oh, okay.

6 DR. FOX: The CAMI measures, yes.

7 DR. BURSTIN: Most of those measures
8 that came in through CAMI were all parent self-
9 report as part of a special survey. This one is
10 not?

11 DR. FOX: This one is not.

12 DR. BURSTIN: And it is still owned by
13 Oregon, and they just -- Elisa probably could
14 finish the story, then, of what happened.

15 DR. FOX: So, they did not submit it
16 in the pediatric measures for measure re-
17 endorsement because they didn't have the required
18 testing. They weren't able to do the required
19 testing.

20 MS. GORHAM: So, the note that I have
21 for this is the measure lost endorsement because
22 the developer did not have the resources to test

1 and maintain it. The previously-endorsed version
2 isn't up to current standards, and they did not
3 have the ability to test it right now, so
4 withdrew it from consideration.

5 MS. MUNTHALI: Yes, and just to add a
6 little bit of context to that, this measure was
7 reviewed in our Health and Well-Being Project in
8 2016, so just last year. And we did try to work
9 with the developer. And as Shaconna said, they
10 don't have the resources right now to maintain
11 it.

12 And what we do typically in this
13 situation is we will put the measure out there to
14 see if any other developers that we work with --
15 we work with hundreds of developers to see if any
16 of them would like to pick it up. And we didn't
17 hear from anyone.

18 So, I think that was part of the
19 conversation when Helen and I were out of the
20 room, is, you know, perhaps somebody else would
21 be interested in maintaining this measure, but we
22 haven't heard yet. It has been almost, I think,

1 about a year since it has lost endorsement.

2 DR. FOX: Yes, and then, we encouraged
3 the developer to submit to the Pediatric Measures
4 Committee that met in the fall, and that was the
5 other followup, yes.

6 MS. MUNTHALI: And so, what we could
7 do, even though they are not maintaining NQF
8 endorsement, it does not mean that they are not
9 maintaining their measure for their own needs.
10 And so, we may be able to find that out. And I
11 know there is a strong preference for NQF
12 endorsement, endorsed measures in the core sets,
13 but we could find that out for the group, if that
14 would work as well.

15 CHAIR ANTONELLI: So, I think, to
16 clarify, I am trying to process what you were
17 saying before. You are suggesting that we do an
18 up/down and the commentary serve as the condition
19 itself, yes? Yes, okay.

20 I can't remember, Amy, if somebody
21 seconded your -- okay. All right. So, then, I
22 don't know if the Chair is allowed to make a

1 motion. Yes.

2 So, basically, then, I am going to
3 follow Debjani's lead suggestion which is that we
4 vote up/down on this, but that the commentary
5 serve as the condition.

6 And I do want to remind people, to the
7 degree that the commentary would say it needs to
8 be NQF-endorsed, that's not really the end-game
9 here, right? The loss of stewardship implies
10 maintenance, et cetera, et cetera, those are
11 highly aligned, but they are not the same thing.
12 In fact, I would make an editorial comment. The
13 fact that such an important measure doesn't have
14 resources attached to it says more about the
15 country's ethos than it does necessarily about
16 the underlying science. So, that is the elephant
17 in the room. So, nobody has to check their souls
18 at the door. This is a big deal. So, let's make
19 sure the commentary gets done well and gets done
20 right.

21 And I will end my comment by coming
22 back to what Karen said. CMS does not need to

1 have NQF-endorsed measures to have measures in
2 the core set.

3 So, would somebody like to second the
4 motion that I just made?

5 Andrea seconds?

6 MEMBER BENIN: I'll second it.

7 CHAIR ANTONELLI: Okay. All right.

8 So, do we need to ask about coffee?

9 (Laughter.)

10 MS. KUWAHARA: Because we used the
11 clickers yesterday, I think we can skip over that
12 question.

13 (Laughter.)

14 And we can move straight into Measure
15 No. 1448. This is developmental screening for
16 the first three years of life.

17 If you would like to see this measure
18 removed, please select 1, yes, or 2, no.

19 CHAIR ANTONELLI: And somebody with a
20 vote left.

21 MS. KUWAHARA: Yes.

22 CHAIR ANTONELLI: Do we have her vote?

1 MS. KUWAHARA: Yes. Ann Greiner
2 stepped out of the room, but she gave us all of
3 her votes --

4 CHAIR ANTONELLI: She did?

5 MS. KUWAHARA: -- and staff will be
6 submitting them via the system.

7 CHAIR ANTONELLI: Okay. Thank you.
8 Okay.

9 MS. KUWAHARA: Yes.

10 (Vote.)

11 CHAIR ANTONELLI: Mine went
12 flatlining, too.

13 (Laughter.)

14 Do you guys have any Epi?

15 (Laughter.)

16 MS. KUWAHARA: Maybe we should have
17 done that coffee question.

18 All right. So, it looks like a number
19 of us are flatlining over here. So, why don't we
20 move to a hand vote?

21 CHAIR ANTONELLI: May I have the Chair
22 privilege of taking a vote to see if people are

1 comfortable with a hand vote?

2 MS. KUWAHARA: Sure.

3 CHAIR ANTONELLI: Is that okay? All
4 right.

5 And Dr. Smith is not a voting member,
6 right, because she is federal?

7 MS. KUWAHARA: Yes.

8 CHAIR ANTONELLI: Okay. So, for
9 people in the room, this is not a vote on the
10 measure. This is a vote on whether we're
11 comfortable, given the fact that all of our
12 clickers are flatlined, are we comfortable with a
13 hand vote?

14 All that are comfortable with hand
15 vote show your hand.

16 (Show of hands.)

17 We need to count? Okay.

18 MS. KUWAHARA: And to answer you
19 question, we need 9 for a quorum.

20 So, I will be voting on Ann's behalf.

21 All of those who would like to see
22 this measure removed for 1448 please raise your

1 hand.

2 I don't believe that there is a
3 condition with this measure.

4 DR. BURSTIN: With the comment.

5 CHAIR ANTONELLI: Yes.

6 (Show of hands.)

7 MS. KUWAHARA: And those who vote no?

8 (Show of hands.)

9 So, what's the final?

10 So, 7 yes and 6 no.

11 DR. BURSTIN: It sounds like to
12 reflects your conversation, I think. CMS has
13 heard the discussion. I don't know that it
14 reaching 60 percent or not is going to
15 necessarily change.

16 And again, we would be happy to work
17 with Karen and her team to see if we might be
18 able to find somebody. Particularly, I don't
19 know if there are any available dollars even to
20 help them do the minimum amount of testing it
21 sounds like they would need to do to bring it
22 back in.

1 Seven to 6 is kind of split. It is
2 pretty obvious it is not 60 percent.

3 CHAIR ANTONELLI: Could staff tell the
4 Task Force what the outcome is, please?

5 MS. KUWAHARA: Yes. So, it was 7
6 voted to remove and 5 -- I'm sorry -- 6 voted not
7 to remove. Therefore, 54 percent voted to
8 remove.

9 CHAIR ANTONELLI: But it has to
10 achieve 60 percent?

11 MS. GORHAM: So, therefore, the Task
12 Force will not be recommending to remove this
13 measure because you had to have greater than 60
14 percent.

15 DR. BURSTIN: But, again, the
16 commentary here is the most important piece of
17 it, and I think it has been heard loud and clear.

18 CHAIR ANTONELLI: Yes.

19 Helen, thank you for coming in.

20 And, Debjani, thank you for the
21 suggestion. And thanks to the Task Force.

22 Okay. One down and three to go.

1 What's next, May?

2 DR. NACION: 0471.

3 CHAIR ANTONELLI: 0471. We're not
4 moving to a vote. We're in a discussion for
5 this.

6 Actually, let's start with Amy. Then,
7 we will go to Carol.

8 MEMBER POOLE-YAEGER: So, I just
9 wanted to ask a question. Again, since the Joint
10 Commission reports on this on a hospital level, I
11 just don't know the logistics of getting it, you
12 know, in the short-term getting it collected.
13 Because I agree that it is a good measure to
14 have. It is probably the best C-section measure
15 that we have.

16 You know, we do try to work with
17 providers with high C-section rates, but, overall
18 C-section rate is really not a useful measure.
19 So, this at least gets to first-time moms, term,
20 head-down, probably shouldn't have a C-section,
21 you know, in many cases. And the numbers are
22 really high in that group, and you would think,

1 well, why is this happening?

2 So, personally, I like the measure,
3 but I just was wondering if, you know, again,
4 from the discussion perspective, recognizing that
5 it is difficult to obtain, hopefully, somebody
6 will hear that we would like a way to get it a
7 little more easily than it is now.

8 CHAIR ANTONELLI: Thanks.

9 MEMBER SAKALA: So, just three more
10 points that I would like to share with you.

11 First of all, we do have a national
12 benchmark for this measure. I think that is
13 really important, that Healthy People 2020 has a
14 benchmark, and that is being used in California
15 by -- I can't think of the Exchange name now.
16 And they have set some standards for that, and
17 100 hospitals in California are using this
18 measure as a QI effort and there is a toolkit to
19 do that.

20 Second, it is first births and women
21 who have a Caesarian; 9 out of 10 will go on to
22 have another Caesarian. So, another child health

1 issue is the hazards of intrauterine development
2 in a scarred, damaged uterus. And we have
3 increased rates of stillbirth, and the children
4 in future pregnancies face some pretty severe
5 hazards, especially as those scars accumulate.
6 So, that is another relationship to us.

7 And then, finally, our proven health
8 analytics, we Commissioned a report a few years
9 ago that was adjusted to national costs, and the
10 payments made on behalf of all maternal/newborn
11 care are about 50-percent higher, whether it is
12 Medicaid or commercial, with a Caesarian birth
13 relative to a vaginal birth.

14 So that, when we look at our value-
15 based care opportunities, that is where we can
16 pick up resources to do the good things, to do
17 care coordination and better referrals, and all
18 kinds of things that are not getting done now
19 because that intrapartum phase of care with its
20 high Caesarians and other technology-intensive
21 stuff that many women don't need is sucking up so
22 many resources. So, it really has a role in

1 where we need our maternity care system and
2 healthcare system to go.

3 Thank you.

4 CHAIR ANTONELLI: Thanks, Carol.

5 Amy? And then, Kathryn.

6 MEMBER RICHARDSON: So, agree with all
7 of the bad stuff from unnecessary Caesarians. My
8 question is, from the state perspective, what can
9 you do about it at the state level versus what
10 the Joint Commission can actually do to move the
11 needle?

12 There is a reason that the states
13 aren't collecting it. And so, that link between
14 the measure and what you can do with the outcomes
15 of the measure, that is what I am searching for.
16 It seems to me the locus of control is with the
17 Joint Commission.

18 CHAIR ANTONELLI: Helen?

19 DR. BURSTIN: I did reach out to David
20 Baker yesterday -- he is the Executive Vice
21 President of the Joint Commission -- just to see
22 if there was a possibility of bringing these data

1 in. They don't get patient-level data at the
2 Joint Commission. So, they couldn't actually
3 help here.

4 So, I think it is back to what CMS
5 might be able to do internally, because this is
6 on the IQR, right, possible IQR? So, it is
7 already a measure submitted through the Inpatient
8 Quality Reporting Program. And one question
9 might be, internally, can you try to pull state-
10 level data from that, if we can be helpful here?

11 DR. MATSUOKA: Yes, we're looking into
12 that. Yes.

13 DR. SMITH: Yes, I just sent an
14 inquiry and I'm waiting back to hear -- this is
15 Marsha -- to see if that is possible.

16 CHAIR ANTONELLI: So, Karen, can you
17 say a little bit more detail on that? Because I
18 think that what you and Helen and the voice from
19 above just said something very important for us
20 to hear, and I would like the group to hear it.

21 DR. MATSUOKA: So, the Joint
22 Commission measures are a good example of -- and

1 I think to an earlier speaker's point -- it's the
2 rare setting where you are only seeing Medicare
3 patients or Medicaid patients, commercial
4 patients. In many settings of care, not just
5 hospitals, but, you know, school nursing
6 facilities, home healthcare providers, they are
7 seeing a broad array of patients from many
8 different payer sources.

9 And it turns out that different parts
10 of CMS are collecting information, and it is
11 possible that we are collecting information and
12 discarding things that aren't relevant to the
13 given center within Medicare. So, this is what
14 we are exploring. We don't know whether there is
15 truth to that or not.

16 But, just as an example, we know that
17 because this measure and all the PC measures are
18 on the hospital and patient quality reporting
19 activities; that the information is being
20 submitted to CMS in some form or fashion. So,
21 our next step is to work internally with CCSQ to
22 see, is there some mechanism by which we can

1 start to attach a flag for payer source, to come
2 at a state and payer level number on this kind of
3 measure?

4 But you can imagine the same thing
5 could be said for skilled nursing facilities.
6 Oftentimes, bennies come in starting out as a
7 Medicare patient, but they become a long-term
8 patient; they become Medicaid.

9 So, a lot of the kind of reporting is
10 the same for the patients at the nursing
11 facility. It's just that we only report on a
12 subset of that. So, this is what we are just
13 now, literally starting yesterday, looking into.
14 So, hopefully, coming back next year, we will
15 have something to report about that.

16 CHAIR ANTONELLI: Thank you.

17 Kathryn? And then, Rachel, I thought
18 I saw you come up and, then, you went down?
19 Okay. All right. Kathryn?

20 MEMBER BEATTIE: Just in response to
21 what the state level can do, I know --

22 CHAIR ANTONELLI: Lean in a little

1 closer.

2 MEMBER BEATTIE: -- I know, for
3 example, at the State level in Washington, it is
4 part of the pay-for-performance program within
5 the Medicaid system. And that had a big impact
6 on how that measure was picked up by commercial
7 networks in their pay-for-performance, because it
8 was an expectation.

9 With reference to the relevance to the
10 child core set, I did look up some data and,
11 actually, it was about the increase in NICU
12 admission rates, the higher use of oxygen
13 supplementation, and extended length of stay.
14 And some of those metrics were almost double for
15 kids who had had C-section versus a VBAC. So, it
16 really does have a big impact on our children,
17 both their healthcare and their newborn period,
18 as well as outcomes and, then, of course, the
19 efficiency of care we deliver.

20 MEMBER LA CROIX: We also have
21 included for some of our provider-level
22 incentives that our health plans are offering to

1 providers in their network, we do have looking at
2 reduced C-section rates, especially for OB/GYNs,
3 as a possible pay-for-performance or incentive
4 payment measure. But, also, at a state level
5 there is the possibility of not just for
6 C-sections in general, but look at not paying for
7 elective C-section deliveries and making some of
8 those policy changes to support health plans in
9 having those policies and not reimbursing for
10 those elective non-medically-indicated
11 C-sections. So, there are some policy things
12 states can do around that.

13 CHAIR ANTONELLI: Lindsay?

14 MS. COGAN: So, that is a tool that we
15 have employed for early elective delivery that
16 you could think about for C-section.

17 Just a caveat. So, I have been asked
18 a lot about this measure lately, especially in
19 the value-based payment space. And I acknowledge
20 the risks of sort of the child health as a
21 result. But I also want to put some context that
22 this measure is relatively low in the Medicaid

1 population in New York. So, we're looking at
2 statewide rates of about 13 or 14 percent. So,
3 it is getting pretty low.

4 We've done a lot in this space. It
5 used to be double in commercial what it is in
6 Medicaid. So, there has been a lot of work in
7 the commercial space as of late.

8 So, when people come to me with this
9 measure, my first inclination is it's not really
10 a Medicaid problem; it is really it used to be a
11 commercial problem.

12 So, I just want to kind of provide
13 that level of context around the measure, that is
14 it getting really lower and lower every year.
15 So, just from that state-side perspective.

16 (Question asked off-microphone.)

17 MS. COGAN: I don't know that I could
18 answer that question with certainty, but it is
19 costly. And so, costs often can drive changes in
20 behavior. So, I think the attention that has
21 gone to things like early elective delivery and
22 this move of states just not to pay for things

1 anymore could be an alarming trend that people
2 not want to change their behavior. But I don't
3 know the -- I can't answer that question.

4 CHAIR ANTONELLI: So, at the risk of
5 putting you on the spot, I will.

6 (Laughter.)

7 If this was pulled from the core set,
8 what would happen to 13 percent? North? South?
9 No difference? Or are you making the case that
10 there are other things being tracked that would
11 actually continue to maintain or drive that
12 trend?

13 MS. COGAN: Whether or not this
14 measure is in the core set hasn't influenced us
15 as a State on where we think the movement is. Of
16 course, we want parsimony in sets. So, I don't
17 know where else this is in other sets. I don't
18 know if anybody can answer that. Besides the
19 child core set, is it in your maternity set? So,
20 you have a maternity core set, too, correct, at
21 the federal level?

22 DR. MATSUOKA: Yes.

1 MS. COGAN: Yes?

2 DR. MATSUOKA: It is the maternity
3 core set and, to Carol's point, we have developed
4 those to the public/private alignment issues. We
5 have been working with CCSQ. They have an AHIP
6 collaborative to do some public/private
7 alignment. So, internally, we have been doing
8 Medicaid/Medicare alignment, and this measure is
9 on the OB/GYN list. So, it is in several
10 different federal reporting programs.

11 CHAIR ANTONELLI: Thanks.

12 Kim? And then, Carol.

13 DR. ELLIOTT: My only comment is that
14 I think that most states would report it, but
15 there are very similar things like the elective
16 delivery, which gets to a lot of the root of what
17 they're trying to address. And then, there's the
18 cost factor. It is really an expensive measure
19 to collect at the state or the health plan level
20 because it is chart review.

21 MEMBER SAKALA: Nobody in maternity
22 care would say this measure is topping out.

1 Twenty-three point nine is the benchmark for
2 Healthy People 2020. And there is a huge
3 variation and lots of states and facilities above
4 that rate.

5 As far as fully elective Caesarians,
6 we have looked at that in our National Listening
7 to Mothers Surveys, and that was initially the
8 idea. People are clamoring for this and it's
9 casual. People are giving a code for it that
10 they believe, with very rare exception, it needs
11 to happen.

12 Now the elective delivery really was
13 about waiting to 39 weeks and, then, it is a
14 green light and there is almost a stampede in
15 many settings. Okay? So, that helped people
16 wait, but didn't deal with the inductions and
17 Caesarians that are happening in many contexts.
18 So, that would be really a new measure to say
19 wait to a certain point beyond 39 weeks, for
20 example. So, I just want to share that.

21 CHAIR ANTONELLI: Let's do Terry, then
22 Amy.

1 MEMBER ADIRIM: No, I just wanted to
2 emphasize, I mean, I hear from our state
3 colleagues that this is an expensive
4 intervention. And so, avoiding it, C-sections,
5 is very important for that basis and, also, for
6 the health of the mother and the child.

7 But it still strikes me that this
8 would be better on the adult core set, since it
9 directly affects health care of the woman. So, I
10 think that is what I am sort of stuck on, the
11 fact that it is on our core set and not on the
12 adult core set. I am having a little trouble
13 with that.

14 MEMBER RICHARDSON: So, I would
15 actually like to ask for a clarification and,
16 then, may modify my motion. Did I just hear that
17 this actually sits in another CMS core set, so
18 that it is redundant?

19 DR. MATSUOKA: Being a core set means
20 that, for that given program, it is being
21 collected. So, in this particular case, let's
22 say we are talking about the Medicare inpatient

1 program. They have all the Joint Commission, the
2 PC series in there, but they are reporting it on
3 the Medicare providers, the patients who get
4 their care through Medicare providers. There is
5 just a small number. But, nevertheless, that is
6 what they are measuring.

7 So, what this measure would be is this
8 measure but for the Medicaid population at the
9 state level. So, the fact that a measure sits on
10 different core sets is more a signal of alignment
11 as opposed to duplication of effort.

12 MEMBER RICHARDSON: So, may I modify
13 my motion? Is that permissible?

14 So, my modification would be that it
15 is taken out of the core child set after a
16 recommendation is adopted to move it to the adult
17 set. No? We can't, conditional on moving it to
18 -- conditional on its being considered for -- no?
19 Who's going to act on it? What's the right
20 context for it?

