NATIONAL QUALITY FORUM

+ + + + +

MEASURE APPLICATION PARTNERSHIP
MEDICAID CHILD TASK FORCE

+ + + + +

THURSDAY
MAY 25, 2017

+ + + + +

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**

CONTENTS

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

9:08 a.m.

MS. MUKHERJEE: Hi, everybody. Welcome back. Good morning.

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

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

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

CHAIR ANTONELLI: Good morning, everybody.

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

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

Task Force partners.

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

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

You should have all received the discussion guide materials.

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

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

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

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

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

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

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

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

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

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

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

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

DR. SMITH: Hi. This is Marsha Smith.

CHAIR ANTONELLI: Who is that? Marsha? Okay, good.

Good morning, Marsha.

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

May?

DR. NACION: Hello. Okay? Okay.

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

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

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

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

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

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

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

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

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

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

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

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

discussed yesterday.

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

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

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

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

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

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

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

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

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

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

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

2015 core set, with one state reporting this measure.

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

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

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

Okay.

CHAIR ANTONELLI: Thank you, May.

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

Ann?

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

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

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

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

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

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

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

MEMBER GREINER: Thank you.

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

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

MS. RANEY: Sure. Any specific one

that you would like us to focus on?

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

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

MEMBER POOLE-YAEGER: Okay.

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

DR. FOX: Who will be speaking later.

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

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

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

MEMBER POOLE-YAEGER: Great. Thank you.

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

MS. NORRIS: It's 6 to 9.

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

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

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

MEMBER POOLE-YAEGER: Yes.

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

MEMBER POOLE-YAEGER: Got it. Got it.

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

MEMBER POOLE-YAEGER: Okay.

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

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

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

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

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

I'm just curious about --

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

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

CHAIR ANTONELLI: -- because the next

item is dental.

(Laughter.)

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

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

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

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

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

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

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

would actually be worth pursuing going forward?

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

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

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

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

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

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

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

DR. FOX: Yes, we have really

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

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

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

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

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

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

CHAIR ANTONELLI: Microphone, please.

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

DR. FOX: Right.

MEMBER POOLE-YAEGER: Okay.

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

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

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

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

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

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

DR. FOX: Well, the word

"parsimony" --

MEMBER POOLE-YAEGER: Yes.

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

CHAIR ANTONELLI: Roanne?

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

DR. FOX: There's two --

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

DR. FOX: It's 0038.

Yes, it's getting all of your

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

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

DR. FOX: Yes.

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

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

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

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

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

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

MS. NORRIS: I'm ready.

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

the Oral Health Initiative, please.

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

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

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

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

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

(Laughter.)

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

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

So, how does CMS use the measures to

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

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

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

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

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

Next slide.

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

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

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

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

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

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

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

Okay, next slide.

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

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

beginning.

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

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

Next slide.

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

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

preventive dental service.

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

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

Next slide.

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

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

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

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

(Laughter.)

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

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

improvement efforts.

Next slide.

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

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

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

And we have about 36 states now, I

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

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

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

the measure specification, to do that.

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

Next slide.

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

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

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

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

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

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

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

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

Next slide.

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

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

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

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

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

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

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

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

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

I think that's my last slide. Yes. Thank you.

CHAIR ANTONELLI: Thank you, Laurie.

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

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

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

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

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

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

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

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

MS. NORRIS: Yes.

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

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

We do, thanks to the American Dental

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

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

Where it is more challenging is in the

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

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

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

care.

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

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

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

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

MS. NORRIS: Yes.

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

CHAIR ANTONELLI: Yes. Thank you.

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

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

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

Okay. So, Deborah?

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

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

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

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

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

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

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

MS. NORRIS: Actually, it doesn't.

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

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

issues.

CHAIR ANTONELLI: Lindsay?

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

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

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

one plan met the goal.

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

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

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

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

then, launch into the discussion?

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

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

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

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

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

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

So, next slide.

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

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

Next slide.

So, here's just a brief snapshot of

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

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

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

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

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

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

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

Next slide.

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

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

Next slide.

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

Next slide.

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

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

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

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

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

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

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

Next slide.

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

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

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

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

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

Next slide.

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

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

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

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

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

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

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

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

for care.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

And if you just hit down once, there is an animation in the slide. So, are you really ready today to give us additional screening measures to track when it is the followup that we seem to fall down on time and time again? Caveat: I didn't look ahead at the measures that you propose today.

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

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

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

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

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

Are people getting to the care? Do

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

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

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

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

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

right?

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

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

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

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

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

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

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

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

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

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

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

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

And that's tricky. I have been doing

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

So, next slide.

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

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

Next slide.

We're fostering a cross-sector

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

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

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

So, I struggle, constantly going back

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

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

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

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

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

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

CHAIR ANTONELLI: Bravo, and thank you so much.

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

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

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

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

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

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

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

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

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

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

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

to achieve improvement around some of those measures.

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

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

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

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

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

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

forth.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

conversation?

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

(Laughter.)

All right, go ahead, Kim.

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

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

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

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

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

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

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

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

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

Andrea?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

right?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I just want to make sure we still have

Dr. Smith on the phone.

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

CHAIR ANTONELLI: Great. Okay, thank you.

(Pause.)

We're solving a technical issue.

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

So, please move to the next slide. So, right now, we're on slide 307.

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

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

So, we can go to the next slide.

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

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

Okay. Slide 310.

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

Next slide.

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

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

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

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

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

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

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

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

If we advance the slide, please? Thank you.

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

Next slide. Okay.

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

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

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

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

Next measure, next slide.

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

Rich?

CHAIR ANTONELLI: Okay. Thank you.

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

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

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

DR. MATSUOKA: Yes. I just wanted to

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

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

CHAIR ANTONELLI: Really important. Thank you very much.

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

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

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

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

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

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

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

MS. GORHAM: Exactly.

MEMBER OSBORNE-GASKIN: Okay.

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

want to speak about the reason, but --

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

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

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

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

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

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

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

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

But we also have the PQI-15 measure

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

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

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

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

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

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

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

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

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

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

CHAIR ANTONELLI: Okay. Okay. Thank you. Thank you.

Amy?

MEMBER RICHARDSON: Thank you.

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

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

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

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

MEMBER BENIN: Second.

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

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

Rachel?

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

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

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

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

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

CHAIR ANTONELLI: Thank you.

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

Terry?

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

CHAIR ANTONELLI: Go ahead.

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

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

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

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

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

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

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

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

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

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

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

MS. GORHAM: Yes.

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

Karen, did you want to weigh-in?

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

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

So, just as an example for Caesarian

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

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

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

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

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

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

MEMBER ADIRIM: Yes.

CHAIR ANTONELLI: Okay.

MEMBER RICHARDSON: Thank you.

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

CHAIR ANTONELLI: Could you lean into

the microphone, please?

MEMBER RICHARDSON: Sorry.

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

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

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

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

So, I agree that it is important. I

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

CHAIR ANTONELLI: Carol?

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

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

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

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

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

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

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

reaffirmed that.

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

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

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

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

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

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

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

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

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

Deborah?

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

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

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

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

CHAIR ANTONELLI: 1448.

MEMBER KILSTEIN: Yes.

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

DR. ELLIOTT: I'll second that.

CHAIR ANTONELLI: There's a second. Okay. Okay.

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

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

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

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

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

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

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

So, that would be my motion.

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

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

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

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

CHAIR ANTONELLI: Okay. Okay. Thank you.

Any seconds?

MEMBER POOLE-YAEGER: I'll second that.

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

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

(No response.)

Okay. So, what order should we go in?

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

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

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

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

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

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

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

Is there a second for 1365?

MEMBER OSBORNE-GASKIN: Second.

CHAIR ANTONELLI: Second. Okay. All right.

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

Okay. Terry?

MEMBER ADIRIM: Thank you.

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

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

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

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

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

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

CHAIR ANTONELLI: Okay. Thank you.

Deborah?

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

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

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

MEMBER KILSTEIN: Okay. Thank you.

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

MEMBER KILSTEIN: Thank you.

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

Yes?

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

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

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

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

CHAIR ANTONELLI: Okay. Thank you.

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

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

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

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

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

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

Could you restate the condition, please?

MEMBER POOLE-YAEGER: Oh, sure. That

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

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

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

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

for that to be a condition --

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. BURSTIN: Oh, okay.

DR. FOX: The CAMI measures, yes.

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

DR. FOX: This one is not.

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

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

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

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

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

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

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

about a year since it has lost endorsement.

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

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

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

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

motion. Yes.

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

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

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

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

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

Andrea seconds?

MEMBER BENIN: I'll second it.

CHAIR ANTONELLI: Okay. All right.

So, do we need to ask about coffee?

(Laughter.)

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

(Laughter.)

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

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

CHAIR ANTONELLI: And somebody with a vote left.

MS. KUWAHARA: Yes.

CHAIR ANTONELLI: Do we have her vote?

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

CHAIR ANTONELLI: She did?

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

CHAIR ANTONELLI: Okay. Thank you. Okay.

MS. KUWAHARA: Yes.

(Vote.)

CHAIR ANTONELLI: Mine went flatlining, too.

(Laughter.)

Do you guys have any Epi?

(Laughter.)

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

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

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

comfortable with a hand vote?

MS. KUWAHARA: Sure.

CHAIR ANTONELLI: Is that okay? All right.

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

MS. KUWAHARA: Yes.

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

All that are comfortable with hand vote show your hand.

(Show of hands.)

We need to count? Okay.

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

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

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

hand.

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

DR. BURSTIN: With the comment.

CHAIR ANTONELLI: Yes.

(Show of hands.)

MS. KUWAHARA: And those who vote no?

(Show of hands.)

So, what's the final?

So, 7 yes and 6 no.

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

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

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

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

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

CHAIR ANTONELLI: But it has to achieve 60 percent?

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

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

CHAIR ANTONELLI: Yes.

Helen, thank you for coming in.

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

Okay. One down and three to go.

What's next, May?

DR. NACION: 0471.

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

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

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

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

well, why is this happening?

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

CHAIR ANTONELLI: Thanks.

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

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

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

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

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

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

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

Thank you.

CHAIR ANTONELLI: Thanks, Carol.

Amy? And then, Kathryn.

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

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

CHAIR ANTONELLI: Helen?

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

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

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

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

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

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

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

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

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

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

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

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

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

CHAIR ANTONELLI: Thank you.

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

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

CHAIR ANTONELLI: Lean in a little

closer.

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

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

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

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

CHAIR ANTONELLI: Lindsay?

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

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

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

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

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

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

(Question asked off-microphone.)

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

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

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

(Laughter.)

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

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

DR. MATSUOKA: Yes.

MS. COGAN: Yes?

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

CHAIR ANTONELLI: Thanks.

Kim? And then, Carol.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MEMBER RICHARDSON: In the right place.

CHAIR ANTONELLI: Yes. Okay.

Karen, would you like to comment, please?

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

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

landed there.

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

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

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

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

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

CHAIR ANTONELLI: Withdraw the motion for removal?

MEMBER RICHARDSON: Removal.

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

Other Amy?

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

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

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

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

-- it's not up? Okay.

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

(No response.)

Okay. Next --

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

CHAIR ANTONELLI: Yes.

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

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

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

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

(Laughter.)

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

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

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

CHAIR ANTONELLI: Right.

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

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

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

You should just leave your card up.

(Laughter.)

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

CHAIR ANTONELLI: Yes.

MEMBER POOLE-YAEGER: Yes.

CHAIR ANTONELLI: Absolutely. Now is the time.

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

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

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

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

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

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

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

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

MEMBER POOLE-YAEGER: Okay.

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

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

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

MEMBER POOLE-YAEGER: Okay, yes.

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

MEMBER POOLE-YAEGER: Okay, yes.

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

MEMBER BEATTIE: Second.

CHAIR ANTONELLI: Is that a second?

MEMBER BEATTIE: Yes.

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

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

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

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

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

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

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

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

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

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

CHAIR ANTONELLI: Yes.

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

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

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

specifications. It would be useful moving forward.

Thanks.

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

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

CHAIR ANTONELLI: Yes.

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

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

CHAIR ANTONELLI: Yes.

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

CHAIR ANTONELLI: Yes.

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

CHAIR ANTONELLI: Good. Good. Okay.

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

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

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

(Show of hands.)

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

CHAIR ANTONELLI: Thank you.

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

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

CHAIR ANTONELLI: 1365.

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

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

(Laughter.)

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

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

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

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

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

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

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

impact overall.

CHAIR ANTONELLI: Andrea?

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

CHAIR ANTONELLI: No, I want comments specifically --

MEMBER BENIN: Just specifically?

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

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

there.

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

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

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

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

The numerator is patient visits with

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

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

Or, Terry, are you --

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

CHAIR ANTONELLI: This is it. Yes. Yes.

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

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

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

(Show of hands.)

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

hand.

(Show of hand.)

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

DR. BURSTIN: Recommended --

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

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

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

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

And I will open for conversation on this measure.

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

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

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

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

CHAIR ANTONELLI: Other questions or comments?

Amy?

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

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

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

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

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

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

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

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

CHAIR ANTONELLI: Andrea, Amy, and Deborah?

MEMBER BENIN: As previously discussed, we have very few good metrics for truly understanding access, and we are in an environment where access to services for folks with Medicaid may become even more compromised than it already is.

And the only way that we can really understand access, I think, is probably by

triangulating a number of different metrics around the problem and understanding it by kind of fleshing out the whole circle of the issues. I don't know that there's any one perfect isometric out there that we are going to be able to find.

So, I would strongly advocate for us at this point not removing metrics that give us any hope of understanding access, and especially if following a metric over time that may benefit that and give us the ability to watch and see what happens. As the environment around us changes, it is critical that we understand what is going on, and we are not going to be able to understand that with one little slice of the pie. And the pie is multidimensional.

So, I strongly advocate for leaving this metric in the set.

MS. MUKHERJEE: So, I'm just going to quickly read out all the different areas where you could sort of code for this measure, and it has CPT codes for: office or other outpatient

services, home services, preventive medicine, and general medicine examinations. So, all of that falls under this measure.

CHAIR ANTONELLI: Amy?

