NATIONAL QUALITY FORUM

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MEASURE APPLICATION PARTNERSHIP
MEDICAID CHILD TASK FORCE

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THURSDAY
MAY 26, 2016

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The Task Force met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 8:30 a.m., Foster Gesten, Chair, presiding.

MEMBERS PRESENT:

FOSTER GESTEN, MD, FACP, Chair
TERRY ADIRIM, MD, MPH, FAAP, Drexel University College of Medicine
KATHRYN BEATTIE, MD, St. Luke's Children's Hospital
ANDREA BENIN, MD, Children's Hospital Association
SUSAN LACEY, RN, PhD, FAAN, American Nurses Association
MARGARET A. MURRAY, MPA, Association for Community Affiliated Plans
CYNTHIA PELLEGRINI, March of Dimes

ROBERT RIEWERTS, MD, Kaiser Permanente

CAROL SAKALA, PhD, MSPH, National Partnership for Women & Families

FATEMA SALAM, MPH, Patient-Centered Primary Care Collaborative

SUBJECT MATTER EXPERTS PRESENT:

RICHARD ANTONELLI, MD, Boston Children's Hospital; Harvard Medical School

FEDERAL GOVERNMENT MEMBERS PRESENT (NON-VOTING):

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

NQF STAFF:

NADINE ALLEN, Project Manager
ELISA MUNTHALI, Vice President, Quality Measurement

SHACONNA GORHAM, MS, PMP, Senior Project Manager

JOSH HARDY, Division of Quality

DEBJANI MUKHERJEE, MPH, Senior Director

YETUNDE ALEXANDRA OGUNGBEMI, Project Analyst

GIGI RANEY, Division of Quality

MEGAN THOMAS, Technical Director, Division of Quality

REVA WINKLER, Senior Director*

ALSO PRESENT:

SEAN CURRIGAN, MPH, American College of Obstetricians and Gynecologists
CHARLES GALLIA, PhD, Oregon Health Authority
LARRY KLEINMAN, MD, MPH, Icahn School of Medicine at Mount Sinai*
MARSHA LILLIE-BLANTON, DrPH, Centers for Medicare and Medicaid Services
RITA MANGIONE-SMITH, MD, MPH, University of Washington*
KAREN MATSUOKA, PhD, Centers for Medicare and Medicaid Services
KEVIN OLKOWSKI, University of Michigan*
GIGI RANEY, LCSW, Centers for Medicare and Medicaid Services
SARAH REESE, University of Michigan*
JEFF SCHIFF, MD, MBA, Minnesota Health Care Programs

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

JEFFREY SILBER, MD, PhD, Children's Hospital of Philadelphia*

SARA TOOMEY, MD, Mphil, MPH, MSc, Boston Children's Hospital*

SALLY TURBYVILLE, DrPH, Children's Hospital Association

DONNA WOODS, PhD, Northwestern University*

*** present by teleconference**

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

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

9:05 a.m.

MS. MUKHERJEE: At this point, I would like to thank Yetunde and Sheila and Donna for helping us. They're the staff on the side. They've been helping us for the past couple of days. Sheila is not here today, but she was here the past two days, and -- and they've done a heroic job on sort of keeping us on task, so I would like to thank them.

And I will welcome everybody to today and turn it over to Foster to get us started.

CHAIR GESTEN: Hey, good morning everyone. If you thought yesterday was fun, today is going to be much more fun, so welcome back. Glad to see everybody came back and returned.

We -- we have an agenda. You know, it's a pretty full agenda. We have some great presentations from -- from Oregon and Minnesota, and, you know, have a -- a similar mix of issues and agenda items as we did yesterday, some of

them sort of policy and conceptual, and some of them really getting into the nitty-gritty of refining and improving the Child Core Measure Set.

So our -- our key objectives are on the screen in the slide set. As I mentioned, we'll hear from a couple of states about the experience of actually using the Child Core Set as we did intermittently in the conversations yesterday. We want to provide some -- some recommendations that are higher-level and strategic about how to -- how to improve and strengthen the set, including sort of Old Faithful, which is looking at priority gap areas and measures to address them as well as looking at potentially measures that we think warrant removal, and we'll talk about sort of the criteria for how we think about that.

We also want to give whatever guidance along the way about how we not only today but over time can strengthen the Child Core Set, which in -- I think in my mind means

strengthening so that it actually serves the purpose for which it was created, which is to improve care for -- for patients and families and children. And then any -- any overarching policy issues to -- that we need to consider about -- about updates and so on.

So before we get too much into the next slide, why don't we just go around so that whoever is on the -- we can find out who is on the phone and folks on the phone know who is here, so just a brief hello and where you're from. So Kamila, should we start with you?

DR. MISTRY: Hi. I am Kamila Mistry from AHRQ. I am the Senior Advisor for Child Health and Quality Improvement.

MS. DE NOBEL: Laura de Nobel from CMS out of CCSQ, which is Clinical Standards and Quality. Laura de Nobel from CMS in the Center for Clinical Standards and Quality.

MEMBER BENIN: I am Andrea Benin. I'm at Connecticut Children's Medical Center in Hartford, and I'm representing the Children's

Hospital Association.

DR. ANTONELLI: Rich Antonelli, Medical Director of Integrated Care at Boston Children's Hospital.

MEMBER LACEY: Susan Lacey representing the American Nurses Association. I am at Medical University of South Carolina.

MEMBER RIEWERTS: Bo Riewerts, I am a pediatrician from Kaiser Permanente, and I'm from Pasadena, California.

MEMBER ADIRIM: Hi. I am Terry Adirim. I am a pediatric emergency physician at St. Christopher's Hospital for Children, and I am here representing the American Academy of Pediatrics.

MS. MUKHERJEE: Debjani Mukherjee, I am on NQF staff and Senior Director for the Adult and Child Core Set.

MEMBER SAKALA: Good morning, Carol Sakala with the National Partnership for Women and Families.

CHAIR GESTEN: Foster Gesten, I work

in the New York State Health Department, representing the -- and here in this group, representing the National Association of Medicaid Directors.

MS. GORHAM: Hi, my name is Shaconna Gorham, and I'm the Senior Director for the Medicaid Child and Adult Task Forces.

MS. ALLEN: Hi. I am Nadine Allen, NQF staff. I am the Project Manager for the Child Task Force.