21 CHAIR ANTONELLI: So, again, I'm not
22 going to make your motion, but what you're

1 looking for is, if it is not in the child core
2 set, what is the line of sight, so that it is
3 somewhere that is meaningful?

4 MEMBER RICHARDSON: In the right
5 place.

6 CHAIR ANTONELLI: Yes. Okay.

7 Karen, would you like to comment,
8 please?

9 DR. MATSUOKA: So, this is another one
10 of those strange things about the history of
11 these core sets. And it alludes to how the two
12 different core sets had a different origin point.
13 So, initially, we only had the child core set.
14 ACA added the adult core set. That sometimes
15 describes why measures sort of landed in one set
16 or the other.

17 I think Lucretia is on the phone and
18 can say more about the history of why this
19 particular measure landed on the child core set.
20 It could be as simple as this is recognized as
21 being very important from the very beginning. We
22 only had a child core set to begin with and it

1 landed there.

2 It is not to say that, in terms of
3 implementation and use -- I mean, I think we
4 should hear from the state perspectives. But,
5 certainly at the federal level when we are
6 looking at this measure, we are not saying, you
7 know, it's on the adult core set. And so,
8 therefore, we're targeting like adult healthcare
9 providers. That's not it at all. It is, is it
10 an important measure to measure? If it is in the
11 child core set, is there some link to child's
12 care outcomes, which there are? So, is there a
13 link that we can at least make to the fact that
14 it is important for child health care. And if it
15 is, typically, we will use it, looking at that
16 lifespan perspective that Lucretia talked about
17 yesterday.

18 So, here, too, I would say, you know,
19 I would worry less about where the measure has
20 landed. I think we will in the future look
21 towards rationalizing where measures land. I
22 don't think that should necessarily affect the

1 way you vote on the measure. So, know that if
2 you vote for this measure, it will be used to
3 reduce the rate, knowing that it is important for
4 both the mother's health, but also for the
5 child's health. Certainly at the federal level
6 we don't think about -- you know, we think about
7 the entire lifespan.

8 CHAIR ANTONELLI: So, reformulation or
9 are you good where we are?

10 MEMBER RICHARDSON: Well, actually,
11 what I'm thinking is probably withdraw my motion.

12 CHAIR ANTONELLI: Withdraw the motion
13 for removal?

14 MEMBER RICHARDSON: Removal.

15 CHAIR ANTONELLI: Okay. I don't think
16 we have to vote on that because it was her
17 motion. Okay.

18 Other Amy?

19 MEMBER POOLE-YAEGER: I was just going
20 to make a comment about what you can do around
21 it. I think some of the things that we're
22 looking at are some payment reform. I'm a

1 pediatrician, right; I'm not an OB. But, from
2 what I hear from my OB colleagues, trying to take
3 -- how should I say this? -- the convenience of
4 doing a C-section versus sitting in a hospital
5 and waiting for somebody to labor through
6 sometimes will win over. You know, again, nobody
7 dies from a C-section. So, like there are some
8 outcomes that happen when you do that. Right,
9 right.

10 So, the idea of not paying hospitals
11 or physicians more for a C-section than a
12 vaginal, if you're making bundle payments, that
13 is basically the same whether it is a vaginal or
14 a C-section. Just for the delivery is something
15 we are tossing around. I think probably the
16 states could toss around something. I mean, we
17 would be interested in the states tossing around
18 something like that. I think that might be
19 something that would be effective at driving that
20 down.

21 CHAIR ANTONELLI: So, Rachel, I see
22 that your card is up, but I just want to make an

1 -- it's not up? Okay.

2 All right. Since Amy has withdrawn
3 the motion to consider removal of 0471, I am
4 going to ask, does anybody want to make that
5 motion? Otherwise, I want to stop the
6 conversation and move on to the next measure.

7 (No response.)

8 Okay. Next --

9 DR. BURSTIN: Just one general comment
10 I think would be helpful for us, as we think
11 about the overall report. In both the child and
12 the adult set, having sat through several of
13 these days, this issue of what to do with
14 hospital-based measures is something I think
15 oftentimes people get tripped up, not because the
16 measure isn't important, but how incredibly
17 difficult it is to get provider-level data
18 stratified by payer.

19 CHAIR ANTONELLI: Yes.

20 DR. BURSTIN: And so, it just feels
21 like that is an opportunity for us to think about
22 -- it's not so much the measure; it is the

1 mechanism to gather the data, and that seems like
2 a place where I hope the report from this Task
3 Force would be pretty clear; that is an issue we
4 need to resolve -- and Karen is clearly shaking
5 her head, for those on the phone -- as being a
6 really important piece of this.

7 Because the data are being routinely
8 collected. It is a core measure of the Joint
9 Commission. It is in the IQR, although, oddly,
10 only for Medicare, which is strange. But it's
11 being collected at every hospital in America, as
12 Carol knows. So, how hard could it truly be to
13 have payer-level data to bring it up at the state
14 level, is something I think needs to be explored.

15 CHAIR ANTONELLI: Yes. You are so
16 much more eloquent than I, but if the staff could
17 be sure to include that, even though we removed
18 the motion to remove this measure, I think this
19 is really a critical statement for the Child
20 Health Task Force. This is really important.
21 Figure it out, CMS. You have our full blessing.

22 (Laughter.)

1 And we don't want to burn real estate
2 in the child core set if somebody else is doing
3 it. So, I mean, that is parsimony. That is
4 alignment. It's synergy. It is using us to
5 affirm the value of this. But that spirit is so
6 critically important.

7 DR. BURSTIN: Right. And I don't want
8 to put all the emphasis here on CMS, either,
9 right? So, the Joint Commission, the American
10 Hospital Association; as she pointed out, AHIP
11 and CMS have this measure on the core set; ACOG.

12 So, there is an opportunity here for a
13 meeting of the minds.

14 CHAIR ANTONELLI: Right.

15 DR. BURSTIN: And you can say we live
16 in a consensus world. There should be a solution
17 for these hospital-based measures of import to
18 Medicaid that could make this work.

19 CHAIR ANTONELLI: Right. Walking the
20 talk of alignment, I love it. Thank you.

21 Okay, 1365, we have a motion on the
22 floor to remove. Open for comments, questions.

1 You should just leave your card up.

2 (Laughter.)

3 MEMBER POOLE-YAEGER: I had to say the
4 condition to replace, right? So, can we add that
5 in there.

6 CHAIR ANTONELLI: Yes.

7 MEMBER POOLE-YAEGER: Yes.

8 CHAIR ANTONELLI: Absolutely. Now is
9 the time.

10 MEMBER POOLE-YAEGER: Right. Okay.
11 So, yes, I do want to make sure we replace with
12 the other more encompassing measure.

13 CHAIR ANTONELLI: Yes. And can we
14 actually have a number? Or can the staff provide
15 the number that Amy has got in mind?

16 Okay. So, for the sake of due
17 diligence, would we put 0418 up, so that people
18 see what we're removing and we're potentially
19 promoting?

20 MS. GORHAM: So, this measure was
21 discussed on day one by the Adult Task Force. It
22 is currently on the Adult Task Force. But the

1 facts for the measure, it includes patients age
2 12 and older.

3 CHAIR ANTONELLI: So, in fact, this is
4 a clarifying question. I'm not going to make
5 your motion. So, your motion was to pull the
6 existing measure and replace it with this one.

7 My question is for the staff. Rather
8 than having that be a condition, can we vote one
9 down and potentially promote inclusion of another
10 one? So, in other words, uncouple the
11 conditionality and just do it separate votes? Is
12 that acceptable? Okay.

13 So, back to you, Amy. Would you like
14 to potentially reformulate your motion? Yes,
15 essentially, remove the conditionality --

16 MEMBER POOLE-YAEGER: Okay.

17 CHAIR ANTONELLI: -- and you could
18 actually make -- you know, then this would be a
19 second motion. And if you're afraid that, you
20 know, if we vote one down and nothing gets -- you
21 can go in either order. So, I will give you the
22 prerogative.

1 MEMBER POOLE-YAEGER: Yes. Okay. So,
2 I move that we add the NQF 0418 measure to the
3 child set. Down to the age of 12 is already in
4 the adult set. And we are going to remove my
5 condition from --

6 CHAIR ANTONELLI: Actually, let's
7 leave that there.

8 MEMBER POOLE-YAEGER: Okay, yes.

9 CHAIR ANTONELLI: Let's leave it as
10 that motion.

11 MEMBER POOLE-YAEGER: Okay, yes.

12 CHAIR ANTONELLI: Is there a second to
13 include 0418 in the child core set? I'm looking
14 for a second.

15 MEMBER BEATTIE: Second.

16 CHAIR ANTONELLI: Is that a second?

17 MEMBER BEATTIE: Yes.

18 CHAIR ANTONELLI: It is? Okay. So,
19 the motion has been seconded. We'll come back to
20 the other one. Let's start with this. So, open
21 for discussion for promoting 0418 into the child
22 core set.

1 Kathryn, you didn't have a comment?
2 That was just flagging? Because you were ahead
3 of Deb if you had a comment.

4 MEMBER BEATTIE: I was seconding, but
5 I can comment as well.

6 CHAIR ANTONELLI: All right. So,
7 let's let Deb go first. And then, you are next.
8 Go ahead.

9 MEMBER KILSTEIN: Just a question. If
10 staff could just kind of go back and confirm what
11 the conversation was at the adult core measure
12 meeting, because this did get discussed?

13 DR. BURSTIN: While they are looking,
14 a lot of discussion was around the fact that the
15 U.S. Preventive Services Task Force requires not
16 just depression screening, but depression
17 screening with a referral for followup or some
18 action. And that was the logic of this measure.
19 And I believe it stayed in the adult core set.
20 Yes, it did.

21 MS. MUKHERJEE: Yes, and they said
22 that followup should technically be beyond the

1 initial followup. It just shouldn't be one. It
2 should be six months, one year, things like that.
3 And USPTF, they talked about that and about how
4 they only endorse measures that screen and, then,
5 follow up.

6 And they said that PHQ-9 is not
7 collected in claims. That was one of the other
8 discussions in keeping it. And for now, they
9 said this is sufficient as a core set measure,
10 but, technically, they would like to see
11 something that has a lot more followup. And it
12 was one of those, you know, this is good for now,
13 not necessarily the perfect. That was the
14 decision.

15 DR. BURSTIN: Now that Debjani said
16 it, there was also discussion of whether you
17 could move to a measure of actually depression
18 remission as opposed to looking at patient-
19 reported outcome and seeing improvement, but, for
20 now, left this in place with an eye toward the
21 future of looking more at remission.

22 CHAIR ANTONELLI: Yes.

1 MEMBER KILSTEIN: And that was my
2 recollection, but there was a lot of commentary
3 to CMS around this measure. So, I just wanted to
4 make sure everyone understood that.

5 MEMBER BEATTIE: So, I'm really
6 thrilled to have this added as it is an AP
7 recommendation down to the age of 12. Some of
8 the nuances for inclusion for consideration with
9 CMS is how we define the standardized test;
10 what's appropriate. PHQ-9; for adolescents, the
11 PHQA versus the PHQ-2, is that enough? How do we
12 identify what adequate followup is and when
13 followup is indicated?

14 At my own organization, there was
15 extensive discussion, well, on the PHQ-9, do you
16 need a score of 6 or a score of 9 to count as
17 positive? I think some of those details need to
18 actually be included in the specifications, so
19 that we can drive consistency and make sure that
20 it really makes a difference. So, is a 6
21 important or just 9 out of 30 on a PHQ-9? Those
22 are things that aren't currently in the

1 specifications. It would be useful moving
2 forward.

3 Thanks.

4 CHAIR ANTONELLI: So, at the risk of
5 recognizing you're opening a can of worms, we are
6 not in a position to tweak specifications. So,
7 are you arguing against the motion that you
8 already seconded?

9 MEMBER BEATTIE: No. No, I'm in
10 support of the motion that I'm seconding.
11 However, it has repeatedly been stated that the
12 commentary is taken into consideration.

13 CHAIR ANTONELLI: Yes.

14 MEMBER BEATTIE: So, I just wanted to
15 state that for the record. Thanks.

16 DR. BURSTIN: And we can certainly
17 take that back to the Behavioral Health
18 Committee.

19 CHAIR ANTONELLI: Yes.

20 DR. BURSTIN: Harold Pincus co-chairs
21 that, as a matter of fact. So, we can certainly
22 bring that and --

1 CHAIR ANTONELLI: Yes.

2 DR. BURSTIN: -- see whether there is
3 additional work to be done. That's a good
4 suggestion.

5 CHAIR ANTONELLI: Good. Good. Okay.

6 So, for the sake of time management, I
7 don't have a sense that there's very much
8 negative energy in the room on this measure. So,
9 would you like to tee it up for the motion on the
10 -- oh, we're still using our hands, aren't we?
11 That's right.

12 So, 0418 being recommended for
13 inclusion for the child core set.

14 MS. KUWAHARA: So, those who would
15 like -- is there a question? Those who would
16 like to support inclusion of 0418, screening for
17 clinical depression and followup, please raise
18 your hand.

19 (Show of hands.)

20 So, 100 percent of the 12 voting
21 members in the room voted to support 0418 into
22 the child core set.

1 CHAIR ANTONELLI: Thank you.

2 And then, Amy, do you want to come
3 back to --

4 MEMBER POOLE-YAEGER: I will repeat my
5 motion to remove -- I forget the number --

6 CHAIR ANTONELLI: 1365.

7 MEMBER POOLE-YAEGER: -- 1365, which
8 was just more of a subset of this measure to kind
9 of reduce the duplications.

10 CHAIR ANTONELLI: Does anybody feel
11 the need for discussion on 1365? Otherwise, I'm
12 going to move us to a vote. Was that an "Um"?

13 (Laughter.)

14 MEMBER ADIRIM: So, I was just going
15 to say, just because we added this one doesn't
16 mean that you have to remove the other, right?
17 So, it's uncoupled? I just want -- okay.

18 CHAIR ANTONELLI: Oh, yes. That's why
19 I split them. These are two separate votes.

20 MEMBER ADIRIM: Right, right. No, but
21 I don't want people to think, just because we
22 voted that one in, that you necessarily have to

1 the suicide risk assessment, right? Okay,
2 suicide --

3 CHAIR ANTONELLI: No. As I said,
4 these are two separate votes, period, hard stop.
5 Now we're on to 1365. Motion on the floor is to
6 remove this.

7 We do have two people that want to
8 make comments. And I apologize, I didn't see
9 whose card went up. So, honor system, whoever
10 was first, jump in.

11 MEMBER BEATTIE: So, I was just going
12 to comment that this specific 1365 is for a very
13 small subset of the population, and that was, I
14 believe, the reason behind considering removal of
15 it from the subset, because of the small impact
16 it would have, where you truly have to have
17 already had the major depressive disorder
18 diagnosis for you to be in the denominator. And
19 presumably, the majority of those children are
20 now identified and receiving care. Because it's,
21 did you assess them when they were in your
22 encounter for care? So, it just is a lower

1 impact overall.

2 CHAIR ANTONELLI: Andrea?

3 MEMBER BENIN: Did you want discussion
4 about gaps around these kinds of things now? Or
5 do you want to save that for later?

6 CHAIR ANTONELLI: No, I want comments
7 specifically --

8 MEMBER BENIN: Just specifically?

9 CHAIR ANTONELLI: -- on the motion to
10 remove 1365.

11 MEMBER ADIRIM: I just have a
12 question. So, just because somebody is being
13 assessed for having a depression doesn't
14 necessarily mean they're being assessed for risk
15 of suicide. So, I just want to make that clear.
16 So that they are not the same measure. There may
17 be some overlap. But this is a subset, as was
18 just said, but that suicide is a high-impact
19 thing. I mean, this is people dying. Maybe I
20 come from the ER perspective, but I see a lot of
21 suicide ideations, suicide attempts, and so on,
22 in teenagers. So, I just want to throw that out

1 there.

2 MEMBER BEATTIE: May I ask a
3 clarification, so I understand exactly what the
4 measure is? Is it that you are assessing at
5 every single encounter?

6 So, I have a 15-year-old that on their
7 record they have that diagnosis code. Does that
8 mean that, when they break their arm and they go
9 to the orthopedist, the orthopedist is supposed
10 to complete a suicide -- what specifically are
11 the encounters? Because I want to make sure that
12 I am understanding exactly what the request is
13 here.

14 CHAIR ANTONELLI: Can you pull the
15 specs up, please?

16 MS. MUKHERJEE: So, the measure
17 description was up there, and it is the same.
18 Percentage of patient visits of those patients
19 age 6 through 17 years with a diagnosis of major
20 depressive disorder or an assessment for suicide
21 risk.

22 The numerator is patient visits with

1 an assessment for suicide rate, and the
2 denominator is all patients for those patients
3 age 6 through 17 years with a diagnosis of major
4 depressive disorder, and there are no exclusions.

5 CHAIR ANTONELLI: So, I would like to
6 call the question?

7 Or, Terry, are you --

8 MEMBER ADIRIM: Is there a timeframe
9 for this or no?

10 CHAIR ANTONELLI: This is it. Yes.
11 Yes.

12 So, I'm going to ask Miranda to set us
13 up for a vote on 1365, please.

14 MS. KUWAHARA: Sure. So, this is a
15 vote to remove NQF No. 1365, child and adolescent
16 major depressive disorder, suicide risk
17 assessment.

18 If you would like to see this measure
19 removed please raise your hand.

20 (Show of hands.)

21 And if you would like to see this
22 measure remain on the core set please raise your

1 hand.

2 (Show of hand.)

3 Eight were in favor of removing and 5
4 were in favor of keeping it. So, therefore, we
5 achieved the 60-percent threshold. This measure
6 will be removed from the child core set.

7 DR. BURSTIN: Recommended --

8 MS. KUWAHARA: I'm sorry. Recommended
9 for removal.

10 DR. BURSTIN: One state is currently
11 reporting it. That is what that says at the
12 bottom there. It must be pretty hard, huh?

13 CHAIR ANTONELLI: So, plow through,
14 because we are going to do a working lunch in
15 case anybody is doubting that. But I think we
16 have one more measure, the access to primary care
17 measure. I'm going to exercise the prerogative;
18 we are just going to finish out and, then, we'll
19 grab some lunch. Okay?

20 So, can we put -- it's not an NQF-
21 endorsed measure. So, it doesn't have a number.
22 Can we put the measure up on the screen, please?

1 And I will open for conversation on
2 this measure.

3 Would you like to restate or remind
4 people what your motion was? And then, if you
5 would like to open up the commentary?

6 MEMBER OSBORNE-GASKIN: So, child and
7 adolescent access to primary care practitioners,
8 my motion was to remove it from the child core
9 set. And I think part of my rationale was that
10 the access does not necessarily mean that these
11 patients or these children are visiting the
12 primary care practitioners. There is also geo-
13 access that is done by health plans, and they
14 have to make sure that there are primary care
15 providers within a certain distance or mileage
16 from their populations that they serve.

17 And so, I just had some difficulties
18 sort of crosswalking this to the quality. If we
19 want to look at the quality of care or whether
20 the kids are getting their well childcare visits,
21 that is also addressed in the immunizations for
22 adolescents and adolescent well care, as opposed

1 to just looking at access, which just kind of
2 gives you how many primary care providers, not
3 necessarily how many patients are being seen by
4 the providers.

5 CHAIR ANTONELLI: Other questions or
6 comments?

7 Amy?

8 MEMBER POOLE-YAEGER: Yes, I would
9 like to see the specs. I don't know this measure
10 perfectly well, but my recollection about how it
11 works is that, you know, it is any visit to a
12 PCP, right, but not a primary care visit? And
13 maybe the reason the teenagers -- you know,
14 they're just not sick, right? So, that's why
15 they are not going in and that's why they look --
16 it is not that they don't have access or have a
17 place to go, to kind of highlight on that. But I
18 am not sure if we can see the --

19 MS. MUKHERJEE: So, I have the specs
20 up. It is the percentage of members 12 months
21 and 19 years of age who had a visit with a PCP.
22 The organization reports four separate

1 percentages for each product line, and the two
2 product lines are commercial and Medicaid, and
3 they are reported separately. And it is children
4 12 to 24 months and 25 months to 6 years who had
5 a PCP visit during the measurement year. And
6 then, the second is children 7 to 11 years and
7 adolescents 12 to 19 years who had a visit with a
8 PCP during the measurement year or the year prior
9 to the measurement year.