MEMBER RICHARDSON: I just have a question, please. I can't tell from this spreadsheet here. What is the source of these data? Is this claims data? Okay. Thank you.

CHAIR ANTONELLI: Okay. Deborah?

MEMBER KILSTEIN: I'm just not sure that this measure measures access. I mean, what it does is it tells you, for example, adolescents, they are not getting well care visits. Are they getting sick visits? And then, you will see how many kids are being seen, but it doesn't mean that there is an access problem or not an access problem. It just means they weren't sick; they didn't need to go in.

But, I mean, I have no problems with the measure as it is. I'm just not sure it actually measures access.

CHAIR ANTONELLI: Are you ready for a

vote, although I did now maintain the paradigm from yesterday and the conditions, so we know whether this is a dichotomous or trichotomous vote? No conditions.

Okay, Miranda. So, we're looking at an up/down.

MS. KUWAHARA: So, we are voting to remove the measure child and adolescents' access to primary care practitioners.

If you would like to see this measure removed from the core set, please raise your hand.

(Show of hands.)

If you would like to see this measure remain on the core set please raise your hand.

(Show of hands.)

Yes, this vote is to remain on the core set.

Okay, perfect.

So, 1 voting member voted to remove this measure; 12 voted to include this measure. So, the measure will be recommended to remain on

the core set.

CHAIR ANTONELLI: Thank you, everybody.

Operator, can you open the line to see if there's any public comment, please?

OPERATOR: Ladies and gentlemen, if you would like to make a public comment, please press *, then 1, on your telephone keypad. Again, *1 to make a public comment.

(Pause.)

And currently, we have no public comments at this time.

CHAIR ANTONELLI: Thank you.

Miranda, any in the chat to you?

MS. KUWAHARA: No.

CHAIR ANTONELLI: Okay. Anybody in the room, public comment?

(No response.)

All right. So, if the staff can give us directions for the lunch break? I think the food is here. Yes. Okay.

Debjani, do you want to tell us?

MS. MUKHERJEE: So, let's take a 10, a

15-minute. Well, let's take a 15-minute break. And then, we'll do a working lunch back here. So, when it's 1:00, we will be back and do a working lunch for the rest of the afternoon.

(Whereupon, the foregoing matter went off the record for lunch at 12:45 p.m. and went back on the record at 1:10 p.m.)

CHAIR ANTONELLI: Welcome back, everybody.

So, we are going to pivot from pruning to planting, or in this case nominating measures for the child core set. I know the staff is working on teeing things up. So, it will just take another minute or so.

(Pause.)

Ready? Okay.

So, May is going to give us an update on the Pediatric Quality Measures Program measures. Then, we will proceed into a discussion about measures that folks suggested a few weeks back. The staff has done some work to tee them up for discussion.

All right. So, May, if you can proceed, please?

DR. NACION: Okay. So, I will just briefly review what PQMP is and measures that have been developed under PQMP.

So, the Pediatric Quality Measures Program, PQMP, was established under CHIPRA and intended to improve and strengthen this core set of measures, to generally expand the availability of pediatric quality measures for use by public and private healthcare purchasers, to advance development and innovation around new and emerging quality measures, and to increase the portfolio of evidence-based, consensus-driven pediatric quality measures available to the field.

In terms of a breakdown of what has been endorsed and what has not, to date, this is a moving target. So, currently, we have 16 NQF-endorsed PQMP measures. Four are behavioral health, mental health, substance-abuse-type measures. Two are readmission measures, one

patient-reported outcome measure, and one sickle cell measure, as well as eight family experiences with coordination of care measures. So, many of these measures will be discussed today, as Task Force members have recommended them for addition to the core set.

Not listed on this slide, but development of the child HCAHPS tool also took place under PQMP. But, since MAP already has the standing recommendation that this measure be part of the child core set, it's not listed here.

In addition, there are six PMQP measures currently undergoing endorsement review and fall under topics such as appropriate use of antibiotics, asthma, and insurance coverage.

There are a total of 90 PMQP measures available, including perinatal care, child clinical preventative services, management of acute conditions and chronic conditions, patient-reported outcomes, duration of enrollment and coverage, availability of services, and medication reconciliation.

As of 2015, 24 measures are under development. I believe later Dr. Mistry can elaborate on any others in development or any other current priorities.

MS. GORHAM: So, we actually have Renee here.

So, Renee, if you would like to add anything else?

DR. FOX: Thank you. And Karen is here as well.

And, yes, there are measures that were developed in phase 1. I just wanted to let everybody know that AHRQ, with funding from CMS, has begun phase 2 with Centers of Excellence to look at taking the measures developed by the COEs and testing them, implementing them at the state health plan and provider level, so to look at how useful the measures are, with two key goals of assessing both the feasibility and the usability of some of these measures within the Medicaid and CHIP patient populations, and as well as to support performance monitoring and quality

improvement through both field testing, refinement, data collection, reporting on new measures, and use of performance data to define QI goals and test multilevel improvement strategies.

So, we were hoping to take these measures and the work that was done previously, as well as the ongoing work, to sort of bring it to the next level of not just having a measure, but having a measure that is useful at various levels.

I don't know if people have specific questions about that. The HCAHPS measure, which is the measure that is on our core set, but we don't currently report, one of our grantees -- thank you; I'm sorry, I should have a lavalier mic -- one of our grantees is going to explore that measure and how we can look at it, take it from the hospital measure to a state-reporting measure.

MS. GORHAM: Okay. So now we will look at measure review, and these are measures

for potential addition to the core set.

Next slide.

This is a review from yesterday, and just a general overview of how the measure is submitted and analyzed. So, as we did yesterday, for those folks who recommended a measure, you will be the lead discussant for that measure or measures that you recommended.

Again, we discussed the measure selection criteria earlier. We heard feedback from the state. And so that, we ask that you take all of that into consideration and, also, whether or not the measure addresses a gap area.

Next slide.

We discussed the preliminary analysis algorithm yesterday, some of those points, and how the staff used the algorithm in order to assess the measure.

Okay, move forward.

This is just the specific subcriteria we used for Medicaid.

You can move forward.

Again, discussing vote, but after day two, you all are pros at voting. So, we do not need to discuss that.

Again, decision categories you have in front of you, but, again, you are familiar with them by now: support, conditional support, and do not support.

Next slide.

So, the next several slides, the next three slides to be exact, are the gap areas identified in 2015 and 2016. The asterisk denotes new gaps, newly-identified gaps. And later on in the day, we will really have a good gaps discussion. So, I won't go into detail about the gaps now.

But, if we go to slide 333, okay, so this slide, not including the maternal measures and not including the measures that MAP recommended for removal, these are the recommendations, 2015 and 2016, that this Task Force recommended to CMS that were not added to the core set.

So, 2393, pediatric oral condition readmission measure and, also, 2797, the sickle cell anemia measure.

Next slide.

This slide and the next are a list of measures that were recommended by your peers. So, the first measure -- and we will go over each in detail a little later -- but the first measure, 1659, influenza immunization; 2800, metabolic monitoring for children and adolescents on antipsychotics; 1354, informed coverage; 3166, antibiotic prophylaxis among children with sickle cell anemia, and then, the last, emergency department visits potentially treatable in primary care.

Let me just say the two measures with the asterisk are pending endorsement. So, they are currently in a project right now.

And then, the next slide, we have the FECC measures that were recommended.

So, this is a good spot, before we go into each individual discussion of the measures,

if you open your discussion guide, there we have the specs and, also, the results of the algorithm.

So, the first measure that we are going to discuss is the 1659. If you click on that measure, it's best if you are in your discussion guide. If you go to your gray tab, you have a button for measure. That is the easiest way to find the measures, I believe, and 1659 is the first measure under care coordination. So, we will give you a little while to get there.

(Pause.)

Okay. Andrea suggested this measure. And so, I will turn it over to her, as the lead discussant.

MEMBER BENIN: This metric is the metric of inpatients who get screened for needing a flu vaccine and receiving a flu vaccine before the time of discharge. This is a metric that is used in other federal reporting areas, and I think in at least one it looks like it is used --

implicit here, it has been used in two other federal reporting programs.

It is an opportunity to round out the panel around immunizations as well as providing a metric that can address truly preventable admissions down the line and preventable harm to patients. And so, it is an important access point, when children are in the hospital, for them to have their flu shots evaluated and taken a look at. And so, having this on the set would round out that process and add this in. It also is, like the other immunization metrics, something of a proxy for access. You know, the downside of it are the issues that have previously been discussed about how it is involved in other programs, and people may be getting at this in different ways. I do not know about the feasibility of reporting.

I also do know that, in general, the performance on this metric in adult hospitals is fairly high, and there has been a lot of work done in adult facilities to make this metric

pretty high. But there is little to no insight into what this looks like across the board in children's hospitals. And so, there is not a way to really benchmark this metric for children's hospitals. And so, whether this would be a mechanism for that would be interesting.

CHAIR ANTONELLI: I'll open this up, but I actually want to seize the prerogative of a question. The exclusion about the vaccine production gap and distribution gap is intriguing to me because I am sort of thinking of this as a population measure. And so, are you familiar enough with the measure to speak to -- and just to be clear, I'm not saying the hospital is responsible for having vaccines that are not available, but I am trying to think of this at the level of a population that merits vaccine, and if they don't get it, you know, I am not sure that that is a patient-centered type of a metric. So, comment, please.

MEMBER BENIN: Yes. I mean, there may be somebody who knows the idiosyncracies of the

development of this particular metric better than I do. I do believe that this stems from the years when there were those pretty massive shortages, when you remember everyone was waiting in line.

And it has only been in the past few years that the recommendation has been expanded to really be everybody six months and older. So, I suspect that that was sort of the legacy from those years, which hasn't happened in a few years, but certainly could again. I think every year the supply is at risk.

And then, combining in now, we are also recommending it to everybody. So, if there is no vaccine to be had, who are you holding accountable for that? I don't know the answer, but there may be some who actually was involved more in the development. I don't know.

CHAIR ANTONELLI: Yes, because I just think if hospital A doesn't have vaccine, hospital B likely wouldn't. And so, that would affect everybody's performance. And it just

seems to me that, if your central supply person forgot to put the order in on time, that that's not a good reason against that measure. So, I just step back into my share.

Terry?

MEMBER ADIRIM: Yes, I have one really naive question. Implement of vaccine is not included in any of the other measures, right?

MEMBER POOLE-YAEGER: It's in the combo for the first two years of life.

MEMBER ADIRIM: Okay.

MEMBER POOLE-YAEGER: One of the combos for that.

MEMBER ADIRIM: Right. So, yes, I thought so.

CHAIR ANTONELLI: So, none of us heard that.

MEMBER POOLE-YAEGER: Sorry. Immunization is in the CIS measure, the Combo Immunization Series for the infants. There's Combo 1, 2, 3, 4, all the way up to 10. In one of those combos -- I don't remember which --

influenza vaccine is in there.

MEMBER ADIRIM: Right. So, I was just kind of curious about the additional benefit to -- I know this gets at it a different way, vaccination a different way, but about the additional benefit to this measure.

As you were talking, the first thought that went into my head is, yes, I would like to have a measure for healthcare providers at children's hospitals. But I was just kind of curious about what your thinking is with regard to the additional benefit to this measure with the other measure that's measuring, that includes influenza vaccines.

MEMBER BENIN: Maybe I am not remembering the details of these other metrics well enough, but my understanding is they are truly around your childhood immunization. So, you are up to about age 5-ish between those two metrics and, then, the adolescents.

But if you take your chronic -- who is in our hospitals, right? There is a little bit

of that and, then, there is a lot of your chronic players. And those are your players who are on Medicaid often, and those children may not be captured entirely by your routine vaccination schedules, just because everybody should get one every year, right? So, it is more than just what is in your routine schedule.

But I would have to go back through, to your point, Terry, just to confirm that 0038 -- I mean, I thought 0038 was the infant one, but I'm not remembering.

MEMBER POOLE-YAEGER: So, we have done -- again, you know, I have 23 Medicaid health plans -- we have done a lot of work around flu vaccination rates in our population. And we have looked at claims for flu vaccinations. And then, there is also a question in the CAHPS survey about, did your child get a flu vaccine?

I can tell you that the rates are vastly different. So, probably half of what is reported in the CAHPS survey is what we get in claims. So, I struggled with this for a long

time. Like how do we judge the flu vaccination rate of our population? The only thing what I worry about this one is I think it is going to be really hard. I don't know that the hospital -- you know, you're going to have to get into the hospital record to see if they offered flu vaccination. If somebody got a flu vaccine from their provider office report, they won't need one when they are discharged from the hospital. So, I just have a little concern about this.

I think flu vaccination is an important one. I'm not sure that that's the best one to pick out of all of them from my perspective.

But CAHPS, I don't know, CAHPS survey results could be one, right? Is that on the --

DR. MATSUOKA: So, CAHPS, the health plan CAHPS is on both the adult and child core set, but not all --

MEMBER POOLE-YAEGER: Not all questions --

DR. MATSUOKA: Not all plans are

reporting those to the states, and if a state is a fee-for-service state, they may not be administering it at all.

MEMBER POOLE-YAEGER: Yes, got it. Okay.

CHAIR ANTONELLI: Further discussion? Should we vote sometime --

MS. GORHAM: Sure. I just wanted to highlight, if you just scroll down a little bit more, some of your questions about feasibility and that type of thing, we did attempt to answer some of those questions, so highlighted in your discussion guide, and May just highlighted the bullet point. I think it is maybe one, two, three, four down, we talk about feasibility.

This measure was reviewed in our Health and Well-Being Project. So, we have a little bit of information from the Health and Well-Being Project and from those experts that sat on that standing committee.

And so, I know that this measure, the evidence for the measure is based on

recommendations from ACIP on routine vaccinations.

I would say that, just as you are thinking and deliberating, this measure did not fall into a gap identified in 2016, but that definitely doesn't mean that you can't consider it.

As far as the Health and Well-Being Committee, this measure was endorsed with reserve status, just because the performance is rather high. And so, kind of narrowing the performance gap was clinically significant, but they did not allow and they did not believe that narrowing the performance gaps was clinically significant.