DR. LILLIE-BLANTON: Hi. I am Marsha Lillie-Blanton. I'm a Senior Policy Advisor with the Center for Medicaid and CHIP Services.

MEMBER SALAM: Fatema Salam with the Patient-Centered Primary Care Collaborative.

MEMBER PELLEGRINI: Cindy Pellegrini, March of Dimes.

MEMBER BEATTIE: Good morning, Kathryn Beattie. I am the Executive Med Director and Administrator for St. Luke's Children's in Boise, Idaho, representing America's Essential Hospitals.

MEMBER MURRAY: Hi, I am Meg Murray with the Association for Community Affiliated Plans, representing the Non-Profit Medicaid Plans.

DR. GALLIA: My name is Charles Gallia. I am Speaker and Senior Policy Advisor with the State of Oregon.

DR. SCHIFF: Hi, I am Jeff Schiff. I am the Medical Director at the Minnesota Medicaid Program, a pediatric ER doc, and the past President of the National -- of the Medicaid Medical Directors Network.

CHAIR GESTEN: And do we have any members on the phone? Not yet. Okay.

So the -- we're going to review very briefly the highlights and just remind folks about what went on yesterday, what we decided on measures. Oh, I am sorry, yes?

DR. FOX: Renee Fox, CMS.

MS. RANEY: Hi, I am Gigi Raney from the Division of Quality, and I work on the Adult Quality Grants.

MS. THOMAS: Hi, I am Megan Thomas, Technical Director in the Division of Quality, and I'm the Team Lead for Performance Measurement.

MR. HARDY: Josh Hardy, Division of Quality, CMCS HIT.

CHAIR GESTEN: Great, thank you.

So we're going to go over the highlights of -- of yesterday. The good news is that we -- since we voted on a number of measures, it means that some measures we don't have to vote on today.

We will be describing, staff will be talking about the analysis of both the 2015 Child Core Set reporting, what we know about the reporting to date from the states. We will look at measures with an eye towards are there measures that have low uptake or other issues that might warrant removal? We'll also be talking about measures to add.

There will be a process as we've done previously to rank selected measures for

potential addition and priority. And those are really the -- sort of the work and the objectives that we have for today.

Just a couple of things before we get started: Carol has graciously agreed to take over at various times in the discussion for various items when we discuss measures that I'm going to need to recuse myself from. Our -- our office was involved in one of the Centers of Excellence development of measures.

None of those measures currently are proposed for -- for discussion, nor have they been previously, but in the second round of the funding for pediatric quality measures, Centers have been directed to reach out to states for work on implementation and quality improvement. Those applications are still -- I think letter of intent is due on Friday, but we've been reached out to by three Centers of Excellence that involve about four of the measures we're going to discuss today, so we don't know whether we're going to be involved or engaged, but I think it's

prudent that I recuse myself from both the discussion and also the voting on those measures, and we can identify them when we get to them. But Carol has agreed to -- to take over during those times.

So are we ready to roll? Hey Karen, welcome. Karen, you want to introduce yourself before we get started? We just went around, sorry.

DR. MATSUOKA: Hi, I am Karen Matsuoka. I am the Chief -- or Chief Quality Officer for Medicaid and CHIP, and I'm also the Director of the Division of Health Outcomes and -- Division of Quality and Health Outcomes. Sorry, a lot of acronyms.

CHAIR GESTEN: So this is yesterday, yes?

PARTICIPANT: Yes.

CHAIR GESTEN: Okay. And so we added to the -- to the Child Core Set Measure 2902, which was Contraceptive Care: Postpartum Care with Conditional Support. And as you may recall,

that measure is a broader age group, so Marsha and I were talking before the meeting about, you know, this may be, like some of the other pregnancy measures, a measure that, while it's in the Child Core Set, actually involves adults as well.

We voted conditional support for 0480, Exclusive Breast Milk Feeding, conditional support pending NQF endorsement of I believe it's the eMeasure, right? These two were sort of voted together, 0480 and 2830, and there was a vote yesterday to remove from the Child Core Set Measure 1391, Frequency of Ongoing Prenatal Care.

So that was yesterday's sort of voting summary that affects at least the Child Task Force. Are there any questions about -- about this?

(No response.)

CHAIR GESTEN: Okay. Why don't we go on to the next slide?

So I think Nadine this is you. It's going to review a little bit of some of the

background material, some of this will be familiar to folks who have been here before, about -- it's some contextual information about Medicaid and children's healthcare as well as review, what we know about use of an uptake of the core set, so Nadine? Thanks.

MS. ALLEN: Hi, good morning again. So I am going to provide a brief overview of the meeting materials, and my colleague Shaconna will be presenting the key points from staff review of the -- the core set.

This slide provides some background information about the Medicaid and CHIP programs, the kids they cover as well as an overview of the children's health issues, and I know for -- you have seen these slides over and over again, but you know, the most important part to note is that Medicaid and CHIP covers more than 43 million children, which is more than one in every three, and half of all low-income children in the U.S. Medicaid plays a key role in child and maternal health financial healthcare services for about 40

percent of all births on average across the states.

So the reason we are seeking to understand the health-related needs of this population is so that we can select measures that correspond to what is most important for Medicaid and CHIP enrollees. We have noted primary care access and preventative care, perinatal health issues, the management of acute and chronic conditions, and particularly with the lens of children with complex health needs, behavioral health, dental and oral health.

So these slides illustrate how children health is different from adult health. And so just to remind everyone, the nature of pediatric benefits in Medicare are a little bit different than in adult-oriented healthcare. Lots of attention needs to be paid to development risk as opposed to acute conditions. Acute health conditions in children have declined over the past several decades, but the relative importance of chronic health condition and those

risks are growing.

So today, as opposed to historically, a more significant portion of children are living with chronic illnesses like asthma, autism, sickle cell disease, CF, obesity, and birth conditions that need to be managed in an ongoing way.

So when you think of the whole overarching picture of children, it influences the way healthcare expenditures is allocated towards pediatric population, and the healthcare system needs to continue to improve its capacity to detect, then treat, then manage, and then reduce the impact of physical and mental health conditions that affect development.

So this might correspond to the task force thinking about gap areas and opportunity for measurement. The main things in preventative care with implications for a long-term physical, emotional, social, educational function outcomes include giving parents guidance about what to anticipate in their children's development:

immunization, preventative dental care, vision and hearing screening, blood screening, mental health screening, development screening, and body mass index. Again, some of these topics are already covered in measures, and others are not.