10 They have continuous enrollment
11 requirements in this measure. They have
12 allowable gaps in this measure. And, yes.

13 MEMBER POOLE-YAEGER: Yes. And again,
14 you know, could it be access -- I guess it could
15 be access, but, more or less, if you are not
16 going in for -- you know, teenagers just maybe
17 don't go in for their -- you know, they're not
18 sick very often. So, they are not going in. So,
19 that's why it looks less often. That would be my
20 hypothesis, but I'm not sure.

21 MEMBER ADIRIM: Yes, the way I read
22 this measure, it's not necessarily access to

1 primary care; it's access to the primary care
2 practitioner. So, you would still want the child
3 or the adolescent to have access to a primary
4 care practitioner even when they are sick, for
5 sick visits. I mean, that is the way I read it.

6 MEMBER POOLE-YAEGER: Yes, and I
7 agree. But I think what Roanne was saying was
8 that we have the adolescent well care visit
9 measure already, and we know that they don't go
10 in for their well visits. So, are we getting
11 much more from this measure? Then, that would be
12 my question.

13 CHAIR ANTONELLI: Andrea, Amy, and
14 Deborah?

15 MEMBER BENIN: As previously
16 discussed, we have very few good metrics for
17 truly understanding access, and we are in an
18 environment where access to services for folks
19 with Medicaid may become even more compromised
20 than it already is.

21 And the only way that we can really
22 understand access, I think, is probably by

1 triangulating a number of different metrics
2 around the problem and understanding it by kind
3 of fleshing out the whole circle of the issues.
4 I don't know that there's any one perfect
5 isometric out there that we are going to be able
6 to find.

7 So, I would strongly advocate for us
8 at this point not removing metrics that give us
9 any hope of understanding access, and especially
10 if following a metric over time that may benefit
11 that and give us the ability to watch and see
12 what happens. As the environment around us
13 changes, it is critical that we understand what
14 is going on, and we are not going to be able to
15 understand that with one little slice of the pie.
16 And the pie is multidimensional.

17 So, I strongly advocate for leaving
18 this metric in the set.

19 MS. MUKHERJEE: So, I'm just going to
20 quickly read out all the different areas where
21 you could sort of code for this measure, and it
22 has CPT codes for: office or other outpatient

1 services, home services, preventive medicine, and
2 general medicine examinations. So, all of that
3 falls under this measure.

4 CHAIR ANTONELLI: Amy?

5 MEMBER RICHARDSON: I just have a
6 question, please. I can't tell from this
7 spreadsheet here. What is the source of these
8 data? Is this claims data? Okay. Thank you.

9 CHAIR ANTONELLI: Okay. Deborah?

10 MEMBER KILSTEIN: I'm just not sure
11 that this measure measures access. I mean, what
12 it does is it tells you, for example,
13 adolescents, they are not getting well care
14 visits. Are they getting sick visits? And then,
15 you will see how many kids are being seen, but it
16 doesn't mean that there is an access problem or
17 not an access problem. It just means they
18 weren't sick; they didn't need to go in.

19 But, I mean, I have no problems with
20 the measure as it is. I'm just not sure it
21 actually measures access.

22 CHAIR ANTONELLI: Are you ready for a

1 vote, although I did now maintain the paradigm
2 from yesterday and the conditions, so we know
3 whether this is a dichotomous or trichotomous
4 vote? No conditions.

5 Okay, Miranda. So, we're looking at
6 an up/down.

7 MS. KUWAHARA: So, we are voting to
8 remove the measure child and adolescents' access
9 to primary care practitioners.

10 If you would like to see this measure
11 removed from the core set, please raise your
12 hand.

13 (Show of hands.)

14 If you would like to see this measure
15 remain on the core set please raise your hand.

16 (Show of hands.)

17 Yes, this vote is to remain on the
18 core set.

19 Okay, perfect.

20 So, 1 voting member voted to remove
21 this measure; 12 voted to include this measure.
22 So, the measure will be recommended to remain on

1 the core set.

2 CHAIR ANTONELLI: Thank you, everybody.

3 Operator, can you open the line to see
4 if there's any public comment, please?

5 OPERATOR: Ladies and gentlemen, if
6 you would like to make a public comment, please
7 press *, then 1, on your telephone keypad.
8 Again, *1 to make a public comment.

9 (Pause.)

10 And currently, we have no public
11 comments at this time.

12 CHAIR ANTONELLI: Thank you.

13 Miranda, any in the chat to you?

14 MS. KUWAHARA: No.

15 CHAIR ANTONELLI: Okay. Anybody in
16 the room, public comment?

17 (No response.)

18 All right. So, if the staff can give
19 us directions for the lunch break? I think the
20 food is here. Yes. Okay.

21 Debjani, do you want to tell us?

22 MS. MUKHERJEE: So, let's take a 10, a

1 15-minute. Well, let's take a 15-minute break.
2 And then, we'll do a working lunch back here.
3 So, when it's 1:00, we will be back and do a
4 working lunch for the rest of the afternoon.

5 (Whereupon, the foregoing matter went
6 off the record for lunch at 12:45 p.m. and went
7 back on the record at 1:10 p.m.)

8 CHAIR ANTONELLI: Welcome back,
9 everybody.

10 So, we are going to pivot from pruning
11 to planting, or in this case nominating measures
12 for the child core set. I know the staff is
13 working on teeing things up. So, it will just
14 take another minute or so.

15 (Pause.)

16 Ready? Okay.

17 So, May is going to give us an update
18 on the Pediatric Quality Measures Program
19 measures. Then, we will proceed into a
20 discussion about measures that folks suggested a
21 few weeks back. The staff has done some work to
22 tee them up for discussion.

1 All right. So, May, if you can
2 proceed, please?

3 DR. NACION: Okay. So, I will just
4 briefly review what PQMP is and measures that
5 have been developed under PQMP.

6 So, the Pediatric Quality Measures
7 Program, PQMP, was established under CHIPRA and
8 intended to improve and strengthen this core set
9 of measures, to generally expand the availability
10 of pediatric quality measures for use by public
11 and private healthcare purchasers, to advance
12 development and innovation around new and
13 emerging quality measures, and to increase the
14 portfolio of evidence-based, consensus-driven
15 pediatric quality measures available to the
16 field.

17 In terms of a breakdown of what has
18 been endorsed and what has not, to date, this is
19 a moving target. So, currently, we have 16 NQF-
20 endorsed PQMP measures. Four are behavioral
21 health, mental health, substance-abuse-type
22 measures. Two are readmission measures, one

1 patient-reported outcome measure, and one sickle
2 cell measure, as well as eight family experiences
3 with coordination of care measures. So, many of
4 these measures will be discussed today, as Task
5 Force members have recommended them for addition
6 to the core set.

7 Not listed on this slide, but
8 development of the child HCAHPS tool also took
9 place under PQMP. But, since MAP already has the
10 standing recommendation that this measure be part
11 of the child core set, it's not listed here.

12 In addition, there are six PMQP
13 measures currently undergoing endorsement review
14 and fall under topics such as appropriate use of
15 antibiotics, asthma, and insurance coverage.

16 There are a total of 90 PMQP measures
17 available, including perinatal care, child
18 clinical preventative services, management of
19 acute conditions and chronic conditions, patient-
20 reported outcomes, duration of enrollment and
21 coverage, availability of services, and
22 medication reconciliation.

1 As of 2015, 24 measures are under
2 development. I believe later Dr. Mistry can
3 elaborate on any others in development or any
4 other current priorities.

5 MS. GORHAM: So, we actually have
6 Renee here.

7 So, Renee, if you would like to add
8 anything else?

9 DR. FOX: Thank you. And Karen is
10 here as well.

11 And, yes, there are measures that were
12 developed in phase 1. I just wanted to let
13 everybody know that AHRQ, with funding from CMS,
14 has begun phase 2 with Centers of Excellence to
15 look at taking the measures developed by the COEs
16 and testing them, implementing them at the state
17 health plan and provider level, so to look at how
18 useful the measures are, with two key goals of
19 assessing both the feasibility and the usability
20 of some of these measures within the Medicaid and
21 CHIP patient populations, and as well as to
22 support performance monitoring and quality

1 improvement through both field testing,
2 refinement, data collection, reporting on new
3 measures, and use of performance data to define
4 QI goals and test multilevel improvement
5 strategies.

6 So, we were hoping to take these
7 measures and the work that was done previously,
8 as well as the ongoing work, to sort of bring it
9 to the next level of not just having a measure,
10 but having a measure that is useful at various
11 levels.

12 I don't know if people have specific
13 questions about that. The HCAHPS measure, which
14 is the measure that is on our core set, but we
15 don't currently report, one of our grantees --
16 thank you; I'm sorry, I should have a lavalier
17 mic -- one of our grantees is going to explore
18 that measure and how we can look at it, take it
19 from the hospital measure to a state-reporting
20 measure.

21 MS. GORHAM: Okay. So now we will
22 look at measure review, and these are measures

1 for potential addition to the core set.

2 Next slide.

3 This is a review from yesterday, and
4 just a general overview of how the measure is
5 submitted and analyzed. So, as we did yesterday,
6 for those folks who recommended a measure, you
7 will be the lead discussant for that measure or
8 measures that you recommended.

9 Again, we discussed the measure
10 selection criteria earlier. We heard feedback
11 from the state. And so that, we ask that you
12 take all of that into consideration and, also,
13 whether or not the measure addresses a gap area.

14 Next slide.

15 We discussed the preliminary analysis
16 algorithm yesterday, some of those points, and
17 how the staff used the algorithm in order to
18 assess the measure.

19 Okay, move forward.

20 This is just the specific subcriteria
21 we used for Medicaid.

22 You can move forward.

1 Again, discussing vote, but after day
2 two, you all are pros at voting. So, we do not
3 need to discuss that.

4 Again, decision categories you have in
5 front of you, but, again, you are familiar with
6 them by now: support, conditional support, and
7 do not support.

8 Next slide.

9 So, the next several slides, the next
10 three slides to be exact, are the gap areas
11 identified in 2015 and 2016. The asterisk
12 denotes new gaps, newly-identified gaps. And
13 later on in the day, we will really have a good
14 gaps discussion. So, I won't go into detail
15 about the gaps now.

16 But, if we go to slide 333, okay, so
17 this slide, not including the maternal measures
18 and not including the measures that MAP
19 recommended for removal, these are the
20 recommendations, 2015 and 2016, that this Task
21 Force recommended to CMS that were not added to
22 the core set.

1 So, 2393, pediatric oral condition
2 readmission measure and, also, 2797, the sickle
3 cell anemia measure.

4 Next slide.

5 This slide and the next are a list of
6 measures that were recommended by your peers.

7 So, the first measure -- and we will go over each
8 in detail a little later -- but the first
9 measure, 1659, influenza immunization; 2800,
10 metabolic monitoring for children and adolescents
11 on antipsychotics; 1354, informed coverage; 3166,
12 antibiotic prophylaxis among children with sickle
13 cell anemia, and then, the last, emergency
14 department visits potentially treatable in
15 primary care.

16 Let me just say the two measures with
17 the asterisk are pending endorsement. So, they
18 are currently in a project right now.

19 And then, the next slide, we have the
20 FECC measures that were recommended.

21 So, this is a good spot, before we go
22 into each individual discussion of the measures,

1 if you open your discussion guide, there we have
2 the specs and, also, the results of the
3 algorithm.

4 So, the first measure that we are
5 going to discuss is the 1659. If you click on
6 that measure, it's best if you are in your
7 discussion guide. If you go to your gray tab,
8 you have a button for measure. That is the
9 easiest way to find the measures, I believe, and
10 1659 is the first measure under care
11 coordination. So, we will give you a little
12 while to get there.

13 (Pause.)

14 Okay. Andrea suggested this measure.
15 And so, I will turn it over to her, as the lead
16 discussant.

17 MEMBER BENIN: This metric is the
18 metric of inpatients who get screened for needing
19 a flu vaccine and receiving a flu vaccine before
20 the time of discharge. This is a metric that is
21 used in other federal reporting areas, and I
22 think in at least one it looks like it is used --

1 implicit here, it has been used in two other
2 federal reporting programs.

3 It is an opportunity to round out the
4 panel around immunizations as well as providing a
5 metric that can address truly preventable
6 admissions down the line and preventable harm to
7 patients. And so, it is an important access
8 point, when children are in the hospital, for
9 them to have their flu shots evaluated and taken
10 a look at. And so, having this on the set would
11 round out that process and add this in. It also
12 is, like the other immunization metrics,
13 something of a proxy for access. You know, the
14 downside of it are the issues that have
15 previously been discussed about how it is
16 involved in other programs, and people may be
17 getting at this in different ways. I do not know
18 about the feasibility of reporting.

19 I also do know that, in general, the
20 performance on this metric in adult hospitals is
21 fairly high, and there has been a lot of work
22 done in adult facilities to make this metric

1 pretty high. But there is little to no insight
2 into what this looks like across the board in
3 children's hospitals. And so, there is not a way
4 to really benchmark this metric for children's
5 hospitals. And so, whether this would be a
6 mechanism for that would be interesting.

7 CHAIR ANTONELLI: I'll open this up,
8 but I actually want to seize the prerogative of a
9 question. The exclusion about the vaccine
10 production gap and distribution gap is intriguing
11 to me because I am sort of thinking of this as a
12 population measure. And so, are you familiar
13 enough with the measure to speak to -- and just
14 to be clear, I'm not saying the hospital is
15 responsible for having vaccines that are not
16 available, but I am trying to think of this at
17 the level of a population that merits vaccine,
18 and if they don't get it, you know, I am not sure
19 that that is a patient-centered type of a metric.
20 So, comment, please.

21 MEMBER BENIN: Yes. I mean, there may
22 be somebody who knows the idiosyncracies of the

1 development of this particular metric better than
2 I do. I do believe that this stems from the
3 years when there were those pretty massive
4 shortages, when you remember everyone was waiting
5 in line.

6 And it has only been in the past few
7 years that the recommendation has been expanded
8 to really be everybody six months and older. So,
9 I suspect that that was sort of the legacy from
10 those years, which hasn't happened in a few
11 years, but certainly could again. I think every
12 year the supply is at risk.

13 And then, combining in now, we are
14 also recommending it to everybody. So, if there
15 is no vaccine to be had, who are you holding
16 accountable for that? I don't know the answer,
17 but there may be some who actually was involved
18 more in the development. I don't know.

19 CHAIR ANTONELLI: Yes, because I just
20 think if hospital A doesn't have vaccine,
21 hospital B likely wouldn't. And so, that would
22 affect everybody's performance. And it just

1 seems to me that, if your central supply person
2 forgot to put the order in on time, that that's
3 not a good reason against that measure. So, I
4 just step back into my share.

5 Terry?

6 MEMBER ADIRIM: Yes, I have one really
7 naive question. Implement of vaccine is not
8 included in any of the other measures, right?

9 MEMBER POOLE-YAEGER: It's in the
10 combo for the first two years of life.

11 MEMBER ADIRIM: Okay.

12 MEMBER POOLE-YAEGER: One of the
13 combos for that.

14 MEMBER ADIRIM: Right. So, yes, I
15 thought so.

16 CHAIR ANTONELLI: So, none of us heard
17 that.

18 MEMBER POOLE-YAEGER: Sorry.
19 Immunization is in the CIS measure, the Combo
20 Immunization Series for the infants. There's
21 Combo 1, 2, 3, 4, all the way up to 10. In one
22 of those combos -- I don't remember which --

1 influenza vaccine is in there.

2 MEMBER ADIRIM: Right. So, I was just
3 kind of curious about the additional benefit to
4 -- I know this gets at it a different way,
5 vaccination a different way, but about the
6 additional benefit to this measure.

7 As you were talking, the first thought
8 that went into my head is, yes, I would like to
9 have a measure for healthcare providers at
10 children's hospitals. But I was just kind of
11 curious about what your thinking is with regard
12 to the additional benefit to this measure with
13 the other measure that's measuring, that includes
14 influenza vaccines.

15 MEMBER BENIN: Maybe I am not
16 remembering the details of these other metrics
17 well enough, but my understanding is they are
18 truly around your childhood immunization. So,
19 you are up to about age 5-ish between those two
20 metrics and, then, the adolescents.

21 But if you take your chronic -- who is
22 in our hospitals, right? There is a little bit

1 of that and, then, there is a lot of your chronic
2 players. And those are your players who are on
3 Medicaid often, and those children may not be
4 captured entirely by your routine vaccination
5 schedules, just because everybody should get one
6 every year, right? So, it is more than just what
7 is in your routine schedule.

8 But I would have to go back through,
9 to your point, Terry, just to confirm that 0038
10 -- I mean, I thought 0038 was the infant one, but
11 I'm not remembering.

12 MEMBER POOLE-YAEGER: So, we have done
13 -- again, you know, I have 23 Medicaid health
14 plans -- we have done a lot of work around flu
15 vaccination rates in our population. And we have
16 looked at claims for flu vaccinations. And then,
17 there is also a question in the CAHPS survey
18 about, did your child get a flu vaccine?

19 I can tell you that the rates are
20 vastly different. So, probably half of what is
21 reported in the CAHPS survey is what we get in
22 claims. So, I struggled with this for a long

1 time. Like how do we judge the flu vaccination
2 rate of our population? The only thing what I
3 worry about this one is I think it is going to be
4 really hard. I don't know that the hospital --
5 you know, you're going to have to get into the
6 hospital record to see if they offered flu
7 vaccination. If somebody got a flu vaccine from
8 their provider office report, they won't need one
9 when they are discharged from the hospital. So,
10 I just have a little concern about this.

11 I think flu vaccination is an
12 important one. I'm not sure that that's the best
13 one to pick out of all of them from my
14 perspective.

15 But CAHPS, I don't know, CAHPS survey
16 results could be one, right? Is that on the --

17 DR. MATSUOKA: So, CAHPS, the health
18 plan CAHPS is on both the adult and child core
19 set, but not all --

20 MEMBER POOLE-YAEGER: Not all
21 questions --

22 DR. MATSUOKA: Not all plans are

1 reporting those to the states, and if a state is
2 a fee-for-service state, they may not be
3 administering it at all.

4 MEMBER POOLE-YAEGER: Yes, got it.
5 Okay.

6 CHAIR ANTONELLI: Further discussion?
7 Should we vote sometime --

8 MS. GORHAM: Sure. I just wanted to
9 highlight, if you just scroll down a little bit
10 more, some of your questions about feasibility
11 and that type of thing, we did attempt to answer
12 some of those questions, so highlighted in your
13 discussion guide, and May just highlighted the
14 bullet point. I think it is maybe one, two,
15 three, four down, we talk about feasibility.

16 This measure was reviewed in our
17 Health and Well-Being Project. So, we have a
18 little bit of information from the Health and
19 Well-Being Project and from those experts that
20 sat on that standing committee.

21 And so, I know that this measure, the
22 evidence for the measure is based on

1 recommendations from ACIP on routine
2 vaccinations.

3 I would say that, just as you are
4 thinking and deliberating, this measure did not
5 fall into a gap identified in 2016, but that
6 definitely doesn't mean that you can't consider
7 it.

8 As far as the Health and Well-Being
9 Committee, this measure was endorsed with reserve
10 status, just because the performance is rather
11 high. And so, kind of narrowing the performance
12 gap was clinically significant, but they did not
13 allow and they did not believe that narrowing the
14 performance gaps was clinically significant.

15 But, again, we outlined for you just
16 where the measure is currently used because it is
17 in use now. So, that is on your screen.

18 MEMBER BENIN: Do you know, Shaconna,
19 if they were able to identify that this was a
20 problem, that the performance was high for
21 children? Because my understanding is that,
22 while the performance is high overall for

1 hospitals in the CMS IQR, I don't know that we
2 know the answer for what that always looks like
3 for children; that that in children may be
4 different. I don't know.

5 DR. BURSTIN: We could check the
6 actual submission form and see if they stratify
7 by populations. I don't recall. I think they
8 have tended to do race and ethnicity, but it is
9 an easy enough question to try to get answered.