But, again, we outlined for you just where the measure is currently used because it is in use now. So, that is on your screen.

MEMBER BENIN: Do you know, Shaconna, if they were able to identify that this was a problem, that the performance was high for children? Because my understanding is that, while the performance is high overall for

hospitals in the CMS IQR, I don't know that we know the answer for what that always looks like for children; that that in children may be different. I don't know.

DR. BURSTIN: We could check the actual submission form and see if they stratify by populations. I don't recall. I think they have tended to do race and ethnicity, but it is an easy enough question to try to get answered.

MEMBER BENIN: And the children's hospitals would not be submitting to that program anyway. So, you wouldn't have that data there. So, the only mechanism right now where you get this data is through U.S. News and World Report. This is where people put it.

So, I think we just have to think about what are our sources of how -- for children's hospitals, it is an ORYX metric, but the one place that it gets gathered and sort of looked at globally, if you will, is in U.S. News and World Report. There is not a real context for it in the other discussion. This may provide

such a context, the Medicaid side.

CHAIR ANTONELLI: About how long will it take to get the stratification data?

DR. BURSTIN: I'm not sure they would actually have enough data if children's hospitals aren't reporting it. So, CMS may not be the best source to find that out.

CHAIR ANTONELLI: Yes, because what I am grappling with is the inactive endorsement and reserve status with the NQF. Because if that decision was made on adult-only data -- okay. Okay.

Would you like to make a motion?

MEMBER BENIN: Sure. I move that we suggest adding this, you know, for CMS's consideration, to add this metric to the panel.

CHAIR ANTONELLI: Is there a second?

(No response.)

I don't see a second. I'll give people another minute or so, since Helen is distracting us.

(Laughter.)

Is there a second? Was that a hand? If you could speak, please.

MEMBER GREINER: I'll second, yes.

CHAIR ANTONELLI: Okay. So, the motion has been made to recommend 1659 be advanced to be part of the child core set, and it has been seconded.

Comments or questions before we proceed to a vote?

Amy?

MEMBER RICHARDSON: So, if I understand, the previous question is we don't have baseline data to know to what extent this is a problem we're trying to solve. Is that correct? Or pediatric data?

CHAIR ANTONELLI: We're trying to confirm that. That's what Andrea's belief is, and the staff is going to see if they can pull that up for us.

We could put this one on pause, go to the next one, and come back. I'm assuming we are talking minutes and not days. Yes.

So, Andrea, is that okay with you? Let's hold this motion on 1659. Let's move on to the next question. We'll come back to this one, and the staff will let us know the affirmation of Andrea's observation.

Okay. So, the next one is 2800.

MS. GORHAM: So, actually, I think our Chair -- we're telling people about using the mic, and then, I don't turn mine on.

Actually, our Chair Rich and Kim are our lead discussants for this measure.

CHAIR ANTONELLI: So, 2800 is NQF endorsement about screening for children and adolescents newly on antipsychotics. The measure steward is NCQA.

The description, I'll read it quickly. Percentage of children and adolescents 1 to 17 who have had two or more antipsychotic prescriptions and had metabolic testing.

The denominator is ongoing treatment, at least two prescriptions for these medications. There's no exclusions. It is administrative

claims data.

And we wanted to bring this forward for discussion in this group.

Kim?

DR. ELLIOTT: I agree. I think that this is an area, since we have been increasing our use of behavioral health medications, we have been really putting a lot more emphasis from a measurement perspective on behavioral health services in general. I think that this is an area from the future for these children to really do a better job of monitoring their metabolic conditions.

And it's an easy one to measure. It's prescription-based. Kids are already diagnosed, and it just should not be a challenging one. I think it would have a huge benefit to make sure those kids that are not having those things monitored actually have them monitored, so that we can make sure the long-term consequences of these medications don't impact their lives.

MEMBER ADIRIM: Yes, I was going to

say I support that this is a really important thing to improve on. And I see where, down to the clinical level, I know people have mentioned that before. Like how can the states use this to improve care? So, I definitely could see how this would be useful for that.

And I think, as pediatricians are more and more prescribing these medications and may not have the experience or education or training, or whatever, for these meds, that it would be important.

I think what I would want to know, because, again, to the theme of real estate, not that that's as big of an issue for me, but how many children would this affect and, within each state, what would be the number of children? Because for the diagnoses that children would require antipsychotics, it is like 1 percent of the population, you know, like bipolar with psychotic breaks. Schizophrenia doesn't exist in young children. So, yes, I would want to get an idea of the numbers of children affected before

making a decision.

CHAIR ANTONELLI: Do you have an answer? And also, is the measure developer on the line, if we need him or her? Do we know? They're not on? Okay.

Rachel?

MEMBER LA CROIX: I believe we had our plans report it last year. So, I am trying to pull up the file -- it's just taking a minute -- so that I can tell you how many folks we had eligible for the measure. But, once I have it, I'll let you know.

MEMBER POOLE-YAEGER: I can just give my gut concept. I don't have any numbers in front of me. But, in Medicaid, especially in foster care, the use of antipsychotics is quite a bit higher than in the overall population. So, I think this would be one of those things that would be disproportionately high in Medicaid probably.

DR. ELLIOTT: And also in the disability population.

MEMBER POOLE-YAEGER: Correct, correct.

CHAIR ANTONELLI: Terry?

MEMBER ADIRIM: Yes, but my concern within the foster care population would be about appropriate use of antipsychotics. So, that, I think, is the issue with that population. I think the appropriate use, you want to make sure that there's appropriate monitoring and all of that.

So, I'm really conflicted about this measure because I see its importance. I'm just concerned that the numbers would be small, that it wouldn't affect as large a population as some of the other measures.

DR. MATSUOKA: So, to Terry's point -- I'm curious to know Rachel's numbers, too. But while we're waiting, to Terry's point, we do have two antipsychotic medication-related measures already in the child core set. One is looking at the use of multiple concurrent antipsychotics to get to the sense of utilization and

appropriateness. The other one is first-line psychosocial care for children who are using these medications for a certain period of time, to try to get at, you know, is it an inappropriate substitution of medication for psychosocial care? So, we have those two in the core set.

We do have an affinity group that we have been running with around eight states looking at the issue in general, but, also, around the measurement of the issue. I am going to ask Renee to see -- we have some preliminary data from NCQA just from the plans that they are -- the core measure, like what the rate is of even just the utilization piece. And that might help to back into, of the subset for whom this might be appropriate, is there some metabolic monitoring going on?

MEMBER ADIRIM: And didn't somebody say -- this was maybe two years ago we had that person from Louisiana come and say that 40 percent of the boys in her state on Medicaid were

on antipsychotics? Am I like hallucinating? But it was some really ridiculous --

DR. ELLIOTT: I wasn't there, but, yes, I think that that is true.

MEMBER ADIRIM: Right, and that's why we put these measures on there, because it's inappropriate use of antipsychotics. It is really a huge issue.

MEMBER POOLE-YAEGER: Rachel has her numbers?

MEMBER LA CROIX: I do, and we required last year our plans to report on the use of multiple concurrent, and we also have them report on the metabolic monitoring. So, for the use of multiple concurrent antipsychotics -- and, of course, this is an inverse measure; we want rates to be low for this -- but across all of our plans we had 10,300 eligible members for the measure. And the weighted rate across our plans was 1.77 percent, so a relatively low rate, which is what we want.

And then, for the metabolic monitoring

for children and adolescents on antipsychotics, the total rate -- so, this is bringing together the three different age bands that are reported -- it was a total of 13,732 eligible members across the plans met the criteria for the measure. And our weighted rate across our plans was 37.77 percent. So, yes.

CHAIR ANTONELLI: Any other discussion?

Yes, go ahead.

DR. FOX: Well, I can just explain a little bit about the affinity group. As Karen said, we have our two measures, one of which is NQF-endorsed and the other one is not.

We had eight states, and many states actually use the whole HEDIS bundle, which is three measures. And so, there were several states that chose to look at metabolic monitoring because there's a disconnect. Either it's the subspecialty provider who does the prescription and, then, the PCP does the followup. There is a question about getting the labs back. Also, it's

hard to get people to go from a doctor's office to a lab to get blood drawn. They get lost in between. And so, there were multiple challenges, but they have chosen to work on that.

And California found they had a wide range of numbers of people; plus, they also had, if they only looked at blood glucose instead of lipids, there were many more people who got their --

MEMBER ADIRIM: So there's room for improvement?

DR. FOX: There is definitely room for improvement. I think the numbers -- that our NCQA friends are here now.

CHAIR ANTONELLI: If we can ask you to come up to the microphone, identify yourself?

We can come back to the -- terrific. If you can identify yourself and, then, jump in for the question?

MS. BYRON: Sure. Hi. I'm Sepheen Byron. I'm the Assistant Vice President, Performance Measurement at NCQA, and worked on

the Center of Excellence that developed these measures that we eventually adopted into the HEDIS health plan measure set.

And I apologize, I got here a few minutes ago, and I may have missed what the actual questions were. So, if you don't mind repeating?

CHAIR ANTONELLI: So, I think that we're riffing on the questions that Terry had raised about population size, potential room for improvement. But I think that we've actually had that data. So, I'm going to pause.

Task Force Members, do you need anything else to inform your thinking on 2800?

And please don't leave that seat because we will pull you back in for a different question.

(Laughter.)

But, focusing on 2800, any other question for the measure developer?

Otherwise, I am going to make a request for a motion.

(No response.)

Okay. Kim?

DR. ELLIOTT: I'd like to move that this measure -- I forget the number right now -- be added to the child core measure set.

CHAIR ANTONELLI: Is there a second?

MEMBER ADIRIM: I second.

CHAIR ANTONELLI: Okay.

MS. GORHAM: So, just as a reminder, because we have folks on the phone, we can hear you in the room, but they can't hear you if you don't use your mic. So, just a reminder to speak into your mic, please.

CHAIR ANTONELLI: Miranda?

MS. KUWAHARA: So, if we are ready to vote on Measure No. 2800, we will go back to trying to use the clickers. We believe we have resolved the issue. But, just to ensure that the clickers are working properly, if you could please use the test question, "Did you have coffee with your breakfast this morning?" And please direct your clickers in this direction.

We're still waiting on a few responses.

A new one coming down.

All right, we just got the 13th vote. All right, we should be good to go.

Again, this is Measure No. 2800, metabolic monitoring for children and adolescents on antipsychotics.

Should this measure be added to the core set? If you support, please press 1; if not, press 3.

Eighty-five percent of the 13 voting members voted to support this measure.

CHAIR ANTONELLI: All right. So, let's go back to the motion that's still on the table for 1659. I think we have an update to the questions that were raised about the influenza vaccine. But, I think, with the presence of NCQA in the room now, Andrea, would you like to just give us a quick summary, so that she can weigh-in?

MEMBER BENIN: I don't think it's an

NQCA measure, but I'm happy to. It's a Joint Commission measure. I mean it is an ORYX CMS measure, yes.

CHAIR ANTONELLI: Mine says NCQA. Okay. Okay.

DR. BURSTIN: If 1659 was the one we were talking about, which is inpatient influenza screening, which is not NCQA. That's CMS.

CHAIR ANTONELLI: Okay. So, it's a typo on the slide then? Okay.

DR. BURSTIN: They do the outpatient one by survey.

CHAIR ANTONELLI: Okay. Use the microphone, please.

MS. BYRON: So, the HEDIS measure, childhood immunization status, does have flu in it. That's for up to age 2.

CHAIR ANTONELLI: Right. Okay. Okay.

Debjani, you have something, I think, to report on, and then, I'm going to call for a vote on 1659.

MS. MUKHERJEE: So, it is a facility-

level measure, and it does include children and older individuals, adults, but it's facility level, so we don't have stratification, stratified data that was submitted to us. So, if you're a children's hospital, you will be submitting that data, but we don't have the sort of parsing.

MEMBER BENIN: But children's hospitals do not submit to the IQR. Adult hospitals with children's units would submit, but children's hospitals would not be submitting.

CHAIR ANTONELLI: Right, right.

DR. BURSTIN: She checked with the people who led the project as well as the submission form, and it only indicates disparities by race/ethnicity.

CHAIR ANTONELLI: Yes.

DR. BURSTIN: Nothing at all by age. And I think probably because they just don't have the data.

CHAIR ANTONELLI: Right. Okay.

So, the motion has already been made

and seconded on 1659.

Any further discussion before Miranda calls for a vote?

(No response.)

Go ahead.

MS. KUWAHARA: Hearing none, we will take it to a vote. Again, this is Measure No. 1659, influenza immunization.

If you would like to support this measure for inclusion in the core set, please select 1; if not, please select 3.

We are still waiting on one response.

Eighty-five percent of the 13 voting members voted not to support this measure.

CHAIR ANTONELLI: Okay.

MS. GORHAM: Okay. Measure 3154, informed coverage, is a CHOP measure, and I do believe they are on the line.

But we can continue. So, Andrea recommended this measure, and this measure is currently undergoing evaluation.

MEMBER BENIN: So, this metric gets

back to the issue that I really believe to be critically important right now, which is around access. And anything that we can to understand access in this environment and in this population is essential. And I think it is also essential that we position ourselves to be able to look at it over time. And this is another metric that can get us at that.

This metric is a little bit different in that -- and I believe that Jeff Silber is on the phone. So, I am going to let him actually explain it. But at its highest level, the idea here is that the denominator is patients who would be eligible for services, and then, the numerator is ones who actually get into coverage.

And so, this is a different type of metric than the other access metrics that we have. The other access metrics that we have are truly, I think, metrics of, once you have coverage, do you get services? And that is substantially relevant, but this metric may actually may become increasingly relevant as the

opportunities to cover children go down.

And while this metric may still have some kinks that are being worked out, especially given some of the lag issues and what happens over the next year or so, I think it's critically important to give the states the opportunity to be able to take a look at it and figure out if they can mount it, and what that would look like. And I don't think that delaying is in the best interest of the children that we serve here.

But I would like just to have, Jeff, if you don't mind explaining the metric in a little bit more detail, because I think this is a really critically important issue.