So during MAP's 2015 measure recommendation, the following measures were recommended for phase addition to the Child Core Set. The measures that are outlined in orange are still on the table for future action, so some of these measures will also be -- I know a couple was put forward yesterday that you got an opportunity to review, but the others will be reviewed later on today.

So when MAP provides these recommendations, CMS does listen to us, and, you know, a way of highlighting how they have done so is they've added two measures from our recommendation, The Use of Multiple Concurrent Psychotics in Children and Adolescents, and also the Audiological Evaluation No Later Than Three Months of Age.

In addition, CMS will continue to pilot and report progress for the -- the child version of the -- the Hospital Consumer Assessment, the Healthcare Providers and Systems survey, so that is still being pilot tested. And do we have any information about that, Marsha, that you would like to share on the status of that?

DR. LILLIE-BLANTON: You know, only that we have made -- we have made progress in understanding. We actually had our contractor work with us in assessing how widespread use -- the extent to which the hospital CAHPS is now in use, and we've talked with our internal staff who -- CMS staff who work on the CAHPS survey to see how the data now come from hospitals to CMS.

And at this point, we are still facing some challenges in how we would get the data in to CMS, but also, at this point, we are concerned that it's not widespread -- it's not in use widely enough that we could get data and report on its use and have some meaningful information.

So that's -- but so we're still, you know, we're still trying to think through it. But let me try and explain a little bit more what I mean.

So there are some states, like Boston for example, that seem to be using this survey, but if -- if we were able to get data from three states, or data from one hospital in a state, and that's it, then what does that tell us? You know, that's -- so it's like, would we be getting meaningful information until -- until we can increase -- until the reporting or the use of the survey is at a higher level?

So the -- and unlike CAHPS surveys with Medicare or hospital surveys in general where it's there for payment and, you know, there's a requirement, this would be another voluntary reporting.

So we are still -- and we have not been able to get the Children's Hospital Association to say that they would require it or strongly recommend it, so for us to add it to our

core set means we -- we potentially would have another measure that we signal the importance of it, but that we're not sure how to interpret what we're getting when we get it.

So -- so we're -- we're still -- we have not decided that we will not include it. We are still saying we're pilot testing it, and by December, we will hope we'll be more definitive.

MS. ALLEN: Thanks Marsha, that was very helpful. Andrea?

MEMBER BEATTIE: Sorry, and I -- I actually can't speak to the Children's Hospital Association issue, but I can take that question back.

But one of the catch-22s that we're in, if I understand it correctly from the person in my organization who works with the vendor, is that the vendor is saying you don't have to switch because it's not going to be mandatory because we don't see that CMS has a way to really make this mandatory, and the vendors are invested in us continuing to use their proprietary thing

because as soon as we go to something that's actually a publically available survey, we could truly switch to any vendor.

So as long as we're -- so there is a -- a -- so the -- so if I say to my patient experience person, look, we need to switch surveys, this is the survey that's going to be coming down the road, this is the survey that's better, they're like, whatever. Then I have to explain that to the board: right now I got this Press Ganey survey, it's working fine. Like why would I do that when the vendor is telling me that this thing isn't really becoming real any time soon?

So there is a little bit of a catch-22 in being able to get the transition made, and I don't know if that helps inform how we need to tackle it. Because I just -- I do think that the extent to which we can all be on a free, publically available -- you know, a survey that is standardized and publically available and it's not -- the benchmarking isn't subject so much to

which vendor you're using is -- is a big deal, right?

It will make -- it's game-changing, but the vendors are -- so there's a problem in all of this that I don't know how it gets tackled.

MEMBER RIEWERTS: I just had a question for someone new to this work. How did -- how -- why is there that disparity? Why aren't children's hospitals or hospitals -- why aren't hospitals that take care of children held to the same standard where they have to publically report that data for reimbursement?

DR. LILLIE-BLANTON: Well, there is -- you know, this is something we're trying to understand better with Hospital Compare. Initially, we -- we were told that Hospital Compare is defined by Medicare requirements. We've -- we've worked through the legislation a little bit more and understood that that is not fully the case, but it does have to be a part of rulemaking.

Is that -- I mean, I am looking to Laura. So what we would have to do is add this measure to the rulemaking process that we would require, and then with the rulemaking process, you have an opportunity for public comment, and a decision could be made.

So now that we understand that, because we -- we did probe that a little bit further, you know, that would be the next process that we could use, but -- but that's the best explanation I can give you now, that it's -- it's a rulemaking that has not thus far been a part of the rulemaking process, which is being driven largely by Medicare payment policy issues and reporting issues as opposed to Medicaid.

It doesn't mean that couldn't change, but it's just it -- it would take some broader work at -- within our CMS, and I'm looking at our Center for Clinical Standards and Quality colleague because she knows a little bit more about this than I do.

MS. DE NOBEL: Yes, I mean, it does

take legislation, you know, the authority to do this, and so you would have to put it in a rule, and, you know, that authority has to come from somewhere --

DR. LILLIE-BLANTON: Right.

MS. DE NOBEL: -- to require, you know, a mandatory reporting of a CAHPS-type survey. I mean, the Hospital -- Hospital Compare and all the compare sites, you know, they are in Medicare-type reporting programs like Inpatient Hospital Quality Reporting Program, there is a series of reporting programs where, you know, those are required.

DR. LILLIE-BLANTON: And let me just say, we have some -- a precedent has been set with the early elected delivery measure. We were able to get the early elected delivery measure in Hospital Compare, and we had to document in order -- what we were asked to do was to document births in Medicare, which are very small, but there are births in Medicare, largely to women with disabilities.

And then that was part of the impetus for CCSQ to include it. It was also part of an agency-wide effort to reduce complications, birth complications, so it was a part of -- you know, it was a big effort at CMS, whereas, you know, we're still trying to get children's issues more widely -- better integrated throughout the rest of the agency's work.

CHAIR GESTEN: But am I wrong in thinking that the -- Marsha, that the -- that the work of the MAP Coordinating Committee and the subcommittees which make recommendations for the Hospital Value-Based Purchasing Programs are -- is another venue in which those groups could recommend that HCAHPS for kids be included as part of the measure set? Is that -- is that correct?

DR. LILLIE-BLANTON: Yes.

CHAIR GESTEN: That's -- that's the other venue in addition to legislative. Rich?

DR. ANTONELLI: I start with a disclosure. So this measure was developed at

Boston Children's Hospital, but I had nothing to do with its development.