10 MEMBER BENIN: And the children's
11 hospitals would not be submitting to that program
12 anyway. So, you wouldn't have that data there.
13 So, the only mechanism right now where you get
14 this data is through U.S. News and World Report.
15 This is where people put it.

16 So, I think we just have to think
17 about what are our sources of how -- for
18 children's hospitals, it is an ORYX metric, but
19 the one place that it gets gathered and sort of
20 looked at globally, if you will, is in U.S. News
21 and World Report. There is not a real context
22 for it in the other discussion. This may provide

1 such a context, the Medicaid side.

2 CHAIR ANTONELLI: About how long will
3 it take to get the stratification data?

4 DR. BURSTIN: I'm not sure they would
5 actually have enough data if children's hospitals
6 aren't reporting it. So, CMS may not be the best
7 source to find that out.

8 CHAIR ANTONELLI: Yes, because what I
9 am grappling with is the inactive endorsement and
10 reserve status with the NQF. Because if that
11 decision was made on adult-only data -- okay.
12 Okay.

13 Would you like to make a motion?

14 MEMBER BENIN: Sure. I move that we
15 suggest adding this, you know, for CMS's
16 consideration, to add this metric to the panel.

17 CHAIR ANTONELLI: Is there a second?

18 (No response.)

19 I don't see a second. I'll give
20 people another minute or so, since Helen is
21 distracting us.

22 (Laughter.)

1 Is there a second? Was that a hand?
2 If you could speak, please.

3 MEMBER GREINER: I'll second, yes.

4 CHAIR ANTONELLI: Okay. So, the
5 motion has been made to recommend 1659 be
6 advanced to be part of the child core set, and it
7 has been seconded.

8 Comments or questions before we
9 proceed to a vote?

10 Amy?

11 MEMBER RICHARDSON: So, if I
12 understand, the previous question is we don't
13 have baseline data to know to what extent this is
14 a problem we're trying to solve. Is that
15 correct? Or pediatric data?

16 CHAIR ANTONELLI: We're trying to
17 confirm that. That's what Andrea's belief is,
18 and the staff is going to see if they can pull
19 that up for us.

20 We could put this one on pause, go to
21 the next one, and come back. I'm assuming we are
22 talking minutes and not days. Yes.

1 So, Andrea, is that okay with you?
2 Let's hold this motion on 1659. Let's move on to
3 the next question. We'll come back to this one,
4 and the staff will let us know the affirmation of
5 Andrea's observation.

6 Okay. So, the next one is 2800.

7 MS. GORHAM: So, actually, I think our
8 Chair -- we're telling people about using the
9 mic, and then, I don't turn mine on.

10 Actually, our Chair Rich and Kim are
11 our lead discussants for this measure.

12 CHAIR ANTONELLI: So, 2800 is NQF
13 endorsement about screening for children and
14 adolescents newly on antipsychotics. The measure
15 steward is NCQA.

16 The description, I'll read it quickly.
17 Percentage of children and adolescents 1 to 17
18 who have had two or more antipsychotic
19 prescriptions and had metabolic testing.

20 The denominator is ongoing treatment,
21 at least two prescriptions for these medications.
22 There's no exclusions. It is administrative

1 claims data.

2 And we wanted to bring this forward
3 for discussion in this group.

4 Kim?

5 DR. ELLIOTT: I agree. I think that
6 this is an area, since we have been increasing
7 our use of behavioral health medications, we have
8 been really putting a lot more emphasis from a
9 measurement perspective on behavioral health
10 services in general. I think that this is an
11 area from the future for these children to really
12 do a better job of monitoring their metabolic
13 conditions.

14 And it's an easy one to measure. It's
15 prescription-based. Kids are already diagnosed,
16 and it just should not be a challenging one. I
17 think it would have a huge benefit to make sure
18 those kids that are not having those things
19 monitored actually have them monitored, so that
20 we can make sure the long-term consequences of
21 these medications don't impact their lives.

22 MEMBER ADIRIM: Yes, I was going to

1 say I support that this is a really important
2 thing to improve on. And I see where, down to
3 the clinical level, I know people have mentioned
4 that before. Like how can the states use this to
5 improve care? So, I definitely could see how
6 this would be useful for that.

7 And I think, as pediatricians are more
8 and more prescribing these medications and may
9 not have the experience or education or training,
10 or whatever, for these meds, that it would be
11 important.

12 I think what I would want to know,
13 because, again, to the theme of real estate, not
14 that that's as big of an issue for me, but how
15 many children would this affect and, within each
16 state, what would be the number of children?
17 Because for the diagnoses that children would
18 require antipsychotics, it is like 1 percent of
19 the population, you know, like bipolar with
20 psychotic breaks. Schizophrenia doesn't exist in
21 young children. So, yes, I would want to get an
22 idea of the numbers of children affected before

1 making a decision.

2 CHAIR ANTONELLI: Do you have an
3 answer? And also, is the measure developer on
4 the line, if we need him or her? Do we know?
5 They're not on? Okay.

6 Rachel?

7 MEMBER LA CROIX: I believe we had our
8 plans report it last year. So, I am trying to
9 pull up the file -- it's just taking a minute --
10 so that I can tell you how many folks we had
11 eligible for the measure. But, once I have it,
12 I'll let you know.

13 MEMBER POOLE-YAEGER: I can just give
14 my gut concept. I don't have any numbers in
15 front of me. But, in Medicaid, especially in
16 foster care, the use of antipsychotics is quite a
17 bit higher than in the overall population. So, I
18 think this would be one of those things that
19 would be disproportionately high in Medicaid
20 probably.

21 DR. ELLIOTT: And also in the
22 disability population.

1 MEMBER POOLE-YAEGER: Correct,
2 correct.

3 CHAIR ANTONELLI: Terry?

4 MEMBER ADIRIM: Yes, but my concern
5 within the foster care population would be about
6 appropriate use of antipsychotics. So, that, I
7 think, is the issue with that population. I
8 think the appropriate use, you want to make sure
9 that there's appropriate monitoring and all of
10 that.

11 So, I'm really conflicted about this
12 measure because I see its importance. I'm just
13 concerned that the numbers would be small, that
14 it wouldn't affect as large a population as some
15 of the other measures.

16 DR. MATSUOKA: So, to Terry's point --
17 I'm curious to know Rachel's numbers, too. But
18 while we're waiting, to Terry's point, we do have
19 two antipsychotic medication-related measures
20 already in the child core set. One is looking at
21 the use of multiple concurrent antipsychotics to
22 get to the sense of utilization and

1 appropriateness. The other one is first-line
2 psychosocial care for children who are using
3 these medications for a certain period of time,
4 to try to get at, you know, is it an
5 inappropriate substitution of medication for
6 psychosocial care? So, we have those two in the
7 core set.

8 We do have an affinity group that we
9 have been running with around eight states
10 looking at the issue in general, but, also,
11 around the measurement of the issue. I am going
12 to ask Renee to see -- we have some preliminary
13 data from NCQA just from the plans that they are
14 -- the core measure, like what the rate is of
15 even just the utilization piece. And that might
16 help to back into, of the subset for whom this
17 might be appropriate, is there some metabolic
18 monitoring going on?

19 MEMBER ADIRIM: And didn't somebody
20 say -- this was maybe two years ago we had that
21 person from Louisiana come and say that 40
22 percent of the boys in her state on Medicaid were

1 on antipsychotics? Am I like hallucinating? But
2 it was some really ridiculous --

3 DR. ELLIOTT: I wasn't there, but,
4 yes, I think that that is true.

5 MEMBER ADIRIM: Right, and that's why
6 we put these measures on there, because it's
7 inappropriate use of antipsychotics. It is
8 really a huge issue.

9 MEMBER POOLE-YAEGER: Rachel has her
10 numbers?

11 MEMBER LA CROIX: I do, and we
12 required last year our plans to report on the use
13 of multiple concurrent, and we also have them
14 report on the metabolic monitoring. So, for the
15 use of multiple concurrent antipsychotics -- and,
16 of course, this is an inverse measure; we want
17 rates to be low for this -- but across all of our
18 plans we had 10,300 eligible members for the
19 measure. And the weighted rate across our plans
20 was 1.77 percent, so a relatively low rate, which
21 is what we want.

22 And then, for the metabolic monitoring

1 for children and adolescents on antipsychotics,
2 the total rate -- so, this is bringing together
3 the three different age bands that are reported
4 -- it was a total of 13,732 eligible members
5 across the plans met the criteria for the
6 measure. And our weighted rate across our plans
7 was 37.77 percent. So, yes.

8 CHAIR ANTONELLI: Any other
9 discussion?

10 Yes, go ahead.

11 DR. FOX: Well, I can just explain a
12 little bit about the affinity group. As Karen
13 said, we have our two measures, one of which is
14 NQF-endorsed and the other one is not.

15 We had eight states, and many states
16 actually use the whole HEDIS bundle, which is
17 three measures. And so, there were several
18 states that chose to look at metabolic monitoring
19 because there's a disconnect. Either it's the
20 subspecialty provider who does the prescription
21 and, then, the PCP does the followup. There is a
22 question about getting the labs back. Also, it's

1 hard to get people to go from a doctor's office
2 to a lab to get blood drawn. They get lost in
3 between. And so, there were multiple challenges,
4 but they have chosen to work on that.

5 And California found they had a wide
6 range of numbers of people; plus, they also had,
7 if they only looked at blood glucose instead of
8 lipids, there were many more people who got
9 their --

10 MEMBER ADIRIM: So there's room for
11 improvement?

12 DR. FOX: There is definitely room for
13 improvement. I think the numbers -- that our
14 NCQA friends are here now.

15 CHAIR ANTONELLI: If we can ask you to
16 come up to the microphone, identify yourself?

17 We can come back to the -- terrific.
18 If you can identify yourself and, then, jump in
19 for the question?

20 MS. BYRON: Sure. Hi. I'm Sepheen
21 Byron. I'm the Assistant Vice President,
22 Performance Measurement at NCQA, and worked on

1 the Center of Excellence that developed these
2 measures that we eventually adopted into the
3 HEDIS health plan measure set.

4 And I apologize, I got here a few
5 minutes ago, and I may have missed what the
6 actual questions were. So, if you don't mind
7 repeating?

8 CHAIR ANTONELLI: So, I think that
9 we're riffing on the questions that Terry had
10 raised about population size, potential room for
11 improvement. But I think that we've actually had
12 that data. So, I'm going to pause.

13 Task Force Members, do you need
14 anything else to inform your thinking on 2800?

15 And please don't leave that seat
16 because we will pull you back in for a different
17 question.

18 (Laughter.)

19 But, focusing on 2800, any other
20 question for the measure developer?

21 Otherwise, I am going to make a
22 request for a motion.

1 (No response.)

2 Okay. Kim?

3 DR. ELLIOTT: I'd like to move that
4 this measure -- I forget the number right now --
5 be added to the child core measure set.

6 CHAIR ANTONELLI: Is there a second?

7 MEMBER ADIRIM: I second.

8 CHAIR ANTONELLI: Okay.

9 MS. GORHAM: So, just as a reminder,
10 because we have folks on the phone, we can hear
11 you in the room, but they can't hear you if you
12 don't use your mic. So, just a reminder to speak
13 into your mic, please.

14 CHAIR ANTONELLI: Miranda?

15 MS. KUWAHARA: So, if we are ready to
16 vote on Measure No. 2800, we will go back to
17 trying to use the clickers. We believe we have
18 resolved the issue. But, just to ensure that the
19 clickers are working properly, if you could
20 please use the test question, "Did you have
21 coffee with your breakfast this morning?" And
22 please direct your clickers in this direction.

1 We're still waiting on a few
2 responses.

3 A new one coming down.

4 All right, we just got the 13th vote.
5 All right, we should be good to go.

6 Again, this is Measure No. 2800,
7 metabolic monitoring for children and adolescents
8 on antipsychotics.

9 Should this measure be added to the
10 core set? If you support, please press 1; if
11 not, press 3.

12 Eighty-five percent of the 13 voting
13 members voted to support this measure.

14 CHAIR ANTONELLI: All right. So,
15 let's go back to the motion that's still on the
16 table for 1659. I think we have an update to the
17 questions that were raised about the influenza
18 vaccine. But, I think, with the presence of NCQA
19 in the room now, Andrea, would you like to just
20 give us a quick summary, so that she can weigh-
21 in?

22 MEMBER BENIN: I don't think it's an

1 NQCA measure, but I'm happy to. It's a Joint
2 Commission measure. I mean it is an ORYX CMS
3 measure, yes.

4 CHAIR ANTONELLI: Mine says NCQA.
5 Okay. Okay.

6 DR. BURSTIN: If 1659 was the one we
7 were talking about, which is inpatient influenza
8 screening, which is not NCQA. That's CMS.

9 CHAIR ANTONELLI: Okay. So, it's a
10 typo on the slide then? Okay.

11 DR. BURSTIN: They do the outpatient
12 one by survey.

13 CHAIR ANTONELLI: Okay. Use the
14 microphone, please.

15 MS. BYRON: So, the HEDIS measure,
16 childhood immunization status, does have flu in
17 it. That's for up to age 2.

18 CHAIR ANTONELLI: Right. Okay. Okay.
19 Debjani, you have something, I think,
20 to report on, and then, I'm going to call for a
21 vote on 1659.

22 MS. MUKHERJEE: So, it is a facility-

1 level measure, and it does include children and
2 older individuals, adults, but it's facility
3 level, so we don't have stratification,
4 stratified data that was submitted to us. So, if
5 you're a children's hospital, you will be
6 submitting that data, but we don't have the sort
7 of parsing.

8 MEMBER BENIN: But children's
9 hospitals do not submit to the IQR. Adult
10 hospitals with children's units would submit, but
11 children's hospitals would not be submitting.

12 CHAIR ANTONELLI: Right, right.

13 DR. BURSTIN: She checked with the
14 people who led the project as well as the
15 submission form, and it only indicates
16 disparities by race/ethnicity.

17 CHAIR ANTONELLI: Yes.

18 DR. BURSTIN: Nothing at all by age.
19 And I think probably because they just don't have
20 the data.

21 CHAIR ANTONELLI: Right. Okay.

22 So, the motion has already been made

1 and seconded on 1659.

2 Any further discussion before Miranda
3 calls for a vote?

4 (No response.)

5 Go ahead.

6 MS. KUWAHARA: Hearing none, we will
7 take it to a vote. Again, this is Measure No.
8 1659, influenza immunization.

9 If you would like to support this
10 measure for inclusion in the core set, please
11 select 1; if not, please select 3.

12 We are still waiting on one response.

13 Eighty-five percent of the 13 voting
14 members voted not to support this measure.

15 CHAIR ANTONELLI: Okay.

16 MS. GORHAM: Okay. Measure 3154,
17 informed coverage, is a CHOP measure, and I do
18 believe they are on the line.

19 But we can continue. So, Andrea
20 recommended this measure, and this measure is
21 currently undergoing evaluation.

22 MEMBER BENIN: So, this metric gets

1 back to the issue that I really believe to be
2 critically important right now, which is around
3 access. And anything that we can to understand
4 access in this environment and in this population
5 is essential. And I think it is also essential
6 that we position ourselves to be able to look at
7 it over time. And this is another metric that
8 can get us at that.

9 This metric is a little bit different
10 in that -- and I believe that Jeff Silber is on
11 the phone. So, I am going to let him actually
12 explain it. But at its highest level, the idea
13 here is that the denominator is patients who
14 would be eligible for services, and then, the
15 numerator is ones who actually get into coverage.

16 And so, this is a different type of
17 metric than the other access metrics that we
18 have. The other access metrics that we have are
19 truly, I think, metrics of, once you have
20 coverage, do you get services? And that is
21 substantially relevant, but this metric may
22 actually may become increasingly relevant as the

1 opportunities to cover children go down.

2 And while this metric may still have
3 some kinks that are being worked out, especially
4 given some of the lag issues and what happens
5 over the next year or so, I think it's critically
6 important to give the states the opportunity to
7 be able to take a look at it and figure out if
8 they can mount it, and what that would look like.
9 And I don't think that delaying is in the best
10 interest of the children that we serve here.

11 But I would like just to have, Jeff,
12 if you don't mind explaining the metric in a
13 little bit more detail, because I think this is a
14 really critically important issue.

15 CHAIR ANTONELLI: Actually, Jeff, I
16 don't know whether you're on mute or not, but
17 we're not hearing anything.

18 But let me ask the Task Force members
19 that are in the room, are you getting in the
20 queue for after Jeff presents or do you have
21 questions?

22 Deborah, do you have a question that

1 you would like to put out there for possibly Jeff
2 before he goes?

3 MEMBER KILSTEIN: Not a question, just
4 a comment.

5 CHAIR ANTONELLI: A comment? Do you
6 want to do that before you hear his presentation?

7 MEMBER KILSTEIN: I am fine either
8 way. I can either do it before or after.

9 CHAIR ANTONELLI: Okay. So, why don't
10 we have you put that down?

11 Jeff, are you there?

12 (No response.)

13 Are you on mute?

14 (No response.)

15 He is? Okay.

16 MEMBER BENIN: Maybe there is someone
17 from AHRQ who could take the discussion. I think
18 Kamila is not here, but I don't know. Who has
19 the -- I think the bottom line here is that the
20 denominator is the patients who are eligible and
21 the numerator is the patients who actually get
22 coverage in the time period.

1 There are some nuances that they use,
2 an appendicitis rate, to kind of adjust and
3 double-check the metric. I was hoping that they
4 could explain that part of it, but it is a way to
5 pick a disease that has a similar -- you're going
6 to show up for appendicitis. And so, whether you
7 have coverage or not, you're probably going to
8 show up. And so, how do you use the rate of
9 coverage amongst those patients to double-check
10 and to adjust for the overall rate that you're
11 ending up with. So, it is a nuanced way to
12 tackle this, but I do understand it to be
13 feasible.

14 So, it would be good if there's
15 anybody else who wants to jump in.

16 CHAIR ANTONELLI: Yes.

17 MS. GORHAM: All right. So, we have a
18 representative from CHOP, not Jeff. But can you
19 introduce yourself, please?

20 MS. SHAH: Hi. I'm Shivani Shah. I
21 am a research assistant for Jeff Silber. He
22 should be on the line, too, but I can try to

1 answer as many questions in the meantime.

2 CHAIR ANTONELLI: Is he for sure going
3 to be joining, because I would rather not have to
4 repeat a set of questions.

5 MS. SHAH: Okay. Let me just -- like
6 give me one minute.

7 CHAIR ANTONELLI: Okay.

8 MS. SHAH: I'll go get him.

9 CHAIR ANTONELLI: Okay. You go ahead
10 and do that.

11 MS. SHAH: Okay.

12 CHAIR ANTONELLI: And, Deborah, go
13 ahead.

14 MS. SHAH: Okay, okay. Hi. Oh, yes.
15 Here, here, here.

16 MEMBER KILSTEIN: I was just going to
17 make a comment in terms of the importance of
18 continuity of care as a quality issue --

19 MR. SILBER: Hi. This is Jeff Silber.

20 MEMBER KILSTEIN: -- and also as an
21 efficiency issue.

22 MR. SILBER: Can anyone hear me?

1 CHAIR ANTONELLI: Jeff, stand by for a
2 moment, please.

3 MR. SILBER: Okay.

4 MEMBER KILSTEIN: Based on some data
5 that we have looked at, per-member per-month
6 costs go down the longer someone's enrolled
7 because of the benefits of the ongoing access to
8 primary preventive care.

9 And there is an efficiency aspect of
10 this as well, because if someone loses
11 eligibility and, then, has to go back through the
12 enrollment process, there is an administrative
13 cost to re-enroll them.

14 So, we think that churn is an ongoing
15 problem in Medicaid and CHIP, and is critical
16 when you are looking at care for kids. And so,
17 this was an important measure from our
18 perspective.

19 CHAIR ANTONELLI: Thank you.

20 MR. SILBER: Can you hear me now?
21 This is Jeff Silber.

22 CHAIR ANTONELLI: We can and the floor

1 is yours. Just give us a 20-second introduction,
2 Jeff, and then, please go.