CHAIR ANTONELLI: Actually, Jeff, I don't know whether you're on mute or not, but we're not hearing anything.

But let me ask the Task Force members that are in the room, are you getting in the queue for after Jeff presents or do you have questions?

Deborah, do you have a question that

you would like to put out there for possibly Jeff before he goes?

MEMBER KILSTEIN: Not a question, just a comment.

CHAIR ANTONELLI: A comment? Do you want to do that before you hear his presentation?

MEMBER KILSTEIN: I am fine either way. I can either do it before or after.

CHAIR ANTONELLI: Okay. So, why don't we have you put that down?

Jeff, are you there?

(No response.)

Are you on mute?

(No response.)

He is? Okay.

MEMBER BENIN: Maybe there is someone from AHRQ who could take the discussion. I think Kamila is not here, but I don't know. Who has the -- I think the bottom line here is that the denominator is the patients who are eligible and the numerator is the patients who actually get coverage in the time period.

There are some nuances that they use, an appendicitis rate, to kind of adjust and double-check the metric. I was hoping that they could explain that part of it, but it is a way to pick a disease that has a similar -- you're going to show up for appendicitis. And so, whether you have coverage or not, you're probably going to show up. And so, how do you use the rate of coverage amongst those patients to double-check and to adjust for the overall rate that you're ending up with. So, it is a nuanced way to tackle this, but I do understand it to be feasible.

So, it would be good if there's anybody else who wants to jump in.

CHAIR ANTONELLI: Yes.

MS. GORHAM: All right. So, we have a representative from CHOP, not Jeff. But can you introduce yourself, please?

MS. SHAH: Hi. I'm Shivani Shah. I am a research assistant for Jeff Silber. He should be on the line, too, but I can try to

answer as many questions in the meantime.

CHAIR ANTONELLI: Is he for sure going to be joining, because I would rather not have to repeat a set of questions.

MS. SHAH: Okay. Let me just -- like give me one minute.

CHAIR ANTONELLI: Okay.

MS. SHAH: I'll go get him.

CHAIR ANTONELLI: Okay. You go ahead and do that.

MS. SHAH: Okay.

CHAIR ANTONELLI: And, Deborah, go ahead.

MS. SHAH: Okay, okay. Hi. Oh, yes. Here, here, here.

MEMBER KILSTEIN: I was just going to make a comment in terms of the importance of continuity of care as a quality issue --

MR. SILBER: Hi. This is Jeff Silber.

MEMBER KILSTEIN: -- and also as an efficiency issue.

MR. SILBER: Can anyone hear me?

CHAIR ANTONELLI: Jeff, stand by for a moment, please.

MR. SILBER: Okay.

MEMBER KILSTEIN: Based on some data that we have looked at, per-member per-month costs go down the longer someone's enrolled because of the benefits of the ongoing access to primary preventive care.

And there is an efficiency aspect of this as well, because if someone loses eligibility and, then, has to go back through the enrollment process, there is an administrative cost to re-enroll them.

So, we think that churn is an ongoing problem in Medicaid and CHIP, and is critical when you are looking at care for kids. And so, this was an important measure from our perspective.

CHAIR ANTONELLI: Thank you.

MR. SILBER: Can you hear me now? This is Jeff Silber.

CHAIR ANTONELLI: We can and the floor

is yours. Just give us a 20-second introduction, Jeff, and then, please go.

MR. SILBER: Okay. I'm sorry?

CHAIR ANTONELLI: Just introduce yourself and please give us your schtick.

MR. SILBER: Oh, okay. Okay. I'm Jeff Silber, the developer of the metric, the Director of the Center for Outcomes Research at Children's Hospital.

I've been on the conference call the whole time, but did not put my phone on mute. But, for whatever reason, I couldn't be heard. But I'm on a different phone now and apologize for your inconvenience.

Shall I go forward with the metric?

CHAIR ANTONELLI: Yes.

MR. SILBER: Okay.

CHAIR ANTONELLI: We would like a succinct description of the metric --

MR. SILBER: Okay.

CHAIR ANTONELLI: -- so that the Child Task Force members can be in a position to ask

questions --

MR. SILBER: Right.

CHAIR ANTONELLI: -- as we proceed to deliberation.

MR. SILBER: Sure. The metric-informed coverage uses appendicitis, a random event that isn't related to primary care or other health conditions, to help estimate the fraction of patients who are covered, or have insurance, divided by those who are eligible, which is often also referred to as the participation rate.

Informed coverage uses appendicitis patients because, if you develop appendicitis, you're going to be hospitalized. If you were eligible for insurance, we would see you in the MAX data. If you were not eligible, MAX data wouldn't pick you up. It is a claims-based measure.

And the development of the metric is based on claims data with the states that have adequate claims data in MAX to be able to be analyzed. And what we have developed is a way to

scan the data and look for adequate data and, then, be able to make this estimate.

We compare our measure to the current metrics that are out there now, which, No. 1, duration, which is looking at children who have been insured, then drop off the rolls, and then, when they come back, duration starts at time zero and sees how long they stay on the rolls.

The problem with that metric -- and we've talked to stakeholders about this -- is that kids that are always enrolled during a time period don't show up in the duration metric. So, that's a major problem of duration.

The other measure is the participation ratio by COO. That metric has a problem in that it assumes that, if you have ever had insurance during a period, you're always eligible and, therefore, that is the rate that they give. And it also doesn't do many adjustments for aging out or for partial time periods in the time period of analysis.

So, we developed this metric based on

appendicitis. The big advantage is that it looks at everyone who could possibly be eligible because they would be ending up being hospitalized for a random event of appendicitis. And then, we look to see whether they did have insurance before they developed their appendicitis. In this way, we are not having those gaps that the other measures have.

Furthermore, what we have done is utilized this and developed the package with a way to look at the statistics around it, so that it is easy for the states to get their variances and their confidence intervals and do the statistics that they need to compare themselves to the rest of the states or to other individual states.

I'll stop there and address any questions you might have.

Actually, I just want to mention one other thing, which is we use as a gold standard for validation the American Community Survey. And that survey, our measure is better

correlated, and that is in the documents that we have provided. It is better correlated than any of the other two metrics, be it the continuity ratio or the duration metric.

So, one of the strong aspects of our measure is that it is better correlated with actual survey data, which would get at that missing population. And secondly, the error rates are lower in our measure versus the survey than the other two measures. So, I just wanted to point that out, too, and I will stop now.

CHAIR ANTONELLI: Okay. Comments or questions?

DR. BURSTIN: At this point, it is still going through the evaluation of the Pediatric Standing Committee. It went through. It was heavily reviewed for everything except there was a lack of consensus around reliability of the measure. In fact, one of the major concerns was this question of whether it might be a great self-assessment tool for states to improve coverage rates. The question was, is it

an appropriate measure for accountability? Again, this is a state-level discussion, so take that as it may.

And I think there was some concern about -- and since you have states here -- the ability of states to accurately calculate the measure, since it was pretty complex. So, experience with using it for this discussion might be helpful.

MEMBER ADIRIM: Is it NQF-endorsed?

DR. BURSTIN: It's in process. Comment period closes May 31st. There is a post-comment call with the Pediatrics Committee on May 31st. So, it's still in process.

MR. SILBER: I wrote an in-depth response to the concerns. One of the concerns was that poorer states might have a different measure than richer states, and I showed that that wasn't something that would throw off our measure.

Secondly, there was a concern that a lot of states were clustered. And what we showed

was that there is a distribution of states in terms of their informed coverage, and we outlined that in the new documents that were sent out, such that we can identify large clusters of states that are way below average and others that are above average, and many in the middle.

So, we can differentiate states as groups, but, also, state-by-state. About two-thirds of the states can be distinguished from other states, but it just so happens that some states have very similar informed coverage, but many don't. There's enough variability, such that you can compare state-by-state and you can also compare states to the group or states to any segment of the state populations.

CHAIR ANTONELLI: Jeff, this is Rich Antonelli. I'm the Chair of this group, but I'm stepping out of the Chair to ask this technical question.

So, for hospitals that are near boundaries, borders, state borders, if you will, -- and I'm thinking about CHOP, but it could

apply pretty much anywhere -- if the child gets admitted for that emergent event, like in appendicitis, does that do anything to the data?

MR. SILBER: Yes, the data is based on what the individual states submit to the federal government. So, it is based on MAX data. So, when you do a state analysis, you are looking at patients who were insured in that state. So, the bills can come back to that state if they were seen out of state, say a New Jersey patient seen at CHOP, but it is dependent on the quality of the state data.

CHAIR ANTONELLI: Thank you.

Terry?

MEMBER ADIRIM: To Andrea's point, I really think this addresses a very critical concern, child health insurance coverage, continuity of child health insurance coverage. But I think I have a little bit of trepidation about it not being quite ready yet for being put on the core set.

I mean, my thinking is I would

advocate for it being looked at next year to be put on the core set. I'm sort of -- something like that, because, you know, I think it needs a little more work before we --

DR. SIBLER: Could I ask in what way? Because we might have addressed it in the memos that we -- I don't know if you've got the memos that we were addressing --

MEMBER ADIRIM: Sure. Well, it's --

DR. SIBLER: Yes?

MEMBER ADIRIM: Yes. No, it just doesn't seem like all the testing and the considerations and all that have been done yet. I think it's a great measure. I think it is an important --

DR. SIBLER: I think they work, but I --

MEMBER ADIRIM: Yes, well, I'm not going to argue with you, but --

DR. SIBLER: Well, it's just, right now, I don't hear a reason. So, it would be nice to hear a reason.

MS. GORHAM: So, just to think about just to state history, we discussed this measure last year as well. So, this was a consideration. But you all deliberated and decided not to recommend the measure. If you decide to recommend this year, you can recommend with conditional support pending NQF endorsement.

Again, CMS is in the room. They are listening to the conversation. It is up to them whether or not they want to add it to the core set now or later.

But, just a matter of history, we did discuss it last year. We decided, as Terry said, to wait. You all decided to wait until it went through NQF endorsement. It is still going through NQF endorsement. If you would like to join the post-comment call on May 31st, you're welcome to do that as a public member, just to listen, and then, you also can, you know, respond during the public comment period.

CHAIR ANTONELLI: Roanne?

MEMBER OSBORNE-GASKIN: So, I would

just like to clarify, because this is an important thing that we are trying to look at, coverage for kids. But the coverage, the limits you are going to use appendicitis, if I got it right, but the limit is 2 to 16, whereas you're trying to look at coverage from zero to 18, right?

So, I'm trying to figure out if using that population -- and maybe I'm not getting it right -- but I assume that you are using that population to sort of base your measurement on, but it is still not -- it is going to leave out a couple of years before and after. I mean, are we okay with that?

DR. SIBLER: May I explain or -- may I explain?

CHAIR ANTONELLI: Yes, Jeff, go ahead.

DR. SIBLER: It doesn't, the appendicitis metric uses 2 to 16 because, first of all, appendicitis doesn't happen in the earlier group and, secondly, that we didn't want to have the states worry about survival

statistics by going up to the edge of 18.

But the metric uses, in its data it uses all kids for all diagnoses, not just appendicitis. It only uses the appendicitis to weight the two assumptions about the populations, whether they were presumed to be eligible or presumed to be ineligible. So, the appendicitis metric itself is used as a way to inform the entire population's coverage or participation.

It's not only using the data from appendicitis. It uses the data from all the kids, but it weights all the kids based on what we get from the appendicitis sample, which is a very random sample over that population. So, it's not only using the kids with appendicitis to come up with that result or any of the subanalyses that we put into the report.

So, we make two main assumptions. You can either be saying that the kids are almost all presumed eligible or presumed ineligible. We still get the rates of their coverage in those two groups. Then, we weight that by the

appendicitis sample, but we are using the whole population in describing the state. And all the numbers from all the kids are used in getting that overall coverage, informed coverage rate. So, it uses appendicitis, but it's not just based on appendicitis.

CHAIR ANTONELLI: Thank you.

DR. SIBLER: And it is far better correlated than the other measures with the gold standard of the community survey.

CHAIR ANTONELLI: Amy, on my left?

MEMBER RICHARDSON: Thank you.

So, I'm curious, as a newcomer, from a CMS perspective and from an NQF perspective. This is an important public policy issue. Everything else we have talked about reflects some dimension of quality of medical care, not extent of insurance coverage. Those two may be related, but they're not the same.

So, I'm curious about the notion of including this public policy measure in the core set. So, maybe I need to understand how it would

be used if it ends up in the core set.

CHAIR ANTONELLI: Karen?

DR. SIBLER: Do you want me to --

CHAIR ANTONELLI: No, Jeff. I think, Jeff, as the Chair, I'll call when we need you to weigh-in, okay?

DR. SIBLER: Okay. Thank you. Thank you.

DR. MATSUOKA: So, I'm trying to call up the actual statutory language. I want to say, though I will confirm this, that there is some language in CHIPRA that alludes to the importance of continuity of coverage as an important indicator of how we're doing as a program.

So, it's true that most of the core set measures deal with quality of care, but, you know, as we've talked about before, we also think about access as an important dimension of quality of care. You can't get good quality of care if you don't have access to that. And one way to think of this might be that continuity of coverage is an important driver of access.

So, how we would use this would be in the same way that we would use every other core set measure, which is it would be voluntary. States could either report it or not. We would do some technical assistance with the states to ensure some consistency between the states that are reporting the measure and, then, publicly report the information.

And then, to the extent that there's interest, we might do some targeted technical assistance like we have done with the antipsychotic medication stuff. But, in general, that's kind of how we use the measures.

CHAIR ANTONELLI: Amy?

MEMBER POOLE-YAEGER: Hi. Jeff, this is Amy Poole-Yaeger. I'm with Centene, which is a large managed care organization.

And I'm just curious. Just to make sure I understand the concept of this message. So, you're going to get at the people -- because somebody had asked, well, can't we get that information? But I can look at people that I

know are eligible, you know, that have had at least one month of eligibility, and see how they have had gaps. But this is going to look at maybe somebody that -- this is going to tell you who should have had eligibility in certain months, right, and then, did they have it? And sort of give a look outside of what we could see just in our data, is that correct?