But I am really grateful for this frank discussion around this because whatever the measure happens to be, this just is the example, you know, it loops back to one of the comments that I made yesterday about how can we work with CMS to get things that are specifically designed to look at the child health experience into the system for implementation?

So I am just wondering, and Foster, I think what you just talked about was -- was really a key, so moving from strategy, the strategy is if we're going to have child-specific measures or child-relevant measures, can we get them into implementation? So can we just think for two minutes, you know, what are some other opportunities whereby the child health advocacy community can help CMS to be able to move this thing forward?

It is for me a bit of an agonizing journey to know we've got a validated tool that

was developed across the country, and, you know, we're -- CMS is in a position where we're saying, okay, we know what we know, but the following thing or things need to happen. This will be paradigmatic for lots of other issues.

So with the Chair's indulgence, maybe just two more minutes on this topic? Are there other suggestions, CMS, that we can do to help you push this forward?

DR. LILLIE-BLANTON: None that come to mind, but I think the Value-Based Purchasing MAP is a good one. I think that's a really good suggestion that we had not pursued before.

DR. ANTONELLI: But the coordinating committee, or is that too high?

DR. LILLIE-BLANTON: I don't know. I don't --

DR. ANTONELLI: Right, well that's why I'm thinking can we do it top-down or bottom-up, or is it basically scattershot, as many places as we can possibly see?

CHAIR GESTEN: You guys probably know

more about the -- and I know you know more about the process than I do, but the measures come both through committees where this might be relevant as well as potentially proposed or brought up by the coordinating committee, is that correct? But --

MS. MUKHERJEE: So MAP gets measures of the MUC list, so measures under consideration, so then they consider that. That's the other MAP side. And then from the Medicaid MAP side, what we do is we talk about measures and sort of bring them up for consideration. So it's sort of both sides, but whether we're on the Medicaid MAP side or on the other MAP hospital side, the final decisions and review is done by the coordinating committee, so they see everything, and they make the final decisions.

CHAIR GESTEN: Laura, did you want to add something to this? And then we should move on.

MS. DE NOBEL: Yes. So I think with the reporting programs, I think we need to look

at what the -- what is the data that goes into those reporting programs?

So if you're talking about a Medicaid fee-for-service data that are posted on Hospital Compare and those type of reporting programs, there is probably a distinction there between having Medicaid type data in the -- like the hospital inpatient quality reporting, you know, because I believe that comes from, you know, Medicare fee-for-service type data, but I am not sure on that because there are some programs that have all payer -- some measures that have all payer data in them.

But I mean I think the reporting program and what's posted on the Compare sites, you have to look at behind, what's the actual data that goes into that? Because we don't have Medicaid data directly as opposed to having Medicare data, you know, availability.

CHAIR GESTEN: So Rich, I would invite you to circle back maybe. I know that there's some questions towards the end of the day, and

hopefully we still have energy for them to take on the sort of broader issue I think that you're inviting some discussion of, which is how to -- what are the various levers and opportunities to do better integration of child health measures and improvement into existing programs, right?

Can we go to the next slide?

MS. ALLEN: Okay. So this is the 2016 Child Core Set. It consists of 26 measures. As I mentioned, the -- Measure 1360, Audiological Evaluation No Later Than Three Months of Age, was just added to the core set this year, as well as the Multiple -- The Use of Multiple Concurrent Antipsychotics in Children and Adolescents, and that's at the bottom of your screen.

MEMBER LACEY: You were showing the -- yes, on those, those are the ones that are in the set, and some -- and you're highlighting the ones that were recommended last year?

MS. ALLEN: Correct.

MEMBER LACEY: If you're going to get to this, just say. Where -- where are we in the

uptake of the -- or the rollout of the sealants, of the dental sealants?

CHAIR GESTEN: I think we are going to get to that.

MEMBER LACEY: We are? Okay.

CHAIR GESTEN: Yes, right.

MEMBER LACEY: Because I didn't hear it yesterday with the PNET presentation, so that's where I thought I was going to hear it from.

CHAIR GESTEN: I think that there's a slide that talks about where we are in the uptake.

The other thing I would point out in the slide just for folks is, you know, we had a conversation about do the measures have to be NQF-endorsed or not? Clearly, they do not, so you can see that there are a number of areas here. Now some of them may be in the pipeline of -- of endorsement, but at least in the Child Set, there's, what is it, six, seven, six measures or so that are not NQF-endorsed.

MS. ALLEN: Okay. So now I am going to turn it over to my colleague Shaconna.

MS. GORHAM: Thank you, Nadine.

Okay. So what I will do is review some of the 2014 state reporting, and in your packet in your electronic file that we sent you via SharePoint, you had a number of CMS documents, the one-pagers as well as the snapshots, and those snapshots and one-pagers are where we gleaned all of our information to develop these slides.

When CMS published their annual report on child health quality and Medicaid, they noted that the completeness of Child Core Set data reported by states improved in 2014. So for example, more states reported measures for both Medicaid and CHIP enrollees, increasing from 38 states in 2012 to 41 states in 2013 to 44 states in 2014 for a good number of the measures.

The most frequently reported measures reflect a continuum of quality measures for children, including overall access to primary

care, use for well-child care, use of dental and oral health services, and receipt of childhood immunization, and satisfaction with care received.

For FY14, the first year of public reporting for four measures, the HPV measure, the low birth weight measure, the asthma medication measure, and the emergency department visits, these measures are reported by 32, 24, 27, and 37 states respectively.

Okay. The chart illustrates the states reporting Medicaid Child Core Set measures in 2013 and 2014, and you will see that, just to bring to your attention, the CLAPC measure has only data for 2013, and that is because the number of states for which standardized infection ratios were captured, and those are reported by CDC. Next slide?

Okay. So this slide shows the measures with consistently high reporting, so greater than 41 states in 2013 and 2014. They tend to be claims-based measures. Most of the

states reporting using the Child Core Set specifications were based on HEDIS 2014 specifications --

MEMBER PELLEGRINI: I am sorry --

MS. GORHAM: -- and most are --

MEMBER PELLEGRINI: -- Shaconna, could you just get a little bit closer? We kind of have to strain to hear you.

MS. GORHAM: I can. Is that better? Okay. But I'll talk louder. My voice, believe me, is loud enough that you should not have to strain, so -- .