3 MR. SILBER: Okay. I'm sorry?

4 CHAIR ANTONELLI: Just introduce
5 yourself and please give us your schtick.

6 MR. SILBER: Oh, okay. Okay. I'm
7 Jeff Silber, the developer of the metric, the
8 Director of the Center for Outcomes Research at
9 Children's Hospital.

10 I've been on the conference call the
11 whole time, but did not put my phone on mute.
12 But, for whatever reason, I couldn't be heard.
13 But I'm on a different phone now and apologize
14 for your inconvenience.

15 Shall I go forward with the metric?

16 CHAIR ANTONELLI: Yes.

17 MR. SILBER: Okay.

18 CHAIR ANTONELLI: We would like a
19 succinct description of the metric --

20 MR. SILBER: Okay.

21 CHAIR ANTONELLI: -- so that the Child
22 Task Force members can be in a position to ask

1 questions --

2 MR. SILBER: Right.

3 CHAIR ANTONELLI: -- as we proceed to
4 deliberation.

5 MR. SILBER: Sure. The metric-
6 informed coverage uses appendicitis, a random
7 event that isn't related to primary care or other
8 health conditions, to help estimate the fraction
9 of patients who are covered, or have insurance,
10 divided by those who are eligible, which is often
11 also referred to as the participation rate.

12 Informed coverage uses appendicitis
13 patients because, if you develop appendicitis,
14 you're going to be hospitalized. If you were
15 eligible for insurance, we would see you in the
16 MAX data. If you were not eligible, MAX data
17 wouldn't pick you up. It is a claims-based
18 measure.

19 And the development of the metric is
20 based on claims data with the states that have
21 adequate claims data in MAX to be able to be
22 analyzed. And what we have developed is a way to

1 scan the data and look for adequate data and,
2 then, be able to make this estimate.

3 We compare our measure to the current
4 metrics that are out there now, which, No. 1,
5 duration, which is looking at children who have
6 been insured, then drop off the rolls, and then,
7 when they come back, duration starts at time zero
8 and sees how long they stay on the rolls.

9 The problem with that metric -- and
10 we've talked to stakeholders about this -- is
11 that kids that are always enrolled during a time
12 period don't show up in the duration metric. So,
13 that's a major problem of duration.

14 The other measure is the participation
15 ratio by COO. That metric has a problem in that
16 it assumes that, if you have ever had insurance
17 during a period, you're always eligible and,
18 therefore, that is the rate that they give. And
19 it also doesn't do many adjustments for aging out
20 or for partial time periods in the time period of
21 analysis.

22 So, we developed this metric based on

1 appendicitis. The big advantage is that it looks
2 at everyone who could possibly be eligible
3 because they would be ending up being
4 hospitalized for a random event of appendicitis.
5 And then, we look to see whether they did have
6 insurance before they developed their
7 appendicitis. In this way, we are not having
8 those gaps that the other measures have.

9 Furthermore, what we have done is
10 utilized this and developed the package with a
11 way to look at the statistics around it, so that
12 it is easy for the states to get their variances
13 and their confidence intervals and do the
14 statistics that they need to compare themselves
15 to the rest of the states or to other individual
16 states.

17 I'll stop there and address any
18 questions you might have.

19 Actually, I just want to mention one
20 other thing, which is we use as a gold standard
21 for validation the American Community Survey.
22 And that survey, our measure is better

1 correlated, and that is in the documents that we
2 have provided. It is better correlated than any
3 of the other two metrics, be it the continuity
4 ratio or the duration metric.

5 So, one of the strong aspects of our
6 measure is that it is better correlated with
7 actual survey data, which would get at that
8 missing population. And secondly, the error
9 rates are lower in our measure versus the survey
10 than the other two measures. So, I just wanted
11 to point that out, too, and I will stop now.

12 CHAIR ANTONELLI: Okay. Comments or
13 questions?

14 DR. BURSTIN: At this point, it is
15 still going through the evaluation of the
16 Pediatric Standing Committee. It went through.
17 It was heavily reviewed for everything except
18 there was a lack of consensus around reliability
19 of the measure. In fact, one of the major
20 concerns was this question of whether it might be
21 a great self-assessment tool for states to
22 improve coverage rates. The question was, is it

1 an appropriate measure for accountability?
2 Again, this is a state-level discussion, so take
3 that as it may.

4 And I think there was some concern
5 about -- and since you have states here -- the
6 ability of states to accurately calculate the
7 measure, since it was pretty complex. So,
8 experience with using it for this discussion
9 might be helpful.

10 MEMBER ADIRIM: Is it NQF-endorsed?

11 DR. BURSTIN: It's in process.

12 Comment period closes May 31st. There is a post-
13 comment call with the Pediatrics Committee on May
14 31st. So, it's still in process.

15 MR. SILBER: I wrote an in-depth
16 response to the concerns. One of the concerns
17 was that poorer states might have a different
18 measure than richer states, and I showed that
19 that wasn't something that would throw off our
20 measure.

21 Secondly, there was a concern that a
22 lot of states were clustered. And what we showed

1 was that there is a distribution of states in
2 terms of their informed coverage, and we outlined
3 that in the new documents that were sent out,
4 such that we can identify large clusters of
5 states that are way below average and others that
6 are above average, and many in the middle.

7 So, we can differentiate states as
8 groups, but, also, state-by-state. About two-
9 thirds of the states can be distinguished from
10 other states, but it just so happens that some
11 states have very similar informed coverage, but
12 many don't. There's enough variability, such
13 that you can compare state-by-state and you can
14 also compare states to the group or states to any
15 segment of the state populations.

16 CHAIR ANTONELLI: Jeff, this is Rich
17 Antonelli. I'm the Chair of this group, but I'm
18 stepping out of the Chair to ask this technical
19 question.

20 So, for hospitals that are near
21 boundaries, borders, state borders, if you will,
22 -- and I'm thinking about CHOP, but it could

1 apply pretty much anywhere -- if the child gets
2 admitted for that emergent event, like in
3 appendicitis, does that do anything to the data?

4 MR. SILBER: Yes, the data is based on
5 what the individual states submit to the federal
6 government. So, it is based on MAX data. So,
7 when you do a state analysis, you are looking at
8 patients who were insured in that state. So, the
9 bills can come back to that state if they were
10 seen out of state, say a New Jersey patient seen
11 at CHOP, but it is dependent on the quality of
12 the state data.

13 CHAIR ANTONELLI: Thank you.

14 Terry?

15 MEMBER ADIRIM: To Andrea's point, I
16 really think this addresses a very critical
17 concern, child health insurance coverage,
18 continuity of child health insurance coverage.
19 But I think I have a little bit of trepidation
20 about it not being quite ready yet for being put
21 on the core set.

22 I mean, my thinking is I would

1 advocate for it being looked at next year to be
2 put on the core set. I'm sort of -- something
3 like that, because, you know, I think it needs a
4 little more work before we --

5 DR. SIBLER: Could I ask in what way?
6 Because we might have addressed it in the memos
7 that we -- I don't know if you've got the memos
8 that we were addressing --

9 MEMBER ADIRIM: Sure. Well, it's --

10 DR. SIBLER: Yes?

11 MEMBER ADIRIM: Yes. No, it just
12 doesn't seem like all the testing and the
13 considerations and all that have been done yet.
14 I think it's a great measure. I think it is an
15 important --

16 DR. SIBLER: I think they work, but
17 I --

18 MEMBER ADIRIM: Yes, well, I'm not
19 going to argue with you, but --

20 DR. SIBLER: Well, it's just, right
21 now, I don't hear a reason. So, it would be nice
22 to hear a reason.

1 MS. GORHAM: So, just to think about
2 just to state history, we discussed this measure
3 last year as well. So, this was a consideration.
4 But you all deliberated and decided not to
5 recommend the measure. If you decide to
6 recommend this year, you can recommend with
7 conditional support pending NQF endorsement.

8 Again, CMS is in the room. They are
9 listening to the conversation. It is up to them
10 whether or not they want to add it to the core
11 set now or later.

12 But, just a matter of history, we did
13 discuss it last year. We decided, as Terry said,
14 to wait. You all decided to wait until it went
15 through NQF endorsement. It is still going
16 through NQF endorsement. If you would like to
17 join the post-comment call on May 31st, you're
18 welcome to do that as a public member, just to
19 listen, and then, you also can, you know, respond
20 during the public comment period.

21 CHAIR ANTONELLI: Roanne?

22 MEMBER OSBORNE-GASKIN: So, I would

1 just like to clarify, because this is an
2 important thing that we are trying to look at,
3 coverage for kids. But the coverage, the limits
4 you are going to use appendicitis, if I got it
5 right, but the limit is 2 to 16, whereas you're
6 trying to look at coverage from zero to 18,
7 right?

8 So, I'm trying to figure out if using
9 that population -- and maybe I'm not getting it
10 right -- but I assume that you are using that
11 population to sort of base your measurement on,
12 but it is still not -- it is going to leave out a
13 couple of years before and after. I mean, are we
14 okay with that?

15 DR. SIBLER: May I explain or -- may I
16 explain?

17 CHAIR ANTONELLI: Yes, Jeff, go ahead.

18 DR. SIBLER: It doesn't, the
19 appendicitis metric uses 2 to 16 because, first
20 of all, appendicitis doesn't happen in the
21 earlier group and, secondly, that we didn't want
22 to have the states worry about survival

1 statistics by going up to the edge of 18.

2 But the metric uses, in its data it
3 uses all kids for all diagnoses, not just
4 appendicitis. It only uses the appendicitis to
5 weight the two assumptions about the populations,
6 whether they were presumed to be eligible or
7 presumed to be ineligible. So, the appendicitis
8 metric itself is used as a way to inform the
9 entire population's coverage or participation.

10 It's not only using the data from
11 appendicitis. It uses the data from all the
12 kids, but it weights all the kids based on what
13 we get from the appendicitis sample, which is a
14 very random sample over that population. So,
15 it's not only using the kids with appendicitis to
16 come up with that result or any of the
17 subanalyses that we put into the report.

18 So, we make two main assumptions. You
19 can either be saying that the kids are almost all
20 presumed eligible or presumed ineligible. We
21 still get the rates of their coverage in those
22 two groups. Then, we weight that by the

1 appendicitis sample, but we are using the whole
2 population in describing the state. And all the
3 numbers from all the kids are used in getting
4 that overall coverage, informed coverage rate.
5 So, it uses appendicitis, but it's not just based
6 on appendicitis.

7 CHAIR ANTONELLI: Thank you.

8 DR. SIBLER: And it is far better
9 correlated than the other measures with the gold
10 standard of the community survey.

11 CHAIR ANTONELLI: Amy, on my left?

12 MEMBER RICHARDSON: Thank you.

13 So, I'm curious, as a newcomer, from a
14 CMS perspective and from an NQF perspective.
15 This is an important public policy issue.
16 Everything else we have talked about reflects
17 some dimension of quality of medical care, not
18 extent of insurance coverage. Those two may be
19 related, but they're not the same.

20 So, I'm curious about the notion of
21 including this public policy measure in the core
22 set. So, maybe I need to understand how it would

1 be used if it ends up in the core set.

2 CHAIR ANTONELLI: Karen?

3 DR. SIBLER: Do you want me to --

4 CHAIR ANTONELLI: No, Jeff. I think,
5 Jeff, as the Chair, I'll call when we need you to
6 weigh-in, okay?

7 DR. SIBLER: Okay. Thank you. Thank
8 you.

9 DR. MATSUOKA: So, I'm trying to call
10 up the actual statutory language. I want to say,
11 though I will confirm this, that there is some
12 language in CHIPRA that alludes to the importance
13 of continuity of coverage as an important
14 indicator of how we're doing as a program.

15 So, it's true that most of the core
16 set measures deal with quality of care, but, you
17 know, as we've talked about before, we also think
18 about access as an important dimension of quality
19 of care. You can't get good quality of care if
20 you don't have access to that. And one way to
21 think of this might be that continuity of
22 coverage is an important driver of access.

1 So, how we would use this would be in
2 the same way that we would use every other core
3 set measure, which is it would be voluntary.
4 States could either report it or not. We would
5 do some technical assistance with the states to
6 ensure some consistency between the states that
7 are reporting the measure and, then, publicly
8 report the information.

9 And then, to the extent that there's
10 interest, we might do some targeted technical
11 assistance like we have done with the
12 antipsychotic medication stuff. But, in general,
13 that's kind of how we use the measures.

14 CHAIR ANTONELLI: Amy?

15 MEMBER POOLE-YAEGER: Hi. Jeff, this
16 is Amy Poole-Yaeger. I'm with Centene, which is
17 a large managed care organization.

18 And I'm just curious. Just to make
19 sure I understand the concept of this message.
20 So, you're going to get at the people -- because
21 somebody had asked, well, can't we get that
22 information? But I can look at people that I

1 know are eligible, you know, that have had at
2 least one month of eligibility, and see how they
3 have had gaps. But this is going to look at
4 maybe somebody that -- this is going to tell you
5 who should have had eligibility in certain
6 months, right, and then, did they have it? And
7 sort of give a look outside of what we could see
8 just in our data, is that correct?

9 DR. SIBLER: Right. It uses, it's a
10 point in time to estimate the overall time over a
11 time period that someone was participating when
12 they were eligible. But it's a point in time.
13 So, we are saying, at the point right before they
14 developed appendicitis, was that child
15 participating with coverage? We knew they were
16 eligible because we wouldn't have seen their
17 records for their appendectomy in Medicaid unless
18 Medicaid paid it, meaning they were covered.

19 At that point in time we show is
20 proportional to or equals the number of months
21 someone is on or off during a given time
22 interval. So, it is talking about a

1 participation rate over a time interval. It is
2 based on a point-in-time estimate for all the
3 kids in the state that are developing
4 appendicitis and, then, for all the kids in the
5 state that did or did not have appendicitis.

6 So, it is telling us whether someone's
7 participating and in the system when they are
8 eligible. If they are often not in the system
9 and not participating, then the point-in-time
10 estimate would be lower. If they are often
11 participating when they are eligible, then we
12 would have a higher estimate for our coverage
13 rate.

14 CHAIR ANTONELLI: Okay. So, I want to
15 follow on the paradigm that we had yesterday and
16 continued. I want to ask the Task Force, does
17 anybody want to submit a condition?

18 No? Again, I apologize because of the
19 gaps. Has this been motioned and approved? Yes.
20 So, why don't we go ahead and do that? Make your
21 motion.

22 MEMBER BENIN: All right. So, I move

1 that we suggest including this in the panel, this
2 metric in the panel.

3 CHAIR ANTONELLI: Okay. Is there a
4 second?

5 MEMBER KILSTEIN: I'll second.

6 CHAIR ANTONELLI: Second. Okay.

7 Any further conversation about the
8 motion? Is that a yes?

9 MEMBER BENIN: Can I make one more
10 comment? Or you don't want to? You want to move
11 on?

12 CHAIR ANTONELLI: Well, I was actually
13 going to revisit, now that the motion has been
14 officially made and seconded, I want to come back
15 to the question about whether people would like
16 to consider a condition attached to it, so that
17 this way, we know whether we are voting on it up
18 or down.

19 But do you want to go ahead?

20 MEMBER BENIN: I mean, I would just
21 make two additional comments. One is that this
22 is a PQMP metric. You know, we have a couple

1 more of the PQMP metrics coming up, but the
2 premise of the PQMP program was to generate
3 metrics that we could use for children and for
4 pediatrics. And this is one of those, and it has
5 been pretty robustly developed, although it is
6 still going through the process, obviously.

7 I would also say that, I think it was
8 Karen, you know, just outlined a process by which
9 using this metric could be very practical, in
10 that adding it to the panel, allowing the states
11 that could muster it to pick it up, and then,
12 next year we would be here and we would have more
13 information, or two years from now we would have
14 more information. I mean, the problem is we
15 won't have any more information for two years
16 from now. And so, it would take a couple of
17 years for us to get that information.

18 CHAIR ANTONELLI: Okay.

19 MEMBER BENIN: So, getting it into the
20 cycle now enables us to have that information a
21 little bit sooner.

22 CHAIR ANTONELLI: Okay.

1 MEMBER BENIN: So, that was my
2 additional comment.

3 CHAIR ANTONELLI: Okay. Thank you.
4 So, Deborah?

5 MEMBER KILSTEIN: Yes, I would suggest
6 conditional support, just because it is pending
7 NQF endorsement.

8 CHAIR ANTONELLI: Okay. And what
9 would the condition be? NQF endorsement, period?

10 MEMBER KILSTEIN: Yes.

11 CHAIR ANTONELLI: Okay. So, can you
12 state that motion, please?

13 MEMBER KILSTEIN: Yes. I would place
14 conditional support pending NQF endorsement.

15 CHAIR ANTONELLI: Is there a second to
16 that motion?

17 MEMBER ADIRIM: Second.

18 CHAIR ANTONELLI: Okay. I will allow
19 one minute to discuss, if people want to speak
20 about the condition and, then, we are going to
21 move to a vote.

22 Any issue? I'm talking about the

1 condition now. Yes, okay.

2 MEMBER ADIRIM: No, and the reason why
3 I support that is that, unlike other measures --
4 because I don't think to be on the measure set
5 you have to be NQF-endorsed. But this is a new
6 measure, and I think having it looked at to make
7 sure that it is measuring what we want it to
8 measure and that it is reliable, I think would be
9 important.

10 I think it is, I agree with Andrea
11 this is a very critical concept, but I would like
12 to see it, before we let it take up the real
13 estate, I would like to see it fully endorsed.

14 CHAIR ANTONELLI: Okay. Thank you.

15 So, let's proceed. And, Miranda,
16 thank you for anticipating this slide.

17 So, the vote is there. So, walk us
18 through, please.

19 MS. KUWAHARA: We are voting on
20 Measure No. 3154, informed coverage. We are
21 asking if this measure should be added to the
22 core set. You have two options, conditional

1 support, the condition being NQF endorsement.

2 If that is your choice, please select
3 2; if not, please select 3.

4 (Voting.)

5 Eight percent of the 13 voting members
6 voted to support this measure; 54 percent voted
7 to conditionally support this measure, and 38
8 percent voted not to support this measure. But,
9 because it rolls up, it is conditionally
10 supported.

11 CHAIR ANTONELLI: Okay. So, we're all
12 set?

13 Did you want to weigh-in?

14 MS. GORHAM: It's fine.

15 CHAIR ANTONELLI: You're okay?

16 MS. GORHAM: Yes.

17 CHAIR ANTONELLI: Okay. Right. Jeff,
18 thank you for being available.

19 All right. Let's move on, please.

20 MS. GORHAM: Okay. So now, we're at
21 Measure 3166, Antibiotic Prophylactics Among
22 Children With Sickle Cell Anemia.

1 I'm sorry. This is horrible. I'll
2 start over.

3 Measure 3166, Antibiotic Prophylactics
4 Among Children With Sickle Cell Anemia, was
5 recommended by Rich and Terry. So, I will turn
6 the floor over to you. Again, we have 3166, the
7 specifications as well as the algorithm on your
8 screen.

9 CHAIR ANTONELLI: Terry, why don't you
10 go first? Okay, I'm happy to do it. Yes, take a
11 cleansing breath. I can do it.

12 MEMBER ADIRIM: This measure is a
13 fairly recently-endorsed measure. It is a key
14 metric measure, and it covers children age three
15 months to five years, prescribed antibiotic
16 prophylaxis for 300 days out of a year.

17 And the reason why I thought this
18 would be a good measure is that sickle cell
19 disease was identified as one of the gap areas.
20 I know we recommended the transdoppler one last
21 year. But, since then, I've talked to our hema
22 docs regarding this. And this is, you know,

1 within our population, we probably have a higher
2 than an average than in the commercial plan
3 population.

4 Antibiotic prophylaxis has been shown
5 very clearly to reduce, to eliminate the
6 incidence of infection and sepsis. And so, even
7 with vaccination, it is still considered
8 recommended, according to the CDC Practice
9 Guideline from 2014. So, I thought that this
10 would be a measure that we should consider for
11 recommending to go into the core set.

12 MS. GORHAM: Can I make one
13 correction? So, the measure is not yet endorsed.
14 It is not finalized. It will not be finalized
15 until June. So, the Standing Committee
16 recommended endorsement, but it has not finalized
17 that.