DR. SIBLER: Right. It uses, it's a point in time to estimate the overall time over a time period that someone was participating when they were eligible. But it's a point in time. So, we are saying, at the point right before they developed appendicitis, was that child participating with coverage? We knew they were eligible because we wouldn't have seen their records for their appendectomy in Medicaid unless Medicaid paid it, meaning they were covered.

At that point in time we show is proportional to or equals the number of months someone is on or off during a given time interval. So, it is talking about a

participation rate over a time interval. It is based on a point-in-time estimate for all the kids in the state that are developing appendicitis and, then, for all the kids in the state that did or did not have appendicitis.

So, it is telling us whether someone's participating and in the system when they are eligible. If they are often not in the system and not participating, then the point-in-time estimate would be lower. If they are often participating when they are eligible, then we would have a higher estimate for our coverage rate.

CHAIR ANTONELLI: Okay. So, I want to follow on the paradigm that we had yesterday and continued. I want to ask the Task Force, does anybody want to submit a condition?

No? Again, I apologize because of the gaps. Has this been motioned and approved? Yes. So, why don't we go ahead and do that? Make your motion.

MEMBER BENIN: All right. So, I move

that we suggest including this in the panel, this metric in the panel.

CHAIR ANTONELLI: Okay. Is there a second?

MEMBER KILSTEIN: I'll second.

CHAIR ANTONELLI: Second. Okay.

Any further conversation about the motion? Is that a yes?

MEMBER BENIN: Can I make one more comment? Or you don't want to? You want to move on?

CHAIR ANTONELLI: Well, I was actually going to revisit, now that the motion has been officially made and seconded, I want to come back to the question about whether people would like to consider a condition attached to it, so that this way, we know whether we are voting on it up or down.

But do you want to go ahead?

MEMBER BENIN: I mean, I would just make two additional comments. One is that this is a PQMP metric. You know, we have a couple

more of the PQMP metrics coming up, but the premise of the PQMP program was to generate metrics that we could use for children and for pediatrics. And this is one of those, and it has been pretty robustly developed, although it is still going through the process, obviously.

I would also say that, I think it was Karen, you know, just outlined a process by which using this metric could be very practical, in that adding it to the panel, allowing the states that could muster it to pick it up, and then, next year we would be here and we would have more information, or two years from now we would have more information. I mean, the problem is we won't have any more information for two years from now. And so, it would take a couple of years for us to get that information.

CHAIR ANTONELLI: Okay.

MEMBER BENIN: So, getting it into the cycle now enables us to have that information a little bit sooner.

CHAIR ANTONELLI: Okay.

MEMBER BENIN: So, that was my additional comment.

CHAIR ANTONELLI: Okay. Thank you.

So, Deborah?

MEMBER KILSTEIN: Yes, I would suggest conditional support, just because it is pending NQF endorsement.

CHAIR ANTONELLI: Okay. And what would the condition be? NQF endorsement, period?

MEMBER KILSTEIN: Yes.

CHAIR ANTONELLI: Okay. So, can you state that motion, please?

MEMBER KILSTEIN: Yes. I would place conditional support pending NQF endorsement.

CHAIR ANTONELLI: Is there a second to that motion?

MEMBER ADIRIM: Second.

CHAIR ANTONELLI: Okay. I will allow one minute to discuss, if people want to speak about the condition and, then, we are going to move to a vote.

Any issue? I'm talking about the

condition now. Yes, okay.

MEMBER ADIRIM: No, and the reason why I support that is that, unlike other measures -- because I don't think to be on the measure set you have to be NQF-endorsed. But this is a new measure, and I think having it looked at to make sure that it is measuring what we want it to measure and that it is reliable, I think would be important.

I think it is, I agree with Andrea this is a very critical concept, but I would like to see it, before we let it take up the real estate, I would like to see it fully endorsed.

CHAIR ANTONELLI: Okay. Thank you.

So, let's proceed. And, Miranda, thank you for anticipating this slide.

So, the vote is there. So, walk us through, please.

MS. KUWAHARA: We are voting on Measure No. 3154, informed coverage. We are asking if this measure should be added to the core set. You have two options, conditional

support, the condition being NQF endorsement.

If that is your choice, please select 2; if not, please select 3.

(Voting.)

Eight percent of the 13 voting members voted to support this measure; 54 percent voted to conditionally support this measure, and 38 percent voted not to support this measure. But, because it rolls up, it is conditionally supported.

CHAIR ANTONELLI: Okay. So, we're all set?

Did you want to weigh-in?

MS. GORHAM: It's fine.

CHAIR ANTONELLI: You're okay?

MS. GORHAM: Yes.

CHAIR ANTONELLI: Okay. Right. Jeff, thank you for being available.

All right. Let's move on, please.

MS. GORHAM: Okay. So now, we're at Measure 3166, Antibiotic Prophylactics Among Children With Sickle Cell Anemia.

I'm sorry. This is horrible. I'll start over.

Measure 3166, Antibiotic Prophylactics Among Children With Sickle Cell Anemia, was recommended by Rich and Terry. So, I will turn the floor over to you. Again, we have 3166, the specifications as well as the algorithm on your screen.

CHAIR ANTONELLI: Terry, why don't you go first? Okay, I'm happy to do it. Yes, take a cleansing breath. I can do it.

MEMBER ADIRIM: This measure is a fairly recently-endorsed measure. It is a key metric measure, and it covers children age three months to five years, prescribed antibiotic prophylaxis for 300 days out of a year.

And the reason why I thought this would be a good measure is that sickle cell disease was identified as one of the gap areas. I know we recommended the transdoppler one last year. But, since then, I've talked to our hema docs regarding this. And this is, you know,

within our population, we probably have a higher than an average than in the commercial plan population.

Antibiotic prophylaxis has been shown very clearly to reduce, to eliminate the incidence of infection and sepsis. And so, even with vaccination, it is still considered recommended, according to the CDC Practice Guideline from 2014. So, I thought that this would be a measure that we should consider for recommending to go into the core set.

MS. GORHAM: Can I make one correction? So, the measure is not yet endorsed. It is not finalized. It will not be finalized until June. So, the Standing Committee recommended endorsement, but it has not finalized that.

MEMBER ADIRIM: Okay, but a previous one was, right? And this was a change or something? No?

CHAIR ANTONELLI: This is the second measure, the transcranial ultrasound last year.

MEMBER ADIRIM: All right.

CHAIR ANTONELLI: But, this one, yes, this one is not yet ready for -- I thought I missed a memo. All right.

MS. GORHAM: But we do have the developer on the phone.

CHAIR ANTONELLI: Yes. So, the developer is on the phone. I guess I will weigh-in as one of the people that wanted to bring this forward.

Sickle cell disease is a high-priority gap area. The population affected by this is significantly at risk for disparate outcomes. This intervention is about as inexpensive as you can get. It's a secondary prevention, to be sure.

The question had been raised about, you know, does the existence of pneumococcal vaccine make a significant impact? The answer to that is that it is not definitively curative, which is why this is still an issue that we need to look at.

So, those are some of the reasons that I wanted to bring this forward as well.

We can talk at length and/or I can have the measure developer step in.

There is an evidence base for this that antibiotic prophylaxis has a very beneficial impact on this at-risk population.

Are there any comments from the Task Force before I ask for a motion?

Amy?

MEMBER POOLE-YAEGER: I just had a question. And again, I think it is a great measure. I am worried a little bit about the denominator size in the states, either because, as you look at how many sickle cell patients you have, and now you are taking away the three to five year-olds, you know, whether you're going to get to such a small number in many of the states that it is not going to be relevant.

I can just tell you, from our perspective, we have trouble with that, even looking across 23 states, although it is just a

portion of the population, not the whole state population. So, I just wanted to bring that up as a question for the states and if that would be a barrier to using this one.

CHAIR ANTONELLI: Okay. Okay. Would our CMS folks like -- is there something that you can add to that point? I don't want to put you on the spot. But, to the degree that you've got a federal view of an important condition that may have a small-ish denominator, does that generate any concern from your perspective?

DR. MATSUOKA: So, for the transcranial doppler, it is one of the ones that was recommended last year, but we didn't accept. One is, of course, parsimony, the overarching thing. So, if we are going to measure something, you know, what comes out in exchange? I think that, factored into the ones that we took versus the ones that we didn't.

But this issue of small "N's" did come up as part of that discussion, as well as the geographical variation. So, you know, our ideal

would be that the states that report on this measure -- you know, as many states as possible report on the measure. That, then, also, the implicit assumption is that, you know, the prevalence of any given condition is somewhat uniform across the states. So that all 50 states and territories might want to report on it.

And so, we weren't sure about absolute numbers in general, but, then, also, just the geographic spread state by state. It is one of the reasons why we are really interested to see what you guys come up with as part of the PQMP phase two grant. Because one of the things we want to think about is, what is the impact of potential small "N's"? Given that this is an area that is important to measure, what do we do about the fact that there are potentially small "N's," that the "N's" might vary state-by-state? And what does that mean for measuring it at the state level?

CHAIR ANTONELLI: Thank you.

So, is your card still up? Okay.

Terry?

MEMBER ADIRIM: Yes. No, just Amy and I were talking about this before. So, I was very surprised at how small the denominator, the "N" was, maybe because I practice in a children's hospital in a very urban area. I don't know. So, we see a lot of sickle cell.

So, that is something to consider, and I think we need to weigh the importance of this measure and being a priority condition. I think we should think about that.

But I think, also, additionally, based on conversation that we have had over the last two days, I mean, it sounds like states really want measures where they can make an impact and where there can be quality improvement. And I think this is one of those areas. But, anyway --

CHAIR ANTONELLI: So, is there a motion?

Ann, did you have a comment?

MEMBER GREINER: A question. So, I know we started off with 27 measures in the core

set for children. And I'm just wondering where we are now in terms of our count. I don't know if it is easy to find in terms of what we've added and what we've taken away.

MS. MUKHERJEE: So, we are still at 27 because we make recommendations. Until CMS/HHS takes and makes changes, we will still be at 27.

MEMBER GREINER: Right. No, I do understand that distinction. So, I wasn't clear. I meant in terms of what we're recommending. Obviously, then, CMS makes their decision.

MS. GORHAM: We're at four right now.

MEMBER GREINER: Four --

MS. GORHAM: Four recommended, but we also removed, and what we will be sure to do at the end, once we make all of the recommendations, is put a slide up.

MEMBER GREINER: Yes.

MS. GORHAM: Because what we will, then, ask the Task Force members to do is prioritize and rank, so that we can say to CMS that the Task Force made these recommendations

and they think they are important in this order.

MEMBER GREINER: Yes. I guess it's just a comment that, you know, these are really important discussions. And after a while -- and I'll speak for myself -- you do begin to get lost in how many are we recommending that are added and removed. And just thinking holistically about the number that practitioners are reporting.

CHAIR ANTONELLI: Does anybody want to make a motion?

MEMBER ADIRIM: I guess you're looking at me. Yes. I move that we recommend this measure, whatever number it is, 3166, to add to the child core set.

CHAIR ANTONELLI: Is there a second? I'll second.

Any conditions that somebody would like to propose to the motion on the floor for 3166?

And remember, it is not NQF-endorsed yet. So, I'll go ahead and put in a condition

pending NQF endorsement.

Is there a second to that motion?

MEMBER GREINER: Second.

CHAIR ANTONELLI: Okay. All right. So, Miranda, we have 3166, if you can take us through that, and be mindful that conditional support, do not support. You can vote for support, but there is a condition attached. So, really, you're voting for either number 2 or number 3. Okay?

MS. KUWAHARA: That's right. So, we are voting to recommend No. 3166, antibiotic prophylaxis among children with sickle cell anemia to the child core set.

Please select 2 if you would like to conditionally support this measure for inclusion with the condition that it receives NQF endorsement. If you would like to not support this measure, please select 3.

(Voting.)

Fifty-four percent selected to not support this measure, and 46 percent selected to

conditionally support this measure. We had all 13 respondents, that's correct.

CHAIR ANTONELLI: Okay. Thank you.

We're moving forward. If you can advance us maybe when you get a chance?

This is not an NQF measure that we're looking at. So, there is no number attached. It's emergency department visits potentially treatable in primary care.

The measure steward is the New Hampshire Department of Health and Human Services. I presume that somebody from New Hampshire is on the line.

MS. STEWART: Yes, Andrea Stewart is on.

CHAIR ANTONELLI: Okay. All right.

So, we want to bring this up for discussion. The description here is ambulatory emergency department visits for conditions potentially preventable and treatable in primary care settings per thousand member months by age group. Administrative claims, the data source.

There's no exclusions, and it is being used right now in New Hampshire. And we wanted to bring it to the Task Force for this discussion.

If there are no immediate comments or questions, I'm going to hand it off to Dr. or Ms. Stewart to tee this up a little bit more.

So, seeing no -- oh, I do see a card. No, I don't see a card.

Okay. So, why don't you go ahead and describe the measure a little bit. Be as succinct as possible, please, so that the Child Task Force can formulate its questions.

MS. STEWART: All right. Essentially, we use this to assess inappropriate ED utilization. We're able to easily use this compare across our managed care plans, across age groups, across geography, different breakouts. We are also using it as part of our delivery system transformation waiver. We are using it to assess in determining incentive payments for that particular program.

In terms of the background on this,

for New Hampshire, it is basically six times more likely for a Medicaid member to inappropriately use the ED than it is for a commercial insurance patient.

We do have the diagnoses. There is a bit of an elution on the diagnoses that we use for this. We started with the algorithm that NYU Wagner developed that helps to classify ED utilization. We, then, for about the last 10 years, have been looking at our own claim data and comparing inpatient utilization versus primary care for those diagnoses.

Also, Dr. Watts, who is not able to be on the call today, is our chief medical officer. And she's got 10 years as an ED doctor and was able to do a clinical assessment of what we utilized for this measure.

We also even took the step of removing some diagnoses from the list, basically those where a member might go to the ED with a perceived problem that by the time they are discharged has been discovered not to be the

case. The examples of those would include anxiety, chest pain, stomach pain, things like that.

CHAIR ANTONELLI: Okay. Thank you. Open up for any comments or questions.