Okay. So again, I will just repeat what I said. The measures on the screen are the most consistently high-reported in 2013 and 2014, with greater or equal to 41 states reporting these measures. They tend to be claims-based measures. Most of the states reported using the Child Core Set specifications, which were based on HEDIS 2014 specifications, and most are reflective of primary care encounters. Next slide.

The measures shown in this slide, measures -- 24 to 39 states reporting these measures, 13 measures. Chlamydia remained the same over FY13 and FY 2014. The CAHPS measures decreased from 41 states to 39 states in 2014. It is important to note that the medication management for people with asthma and HPV, as I said earlier, were just added in 2013.

And these are the three measures least reported. The measures were reported -- between four and 20 states reported on these measures. The behavioral health risk assessment measure was the lowest-reported measure, relatively new to the core set, though, and it was reported in the -- for the first time in 2013. Next slide.

So again, you will remember that you had a handout in your packet with the TA requests received, and the measures with the most TA requests ranged from three to four requests for various reasons. Measures are indicated below on the screen. The reasons are included in the handout.

Non-measure-specific requests were also high. They included reasons such as requests for carts, templates, user information, CMS extensions for reporting, clarification on reporting period and population for inclusion in the core set, questions about timeline for release of core set specifications. While a few measures reported out as having relatively low levels of reporting, the staff did not identify any potential for removal, but we'll talk about that later. I just really wanted to give you an update on the 24, kind of an overview of the 24 reporting of these measures.

CHAIR GESTEN: Thank you, Shaconna and Nadine.

Let me, before we open it up for questions or comments, ask, because I misspoke, Susan, I am sorry, the dental sealants was just added, and I think that states are reporting it this year, so I don't think we have any -- any information yet about what the uptake is like. Marsha, do you have any other information about

that?

DR. LILLIE-BLANTON: Only that it was reported this year, and we will be publically hopefully reporting that before the end of 2016, so it's federal fiscal year 2015 reporting. So you only have the results of federal fiscal year 2014 reporting data.

CHAIR GESTEN: Are you allowed or would you go to jail if you told us how many states were able to --

DR. LILLIE-BLANTON: I think --

CHAIR GESTEN: -- report this?

DR. LILLIE-BLANTON: -- I probably should not do that because it --

CHAIR GESTEN: Okay.

DR. LILLIE-BLANTON: -- has not been shared publically with others, so --

CHAIR GESTEN: Jail? Okay.

(Laughter.)

CHAIR GESTEN: Well, some things are worth going to jail for, some things not so much, so --

DR. LILLIE-BLANTON: Right, that's right, that's right.

CHAIR GESTEN: Okay.

DR. LILLIE-BLANTON: But -- but I can tell you -- well, I can't even say that.

(Laughter.)

DR. LILLIE-BLANTON: You will get some data, okay?

(Laughter.)

DR. LILLIE-BLANTON: And if you -- if you all know when you get data and when you don't, that tells you some indication of --

PARTICIPANT: That there's at least one state.

CHAIR GESTEN: You know, and they say --

DR. LILLIE-BLANTON: No, more than that, you have to have -- you should know how many states -- see I know Megan is fussing at me right now.

CHAIR GESTEN: They say people in government can be vague. I don't know what

they're talking about. Rich?

DR. ANTONELLI: So I'm mindful of how Foster opened yesterday's meeting, and I want to bring that into today, so with goals of looking at how many states are reporting and the number of -- of measures that are getting recording, and then that third bucket was the one that is especially of interest to me, and -- and the -- those that are using the measures, what is the improvement experience? So do we have a summary of the improvement experience that goes along with the utilization data that you just showed us? Impact of the measures I guess.

CHAIR GESTEN: In the -- I think in the -- in the reports that were generated from -- typically I think the report from CMS, there is a description of change over time, and I think the good news for the -- for the Child Core measure is a longer experience, so more experience to look for change over time, and I think in almost, virtually all the measures, there has been, you know, incremental improvement, sometimes

substantial. Is that -- ?

DR. LILLIE-BLANTON: Thank you. When you look in the State Snapshot section, you can see the change over time for the stable group of states that reported the measure over time. So in other words, the median for the same group of states that reported it is presented.

What you won't find is state-specific change over time, but we have begun to do that. We've done it for now about five states upon request, you know, as people have come in, as states have come in to CMS asking for support, assistance, what we've been able to do is work with our contract to track over time for those states.

But in the aggregate, you will only see the stable group of states change over time, and unfortunately -- you know, I think that is something maybe in one of our next meetings we should highlight just so that we can see, are we moving forward, are we standing --

DR. ANTONELLI: Yes.

DR. LILLIE-BLANTON: -- still, or going --

DR. ANTONELLI: Follow-up --

DR. LILLIE-BLANTON: -- backwards?

DR. ANTONELLI: -- question please? And so this -- Karen, this goes back to the conversation you and I had at the end of the day yesterday. So to the degree that it sounds like you're getting requests to do some of the analytics, my mind immediately goes to, okay, and what's working? So can we come up with that bag of tricks so that we can actually, you know, shorten the lag time to deciding to engage in a measurement to actually saying and here's what you can do that would work. So is that part of the analytics that your contractors are doing now in those five states or so?

DR. MATSUOKA: Not so much the analytic contractor. I would say that that -- that approach to how we're doing quality improvement at the state and sub-state level is just now beginning, but I think that's the --

that's where we'd like to go.

DR. LILLIE-BLANTON: So can I -- in your packet, I think you have a brief on higher-performing states. And for those higher-performing states, we have identified -- and there are about, I think there are five higher-performing states that we identified based on their performance on -- on a set of measures, but also that they had reported measures for at least I think half of the higher -- most frequently reported measures.

So for those states, we interviewed them and identified what were the strategies they used to drive their higher performance, and this is the first time we've done a brief like that. So first, the -- there is a series of two briefs. The first is just who are the higher-performing states? And the second brief is what were the strategies they used to achieve that higher performance?

And so -- so I think -- and we sent that to you all, so it should be in your website,

and -- and I can tell you, I mean, what's interesting, you know, and I am trying to go from my memory, which is not all that great anymore, putting the measures in a -- some kind of pay-for-performance was a part of the strategies that were used. Working of course closely with the managed care organizations in doing improvement projects was part of it. There were four or five strategies, kind of big bucket strategies, that were identified.