18 MEMBER ADIRIM: Okay, but a previous
19 one was, right? And this was a change or
20 something? No?

21 CHAIR ANTONELLI: This is the second
22 measure, the transcranial ultrasound last year.

1 MEMBER ADIRIM: All right.

2 CHAIR ANTONELLI: But, this one, yes,
3 this one is not yet ready for -- I thought I
4 missed a memo. All right.

5 MS. GORHAM: But we do have the
6 developer on the phone.

7 CHAIR ANTONELLI: Yes. So, the
8 developer is on the phone. I guess I will weigh-
9 in as one of the people that wanted to bring this
10 forward.

11 Sickle cell disease is a high-priority
12 gap area. The population affected by this is
13 significantly at risk for disparate outcomes.
14 This intervention is about as inexpensive as you
15 can get. It's a secondary prevention, to be
16 sure.

17 The question had been raised about,
18 you know, does the existence of pneumococcal
19 vaccine make a significant impact? The answer to
20 that is that it is not definitively curative,
21 which is why this is still an issue that we need
22 to look at.

1 So, those are some of the reasons that
2 I wanted to bring this forward as well.

3 We can talk at length and/or I can
4 have the measure developer step in.

5 There is an evidence base for this
6 that antibiotic prophylaxis has a very beneficial
7 impact on this at-risk population.

8 Are there any comments from the Task
9 Force before I ask for a motion?

10 Amy?

11 MEMBER POOLE-YAEGER: I just had a
12 question. And again, I think it is a great
13 measure. I am worried a little bit about the
14 denominator size in the states, either because,
15 as you look at how many sickle cell patients you
16 have, and now you are taking away the three to
17 five year-olds, you know, whether you're going to
18 get to such a small number in many of the states
19 that it is not going to be relevant.

20 I can just tell you, from our
21 perspective, we have trouble with that, even
22 looking across 23 states, although it is just a

1 portion of the population, not the whole state
2 population. So, I just wanted to bring that up
3 as a question for the states and if that would be
4 a barrier to using this one.

5 CHAIR ANTONELLI: Okay. Okay. Would
6 our CMS folks like -- is there something that you
7 can add to that point? I don't want to put you
8 on the spot. But, to the degree that you've got
9 a federal view of an important condition that may
10 have a small-ish denominator, does that generate
11 any concern from your perspective?

12 DR. MATSUOKA: So, for the
13 transcranial doppler, it is one of the ones that
14 was recommended last year, but we didn't accept.
15 One is, of course, parsimony, the overarching
16 thing. So, if we are going to measure something,
17 you know, what comes out in exchange? I think
18 that, factored into the ones that we took versus
19 the ones that we didn't.

20 But this issue of small "N's" did come
21 up as part of that discussion, as well as the
22 geographical variation. So, you know, our ideal

1 would be that the states that report on this
2 measure -- you know, as many states as possible
3 report on the measure. That, then, also, the
4 implicit assumption is that, you know, the
5 prevalence of any given condition is somewhat
6 uniform across the states. So that all 50 states
7 and territories might want to report on it.

8 And so, we weren't sure about absolute
9 numbers in general, but, then, also, just the
10 geographic spread state by state. It is one of
11 the reasons why we are really interested to see
12 what you guys come up with as part of the PQMP
13 phase two grant. Because one of the things we
14 want to think about is, what is the impact of
15 potential small "N's"? Given that this is an
16 area that is important to measure, what do we do
17 about the fact that there are potentially small
18 "N's," that the "N's" might vary state-by-state?
19 And what does that mean for measuring it at the
20 state level?

21 CHAIR ANTONELLI: Thank you.

22 So, is your card still up? Okay.

1 Terry?

2 MEMBER ADIRIM: Yes. No, just Amy and
3 I were talking about this before. So, I was very
4 surprised at how small the denominator, the "N"
5 was, maybe because I practice in a children's
6 hospital in a very urban area. I don't know.
7 So, we see a lot of sickle cell.

8 So, that is something to consider, and
9 I think we need to weigh the importance of this
10 measure and being a priority condition. I think
11 we should think about that.

12 But I think, also, additionally, based
13 on conversation that we have had over the last
14 two days, I mean, it sounds like states really
15 want measures where they can make an impact and
16 where there can be quality improvement. And I
17 think this is one of those areas. But, anyway --

18 CHAIR ANTONELLI: So, is there a
19 motion?

20 Ann, did you have a comment?

21 MEMBER GREINER: A question. So, I
22 know we started off with 27 measures in the core

1 set for children. And I'm just wondering where
2 we are now in terms of our count. I don't know
3 if it is easy to find in terms of what we've
4 added and what we've taken away.

5 MS. MUKHERJEE: So, we are still at 27
6 because we make recommendations. Until CMS/HHS
7 takes and makes changes, we will still be at 27.

8 MEMBER GREINER: Right. No, I do
9 understand that distinction. So, I wasn't clear.
10 I meant in terms of what we're recommending.
11 Obviously, then, CMS makes their decision.

12 MS. GORHAM: We're at four right now.

13 MEMBER GREINER: Four --

14 MS. GORHAM: Four recommended, but we
15 also removed, and what we will be sure to do at
16 the end, once we make all of the recommendations,
17 is put a slide up.

18 MEMBER GREINER: Yes.

19 MS. GORHAM: Because what we will,
20 then, ask the Task Force members to do is
21 prioritize and rank, so that we can say to CMS
22 that the Task Force made these recommendations

1 and they think they are important in this order.

2 MEMBER GREINER: Yes. I guess it's
3 just a comment that, you know, these are really
4 important discussions. And after a while -- and
5 I'll speak for myself -- you do begin to get lost
6 in how many are we recommending that are added
7 and removed. And just thinking holistically
8 about the number that practitioners are
9 reporting.

10 CHAIR ANTONELLI: Does anybody want to
11 make a motion?

12 MEMBER ADIRIM: I guess you're looking
13 at me. Yes. I move that we recommend this
14 measure, whatever number it is, 3166, to add to
15 the child core set.

16 CHAIR ANTONELLI: Is there a second?
17 I'll second.

18 Any conditions that somebody would
19 like to propose to the motion on the floor for
20 3166?

21 And remember, it is not NQF-endorsed
22 yet. So, I'll go ahead and put in a condition

1 pending NQF endorsement.

2 Is there a second to that motion?

3 MEMBER GREINER: Second.

4 CHAIR ANTONELLI: Okay. All right.

5 So, Miranda, we have 3166, if you can take us
6 through that, and be mindful that conditional
7 support, do not support. You can vote for
8 support, but there is a condition attached. So,
9 really, you're voting for either number 2 or
10 number 3. Okay?

11 MS. KUWAHARA: That's right. So, we
12 are voting to recommend No. 3166, antibiotic
13 prophylaxis among children with sickle cell
14 anemia to the child core set.

15 Please select 2 if you would like to
16 conditionally support this measure for inclusion
17 with the condition that it receives NQF
18 endorsement. If you would like to not support
19 this measure, please select 3.

20 (Voting.)

21 Fifty-four percent selected to not
22 support this measure, and 46 percent selected to

1 conditionally support this measure. We had all
2 13 respondents, that's correct.

3 CHAIR ANTONELLI: Okay. Thank you.

4 We're moving forward. If you can
5 advance us maybe when you get a chance?

6 This is not an NQF measure that we're
7 looking at. So, there is no number attached.
8 It's emergency department visits potentially
9 treatable in primary care.

10 The measure steward is the New
11 Hampshire Department of Health and Human
12 Services. I presume that somebody from New
13 Hampshire is on the line.

14 MS. STEWART: Yes, Andrea Stewart is
15 on.

16 CHAIR ANTONELLI: Okay. All right.

17 So, we want to bring this up for
18 discussion. The description here is ambulatory
19 emergency department visits for conditions
20 potentially preventable and treatable in primary
21 care settings per thousand member months by age
22 group. Administrative claims, the data source.

1 There's no exclusions, and it is being used right
2 now in New Hampshire. And we wanted to bring it
3 to the Task Force for this discussion.

4 If there are no immediate comments or
5 questions, I'm going to hand it off to Dr. or Ms.
6 Stewart to tee this up a little bit more.

7 So, seeing no -- oh, I do see a card.
8 No, I don't see a card.

9 Okay. So, why don't you go ahead and
10 describe the measure a little bit. Be as
11 succinct as possible, please, so that the Child
12 Task Force can formulate its questions.

13 MS. STEWART: All right. Essentially,
14 we use this to assess inappropriate ED
15 utilization. We're able to easily use this
16 compare across our managed care plans, across age
17 groups, across geography, different breakouts.
18 We are also using it as part of our delivery
19 system transformation waiver. We are using it to
20 assess in determining incentive payments for that
21 particular program.

22 In terms of the background on this,

1 for New Hampshire, it is basically six times more
2 likely for a Medicaid member to inappropriately
3 use the ED than it is for a commercial insurance
4 patient.

5 We do have the diagnoses. There is a
6 bit of an elution on the diagnoses that we use
7 for this. We started with the algorithm that NYU
8 Wagner developed that helps to classify ED
9 utilization. We, then, for about the last 10
10 years, have been looking at our own claim data
11 and comparing inpatient utilization versus
12 primary care for those diagnoses.

13 Also, Dr. Watts, who is not able to be
14 on the call today, is our chief medical officer.
15 And she's got 10 years as an ED doctor and was
16 able to do a clinical assessment of what we
17 utilized for this measure.

18 We also even took the step of removing
19 some diagnoses from the list, basically those
20 where a member might go to the ED with a
21 perceived problem that by the time they are
22 discharged has been discovered not to be the

1 case. The examples of those would include
2 anxiety, chest pain, stomach pain, things like
3 that.

4 CHAIR ANTONELLI: Okay. Thank you.
5 Open up for any comments or questions.

6 Deborah?

7 MEMBER KILSTEIN: Just a question. I
8 know a number of states have been looking at this
9 issue, but I assume they have all developed
10 individualized measures on how they are using it.
11 Some are actually using it for payment or pay-
12 for-performance. And I don't know, by choosing
13 one measure over the other, if it is going to
14 cause issues for states that are using a measure.

15 CHAIR ANTONELLI: Karen?

16 MEMBER KILSTEIN: Can any of the state
17 help?

18 DR. MATSUOKA: Yes, I was hoping that
19 Rachel would be here to answer, and maybe we will
20 make sure to ask her when she comes back.

21 But I want to say that the process by
22 which we arrived at this measure was that we

1 reached out to the Medicaid Medical Directors
2 Network to say, first, what do you think are the
3 measure gaps, and some of you have identified a
4 measure gap; how would you propose to fill it?

5 And this is the measure that they put
6 forward. So, at some level, the Medicaid Medical
7 Directors, their representatives, if they had a
8 concern with it, they didn't voice it.

9 But now that Rachel is here --

10 MEMBER LA CROIX: Yes.

11 DR. MATSUOKA: So, the question on the
12 table is, one of the Medicaid Medical Directors
13 from New Hampshire -- well, we reached out to the
14 whole network of Medicaid Medical Directors to
15 say, what do you think the measure gaps are and,
16 if there are gaps, what would you put forward to
17 fill it?

18 This is what that network put forward,
19 which is the preventable ER visit measure that
20 they are using in New Hampshire. So, the
21 question that Deborah put forward is, you know,
22 we know that this measure is probably used by

1 many states, but may be defined in different ways
2 by different states. And so, if we were to adopt
3 this particular specification, what would that do
4 to other states? And so, I gave my input, but,
5 really, I want to hear what you have to say.

6 MEMBER LA CROIX: No, I'm looking at
7 preventable events in general, not just emergency
8 department, as something that has become a
9 priority for Florida Medicaid at least. We've
10 started looking at it using the 3M software. And
11 so, we have been using those algorithms and
12 running it through those, rather than having a
13 separate measure like this.

14 And through that, we have been looking
15 at emergency department admissions, readmissions,
16 and ancillary care. So, we have been starting to
17 try to look at a few different things like that
18 as kind of outcome measures.

19 So, we definitely would agree with the
20 importance of this kind of measure, but I would
21 have to look in more detail at the specifics
22 around it to see whether that would be something

1 that would work well with some of the other ways
2 we're looking at this data.

3 MEMBER POOLE-YAEGER: Hi. This is a
4 question for the measure steward. You mentioned
5 looking at the NYU algorithm and, then, changing.
6 I had looked at the NYU algorithm as well from a
7 pediatric perspective. A lot of those algorithms
8 are based on adult ED visits. And so, when you
9 look at PD conditions on there, it didn't make a
10 lot of sense to me.

11 So, can you just explain a little bit
12 more? Like was it pediatric-based when you
13 looked at those diagnosis codes? And, you know,
14 explain that a little bit more.

15 MS. STEWART: I think one thing that
16 we need to point out with this measure is that we
17 actually do use it across adults and children.
18 So, we realize that this has been selected for
19 discussion for the child core set, but it really
20 does apply to both.

21 MEMBER POOLE-YAEGER: Thanks. Yes, I
22 think, again, from my perspective, the devil's in

1 the details, in the codes that you pick. At
2 least from my perspective -- I don't know; Terry
3 may have some comments -- but it's different in
4 kids sometimes than adults. And so, I would love
5 to have a pediatric-specific one, if we were
6 going to use in the child set.

7 MEMBER ADIRIM: Yes, I think your
8 point is well-taken. I think we might have a
9 different set of conditions or a different bar
10 for emergency department visits than in an adult
11 world.

12 I think this measure gets somewhat
13 indirectly to access. You know, so it would be
14 like one of those measures measuring access to
15 care to primary care, but maybe not, because,
16 supposedly, now we have more access to primary
17 care; we have Patient-Centered Medical Home. And
18 yet, ED visits go up.

19 So, I'm sort of hesitant to want any
20 measure around ED visits at all for that reason,
21 because it is a tough measure because, then, it
22 is often, as somebody mentioned, applied for

1 value-based purchasing programs and incentives,
2 and things like that. So, yes, that's all I
3 would say about that.

4 MEMBER BEATTIE: So, I am just
5 reiterating with an emphasis from Washington
6 state what Amy was saying. I worked on a task
7 force when I was there with our Medicaid
8 department, trying to establish a metric just
9 like this just for the state, where we, then,
10 would track each of the healthcare systems and
11 adjust their reimbursement based on their ability
12 to achieve this. And the devil is truly in the
13 details.

14 Before I could endorse a measure like
15 this, I would have to be able to look at the
16 exact list of what is on the list. And I am not
17 familiar with the NYU criteria. But I can say,
18 when we tried to get to that, we actually settled
19 on something in the state that didn't involve
20 this specific type of a metric, because it was
21 just too hard to say that, based on a code, you
22 should or shouldn't be seen in a particular

1 setting because there are so many other factors.
2 And it just depends, and especially in kids it
3 depends.

4 And I think that when you move towards
5 more and more of our patients being under a
6 managed care model with a per-member per-month,
7 you know, ACO-type model, that indirectly
8 addresses this because the systems are
9 incentivized to direct the patients to get the
10 care at the appropriate location.

11 MEMBER ADIRIM: Yes, I was just going
12 to add, I support what you are saying. In our
13 health system, people insisted -- and I was
14 neutral on it -- but they insisted on including a
15 measure, and it is not a real measure, but just,
16 basically, how many kids had ESI 1 or 2 coded,
17 and that those were assumed to be ambulatory
18 care-sensitive kind of visits.

19 So, there's all different viewpoints.
20 There's all different ways that you can measure
21 this. And I know people who are payers are
22 really looking at this, but there's a lot of

1 issues around child visits to emergency
2 departments.

3 MS. STEWART: This is Andrea Stewart
4 again. We did submit the list of ICD-10 codes
5 that we utilized for this measure when we sent
6 the information to May back in April. And I
7 don't know if anyone has access to that list.

8 CHAIR ANTONELLI: To whom did you
9 submit the codes?

10 MS. STEWART: It was part of the
11 document that we emailed to May when we sent the
12 NQF MAP Measure Form. It was the last section of
13 that document. It starts on page three and goes
14 for about seven pages.

15 MS. GORHAM: Can you speak to the
16 child-specific codes? We are looking for the
17 document that you're referring to now.

18 MS. STEWART: Okay. We have, let's
19 see, we've got conjunctivitis. We've got a whole
20 slew of ear-related diagnoses. Oh, we've got the
21 sinusitis. We've got tonsillitis. We've got
22 other respiratory conditions. We've got nausea

1 and vomiting, a number of pain-related diagnoses.
2 I'm just trying to think kind in general high-
3 level groups. Asthma. Diaper dermatitis is one
4 of the very specific ones.

5 MEMBER BEATTIE: Do you want me to go
6 ahead? So, a number of those diagnoses that you
7 are mentioning have a very broad range of
8 presentation and would appropriately -- for any
9 one of those, I could give a scenario where that
10 may be the diagnosis, but would be appropriate
11 for a kid to be in the ED.

12 Specifically, tonsillitis, I recently
13 had a patient whose primary diagnosis was
14 tonsillitis, but ended up expiring from sepsis
15 within 36 hours. So, had that kid presented to
16 the ED instead of an ambulatory setting, there
17 might have been a different management on the
18 initial presentation.

19 So, I'm just going to have a real
20 challenge in using this as a quality metric. I
21 think there are just way too many variables, and
22 there is a better way for Medicaid systems to get

1 at the outcome they are trying to get, which is
2 appropriate destination care.

3 MEMBER POOLE-YAEGER: And I'm just
4 going to comment that I completely get -- I mean,
5 again, we struggle with this. I know it is the
6 number one measure that the Medicaid Directors
7 ask for. We are all trying to get at the answer
8 to this question, but I think probably every
9 state has a different way of doing it, because it
10 is so hard to figure out.

11 And I will give another example. You
12 know, upper respiratory infection in a 10 year-
13 old may not be bad, but in a two month-old it is.
14 And so, I have never seen an algorithm that kind
15 of does enough in pediatrics to make me feel
16 comfortable from a clinician perspective that it
17 is getting at the right thing. So, if that
18 helps --

19 MEMBER ADIRIM: Right. And just very
20 briefly, I agree with everything that is being
21 said here. I think the problem I have with this
22 is that I just don't see interventions to change.

1 You know, I work in an emergency department. I
2 still work shifts every month. And 80 percent
3 Medicaid, and you can teach them, you can talk to
4 them; it won't change anything. In fact, they
5 don't know the difference between the ER, their
6 primary care doctor, and the urgent care.

7 So, I just don't see interventions
8 that are necessarily going to change this. ACA
9 was supposed to be the intervention to reduce
10 emergency department visits, and they went up.

11 So, I think it is important that we
12 follow this and that we look at this and people
13 research this, but I'm not convinced that there
14 is a lot of state -- well, anyway, sorry.

15 CHAIR ANTONELLI: So, I would like to
16 call the question. Does somebody want to make a
17 motion?

18 Amy? Mic, please.

19 MEMBER RICHARDSON: I move that we not
20 adopt this, recommend this measure for addition
21 to the child core.

22 CHAIR ANTONELLI: Is there a second?

1 MEMBER BEATTIE: I'll second that.

2 MS. GORHAM: So, there is no need to
3 vote on this measure then.

4 CHAIR ANTONELLI: Yes.

5 MS. GORHAM: We can move to the next
6 one. The next set of measures are actually the
7 FECC measures, the measures, that family
8 experience with coordination of care measures.
9 The measure steward is the Seattle Children's
10 Research Institute.

11 And so, the lead discussant for this
12 measure is Terry. I know that Rich wanted to say
13 a few words first.

14 CHAIR ANTONELLI: Thank you.

15 So, first, a disclosure. I was on the
16 Delphi panel that led to the formation of the
17 FECC. But, just to be clear, we weren't putting
18 the questions or measures together. The Delphi
19 panel was basically asked, what does care
20 coordination look and feel like? So that they
21 could eventually lead to that. So, that is my
22 disclosure.

1 And then, I also want to really do
2 some ground rules here. The National Quality
3 Forum doesn't endorse surveys. What it does is
4 it puts forward measures. So, there are a lot of
5 questions, all of which roll up into the FECC.

6 And what I am going to ask Terry to do
7 is to talk about them really and, if you will, en
8 masse. And then, we will get people to react to
9 them, okay, just for the sake of time management.