Deborah?

MEMBER KILSTEIN: Just a question. I know a number of states have been looking at this issue, but I assume they have all developed individualized measures on how they are using it. Some are actually using it for payment or pay-for-performance. And I don't know, by choosing one measure over the other, if it is going to cause issues for states that are using a measure.

CHAIR ANTONELLI: Karen?

MEMBER KILSTEIN: Can any of the state help?

DR. MATSUOKA: Yes, I was hoping that Rachel would be here to answer, and maybe we will make sure to ask her when she comes back.

But I want to say that the process by which we arrived at this measure was that we

reached out to the Medicaid Medical Directors Network to say, first, what do you think are the measure gaps, and some of you have identified a measure gap; how would you propose to fill it?

And this is the measure that they put forward. So, at some level, the Medicaid Medical Directors, their representatives, if they had a concern with it, they didn't voice it.

But now that Rachel is here --

MEMBER LA CROIX: Yes.

DR. MATSUOKA: So, the question on the table is, one of the Medicaid Medical Directors from New Hampshire -- well, we reached out to the whole network of Medicaid Medical Directors to say, what do you think the measure gaps are and, if there are gaps, what would you put forward to fill it?

This is what that network put forward, which is the preventable ER visit measure that they are using in New Hampshire. So, the question that Deborah put forward is, you know, we know that this measure is probably used by

many states, but may be defined in different ways by different states. And so, if we were to adopt this particular specification, what would that do to other states? And so, I gave my input, but, really, I want to hear what you have to say.

MEMBER LA CROIX: No, I'm looking at preventable events in general, not just emergency department, as something that has become a priority for Florida Medicaid at least. We've started looking at it using the 3M software. And so, we have been using those algorithms and running it through those, rather than having a separate measure like this.

And through that, we have been looking at emergency department admissions, readmissions, and ancillary care. So, we have been starting to try to look at a few different things like that as kind of outcome measures.

So, we definitely would agree with the importance of this kind of measure, but I would have to look in more detail at the specifics around it to see whether that would be something

that would work well with some of the other ways we're looking at this data.

MEMBER POOLE-YAEGER: Hi. This is a question for the measure steward. You mentioned looking at the NYU algorithm and, then, changing. I had looked at the NYU algorithm as well from a pediatric perspective. A lot of those algorithms are based on adult ED visits. And so, when you look at PD conditions on there, it didn't make a lot of sense to me.

So, can you just explain a little bit more? Like was it pediatric-based when you looked at those diagnosis codes? And, you know, explain that a little bit more.

MS. STEWART: I think one thing that we need to point out with this measure is that we actually do use it across adults and children. So, we realize that this has been selected for discussion for the child core set, but it really does apply to both.

MEMBER POOLE-YAEGER: Thanks. Yes, I think, again, from my perspective, the devil's in

the details, in the codes that you pick. At least from my perspective -- I don't know; Terry may have some comments -- but it's different in kids sometimes than adults. And so, I would love to have a pediatric-specific one, if we were going to use in the child set.

MEMBER ADIRIM: Yes, I think your point is well-taken. I think we might have a different set of conditions or a different bar for emergency department visits than in an adult world.

I think this measure gets somewhat indirectly to access. You know, so it would be like one of those measures measuring access to care to primary care, but maybe not, because, supposedly, now we have more access to primary care; we have Patient-Centered Medical Home. And yet, ED visits go up.

So, I'm sort of hesitant to want any measure around ED visits at all for that reason, because it is a tough measure because, then, it is often, as somebody mentioned, applied for

value-based purchasing programs and incentives, and things like that. So, yes, that's all I would say about that.

MEMBER BEATTIE: So, I am just reiterating with an emphasis from Washington state what Amy was saying. I worked on a task force when I was there with our Medicaid department, trying to establish a metric just like this just for the state, where we, then, would track each of the healthcare systems and adjust their reimbursement based on their ability to achieve this. And the devil is truly in the details.

Before I could endorse a measure like this, I would have to be able to look at the exact list of what is on the list. And I am not familiar with the NYU criteria. But I can say, when we tried to get to that, we actually settled on something in the state that didn't involve this specific type of a metric, because it was just too hard to say that, based on a code, you should or shouldn't be seen in a particular

setting because there are so many other factors. And it just depends, and especially in kids it depends.

And I think that when you move towards more and more of our patients being under a managed care model with a per-member per-month, you know, ACO-type model, that indirectly addresses this because the systems are incentivized to direct the patients to get the care at the appropriate location.

MEMBER ADIRIM: Yes, I was just going to add, I support what you are saying. In our health system, people insisted -- and I was neutral on it -- but they insisted on including a measure, and it is not a real measure, but just, basically, how many kids had ESI 1 or 2 coded, and that those were assumed to be ambulatory care-sensitive kind of visits.

So, there's all different viewpoints. There's all different ways that you can measure this. And I know people who are payers are really looking at this, but there's a lot of

issues around child visits to emergency departments.

MS. STEWART: This is Andrea Stewart again. We did submit the list of ICD-10 codes that we utilized for this measure when we sent the information to May back in April. And I don't know if anyone has access to that list.

CHAIR ANTONELLI: To whom did you submit the codes?

MS. STEWART: It was part of the document that we emailed to May when we sent the NQF MAP Measure Form. It was the last section of that document. It starts on page three and goes for about seven pages.

MS. GORHAM: Can you speak to the child-specific codes? We are looking for the document that you're referring to now.

MS. STEWART: Okay. We have, let's see, we've got conjunctivitis. We've got a whole slew of ear-related diagnoses. Oh, we've got the sinusitis. We've got tonsillitis. We've got other respiratory conditions. We've got nausea

and vomiting, a number of pain-related diagnoses. I'm just trying to think kind in general high-level groups. Asthma. Diaper dermatitis is one of the very specific ones.

MEMBER BEATTIE: Do you want me to go ahead? So, a number of those diagnoses that you are mentioning have a very broad range of presentation and would appropriately -- for any one of those, I could give a scenario where that may be the diagnosis, but would be appropriate for a kid to be in the ED.

Specifically, tonsillitis, I recently had a patient whose primary diagnosis was tonsillitis, but ended up expiring from sepsis within 36 hours. So, had that kid presented to the ED instead of an ambulatory setting, there might have been a different management on the initial presentation.

So, I'm just going to have a real challenge in using this as a quality metric. I think there are just way too many variables, and there is a better way for Medicaid systems to get

at the outcome they are trying to get, which is appropriate destination care.

MEMBER POOLE-YAEGER: And I'm just going to comment that I completely get -- I mean, again, we struggle with this. I know it is the number one measure that the Medicaid Directors ask for. We are all trying to get at the answer to this question, but I think probably every state has a different way of doing it, because it is so hard to figure out.

And I will give another example. You know, upper respiratory infection in a 10 year-old may not be bad, but in a two month-old it is. And so, I have never seen an algorithm that kind of does enough in pediatrics to make me feel comfortable from a clinician perspective that it is getting at the right thing. So, if that helps --

MEMBER ADIRIM: Right. And just very briefly, I agree with everything that is being said here. I think the problem I have with this is that I just don't see interventions to change.

You know, I work in an emergency department. I still work shifts every month. And 80 percent Medicaid, and you can teach them, you can talk to them; it won't change anything. In fact, they don't know the difference between the ER, their primary care doctor, and the urgent care.

So, I just don't see interventions that are necessarily going to change this. ACA was supposed to be the intervention to reduce emergency department visits, and they went up.

So, I think it is important that we follow this and that we look at this and people research this, but I'm not convinced that there is a lot of state -- well, anyway, sorry.

CHAIR ANTONELLI: So, I would like to call the question. Does somebody want to make a motion?

Amy? Mic, please.

MEMBER RICHARDSON: I move that we not adopt this, recommend this measure for addition to the child core.

CHAIR ANTONELLI: Is there a second?

MEMBER BEATTIE: I'll second that.

MS. GORHAM: So, there is no need to vote on this measure then.

CHAIR ANTONELLI: Yes.

MS. GORHAM: We can move to the next one. The next set of measures are actually the FECC measures, the measures, that family experience with coordination of care measures. The measure steward is the Seattle Children's Research Institute.

And so, the lead discussant for this measure is Terry. I know that Rich wanted to say a few words first.

CHAIR ANTONELLI: Thank you.

So, first, a disclosure. I was on the Delphi panel that led to the formation of the FECC. But, just to be clear, we weren't putting the questions or measures together. The Delphi panel was basically asked, what does care coordination look and feel like? So that they could eventually lead to that. So, that is my disclosure.

And then, I also want to really do some ground rules here. The National Quality Forum doesn't endorse surveys. What it does is it puts forward measures. So, there are a lot of questions, all of which roll up into the FECC.

And what I am going to ask Terry to do is to talk about them really and, if you will, en masse. And then, we will get people to react to them, okay, just for the sake of time management.

MEMBER ADIRIM: Okay.

CHAIR ANTONELLI: All right. Terry, take it away.

MEMBER ADIRIM: I get it. Good. I'm an ED doc. I'll talk in bullets.

So, the reason why I recommended this set be considered by us for inclusion in the core set, there's several reasons. This measure set came to mind when looking over the high-priority gap areas. This fits several of those high-priority gap areas, including care coordination, social services coordination, care coordination for conditions requiring community linkages,

targeting people with chronic needs, patient-reported outcome measures.

So, I really thought that this hit a number of the high-priority gaps. It is a PQMP measure from one of their Centers of Excellence -- the Centers of Excellence which create measures for us to consider for the child core set.

The set of measures are 10 measures. It is based on a survey of families. It is family experience with care coordination. The denominator is elucidated by a pediatric medically-complex algorithm which is an evidence-based tool to identify medically-complex children.

So, the target population is medically-complex children, which for state Medicaid agencies, as you know, are high-cost populations. So, it targets that population.

And of the 10 measures that went up for endorsement, 8 of them were endorsed. And you can see it yourself under the list of measures, but it hits multiple areas for care

coordination for children with special needs or medically-complex children.

So, I really think it is important that we do consider parsimony, but you need to balance that with generating stretch goals. And somebody else used that term. I think Lindsay mentioned that term. So, having some stretch goals, looking at our core set, are we addressing all the needs of this population? And considering a measure set that may be more measures than you would like, but I think really hits areas that we have been talking about for the last several years that we would like to have. I will say that this measure set is an evidenced-based, very well-done measure set.

So, I know that one of the representatives of the measure developers is on the phone who could probably speak better about what the measures specifically are. I believe her name is Layla, is on the phone, in case you have questions.

So, I just wanted us to consider this.

CHAIR ANTONELLI: Okay. Open for comments and questions.

Deborah?

MEMBER KILSTEIN: Yes, my question is the child core set already includes CAHPS, which is a fairly extensive survey. So, this would be adding another, a second survey, which is pretty intensive. Is there no way that some of this can't be put into CAHPS as an additional CAHPS question versus a separate survey?

MEMBER ADIRIM: This is a completely different survey, hits a different population. The CAHPS survey, my understanding -- and you guys correct me if I'm wrong -- is for all children, as opposed to this particular measure set that identifies medically-complex children within Medicaid. So, it is a different measure set.

I don't know if somebody more --

MEMBER KILSTEIN: Isn't there a way that we could do a subset like a -- and additional CAHPS questions that would --- where

we, for the subset, ask a question --

MEMBER ADIRIM: That would, then, take -- I mean, I would imagine that they would have to redo it all, and it is already NQF-endorsed, the measures the way they are.

I don't know. Somebody else might --

CHAIR ANTONELLI: Do we have somebody from Seattle on the line?

MS. PARAST: Layla Parast is here. I'm from RAND, but representing Seattle. I was the statistician on the project. I can comment on that, if it would be helpful.

CHAIR ANTONELLI: Yes. In fact, keep your comments as circumscribed as possible, please.

MS. PARAST: Yes. Okay. So, I didn't hear what was just said. I think it was a little bit far away from the microphone.

But, in terms of adding to CAHPS, they are certainly different surveys and very different populations. But I know that other CAHPS surveys have the opportunity to add

supplemental questions as long as they are at the end of the core CAHPS questions. So, that could be considered for the questions that would be needed for these measures. It would need to be identified such that only kids that should be receiving these questions receive the survey with the supplemental questions, but that is certainly done in other CAHPS settings to tailor the surveys like that.

CHAIR ANTONELLI: Okay. So, your response to Deborah Kilstein's question is that it is possible?

MS. PARAST: Yes.

CHAIR ANTONELLI: Okay. Thank you. Roanne?

MEMBER OSBORNE-GASKIN: So, I just had a question about any idea of the percentage of medically-complex children who would be excluded because their caregivers don't speak English or Spanish. I think there is a need for care coordination especially in that population, and I notice that they are the ones who would be

excluded. So, do we have any idea how many or a percentage? Or I'm just curious about that.

MEMBER ADIRIM: I don't know. I'm not the measure developer. So, I will let them answer that question.

CHAIR ANTONELLI: Could you hear the question.

MEMBER ADIRIM: But it is in English and in Spanish.

MS. PARAST: Yes. Yes, I did hear the question. And, yes, the survey is available in English and Spanish, but you're correct that families who may not speak English or Spanish would not be covered by the survey. It currently is not translated into other languages, but could be.

I don't have numbers on the proportion that were ineligible due to a language barrier. I seem to remember it was quite small. But we tested in the Medicaid population in Washington and Minnesota. So, I think even any percentage I gave you, of course, wouldn't be representative

of the whole country.

So, that would certainly be a concern, but it is something that could be addressed with further translations, just like the CAHPS surveys are certainly translated over time in multiple languages, as you identify what populations are not being targeted.

CHAIR ANTONELLI: Andrea?

MEMBER BENIN: Just a comment on the CAHPS. There is a CAHPS chronic care module that can be added onto the end of CAHPS. We've looked at it up against the FECC questions. The module is extremely long. It is like quite weighty, like all of the CAHPS modules.