But it's -- it is the first time we've done that, and it's also -- I mean, we had to wait until we had enough experience. We certainly are not capable of doing that kind of brief for the Adult measures because we'd only had two years of reporting, but for the Child measures, we've got five years of reporting. We only looked at a, you know, point in time, but -- but at least I mean I think we have some confidence in the -- the data we were using.

And I can try to remember the states. I think it's Rhode Island, Connecticut, Maryland,

I think New York was one of the states, so there's one I'm missing. Massachusetts, yes.

So the brief is in your packet, but that is certainly, as Karen mentioned, where we want to go to do more of that, and we actually reviewed that brief because that is controversial. Whenever you start to, you know, highlight states that are doing better than others, there's a lot of concern about, you know, are we being fair?

And so I think the methodology we used to identify them was one they thought was solid enough that we could move forward on and would not be criticized. And then, you know, the review of the strategies was something that they -- they agreed with that.

So the other thing I remember was assigning -- reassignment of -- there are a couple of states that assigned beneficiaries to the higher-performing plans, only a couple that did that, but so -- so anyway, if you go to the brief, you can see all the strategies.

CHAIR GESTEN: Thank you, Marsha. I would also add that there is more detail about some work with the EQROs in performance improvement projects and so on that are also in the information you provided that gets under the hood of sort of at least what some states are doing in some areas on improvement. Susan?

MEMBER LACEY: The number of states that are, you know, reporting the different measures, what I remember hearing from -- in an overview in one of the years is that some states don't report every year, they report every other year. Or they don't report all measures each year, they report -- they have a strategy by which they report some on one year, even year, odd year. I may be making that up.

So that is what I remember hearing. Is that right?

(No audible response.)

MEMBER LACEY: Okay. So in general, when we're seeing a -- an average of -- or the 41, I remember one of your slides said on average

41 states are reporting that, for that snapshot of that year, that's just whatever states are reporting in that bucket of 41. If you looked at the year before, it might say 41, but it might be different states in the 41 number, right?

PARTICIPANT: That's how I understand it, yes.

MEMBER LACEY: Okay. I just wanted to -- because I think that's helpful to know.

PARTICIPANT: Yes.

CHAIR GESTEN: The other thing I'd just offer in terms of looking at progress over time is not only, you know, movement upwards or for some measures downwards, but what happens to the -- to the variation. I was very interested in looking at the measures, not only where they are and where they changed over time, but looking at the 25th percentile and the 75th percentile, and in some measures, you know, that -- the -- I don't think there was tracking movement of that over time, but I would submit that part of the other objective is to not only raise the bar but

also decrease the amount of variation state-to-state. I assume that that's a goal at the federal level, so being able to actually track that would be interesting.

Other -- do we have somebody on the phone?

PARTICIPANT: Yes.

CHAIR GESTEN: And who might we have? Okay. Dr. Singh, do you want to introduce yourself? Operator, is Dr. Singh's line unmuted?

THE OPERATOR: His line is. However, you may have --

DR. SINGH: I am here. Yes, this is -- yes, hi, my name is Gopal Singh. I am sorry for having muted the telephone.

Yes, I am with the Maternal and Child Health Care for Health Resources and Services Administration. Can you hear me?

CHAIR GESTEN: Yes, I am sorry. Yes, we can hear you --

DR. SINGH: Okay.

CHAIR GESTEN: -- thank you. Thank

you. Other comments or questions? We -- we can right now, since we've just presented on it, the information, some of the measures talk about potential removal, or we can save that until a little bit later when we start getting into the individual measures. Do folks have a preference about that?

(No response.)

CHAIR GESTEN: So if there is no preference, why don't we -- why don't we do it all together when we start doing the measures later? Does that make sense? Okay.

So I think we're going to -- the next part of -- of the agenda is to review where we are on the Pediatric Quality Measurement Program measure development endorsement. Remember, this is a -- this has been a multi-year program, and there's a new cycle as I mentioned earlier, really, you know, a significant investment in trying to fill the gaps and address the issues that both this group and many groups have mentioned around the need for better measures,

more comprehensive measures, measures that evaluate things that truly matter, so I think the -- want to give an update about where we are with this and how it affects our work. So Nadine?

MS. ALLEN: So as Foster mentioned, a lot of these measures are already developed, and there are some being developed, you know, but they've been coming through NQF endorsement in waves. Approximately 26 have already completed endorsement review, and many more are still going through the final stages of the process.

I know Shaconna shared this with you yesterday. I am just going to provide a brief overview. The Pediatric Quality Measures Program was established under CHIPRA and intended to improve and strengthen this core set of measures, specifically to generally expand the availability of pediatric quality measures for use by all sorts of 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 in the field.

The PQMP is comprised of seven CHIPRA-funded Centers for Excellence. They have been supported by cooperative agreement grants within -- with AHRQ, funded by CMS, in a multilevel partnership.

So this is a little bit details about how many measures that have been endorsed, that came through the process, and they are now endorsed. So it's 16 NQF-endorsed measures. There are two around readmissions. One is a PRO, which is the gap measure. We have one sickle cell measure. We have a total of two anti-psychotic measures. Three came through the process, and one was not NQF-endorsed. We have a tobacco measure, a pediatric psychosis, and several family experience with care -- coordination of care measures.

Sorry. I think -- so it's eight total family experience along with coordination of care, and that's also in your analytics packet.

So in total, there are 79 measures available. They're in various topic areas, from acute care, perinatal care, clinical, preventative services, management of acute and chronic conditions, patient-reported outcomes, duration of enrollment and coverage, availability of services, and medication reconciliation.

As I said, there are still some measures under development, so there's 24 measures total in development, including perinatal and prenatal care, child clinical preventative services, management of acute and chronic conditions.

And I have in the room with me Kamila, and she can provide a little bit more information about where they are as far as getting these measures out and available to us.

DR. MISTRY: Hi. So yes, so the 79 measures are available, meaning that they've been submitted to AHRQ. I should note that the grants just ended at the end of February, and so we're in the process of looking at those measures,

cataloging those measures, and we -- our hope is to provide all of the technical specifications, the reports that the Centers of Excellence have provided to us. We want to make all of that publically available. It's no small feat to do so, so we're working on that.

In the meantime, our website does provide fact sheets on those measures that we've had for a longer period of time which are kind of easily accessible to folks. And so the 24 measures under development, I should clarify, the grants are over, but -- and so the work has been completed, but those measures are still being finalized, and so we don't have the final measure specifications on those because they're continuing to be tested and fielded, but the Centers of Excellence are sharing those back as those are being finalized.