10 MEMBER ADIRIM: Okay.

11 CHAIR ANTONELLI: All right. Terry,
12 take it away.

13 MEMBER ADIRIM: I get it. Good. I'm
14 an ED doc. I'll talk in bullets.

15 So, the reason why I recommended this
16 set be considered by us for inclusion in the core
17 set, there's several reasons. This measure set
18 came to mind when looking over the high-priority
19 gap areas. This fits several of those high-
20 priority gap areas, including care coordination,
21 social services coordination, care coordination
22 for conditions requiring community linkages,

1 targeting people with chronic needs, patient-
2 reported outcome measures.

3 So, I really thought that this hit a
4 number of the high-priority gaps. It is a PQMP
5 measure from one of their Centers of Excellence -
6 - the Centers of Excellence which create measures
7 for us to consider for the child core set.

8 The set of measures are 10 measures.
9 It is based on a survey of families. It is
10 family experience with care coordination. The
11 denominator is elucidated by a pediatric
12 medically-complex algorithm which is an evidence-
13 based tool to identify medically-complex
14 children.

15 So, the target population is
16 medically-complex children, which for state
17 Medicaid agencies, as you know, are high-cost
18 populations. So, it targets that population.

19 And of the 10 measures that went up
20 for endorsement, 8 of them were endorsed. And
21 you can see it yourself under the list of
22 measures, but it hits multiple areas for care

1 coordination for children with special needs or
2 medically-complex children.

3 So, I really think it is important
4 that we do consider parsimony, but you need to
5 balance that with generating stretch goals. And
6 somebody else used that term. I think Lindsay
7 mentioned that term. So, having some stretch
8 goals, looking at our core set, are we addressing
9 all the needs of this population? And
10 considering a measure set that may be more
11 measures than you would like, but I think really
12 hits areas that we have been talking about for
13 the last several years that we would like to
14 have. I will say that this measure set is an
15 evidenced-based, very well-done measure set.

16 So, I know that one of the
17 representatives of the measure developers is on
18 the phone who could probably speak better about
19 what the measures specifically are. I believe
20 her name is Layla, is on the phone, in case you
21 have questions.

22 So, I just wanted us to consider this.

1 CHAIR ANTONELLI: Okay. Open for
2 comments and questions.

3 Deborah?

4 MEMBER KILSTEIN: Yes, my question is
5 the child core set already includes CAHPS, which
6 is a fairly extensive survey. So, this would be
7 adding another, a second survey, which is pretty
8 intensive. Is there no way that some of this
9 can't be put into CAHPS as an additional CAHPS
10 question versus a separate survey?

11 MEMBER ADIRIM: This is a completely
12 different survey, hits a different population.
13 The CAHPS survey, my understanding -- and you
14 guys correct me if I'm wrong -- is for all
15 children, as opposed to this particular measure
16 set that identifies medically-complex children
17 within Medicaid. So, it is a different measure
18 set.

19 I don't know if somebody more --

20 MEMBER KILSTEIN: Isn't there a way
21 that we could do a subset like a -- and
22 additional CAHPS questions that would --- where

1 we, for the subset, ask a question --

2 MEMBER ADIRIM: That would, then, take
3 -- I mean, I would imagine that they would have
4 to redo it all, and it is already NQF-endorsed,
5 the measures the way they are.

6 I don't know. Somebody else might --

7 CHAIR ANTONELLI: Do we have somebody
8 from Seattle on the line?

9 MS. PARAST: Layla Parast is here.
10 I'm from RAND, but representing Seattle. I was
11 the statistician on the project. I can comment
12 on that, if it would be helpful.

13 CHAIR ANTONELLI: Yes. In fact, keep
14 your comments as circumscribed as possible,
15 please.

16 MS. PARAST: Yes. Okay. So, I didn't
17 hear what was just said. I think it was a little
18 bit far away from the microphone.

19 But, in terms of adding to CAHPS, they
20 are certainly different surveys and very
21 different populations. But I know that other
22 CAHPS surveys have the opportunity to add

1 supplemental questions as long as they are at the
2 end of the core CAHPS questions. So, that could
3 be considered for the questions that would be
4 needed for these measures. It would need to be
5 identified such that only kids that should be
6 receiving these questions receive the survey with
7 the supplemental questions, but that is certainly
8 done in other CAHPS settings to tailor the
9 surveys like that.

10 CHAIR ANTONELLI: Okay. So, your
11 response to Deborah Kilstein's question is that
12 it is possible?

13 MS. PARAST: Yes.

14 CHAIR ANTONELLI: Okay. Thank you.
15 Roanne?

16 MEMBER OSBORNE-GASKIN: So, I just had
17 a question about any idea of the percentage of
18 medically-complex children who would be excluded
19 because their caregivers don't speak English or
20 Spanish. I think there is a need for care
21 coordination especially in that population, and I
22 notice that they are the ones who would be

1 excluded. So, do we have any idea how many or a
2 percentage? Or I'm just curious about that.

3 MEMBER ADIRIM: I don't know. I'm not
4 the measure developer. So, I will let them
5 answer that question.

6 CHAIR ANTONELLI: Could you hear the
7 question.

8 MEMBER ADIRIM: But it is in English
9 and in Spanish.

10 MS. PARAST: Yes. Yes, I did hear the
11 question. And, yes, the survey is available in
12 English and Spanish, but you're correct that
13 families who may not speak English or Spanish
14 would not be covered by the survey. It currently
15 is not translated into other languages, but could
16 be.

17 I don't have numbers on the proportion
18 that were ineligible due to a language barrier.
19 I seem to remember it was quite small. But we
20 tested in the Medicaid population in Washington
21 and Minnesota. So, I think even any percentage I
22 gave you, of course, wouldn't be representative

1 of the whole country.

2 So, that would certainly be a concern,
3 but it is something that could be addressed with
4 further translations, just like the CAHPS surveys
5 are certainly translated over time in multiple
6 languages, as you identify what populations are
7 not being targeted.

8 CHAIR ANTONELLI: Andrea?

9 MEMBER BENIN: Just a comment on the
10 CAHPS. There is a CAHPS chronic care module that
11 can be added onto the end of CAHPS. We've looked
12 at it up against the FECC questions. The module
13 is extremely long. It is like quite weighty,
14 like all of the CAHPS modules.

15 And the brilliance in the development
16 of the FECC questions is that they are
17 independently-validated. So, the questions stand
18 alone. They don't have to be -- in contrast,
19 when you do a survey, you know, the survey
20 validity depends on the survey being administered
21 in the way that it was designed. And the FECC
22 survey questions, to my understanding, are

1 validated independently. So, they can be used
2 and they don't have to be used a whole. And so,
3 that gives you a little bit more flexibility in
4 the survey burden. In contrast if you were to
5 use the CAHPS chronic care, you have to add that
6 entire module onto an entire CAHPS thing. So,
7 that's my understanding of that.

8 CHAIR ANTONELLI: Helen?

9 DR. BURSTIN: Just some historical
10 context. I think over the years we have seen
11 newer surveys come forward, and, eventually, we
12 have seen some surveys come together.

13 I will say this was particularly
14 different. The developers were charged with
15 doing work on care coordination, which is the
16 biggest gap across everything we do in all health
17 care. We have almost no decent measures on care
18 coordination. They tried to do a targeted
19 review. They tried to do claims. They tried to
20 do e-measures. And truly, the only way to really
21 get at care coordination with this complex
22 population was asking parents. There is almost

1 nothing in the current CAHPS survey that really
2 gets at care coordination.

3 So, I just want to remind us, again, I
4 agree it is patient self-report, which is
5 certainly a burden, but it is the only one that
6 actually gets at the unique and special issue for
7 kids with special healthcare needs around care
8 coordination, which was the intent.

9 MEMBER ADIRIM: And I think it also
10 gets at those things that we have been talking
11 about with regard to outside of the medical
12 sphere. I mean, coordinating with social
13 services and the like. So, I think that is what
14 makes it unique.

15 CHAIR ANTONELLI: So, does somebody
16 want to make a motion?

17 MEMBER ADIRIM: I move that we
18 recommend including the FECC measure set in the
19 child core set.

20 CHAIR ANTONELLI: To get the language
21 precise, it would be the NQF numbers that are in
22 this, as opposed to the FECC itself, right.

1 MEMBER ADIRIM: Okay.

2 CHAIR ANTONELLI: Yes.

3 MEMBER ADIRIM: So, the 2842, 43, 44,
4 45, 46, 47, 49, 50, the eight measures that were
5 NQF-endorsed.

6 CHAIR ANTONELLI: Yes. Okay. Is
7 there a second? Did somebody second?

8 MEMBER GREINER: I'll second.

9 CHAIR ANTONELLI: Okay. So, it's been
10 seconded.

11 Any discussion?

12 Amy looked perplexed. You look
13 perplexed.

14 MEMBER RICHARDSON: I am.

15 CHAIR ANTONELLI: Microphone, please.

16 MEMBER RICHARDSON: Perplexed, just
17 trying to envision how we anticipate this will be
18 done. This will be by the states? This will be
19 done by health plans? Who will do this at what
20 cost?

21 CHAIR ANTONELLI: Renee or Karen?

22 DR. MATSUOKA: So, this is a little

1 bit of an unusual situation because all the core
2 sets are voluntary. And so, if we were to
3 hypothetically put these on the core set, I'm
4 guessing what we would do is the technical
5 specifications would just be the survey
6 questions. And then, I think it would be up to
7 the states to determine how they're going to go
8 about administering those questions.

9 DR. FOX: And I guess this isn't so
10 much a question, but a comment. It is that, if
11 you were going to choose one of these eight, is
12 there one that gets to most of the question?

13 CHAIR ANTONELLI: Boy, at the risk of
14 opening that Pandora's box, I will exercise the
15 Chair's prerogative and ask the developer that
16 question, if that's okay with you. And everybody
17 keep your fingers crossed because there is a
18 holiday on Monday.

19 So, measure developer team, Dr. Fox
20 has a question for you. Did you hear it?

21 MS. PARAST: I did. I did hear it.

22 CHAIR ANTONELLI: Okay.

1 MS. PARAST: Of course, we would say
2 that we certainly think these measures are best
3 used together because we think they provide
4 complementary information to each other.

5 I think that they certainly could be
6 used individually. We did, as was mentioned,
7 validate them individually, so that different
8 states or entities, whoever is interested in
9 this, can pick and choose. It is hard to just
10 pick one because it depends what you're
11 interested in and what you might know is a gap
12 maybe in your specific state or plan.

13 So, I think a lot depends on what you
14 might already know about your particular
15 population. I don't think that there is a single
16 one that captures everything because, I mean, if
17 you just look at them, they cover such a large
18 range of components of care coordination. But I
19 think it would be possible to pick one, depending
20 on what is most important to your population.

21 CHAIR ANTONELLI: So, I'm just going
22 to come back to you. So, based on the experience

1 in Minnesota and in Washington, do you have data
2 that would directionally suggest any kind of a
3 hierarchy and, if so, at what level, at the
4 state, at the region, at the level of a hospital,
5 at the level of a practice?

6 MS. PARAST: A hierarchy, you mean in
7 terms of the measures?

8 CHAIR ANTONELLI: Yes. I know you
9 gave an answer to Dr. Fox. But I'm sort of
10 putting myself in the position; I'm a Medicaid
11 director and I'm going to choose one of these
12 things. What is the guidance that would give me
13 a sense of where to begin the process?

14 MS. PARAST: So, one way to think
15 about it would be that in part of our validation
16 work we looked at how these measures are
17 associated with a caregiver's overall rating of
18 their provider and their overall rating of access
19 to care. And so, we identified measures that
20 were key drivers, like really key drivers of
21 provider rating, and suggested that if you were
22 only to target a certain subset, that perhaps

1 these would be the ones you would want to target.
2 And we found that, basically, having a designated
3 care coordinator and a shared care plan were the
4 strongest ones associated with provider rating.
5 So, those are the two I would put at the top of
6 my list.

7 CHAIR ANTONELLI: Okay. All right.
8 Thank you.

9 Roanne, unless you've got something
10 burning, I think I am going to bring this to a
11 vote. Is that okay? Okay.

12 All right. And then, following our
13 pathway so far, does anybody want to suggest a
14 condition? Otherwise, it's an up/down without a
15 condition.

16 (No audible response.)

17 Okay. No conditions.

18 All right. Miranda?

19 And are we going to have to vote for
20 each one individually since they are NQF
21 measures?

22 DR. BURSTIN: No.

1 CHAIR ANTONELLI: So, all of them
2 together? Okay.

3 MS. KUWAHARA: So, again, we are
4 voting for the measure set, not the eight
5 individual measures previously recited. So, we
6 are voting to add the family experiences with
7 coordination-of-care measure set to the child
8 core set.

9 If you would like to support this
10 measure please select 1; if not, please select 3.

11 Let's try it now.

12 (Voting.)

13 There we go.

14 We are waiting on one more response.

15 There we go.

16 Fifty-four percent of the 13 voting
17 members voted to support this measure, and 46
18 percent voted not to support this measure. So,
19 we will not be recommending this measure for
20 inclusion in the core set.

21 DR. BURSTIN: So, there was one other
22 measure from Seattle Children's from that same

1 set that just came through our process, and I
2 don't want to add it initially for today, but
3 just to point it out to you. There is a
4 continuity of primary care for children with
5 medical complexity that is a new measure that is
6 claims-based. I don't know that anybody has seen
7 it yet.

8 We could certainly pass people on
9 information about that to follow. But it is
10 claims-based, intended at the level of the health
11 plan, specifically using -- you guys probably
12 know more about this -- a Bice-Boxerman
13 Continuity of Care Index over a 12-month period.

14 So, it is a brand-new measure going
15 through our process. It should be endorsed in
16 June.

17 CHAIR ANTONELLI: Thank you.

18 DR. BURSTIN: It's 3153.

19 CHAIR ANTONELLI: All right. So, I
20 think we have gone through the list. Yes?

21 DR. BURSTIN: I think you did.

22 CHAIR ANTONELLI: Yes. So, I'm going

1 to hand it over to Shaconna to tell us what is
2 next.

3 MS. GORHAM: So, we are going to go to
4 public comment before we rank within the room,
5 because I know that some members have to leave,
6 and that is very important that we stick our
7 stickers where we need to. But we want to go to
8 public comment first.

9 So, Operator, can you open the line up
10 please?

11 OPERATOR: Ladies and gentlemen, if
12 you would like to make a public comment, please
13 press *1 on your telephone keypad. Again, that's
14 *1 for a public comment.

15 (No audible response.)

16 And currently, we have no public
17 comments at this time.

18 MS. GORHAM: Thank you so much.

19 So, for the members in the room, we
20 are going to rank. So, the adults did it
21 yesterday. But we are going to put the slide up
22 of all of the measures that you have recommended

1 for inclusion thus far. They are also written
2 behind you, one directly behind me and one to the
3 left of me.

4 We have four measures that were
5 recommended. And we have 1800 as the medication
6 ratio. We have the 2903, contraceptive care,
7 most or moderate effective measure or method.
8 That is with condition. And we have the 2800,
9 metabolic screening. We have the 0418, screening
10 for clinical depression and followup. And then,
11 we have the 3154, informed coverage, and that is
12 also conditional support.

13 So, you have four dots. The colors
14 mean nothing at all. You put your dots where you
15 would like to see the measures ranked. So, we
16 will ask CSM for addition of these members. But,
17 when we put them in the report, we will say that
18 the Child Task Force recommended these measures,
19 and we will put them in order of importance.

20 You can do however you want. If you
21 think that you want to put all four dots on one
22 measure because that measure is that important,

1 you can do that. So, you can put your dots
2 wherever. You only have four, but we have five
3 measures that are recommended. So, that way, it
4 will help us rank.

5 Let's do that now.

6 MS. MUKHERJEE: So, if we can just
7 quickly come back? We're almost done. Our
8 ranking is over.

9 And so, 2903 and 1800, the
10 contraceptive care measure as well as the asthma
11 measure, those two got the most ranking votes at
12 14.

13 And then, we have 3154, which is
14 informed coverage, the third highest one with 10
15 votes.

16 And then, we have 0418, screening,
17 with 9 votes.

18 And the lowest vote was No. 2800 with
19 5 votes.

20 So, we have our top three. Our top
21 three would be 2903 and 1800 being one, and then,
22 two being 3154, and then, 0418 being No. 3.

1 With that, we go into our second
2 activity of the afternoon, which is looking at
3 gaps. And with respect to gaps, what we wanted
4 to do is be, again, not necessarily strategic,
5 but parsimonious and look through all the gaps,
6 which you will see are on the sidewalls and
7 stickies.

8 And we wanted to go through another
9 prioritization exercise with the gaps because we
10 know a lot of these gaps have existed and will
11 exist, and the list will live. But, if we want
12 it to be truly parsimonious and give CMS some
13 concrete direction, we wanted to be able to
14 triage them and provide them with sort of the top
15 five gaps.

16 And so, we'll take part in another
17 exercise now where you will get dots. And then,
18 the gaps, as you can see, are on the sidewall.
19 And we ask you to be thought about sort of
20 ranking them and, again, giving your dots to the
21 different topic areas that you think are sort of
22 most important. And that doesn't mean the rest

1 of the gap areas will go away, but it will add
2 sort of an additional level of analysis, as sort
3 of here are the top five gap areas.

4 MEMBER RICHARDSON: Sorry. For each
5 of your gap areas, do we know that there are
6 existing measures?

7 MS. MUKHERJEE: No, no.

8 MEMBER RICHARDSON: Okay.

9 DR. BURSTIN: So, I'll just mention,
10 for the adult group, and for some of you who were
11 with us the first day, we also shared with this
12 group the new prioritization criteria NQF has put
13 forward across all of our work. And so, this
14 might just be informative as you think and look
15 towards this.

16 So, there's four criteria:

17 The first is we prefer measures to be
18 outcomes-focused, either outcomes or closely
19 related to outcomes.

20 The second is we would like them to be
21 improvable and actionable, something that came up
22 a lot through the course of this discussion over

1 the last several days.

2 The third is we would like the results
3 to be meaningful to patients and caregivers, that
4 those results would be understandable and they
5 would know what to do with them.

6 And the fourth, I think really
7 importantly for a population like kids, in
8 particular, is we would like to see measures that
9 increasingly reflect an integrated view of care.
10 So not measures necessarily that are so site-
11 specific or provider-specific, but more reflect
12 the integrated or a systemic view of care.

13 So, if that is helpful for you, as you
14 look through those, we will be building that into
15 all of our work going forward. So, this is a bit
16 of a preview for you, but I think it is a helpful
17 way to think.

18 Thanks.

19 MEMBER SAKALA: Did you want us to
20 vote on the domains or the subdomains?

21 MS. MUKHERJEE: So, I think the
22 domains because we will keep the subdomains. So,

1 if you really thought you wanted to promote one
2 subdomain, feel free to give it a dot, and we
3 will just highlight as something under the
4 domain. But, if you say one of the domains, like
5 the cost measures, are the most important, we
6 will say these were the two subdomains with it.
7 But it is completely up to you. If you think one
8 of the subdomains is more important than sort of
9 the big criteria, feel free to vote either way.

10 DR. BURSTIN: And shall we also allow
11 them to add a measure, add a gap, as we did for
12 the adult side? But, unfortunately, they were
13 tougher than I would have been. You have to use
14 a dot if you put a new one up. But feel free to
15 add one as well. We probably should do that
16 first before everybody goes up.

17 MS. MUKHERJEE: So, on this side, we
18 will have an "add your gap," and you will lose a
19 dot.

20 (Laughter.)

21 Just for parity, because adults did
22 that, the adult group, and they had to like

1 provide a dot for the new category that they
2 added.

3 DR. BURSTIN: And the added dot got
4 more votes than anything else on the screen. So,
5 don't feel bad about adding a dot.

6 MEMBER SAKALA: So, I have an issue
7 with overuse because I think that often is paired
8 with underuse. Like, if you are not going to do
9 -- so, here's an example -- electronic fetal
10 monitoring, you had better do intermittent
11 auscultation. And so, it is not only about -- or
12 there's a lot of beneficial practices that are
13 not part of the culture, whatever.