And the brilliance in the development of the FECC questions is that they are independently-validated. So, the questions stand alone. They don't have to be -- in contrast, when you do a survey, you know, the survey validity depends on the survey being administered in the way that it was designed. And the FECC survey questions, to my understanding, are

validated independently. So, they can be used and they don't have to be used a whole. And so, that gives you a little bit more flexibility in the survey burden. In contrast if you were to use the CAHPS chronic care, you have to add that entire module onto an entire CAHPS thing. So, that's my understanding of that.

CHAIR ANTONELLI: Helen?

DR. BURSTIN: Just some historical context. I think over the years we have seen newer surveys come forward, and, eventually, we have seen some surveys come together.

I will say this was particularly different. The developers were charged with doing work on care coordination, which is the biggest gap across everything we do in all health care. We have almost no decent measures on care coordination. They tried to do a targeted review. They tried to do claims. They tried to do e-measures. And truly, the only way to really get at care coordination with this complex population was asking parents. There is almost

nothing in the current CAHPS survey that really gets at care coordination.

So, I just want to remind us, again, I agree it is patient self-report, which is certainly a burden, but it is the only one that actually gets at the unique and special issue for kids with special healthcare needs around care coordination, which was the intent.

MEMBER ADIRIM: And I think it also gets at those things that we have been talking about with regard to outside of the medical sphere. I mean, coordinating with social services and the like. So, I think that is what makes it unique.

CHAIR ANTONELLI: So, does somebody want to make a motion?

MEMBER ADIRIM: I move that we recommend including the FECC measure set in the child core set.

CHAIR ANTONELLI: To get the language precise, it would be the NQF numbers that are in this, as opposed to the FECC itself, right.

MEMBER ADIRIM: Okay.

CHAIR ANTONELLI: Yes.

MEMBER ADIRIM: So, the 2842, 43, 44, 45, 46, 47, 49, 50, the eight measures that were NQF-endorsed.

CHAIR ANTONELLI: Yes. Okay. Is there a second? Did somebody second?

MEMBER GREINER: I'll second.

CHAIR ANTONELLI: Okay. So, it's been seconded.

Any discussion?

Amy looked perplexed. You look perplexed.

MEMBER RICHARDSON: I am.

CHAIR ANTONELLI: Microphone, please.

MEMBER RICHARDSON: Perplexed, just trying to envision how we anticipate this will be done. This will by the states? This will be done by health plans? Who will do this at what cost?

CHAIR ANTONELLI: Renee or Karen?

DR. MATSUOKA: So, this is a little

bit of an unusual situation because all the core sets are voluntary. And so, if we were to hypothetically put these on the core set, I'm guessing what we would do is the technical specifications would just be the survey questions. And then, I think it would be up to the states to determine how they're going to go about administering those questions.

DR. FOX: And I guess this isn't so much a question, but a comment. It is that, if you were going to choose one of these eight, is there one that gets to most of the question?

CHAIR ANTONELLI: Boy, at the risk of opening that Pandora's box, I will exercise the Chair's prerogative and ask the developer that question, if that's okay with you. And everybody keep your fingers crossed because there is a holiday on Monday.

So, measure developer team, Dr. Fox has a question for you. Did you hear it?

MS. PARAST: I did. I did hear it.

CHAIR ANTONELLI: Okay.

MS. PARAST: Of course, we would say that we certainly think these measures are best used together because we think they provide complementary information to each other.

I think that they certainly could be used individually. We did, as was mentioned, validate them individually, so that different states or entities, whoever is interested in this, can pick and choose. It is hard to just pick one because it depends what you're interested in and what you might know is a gap maybe in your specific state or plan.

So, I think a lot depends on what you might already know about your particular population. I don't think that there is a single one that captures everything because, I mean, if you just look at them, they cover such a large range of components of care coordination. But I think it would be possible to pick one, depending on what is most important to your population.

CHAIR ANTONELLI: So, I'm just going to come back to you. So, based on the experience

in Minnesota and in Washington, do you have data that would directionally suggest any kind of a hierarchy and, if so, at what level, at the state, at the region, at the level of a hospital, at the level of a practice?

MS. PARAST: A hierarchy, you mean in terms of the measures?

CHAIR ANTONELLI: Yes. I know you gave an answer to Dr. Fox. But I'm sort of putting myself in the position; I'm a Medicaid director and I'm going to choose one of these things. What is the guidance that would give me a sense of where to begin the process?

MS. PARAST: So, one way to think about it would be that in part of our validation work we looked at how these measures are associated with a caregiver's overall rating of their provider and their overall rating of access to care. And so, we identified measures that were key drivers, like really key drivers of provider rating, and suggested that if you were only to target a certain subset, that perhaps

these would be the ones you would want to target. And we found that, basically, having a designated care coordinator and a shared care plan were the strongest ones associated with provider rating. So, those are the two I would put at the top of my list.

CHAIR ANTONELLI: Okay. All right. Thank you.

Roanne, unless you've got something burning, I think I am going to bring this to a vote. Is that okay? Okay.

All right. And then, following our pathway so far, does anybody want to suggest a condition? Otherwise, it's an up/down without a condition.

(No audible response.)

Okay. No conditions.

All right. Miranda?

And are we going to have to vote for each one individually since they are NQF measures?

DR. BURSTIN: No.

CHAIR ANTONELLI: So, all of them together? Okay.

MS. KUWAHARA: So, again, we are voting for the measure set, not the eight individual measures previously recited. So, we are voting to add the family experiences with coordination-of-care measure set to the child core set.

If you would like to support this measure please select 1; if not, please select 3.

Let's try it now.

(Voting.)

There we go.

We are waiting on one more response. There we go.

Fifty-four percent of the 13 voting members voted to support this measure, and 46 percent voted not to support this measure. So, we will not be recommending this measure for inclusion in the core set.

DR. BURSTIN: So, there was one other measure from Seattle Children's from that same

set that just came through our process, and I don't want to add it initially for today, but just to point it out to you. There is a continuity of primary care for children with medical complexity that is a new measure that is claims-based. I don't know that anybody has seen it yet.

We could certainly pass people on information about that to follow. But it is claims-based, intended at the level of the health plan, specifically using -- you guys probably know more about this -- a Bice-Boxerman Continuity of Care Index over a 12-month period.

So, it is a brand-new measure going through our process. It should be endorsed in June.

CHAIR ANTONELLI: Thank you.

DR. BURSTIN: It's 3153.

CHAIR ANTONELLI: All right. So, I think we have gone through the list. Yes?

DR. BURSTIN: I think you did.

CHAIR ANTONELLI: Yes. So, I'm going

to hand it over to Shaconna to tell us what is next.

MS. GORHAM: So, we are going to go to public comment before we rank within the room, because I know that some members have to leave, and that is very important that we stick our stickers where we need to. But we want to go to public comment first.

So, Operator, can you open the line up please?

OPERATOR: Ladies and gentlemen, if you would like to make a public comment, please press *1 on your telephone keypad. Again, that's *1 for a public comment.

(No audible response.)

And currently, we have no public comments at this time.

MS. GORHAM: Thank you so much.

So, for the members in the room, we are going to rank. So, the adults did it yesterday. But we are going to put the slide up of all of the measures that you have recommended

for inclusion thus far. They are also written behind you, one directly behind me and one to the left of me.

We have four measures that were recommended. And we have 1800 as the medication ratio. We have the 2903, contraceptive care, most or moderate effective measure or method. That is with condition. And we have the 2800, metabolic screening. We have the 0418, screening for clinical depression and followup. And then, we have the 3154, informed coverage, and that is also conditional support.

So, you have four dots. The colors mean nothing at all. You put your dots where you would like to see the measures ranked. So, we will ask CSM for addition of these members. But, when we put them in the report, we will say that the Child Task Force recommended these measures, and we will put them in order of importance.

You can do however you want. If you think that you want to put all four dots on one measure because that measure is that important,

you can do that. So, you can put your dots wherever. You only have four, but we have five measures that are recommended. So, that way, it will help us rank.

Let's do that now.

MS. MUKHERJEE: So, if we can just quickly come back? We're almost done. Our ranking is over.

And so, 2903 and 1800, the contraceptive care measure as well as the asthma measure, those two got the most ranking votes at 14.

And then, we have 3154, which is informed coverage, the third highest one with 10 votes.

And then, we have 0418, screening, with 9 votes.

And the lowest vote was No. 2800 with 5 votes.

So, we have our top three. Our top three would be 2903 and 1800 being one, and then, two being 3154, and then, 0418 being No. 3.

With that, we go into our second activity of the afternoon, which is looking at gaps. And with respect to gaps, what we wanted to do is be, again, not necessarily strategic, but parsimonious and look through all the gaps, which you will see are on the sidewalls and stickies.

And we wanted to go through another prioritization exercise with the gaps because we know a lot of these gaps have existed and will exist, and the list will live. But, if we want it to be truly parsimonious and give CMS some concrete direction, we wanted to be able to triage them and provide them with sort of the top five gaps.

And so, we'll take part in another exercise now where you will get dots. And then, the gaps, as you can see, are on the sidewall. And we ask you to be thought about sort of ranking them and, again, giving your dots to the different topic areas that you think are sort of most important. And that doesn't mean the rest

of the gap areas will go away, but it will add sort of an additional level of analysis, as sort of here are the top five gap areas.

MEMBER RICHARDSON: Sorry. For each of your gap areas, do we know that there are existing measures?

MS. MUKHERJEE: No, no.

MEMBER RICHARDSON: Okay.

DR. BURSTIN: So, I'll just mention, for the adult group, and for some of you who were with us the first day, we also shared with this group the new prioritization criteria NQF has put forward across all of our work. And so, this might just be informative as you think and look towards this.

So, there's four criteria:

The first is we prefer measures to be outcomes-focused, either outcomes or closely related to outcomes.

The second is we would like them to be improvable and actionable, something that came up a lot through the course of this discussion over

the last several days.

The third is we would like the results to be meaningful to patients and caregivers, that those results would be understandable and they would know what to do with them.

And the fourth, I think really importantly for a population like kids, in particular, is we would like to see measures that increasingly reflect an integrated view of care. So not measures necessarily that are so site-specific or provider-specific, but more reflect the integrated or a systemic view of care.

So, if that is helpful for you, as you look through those, we will be building that into all of our work going forward. So, this is a bit of a preview for you, but I think it is a helpful way to think.

Thanks.

MEMBER SAKALA: Did you want us to vote on the domains or the subdomains?

MS. MUKHERJEE: So, I think the domains because we will keep the subdomains. So,

if you really thought you wanted to promote one subdomain, feel free to give it a dot, and we will just highlight as something under the domain. But, if you say one of the domains, like the cost measures, are the most important, we will say these were the two subdomains with it. But it is completely up to you. If you think one of the subdomains is more important than sort of the big criteria, feel free to vote either way.

DR. BURSTIN: And shall we also allow them to add a measure, add a gap, as we did for the adult side? But, unfortunately, they were tougher than I would have been. You have to use a dot if you put a new one up. But feel free to add one as well. We probably should do that first before everybody goes up.

MS. MUKHERJEE: So, on this side, we will have an "add your gap," and you will lose a dot.

(Laughter.)

Just for parity, because adults did that, the adult group, and they had to like

provide a dot for the new category that they added.

DR. BURSTIN: And the added dot got more votes than anything else on the screen. So, don't feel bad about adding a dot.

MEMBER SAKALA: So, I have an issue with overuse because I think that often is paired with underuse. Like, if you are not going to do -- so, here's an example -- electronic fetal monitoring, you had better do intermittent auscultation. And so, it is not only about -- or there's a lot of beneficial practices that are not part of the culture, whatever.

So, can I pair that with overuse because I think it goes with it? Or does that become an extra one?

MS. MUKHERJEE: It's not on; it will be a new one.

MEMBER SAKALA: Okay.

MS. MUKHERJEE: You can put it on the blank sheet over here as sort of a new and say it is pairing with that, but you will still lose a

dot.

MEMBER SAKALA: Uh-hum.

MS. MUKHERJEE: It's okay. You can add it.

MEMBER SAKALA: Yes. Thank you.

MS. MUKHERJEE: And we're ready. We have all of that up there on the sides. You all have your dots. So, feel free to sort of get up, move around, add your dots. And the blank sheet is up as well with a marker there. So, we're all set.

No, go ahead.

MEMBER OSBORNE-GASKIN: I just have a question about the durable medical equipment. Was there a specific concern about that or was that a cost thing?

MS. MUKHERJEE: An access issue with that and sort of supply, and things like that.

(Pause.)

CHAIR ANTONELLI: We are all set. So, do we --

MS. MUKHERJEE: We have the data right

there.

CHAIR ANTONELLI: Oh, there it is. There it is. All right. This is you, isn't it?

MS. MUKHERJEE: So, hello, everybody. I am just going to sit back here, so I can see the dots.

And so, the top ones seem to be substance abuse; mental health, and with mental health, we have also the subcategories of ED use for behavioral health, coordination, access, things like that. We also overuse, medically-unnecessary care.

And a point was brought up that, with overuse, we should always pair underuse. Because if you are overusing something, you're underusing something that's more appropriate. So, we might add that and make that modification.

And the others that sort of fell out in the top five were coverage; that was the other one, duration of insurance coverage. And then, we also have a subcategory that was added to that. So, we will capture that.

We have mental health, which I think I've already covered.

So, we have substance abuse, one; mental health, two; coverage, and then, we have cost of measures. And then, the final one -- I can't even read my own handwriting -- is care coordination. Care coordination is huge. That was the other one. That's on the top five.

So, we will roll it up. So, when we talk about the measure, we will say care coordination and, then, we will call out all of these, but, then, highlight the ones that got dots.

It is care integration. Care integration has two yellow, one red. Care coordination for conditions requiring community linkage has one yellow. Cross-sector measures has one yellow. Social services coordination, one red. And then, care coordination all together has one, two, three, four, five, six, seven, eight. Eight dots.

And with that, we have ranked our

measures. We will keep this. We will add them up and add it to the report.

And then, with that, I will turn it over, because we are coming to the final stages of our last day of meeting.

MS. GORHAM: So, we are going to open it up for public comment one more time.

Operator, can you open the lines, please?

OPERATOR: Ladies and gentlemen, if you would like to make a public comment, please press *, then 1, on your telephone keypad. Again, *1 for a public comment.