And so I think from a scientific perspective, they wanted to provide the latest, greatest, best work, and the February deadline, the work ended, but I think they were still

trying to gather some of that data. So again, as soon as that is also -- those measures are available -- and some of those may be part of what they're considering for the follow-up grants as well, so I am not sure about that, but as we get them, we will provide all that information, so -- .

CHAIR GESTEN: Thank you both. Thank you, Nadine and Kamila. Meg, did you have a question?

MEMBER MURRAY: Yes, I had a question because one of these 79 measures is one that I am suggesting the duration of enrollment in coverage, and so just so I am clear, so it is not NQF-endorsed, but it's going through the process?

DR. MISTRY: So I should clarify about that as well.

So a number of measures have gone through the endorsement process. We have been working with the Centers of Excellence. We -- the capacity was not there to put all their measures through, so they selected those measures

that were prioritized and important and they felt were the furthest along with regard to the field testing, and so those measures were put through the processes, and you can see what the results were. Nadine just shared that with you.

Some of those measures, given what we learned from the NQF process, the Centers of Excellence are going back and doing additional testing so they can get through. The specific measures you were asking about were not put through. I guess CHOP, the folks that -- the developer for that -- those measures did not feel that they were prioritized or the ones that they wanted to put through and had the highest sort of chances of getting through that process, and so it was a matter of work time, resources, all of that sort of went into making the decisions about which measures.

There's some additional funding, and so I think there will be another pediatric round of measures that will be -- that might -- that are going to go through NQF endorsement, and so I

think if it's prioritized here, that would send a signal to CHOP to say, hey, get these through. So I think both of those pieces kind of work together with --

MEMBER MURRAY: Because this is an important one, the law actually requires that these core measures have a -- a measure related to duration of coverage, and we don't have that right now, so in a sense, we are out of compliance with the law. And so this is a measure that has been not endorsed by NQF, but it's well along in the process. And I understand it's not endorsed yet --

DR. MISTRY: It has been --

MEMBER MURRAY: -- but it's --

DR. MISTRY: Right, it is not endorsed. It hasn't even gone through that process. CHOP did not put it through this time. It may be that in December or later this year, there's going to be another pediatric call. I don't know the timing of that yet, but we hope, and they can put it through.

They also can put it through other projects. It is just a matter of fit and timing, so -- .

CHAIR GESTEN: May I just ask for clarification about that scofflaw comment, that we scofflaw, that we're all scofflaws?

MEMBER MURRAY: I have a law right here. It says --

CHAIR GESTEN: Yes.

DR. LILLIE-BLANTON: The provision in CHIPRA. The -- CHIPRA did ask that we have a measure of continuity of coverage, and -- but -- but CHIPRA also said we should identify measures in use, so -- so measures -- so we were not supposed to be creating measures, and so right now, we need a measure. And I can tell you that we actually, and Megan can help me on this, there was a measure that was developed, and we tried to put it in our CARTS system. CARTS was the system we used before we shipped it to MACPro.

It was so complicated that -- no, that's not -- it's still there, it's still there,

okay. So we have tried to collect information from states on continuity of coverage with -- with a measure that was developed by one of the COEs, but we -- it is just it was very complicated.

I mean, the operationalizing of the measure meant that we didn't have states reporting on it, and we tried to do training and outreach, so I think having a measure refined that has been validated and tested, it would help us in meeting that requirement because I do -- I mean, CHIPRA asks us to do lots of things, and sometimes the things they asked were, you know, not contradictory, but they were not consistent. So it did say we're supposed to select measures in use, and -- and that measure was under development, and it still -- but it sounds like it's closer to being developed in --

DR. MISTRY: So it has been tested further, Marsha, but I was not sure, I mean, I -- this is going back to my memory, which is not that great, but when Karen Llanos was part of the

program, we did have this discussion. This was early on. And I don't know that we -- I think we did some preliminary work around the CHOP measure and then went back to something else that was kind of in use because it was difficult to --

MEMBER MURRAY: Well that's I think the CARTS one she's talking about.

DR. MISTRY: Yeah --

MEMBER MURRAY: But the --

DR. MISTRY: -- right.

MEMBER MURRAY: -- CHOP one, they have validated --

DR. MISTRY: Yes, and they've gone much further --

MEMBER MURRAY: -- and they've --

DR. MISTRY: -- they've published papers I think. So that's something maybe we could revisit now.

CHAIR GESTEN: We will pick up that discussion because it's on the list for recommended measures. As you said, they put it in. Cindy?

MEMBER PELLEGRINI: So Kamila, I would like to follow up with you maybe offline in the next few weeks about PQMP. March of Dimes, Children's Hospital Association, AAP are the three groups that lobbied for the continuation of PQMP in the next -- in the last CHIPRA reauthorization, and we just barely got the money. I mean, it was a really, really heavy lift to get that money renewed.

And they put us on notice that this program needed to show significant results if we were -- if we came back again in two years. So while the numbers are fine, I am thinking ahead to those conversations and thinking that if we say to them, well, all these measures were developed, but only some of them went through NQF because, you know, we just sort of didn't have enough, I don't know what, resources or whatever, it seems to me like if we're going to put out contracts to Centers of Excellence, taking a measure all the way through the process must be a fundamental requirement.

I understand that some measures may get to a point where you just have to abandon them because they fail, but saying well we could have taken it to NQF but we didn't have enough time, we didn't have enough money, whatever, that's not going to fly with Congress anymore. They are going to say I am sorry, that just means that program doesn't work.

So we -- I would love to follow up with you and maybe others to talk about how we -- how we manage this over the next year or so, so that we can go back to Congress with a compelling argument about how to continue this.

DR. MISTRY: Yes, and I would just say, you know, as somebody who has worked very closely with the Centers of Excellence through this endorsement process and with the team in this room, it's -- it's a tremendous, tremendous amount of work. It's the testing that goes into it.

This was not the bar that was set or even part of the negotiation when the grants went

out, and so this is something that sort of on the back end was decided and thought through. And so I just want to say that up front.

And so I think that it's important work. I think it's -- it's resource- and time-intensive. It's not to say that all the Centers don't know that it is important and that it also I think gets the measures used and -- and disseminated, and so we, I think all of us agree that that is an important facet. It's just a matter of really trying to operationalize that, which is -- has a number of challenges, so I definitely agree. Thanks.