14 So, can I pair that with overuse
15 because I think it goes with it? Or does that
16 become an extra one?

17 MS. MUKHERJEE: It's not on; it will
18 be a new one.

19 MEMBER SAKALA: Okay.

20 MS. MUKHERJEE: You can put it on the
21 blank sheet over here as sort of a new and say it
22 is pairing with that, but you will still lose a

1 dot.

2 MEMBER SAKALA: Uh-hum.

3 MS. MUKHERJEE: It's okay. You can
4 add it.

5 MEMBER SAKALA: Yes. Thank you.

6 MS. MUKHERJEE: And we're ready. We
7 have all of that up there on the sides. You all
8 have your dots. So, feel free to sort of get up,
9 move around, add your dots. And the blank sheet
10 is up as well with a marker there. So, we're all
11 set.

12 No, go ahead.

13 MEMBER OSBORNE-GASKIN: I just have a
14 question about the durable medical equipment.
15 Was there a specific concern about that or was
16 that a cost thing?

17 MS. MUKHERJEE: An access issue with
18 that and sort of supply, and things like that.

19 (Pause.)

20 CHAIR ANTONELLI: We are all set. So,
21 do we --

22 MS. MUKHERJEE: We have the data right

1 there.

2 CHAIR ANTONELLI: Oh, there it is.
3 There it is. All right. This is you, isn't it?

4 MS. MUKHERJEE: So, hello, everybody.
5 I am just going to sit back here, so I can see
6 the dots.

7 And so, the top ones seem to be
8 substance abuse; mental health, and with mental
9 health, we have also the subcategories of ED use
10 for behavioral health, coordination, access,
11 things like that. We also overuse, medically-
12 unnecessary care.

13 And a point was brought up that, with
14 overuse, we should always pair underuse. Because
15 if you are overusing something, you're underusing
16 something that's more appropriate. So, we might
17 add that and make that modification.

18 And the others that sort of fell out
19 in the top five were coverage; that was the other
20 one, duration of insurance coverage. And then,
21 we also have a subcategory that was added to
22 that. So, we will capture that.

1 We have mental health, which I think
2 I've already covered.

3 So, we have substance abuse, one;
4 mental health, two; coverage, and then, we have
5 cost of measures. And then, the final one -- I
6 can't even read my own handwriting -- is care
7 coordination. Care coordination is huge. That
8 was the other one. That's on the top five.

9 So, we will roll it up. So, when we
10 talk about the measure, we will say care
11 coordination and, then, we will call out all of
12 these, but, then, highlight the ones that got
13 dots.

14 It is care integration. Care
15 integration has two yellow, one red. Care
16 coordination for conditions requiring community
17 linkage has one yellow. Cross-sector measures
18 has one yellow. Social services coordination,
19 one red. And then, care coordination all
20 together has one, two, three, four, five, six,
21 seven, eight. Eight dots.

22 And with that, we have ranked our

1 measures. We will keep this. We will add them
2 up and add it to the report.

3 And then, with that, I will turn it
4 over, because we are coming to the final stages
5 of our last day of meeting.

6 MS. GORHAM: So, we are going to open
7 it up for public comment one more time.

8 Operator, can you open the lines,
9 please?

10 OPERATOR: Ladies and gentlemen, if
11 you would like to make a public comment, please
12 press *, then 1, on your telephone keypad.
13 Again, *1 for a public comment.

14 (Pause.)

15 And currently, we have no public
16 comments.

17 MS. GORHAM: Thank you.

18 So, on your screen, for the folks in
19 the room, all of the measures that you ranked, we
20 have them listed:

21 2903, contraceptive care, and 1800,
22 asthma medication ratio, I will rank No. 1. They

1 tied.

2 3154, informed coverage, was No. 2.

3 0418, screening for clinical

4 depression and followup, ranked No. 3.

5 And then, No. 4, 2800, metabolic

6 screening for children and adolescents, ranked

7 No. 4.

8 Okay. So, with that, if there are no
9 questions or comments on the measures that will
10 be recommended to CMS -- Andrea?

11 MEMBER BENIN: I just have a comment
12 about gap. But are you doing that next? No?

13 MS. GORHAM: No. You can now. Now is
14 fine.

15 MEMBER BENIN: Okay.

16 MS. GORHAM: As long as there are no
17 comments on the recommended measures, we
18 definitely can floor and take comments for gaps,
19 or whatever else.

20 MEMBER BENIN: Okay. I just want to
21 really echo what Kathryn said earlier about the
22 mental health issues, particularly the mental

1 health issues in the emergency department.

2 There's an absolute crisis right now in the
3 emergency departments around mental health. And
4 I think whether that is related to the Netflix
5 television activity and the other things that
6 have been going on, it is untenable what is going
7 on in our emergency departments. And that is
8 consistent through -- it is not just --

9 Connecticut is a disaster, but it is consistent
10 throughout children's hospitals that emergency
11 departments are filled -- filled -- with children
12 who are suicidal, and there are no beds for them.

13 We get in our emergency department 30
14 new psych patients a day. And at any given time,
15 we have patients who have been in our emergency
16 department for 20 or more days. So, it is a
17 substantial -- substantial -- problem, and it
18 doesn't just impact those poor children, but it
19 impacts the other septic babies who come in and
20 all those other people who can't access the
21 emergency department because we are running a
22 psych ward in a way that is not the best for

1 those children. They shouldn't be getting their
2 mental health care in an emergency department.
3 That's not ideal for them.

4 So, this is a substantial crisis that
5 I cannot possibly imagine that we, as a sort of
6 field, you know, can't figure out how to measure
7 better, so that we can explain it better in a way
8 that we can make change. Because what's going on
9 out there is really horrifying.

10 CHAIR ANTONELLI: So, I'm going to
11 react to that. And then, Kathryn, I will pick
12 you up.

13 I'm not sure that the answer is
14 necessarily measuring better. Because what you
15 just said actually is universal is for
16 pediatrics; it's adults. EDs are basically, they
17 are holding tanks.

18 In Massachusetts, anywhere between 20
19 and 40 percent of every emergency department bed
20 in the entire Commonwealth is taken up by a
21 patient with acute psych needs, and there is no
22 disposition.

1 And so, I want to sort of challenge
2 that notion. So, I think we have got measures
3 that show that the system, as it is currently
4 functioning, is really, really inefficient,
5 ineffective, and, in fact, undignifying.

6 But are there interventions that
7 would, then, call the need for better measures?
8 I don't mind. I put a lot of those yellow
9 stickers over there that link to the community.
10 So, going upstream for pediatrics as well as
11 adults in the behavioral health space is better.

12 So, I do want us to think, yes, this
13 is the National Quality Forum. We are all about
14 measurement. But I also think that we already
15 know just how horrible this problem is. So, that
16 was my editorial comment.

17 Kathryn, to you, please.

18 MEMBER BEATTIE: So, I am just going
19 to add to what Andrea was saying on two fronts.
20 One, I do think putting a quality metric is a way
21 of communicating with our states' Medicaid.

22 And in the states that I have been an

1 administrator in as a pediatrician, one of the
2 major issues has been access for Medicaid
3 patients because we will have the inpatient
4 facilities are not expanding. Either they don't
5 have enough staff for the beds they have or they
6 are not expanding their beds because they can't
7 afford to, because the reimbursement is so low.

8 Then, we have the challenge of whether
9 or not they will even approve an appropriate
10 stay. So, it is very unlikely that, when you
11 change a medication for a kid, that a seven-day
12 stay is going to be long enough, but that is all
13 they want. They want them to come in for
14 inpatient psych care in seven days.

15 So, I do think somehow getting to the
16 quality is linked to the appropriate location of
17 care by the appropriate providers that are
18 trained to manage these complex mental health
19 concerns of the children that we are dealing
20 with.

21 The second piece that I want to speak
22 to is actual safety. So, yes, the kids are

1 coming to the emergency department. If we admit
2 them into the hospital, then they lose their
3 standing for appropriate placement. And so, they
4 go on the bottom of the list for the inpatient
5 facility. But it is really unsafe to keep them
6 in the ER, and it is often unsafe to admit them.

7 The place where I work now, we just
8 had Joint Commission there, and probably 50
9 percent of their time was talking about risk to
10 our mental health patients, ligature risks. So,
11 if you know what a normal patient room looks
12 like, there are wires and cords all over. You
13 know, it is the pull cord in the bathroom. I
14 have had an adolescent patient, when they are
15 walking one-to-one with a sitter, run into a
16 public bathroom and pull a plastic bag over their
17 head.

18 And so now, we have to not just think
19 about the individual room and how we make that
20 room safe, but how we make all the public areas
21 safe. Because these aren't facilities that are
22 designed to care for these patients.

1 And when you have an adult mental
2 health patient who is sitting, waiting for
3 appropriate placement, they are not kids. Kids,
4 you can't just lock them in a room and put the
5 lights off and give them some meds to sedate
6 them, and that's enough. I mean, we have to do
7 something to create a schedule and activities for
8 these kids, and it is just so unsafe when they
9 are not in an environment that is designed to be
10 safe for them.

11 So, I'm off my soapbox, but it is a
12 very complex issue and we really need Medicaid's
13 help, at least in every state that I have been
14 in.

15 CHAIR ANTONELLI: Terry?

16 MEMBER ADIRIM: No, and I can't repeat
17 enough, I agree with both of them. As somebody
18 who works in a peds emergency department, this is
19 a big issue.

20 So, if we have to have an emergency
21 department measure, this would be a good one
22 because I think there are things that the state

1 can do with regard to their managed care
2 contractors to improve these issues.

3 I mean, kids do not belong in the
4 emergency department with mental health issues
5 unless they are going to be making it soon to an
6 inpatient facility, and that is just not
7 happening anywhere.

8 CHAIR ANTONELLI: Helen?

9 DR. BURSTIN: This brings an issue to
10 me, and I'm not sure this is the case. But I
11 also just wonder whether it would be useful to
12 look to see whether there are some existing adult
13 measures that actually could be specified for
14 kids.

15 I was just trying to find on my
16 computer, which I couldn't. For example, there
17 are ED throughput measures --

18 CHAIR ANTONELLI: Right.

19 DR. BURSTIN: Admit time, decision
20 time, things like that, that I don't know that
21 they're only adults. Or could they be looked at?
22 It might be an easier lift, for example, for the

1 Pediatric Centers of Excellence to take existing
2 measures and think about whether there might be
3 some early modifications to some of those --

4 CHAIR ANTONELLI: Right.

5 DR. BURSTIN: -- to get at issues like
6 boarding.

7 I know psychiatric patients stratified
8 intentionally. So, it might be really
9 interesting data. We would be happy to share
10 that with you guys, just to sort of see if we
11 could find the original specs and see if there is
12 an opportunity there, because this is, obviously,
13 untenable.

14 CHAIR ANTONELLI: And don't forget to
15 measure the gap, right? So, in Massachusetts, we
16 actually have legislation to drive ED boarding.
17 My wife does quality measurement for surgery at
18 Mass General. So, for them, it is boarding for
19 everything surgical. But, when I talk about it,
20 it is exactly what you are just saying, 20-plus
21 days sitting in the ED for a given patient.

22 So, I don't mean to say we don't need

1 additional measures. What I am saying is I think
2 that we have got boarding measures that we could
3 be thinking about.

4 But the gap area for me is the
5 capacity, right? Why are those patients sitting
6 in the ED? It is because they are not going to
7 where it would be a higher-value setting.

8 So, if we think broadly and outside
9 of, let's call it, the traditional brick-and-
10 mortar medical system, of which the ED is the
11 default repository, we should be looking at other
12 measures of acute psychiatric care and high-
13 value, high-safety environments.

14 The number of states that I'm aware of
15 that are reducing inpatient beds, while the
16 country's pandemic of behavioral -- so, there is
17 something wrong with that, and we should be
18 thinking about those. And that is actually
19 something that could happen, could and should be
20 happening at the level of states.

21 Terry, you had something?

22 MEMBER ADIRIM: You know, I was going

1 to say I agree with that. And one of the things
2 -- and this is, again, anecdotal as an ED
3 practitioner -- but what I hear over and over
4 again from the social worker who is trying to
5 find a bed is they don't take Medicare or they
6 don't take this insurance.

7 So, I think there is something that
8 the state could do to move these kids to places.
9 And it is a bed issue, too. I mean, a lot of
10 times the beds are full and there's not enough
11 practitioners, and so on. But I think all of
12 this should be looked at and measured.

13 MEMBER KILSTEIN: I just want to say
14 that, for adults, there are different policy
15 issues and levers than for kids, and it has to do
16 with the Institution for Mental Diseases
17 restrictions that do not apply to kids under 21,
18 but do apply to a facility for more than 16 beds
19 for an adult.

20 CHAIR ANTONELLI: Amy?

21 MEMBER RICHARDSON: So, I don't
22 disagree with anything that has been said. But

1 we haven't talked about ownership of the problem,
2 and I think the states can only go so far until
3 we have sufficient child and adolescent
4 psychiatrists. I don't hear anything happening
5 around workforce. All I do is have a drink with
6 friends who bemoan the fact that there aren't
7 enough of them and don't see any progress on the
8 workforce, and don't understand why some of this
9 isn't under the ownership of big health systems,
10 not the state, but big health systems who want to
11 build the beds that are gravy, right, have a big
12 margin, and don't want to build the beds that are
13 really hard and low-margin. And so, I think
14 there is a lot of ownership, that this doesn't
15 necessarily just belong to the states.

16 MEMBER ADIRIM: How do health systems
17 -- I'm sorry, I'm not sure I understand. Because
18 states and the federal government pay GME. So,
19 they would have a capacity to increase --

20 MEMBER RICHARDSON: If you look at how
21 health systems billed -- I invite you to go to
22 Cleveland and watch the arms race in hospital-

1 building, right? And it's all about the high-
2 margin beds. What kinds of beds, what kinds of
3 services can we build that gives us the biggest
4 margin. And psych beds have a little, tiny
5 margin.

6 MEMBER ADIRIM: Right. There is that,
7 but we just don't have enough practitioners who
8 are willing to practice.

9 MEMBER RICHARDSON: Right. So, I
10 would ask the psychiatrists and the child and
11 adolescent psychiatrists about workforce
12 development.

13 I'm not saying the states and all of
14 us don't have a role in this. I'm saying that we
15 could task the states with fixing this. And
16 until there's workforce and beds built, then it
17 is not going to get solved. It is not just tell
18 the states to fix it.

19 MEMBER BEATTIE: So, I am specifically
20 referring more to child and adolescent access to
21 care. And with that, we oftentimes don't have
22 the continuum of care that we do in the adult

1 world, and that hasn't been acknowledged by
2 states to even develop a reimbursement model.

3 So, a great example is partial
4 hospitalization. A lot of the kids who end up in
5 the ED are somewhere below needing an inpatient,
6 but above being okay with seeing their
7 psychiatrist once a month and a counselor once a
8 week or so.

9 And most states today do not have a
10 reimbursement structure established for either
11 intensive outpatient, where the kid goes to
12 school all day and, then, goes into a therapy
13 setting for two or three hours after school every
14 day or a PHP, where they go to PHP all day and,
15 then, get to go home and sleep at night.

16 We are actually working very
17 aggressively in my team to get that reimbursement
18 structure developed with our Medicaid team. They
19 have reimbursement under Medicare for those
20 facilities, but those are all adults. And they
21 just don't have anything. You know, it is not a
22 code you can ask for.

1 So, there needs to be some
2 acknowledgment of this is a crisis for children
3 and adolescents. We need to develop the
4 reimbursement structure, so that you can even put
5 the program in place.

6 We are not even looking to make money
7 on psych. We're not. We just want to be able to
8 break even or use a moderate amount of foundation
9 money to support care for these kids.

10 But there needs to be some
11 acknowledgment that those are resources that need
12 to be available in our states.

13 CHAIR ANTONELLI: So, if I try to
14 string together the pearls that I have heard in
15 the last 12 minutes or so, what I'm hearing is
16 that it is a pandemic problem and there's lots of
17 opportunity for collaboration, right? So, I
18 agree with you about high-margin beds. There's a
19 reason why people build, you know, cardiac
20 surgery hospitals, right?

21 But, that said, so the delivery system
22 has ownership. The financial incentives, the

1 types of care models that you are referring to,
2 for which in some cases there's already evidence,
3 and just because there's no code, you can't
4 implement them.

5 So, this is a shared responsibility.
6 And frankly, I can't think of any other way of
7 going after the behavioral health crisis in this
8 country without everybody sort of stepping up.

9 So, next steps.

10 Yes, go ahead. You did this so well
11 yesterday.

12 (Laughter.)

13 MS. KUWAHARA: So, between now and
14 July 7th, the project staff will diligently to
15 capture the recommendations and sentiments from
16 the Adult and Child Task Forces. And then, we
17 will go out for public comment on those drafter
18 parts, July 7th through August 6th. Then, the
19 final reports will be submitted to HHS August
20 31st.

21 The MAP Coordinating Committee will
22 meet to be determined, August-September time.

1 And then, CMS will issue its annual update to
2 both core sets late 2017.

3 MS. MUKHERJEE: And then, as just sort
4 of --

5 MS. KUWAHARA: The project staff
6 contact names are here, and our information is
7 also on SharePoint. So, you can feel free to
8 reach out to any of us individually.

9 And on this last slide we have our
10 project contact information. Our project page is
11 listed here as well as the SharePoint site and
12 both email addresses.

13 MS. MUKHERJEE: And just as a final
14 thought, it will happen in August, our
15 Coordinating Committee meeting, because the
16 report is due to CMS by the end of August. So,
17 that will happen in August.

18 And just as a final thought, thank you
19 so much for bearing with us the two days and sort
20 of powering through all these rankings and
21 discussions.

22 And thank you to our Chair for helping

1 sort of guide us through two days of intense
2 discussion. We wouldn't be able to do it --

3 (Applause.)

4 As well as the NQF leadership, Helen
5 sort of being here and helping out in a pinch.

6 And also, the staff. We wouldn't be
7 able to do what we do without the team.

8 (Applause.)

9 DR. BURSTIN: And just lastly, we know
10 this is a volunteer gig for all of you. This is
11 our job. And so, thank you, especially for so
12 many of you who spent three days with us. That
13 is a huge commitment both from our federal
14 partners as well as those of you in the private
15 sector. So, thank you.

16 MS. GORHAM: And I just want to say
17 thank you to CMS. Renee and Gigi work so well
18 with us behind the scenes. And so, we really
19 appreciate it. We definitely could not pull this
20 off without you.

21 And then, I'm going to tell on Rich.
22 I know he doesn't want me to, but I am anyway.

1 This is actually his first year as Chair. And
2 when we approached him about the position, the
3 first thing he said, "Oh, I would love to do it."
4 He was like, "Give me all of the meetings because
5 my schedule is full, and this is so important, I
6 want to make sure that I have time." So, I just
7 wanted to say thank you.

8 CHAIR ANTONELLI: Thank you.

9 (Applause.)

10 DR. FOX: Yes, and from the CMS side,
11 we want to thank the staff, and Rich
12 particularly, because he is just really very
13 helpful, and Helen. And thank you to the Task
14 Force members because you did give your time and
15 your expertise.

16 CHAIR ANTONELLI: I certainly don't
17 deserve the last word. So, somebody from the
18 staff is going to have the last word.

19 But I just basically want to revisit
20 the comment that I ended with yesterday. When
21 you consider what's happening outside these walls
22 politically, and yet, inside the walls the amount

1 of really intense, good work, multidisciplinary,
2 cross-stakeholder, cross-sectoral, discussions
3 around value, transparency, and all of that, if
4 anything, we have redoubled our efforts to get
5 measurement in place and to pull together
6 traditionally or non-traditional bedfellows, so
7 to speak, around alignment. For me, this is
8 actually very sustaining.

9 And we are going to endure. The
10 families for whom we provide care are really
11 depending on us, especially the ones that are
12 already vulnerable.

13 So, thank you. Thank you for the
14 federal partners. And in particular, I know it
15 is tough for you right now. We've got your back.

16 (Whereupon, at 3:49 p.m., the meeting
17 was adjourned.)
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22

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Before: NQF

Date: 05-25-17

Place: Washington, DC

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