(Pause.)

And currently, we have no public comments.

MS. GORHAM: Thank you.

So, on your screen, for the folks in the room, all of the measures that you ranked, we have them listed:

2903, contraceptive care, and 1800, asthma medication ratio, I will rank No. 1. They

tied.

3154, informed coverage, was No. 2.

0418, screening for clinical depression and followup, ranked No. 3.

And then, No. 4, 2800, metabolic screening for children and adolescents, ranked No. 4.

Okay. So, with that, if there are no questions or comments on the measures that will be recommended to CMS -- Andrea?

MEMBER BENIN: I just have a comment about gap. But are you doing that next? No?

MS. GORHAM: No. You can now. Now is fine.

MEMBER BENIN: Okay.

MS. GORHAM: As long as there are no comments on the recommended measures, we definitely can floor and take comments for gaps, or whatever else.

MEMBER BENIN: Okay. I just want to really echo what Kathryn said earlier about the mental health issues, particularly the mental

health issues in the emergency department. There's an absolute crisis right now in the emergency departments around mental health. And I think whether that is related to the Netflix television activity and the other things that have been going on, it is untenable what is going on in our emergency departments. And that is consistent through -- it is not just -- Connecticut is a disaster, but it is consistent throughout children's hospitals that emergency departments are filled -- filled -- with children who are suicidal, and there are no beds for them.

We get in our emergency department 30 new psych patients a day. And at any given time, we have patients who have been in our emergency department for 20 or more days. So, it is a substantial -- substantial -- problem, and it doesn't just impact those poor children, but it impacts the other septic babies who come in and all those other people who can't access the emergency department because we are running a psych ward in a way that is not the best for

those children. They shouldn't be getting their mental health care in an emergency department. That's not ideal for them.

So, this is a substantial crisis that I cannot possibly imagine that we, as a sort of field, you know, can't figure out how to measure better, so that we can explain it better in a way that we can make change. Because what's going on out there is really horrifying.

CHAIR ANTONELLI: So, I'm going to react to that. And then, Kathryn, I will pick you up.

I'm not sure that the answer is necessarily measuring better. Because what you just said actually is universal is for pediatrics; it's adults. EDs are basically, they are holding tanks.

In Massachusetts, anywhere between 20 and 40 percent of every emergency department bed in the entire Commonwealth is taken up by a patient with acute psych needs, and there is no disposition.

And so, I want to sort of challenge that notion. So, I think we have got measures that show that the system, as it is currently functioning, is really, really inefficient, ineffective, and, in fact, undignifying.

But are there interventions that would, then, call the need for better measures? I don't mind. I put a lot of those yellow stickers over there that link to the community. So, going upstream for pediatrics as well as adults in the behavioral health space is better.

So, I do want us to think, yes, this is the National Quality Forum. We are all about measurement. But I also think that we already know just how horrible this problem is. So, that was my editorial comment.

Kathryn, to you, please.

MEMBER BEATTIE: So, I am just going to add to what Andrea was saying on two fronts. One, I do think putting a quality metric is a way of communicating with our states' Medicaids.

And in the states that I have been an

administrator in as a pediatrician, one of the major issues has been access for Medicaid patients because we will have the inpatient facilities are not expanding. Either they don't have enough staff for the beds they have or they are not expanding their beds because they can't afford to, because the reimbursement is so low.

Then, we have the challenge of whether or not they will even approve an appropriate stay. So, it is very unlikely that, when you change a medication for a kid, that a seven-day stay is going to be long enough, but that is all they want. They want them to come in for inpatient psych care in seven days.

So, I do think somehow getting to the quality is linked to the appropriate location of care by the appropriate providers that are trained to manage these complex mental health concerns of the children that we are dealing with.

The second piece that I want to speak to is actual safety. So, yes, the kids are

coming to the emergency department. If we admit them into the hospital, then they lose their standing for appropriate placement. And so, they go on the bottom of the list for the inpatient facility. But it is really unsafe to keep them in the ER, and it is often unsafe to admit them.

The place where I work now, we just had Joint Commission there, and probably 50 percent of their time was talking about risk to our mental health patients, ligature risks. So, if you know what a normal patient room looks like, there are wires and cords all over. You know, it is the pull cord in the bathroom. I have had an adolescent patient, when they are walking one-to-one with a sitter, run into a public bathroom and pull a plastic bag over their head.

And so now, we have to not just think about the individual room and how we make that room safe, but how we make all the public areas safe. Because these aren't facilities that are designed to care for these patients.

And when you have an adult mental health patient who is sitting, waiting for appropriate placement, they are not kids. Kids, you can't just lock them in a room and put the lights off and give them some meds to sedate them, and that's enough. I mean, we have to do something to create a schedule and activities for these kids, and it is just so unsafe when they are not in an environment that is designed to be safe for them.

So, I'm off my soapbox, but it is a very complex issue and we really need Medicaid's help, at least in every state that I have been in.

CHAIR ANTONELLI: Terry?

MEMBER ADIRIM: No, and I can't repeat enough, I agree with both of them. As somebody who works in a peds emergency department, this is a big issue.

So, if we have to have an emergency department measure, this would be a good one because I think there are things that the state

can do with regard to their managed care contractors to improve these issues.

I mean, kids do not belong in the emergency department with mental health issues unless they are going to be making it soon to an inpatient facility, and that is just not happening anywhere.

CHAIR ANTONELLI: Helen?

DR. BURSTIN: This brings an issue to me, and I'm not sure this is the case. But I also just wonder whether it would be useful to look to see whether there are some existing adult measures that actually could be specified for kids.

I was just trying to find on my computer, which I couldn't. For example, there are ED throughput measures --

CHAIR ANTONELLI: Right.

DR. BURSTIN: Admit time, decision time, things like that, that I don't know that they're only adults. Or could they be looked at? It might be an easier lift, for example, for the

Pediatric Centers of Excellence to take existing measures and think about whether there might be some early modifications to some of those --

CHAIR ANTONELLI: Right.

DR. BURSTIN: -- to get at issues like boarding.

I know psychiatric patients stratified intentionally. So, it might be really interesting data. We would be happy to share that with you guys, just to sort of see if we could find the original specs and see if there is an opportunity there, because this is, obviously, untenable.

CHAIR ANTONELLI: And don't forget to measure the gap, right? So, in Massachusetts, we actually have legislation to drive ED boarding. My wife does quality measurement for surgery at Mass General. So, for them, it is boarding for everything surgical. But, when I talk about it, it is exactly what you are just saying, 20-plus days sitting in the ED for a given patient.

So, I don't mean to say we don't need

additional measures. What I am saying is I think that we have got boarding measures that we could be thinking about.

But the gap area for me is the capacity, right? Why are those patients sitting in the ED? It is because they are not going to where it would be a higher-value setting.

So, if we think broadly and outside of, let's call it, the traditional brick-and-mortar medical system, of which the ED is the default repository, we should be looking at other measures of acute psychiatric care and high-value, high-safety environments.

The number of states that I'm aware of that are reducing inpatient beds, while the country's pandemic of behavioral -- so, there is something wrong with that, and we should be thinking about those. And that is actually something that could happen, could and should be happening at the level of states.

Terry, you had something?

MEMBER ADIRIM: You know, I was going

to say I agree with that. And one of the things -- and this is, again, anecdotal as an ED practitioner -- but what I hear over and over again from the social worker who is trying to find a bed is they don't take Medicare or they don't take this insurance.

So, I think there is something that the state could do to move these kids to places. And it is a bed issue, too. I mean, a lot of times the beds are full and there's not enough practitioners, and so on. But I think all of this should be looked at and measured.

MEMBER KILSTEIN: I just want to say that, for adults, there are different policy issues and levers than for kids, and it has to do with the Institution for Mental Diseases restrictions that do not apply to kids under 21, but do apply to a facility for more than 16 beds for an adult.

CHAIR ANTONELLI: Amy?

MEMBER RICHARDSON: So, I don't disagree with anything that has been said. But

we haven't talked about ownership of the problem, and I think the states can only go so far until we have sufficient child and adolescent psychiatrists. I don't hear anything happening around workforce. All I do is have a drink with friends who bemoan the fact that there aren't enough of them and don't see any progress on the workforce, and don't understand why some of this isn't under the ownership of big health systems, not the state, but big health systems who want to build the beds that are gravy, right, have a big margin, and don't want to build the beds that are really hard and low-margin. And so, I think there is a lot of ownership, that this doesn't necessarily just belong to the states.

MEMBER ADIRIM: How do health systems -- I'm sorry, I'm not sure I understand. Because states and the federal government pay GME. So, they would have a capacity to increase --

MEMBER RICHARDSON: If you look at how health systems billed -- I invite you to go to Cleveland and watch the arms race in hospital-

building, right? And it's all about the high-margin beds. What kinds of beds, what kinds of services can we build that gives us the biggest margin. And psych beds have a little, tiny margin.

MEMBER ADIRIM: Right. There is that, but we just don't have enough practitioners who are willing to practice.

MEMBER RICHARDSON: Right. So, I would ask the psychiatrists and the child and adolescent psychiatrists about workforce development.

I'm not saying the states and all of us don't have a role in this. I'm saying that we could task the states with fixing this. And until there's workforce and beds built, then it is not going to get solved. It is not just tell the states to fix it.

MEMBER BEATTIE: So, I am specifically referring more to child and adolescent access to care. And with that, we oftentimes don't have the continuum of care that we do in the adult

world, and that hasn't been acknowledged by states to even develop a reimbursement model.

So, a great example is partial hospitalization. A lot of the kids who end up in the ED are somewhere below needing an inpatient, but above being okay with seeing their psychiatrist once a month and a counselor once a week or so.

And most states today do not have a reimbursement structure established for either intensive outpatient, where the kid goes to school all day and, then, goes into a therapy setting for two or three hours after school every day or a PHP, where they go to PHP all day and, then, get to go home and sleep at night.

We are actually working very aggressively in my team to get that reimbursement structure developed with our Medicaid team. They have reimbursement under Medicare for those facilities, but those are all adults. And they just don't have anything. You know, it is not a code you can ask for.

So, there needs to be some acknowledgment of this is a crisis for children and adolescents. We need to develop the reimbursement structure, so that you can even put the program in place.

We are not even looking to make money on psych. We're not. We just want to be able to break even or use a moderate amount of foundation money to support care for these kids.

But there needs to be some acknowledgment that those are resources that need to be available in our states.

CHAIR ANTONELLI: So, if I try to string together the pearls that I have heard in the last 12 minutes or so, what I'm hearing is that it is a pandemic problem and there's lots of opportunity for collaboration, right? So, I agree with you about high-margin beds. There's a reason why people build, you know, cardiac surgery hospitals, right?

But, that said, so the delivery system has ownership. The financial incentives, the

types of care models that you are referring to, for which in some cases there's already evidence, and just because there's no code, you can't implement them.

So, this is a shared responsibility. And frankly, I can't think of any other way of going after the behavioral health crisis in this country without everybody sort of stepping up.

So, next steps.

Yes, go ahead. You did this so well yesterday.

(Laughter.)

MS. KUWAHARA: So, between now and July 7th, the project staff will diligently to capture the recommendations and sentiments from the Adult and Child Task Forces. And then, we will go out for public comment on those drafter parts, July 7th through August 6th. Then, the final reports will be submitted to HHS August 31st.

The MAP Coordinating Committee will meet to be determined, August-September time.

And then, CMS will issue its annual update to both core sets late 2017.

MS. MUKHERJEE: And then, as just sort of --

MS. KUWAHARA: The project staff contact names are here, and our information is also on SharePoint. So, you can feel free to reach out to any of us individually.

And on this last slide we have our project contact information. Our project page is listed here as well as the SharePoint site and both email addresses.

MS. MUKHERJEE: And just as a final thought, it will happen in August, our Coordinating Committee meeting, because the report is due to CMS by the end of August. So, that will happen in August.

And just as a final thought, thank you so much for bearing with us the two days and sort of powering through all these rankings and discussions.

And thank you to our Chair for helping

sort of guide us through two days of intense discussion. We wouldn't be able to do it --

(Applause.)

As well as the NQF leadership, Helen sort of being here and helping out in a pinch.

And also, the staff. We wouldn't be able to do what we do without the team.

(Applause.)

DR. BURSTIN: And just lastly, we know this is a volunteer gig for all of you. This is our job. And so, thank you, especially for so many of you who spent three days with us. That is a huge commitment both from our federal partners as well as those of you in the private sector. So, thank you.

MS. GORHAM: And I just want to say thank you to CMS. Renee and Gigi work so well with us behind the scenes. And so, we really appreciate it. We definitely could not pull this off without you.

And then, I'm going to tell on Rich. I know he doesn't want me to, but I am anyway.

This is actually his first year as Chair. And when we approached him about the position, the first thing he said, "Oh, I would love to do it." He was like, "Give me all of the meetings because my schedule is full, and this is so important, I want to make sure that I have time." So, I just wanted to say thank you.

CHAIR ANTONELLI: Thank you.

(Applause.)

DR. FOX: Yes, and from the CMS side, we want to thank the staff, and Rich particularly, because he is just really very helpful, and Helen. And thank you to the Task Force members because you did give your time and your expertise.

CHAIR ANTONELLI: I certainly don't deserve the last word. So, somebody from the staff is going to have the last word.

But I just basically want to revisit the comment that I ended with yesterday. When you consider what's happening outside these walls politically, and yet, inside the walls the amount

of really intense, good work, multidisciplinary, cross-stakeholder, cross-sectoral, discussions around value, transparency, and all of that, if anything, we have redoubled our efforts to get measurement in place and to pull together traditionally or non-traditional bedfellows, so to speak, around alignment. For me, this is actually very sustaining.

And we are going to endure. The families for whom we provide care are really depending on us, especially the ones that are already vulnerable.

So, thank you. Thank you for the federal partners. And in particular, I know it is tough for you right now. We've got your back.

(Whereupon, at 3:49 p.m., the meeting was adjourned.)

C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Measure Application Partnership
Medicaid Child Task Force

Before: NQF

Date: 05-25-17

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R. Gross

Court Reporter