CHAIR GESTEN: Not the least of the challenges is convincing people about the value and virtue of parsimony in the development process. Charles?

DR. GALLIA: It's a process question actually more than anything else.

I don't -- I believe it's not necessary to have a measure be NQF-endorsed in order to be part of the Adult or Child Core Set.

Is that -- is that correct?

CHAIR GESTEN: Correct.

DR. GALLIA: Okay. So they could be moved through without that step?

DR. MISTRY: So yes, and I think the Centers of Excellence also know that. I also think that they still believe that, you know, that's an important part of their work, and, you know, continue to do the field testing to sort of meet that bar as well.

CHAIR GESTEN: Jeff?

DR. SILBER: I am just asking for a clarification: what does the process look like if they don't come through NQF? How -- how do measures get into the set -- I mean, how do you consider measures aside from NQF?

CHAIR GESTEN: You guys want to -- well, do you -- if you want to talk about your -- how you come up with the -- how did you come up with the spreadsheet, Excel spreadsheet?

MS. GORHAM: So the Excel spreadsheet that we put together we actually took our

repository here at NQF, so the measures that have been submitted to NQF is what we put in the spreadsheet. We also have measures from PQMP that Kamila also let us know that was ready. Those measures have not been submitted to NQF.

So you will see later for example the CHOP measures. We have on the sheet a task force member recommended those measures. They have not been submitted. So from an NQF perspective, we don't have testing, evidence, all of that type of information, but it is on your sheet. So you can vote on it -- well, the task force members can vote on it, but we would conditionally support that measure because technically, NQF, we don't have any information on the measure.

CHAIR GESTEN: And then the last was the individuals in the lead-up to the meeting were -- task force members could submit measures as well, so the NQF repository, the PQMP program, and submission by members, right? Is that the three sources?

MS. GORHAM: Yes.

CHAIR GESTEN: Okay. Rich and then Kamila?

DR. ANTONELLI: A follow-up question to that: if there's a measure that gets put forward that is not NQF-endorsed but is recommended to CMS for inclusion, is there a fast track mechanism within the NQF to get something endorsed quickly?

MS. GORHAM: The only way a measure is endorsed at NQF, if there is a project that is funded for that measure to actually be submitted to. So is there a fast track? The answer to that would be no. We actually have to have a funded project in order for that measure to go through the endorsement process.

DR. ANTONELLI: And the project would be a grant given to the NQF to evaluate a measure?

MS. GORHAM: So a project, say the -- I am sorry, say your question one more time?

DR. ANTONELLI: So I guess I am not -- what is the operational definition of a -- of a

"project"?

MS. GORHAM: So a project is funded, for example, a project would be funded by CMS, so example, the Pulmonary and Critical Care Project --

DR. ANTONELLI: Yes.

MS. GORHAM: -- a project was funded, we receive funding from CMS. The project was funded. It started in October 2015. Measures were submitted to that project. And then --

MS. MUNTHALI: I think -- okay. What Kamila was saying earlier, we are hopeful. We can't talk right now about confirmation of a Pediatric Measures Project, but that would be a likely project that these measures would go into.

DR. ANTONELLI: So that's -- that's helpful. It segues back to the conversation we had about 30 minutes or so ago. If there -- if the traditional approach is this heavy of a lift, and yet there is urgency, and Cindy, I would actually, if I'm one of those senators or representatives, I don't know that I would be

willing to give us a pass to say well look at how many measures got created. I'd want to take it to the next level and say, you know, what I call the so what factor, and here's how much improvement it was.

And you know, so that is really critical. Okay, so thank you for -- for sharing that.

MS. MUNTHALI: The only -- the other thing I would add is that we also offer technical assistance, and we've been working with Kamila and many of the developers that had previously submitted measures to the Pediatric Measures Project, and we can do that in this interim period as well as we prepare for the next project.

CHAIR GESTEN: Kamila and then Carol?

DR. MISTRY: So I'll just clarify a couple things.

One, before the last pediatric call, one of the main barriers were even as folks were developing measures in the first couple years,

putting them through the endorsement process, those calls were not timed because there was no reason to have them timed, but the asthma call, if I completed an asthma measure, it may be nine or ten months or longer, or not even on the books, with regard to getting it, you know, through that process.

It was only much later that we sort of started to work with NQF and CMS to try to make, you know, make those connections. So not all of the measures went through the pediatric call. Some of them went through pulmonary. Some of them went through --

PARTICIPANT: Perinatal.

DR. MISTRY: -- and -- and health and wellbeing. Some are after the pediatric call, there are additional calls coming up, and so some of these measures, 79 measures, will go through those other calls to get through the -- to get through.

So I think, you know, the Centers are continuing to do that. That said, you know,

endorsement is not a necessary step, but we do consider it to be an important step and something we are working toward.

CHAIR GESTEN: Thank you. Carol?

MEMBER SAKALA: Yes, so Shaconna, I just want to ask you for clarification about the bar on this because we do have measures on our set that do not have NQF endorsement, but at this meeting, I am hearing you steer us to the one option, if they don't have it, is conditional upon it in the future. So that is a higher bar that is now set compared to the past?

MS. GORHAM: So it has always been the same. So when we -- when the task force members recommend a measure that is not NQF-endorsed, we have always said that you're recommending to CMS for addition upon the fact that it is NQF-endorsed, so it has always been a conditional support.

MEMBER SAKALA: So -- so then CMS just decided to take it anyway?

MS. GORHAM: Yes.

MEMBER SAKALA: So that's --

MS. GORHAM: So CMS has --

MEMBER SAKALA: Yes.

MS. GORHAM: -- that option --

MEMBER SAKALA: Got it.

MS. GORHAM: -- too.

MEMBER SAKALA: Okay.

MS. GORHAM: We make the recommendations, and they choose which measures that they want.

CHAIR GESTEN: But let me clarify, the bar is not -- it's not specific or unique to the task force. The bar has been set by the MAP generally around measures, and we'll -- later in this section, we get into the measures, you'll review that measure selection criteria.

So whether it's the MAP making recommendations for, you know, value-based purchasing and other settings or whatever, the -- the agreement of the MAP has been to look for endorsed measures unless there is no relevant endorsed measure there, and then obviously CMS

has some discretion relative to accepting measures that are not NQF-endorsed, right? So this is, again, just to point out this generic policy and not specific to Medicaid Task Force.

MS. GORHAM: One thing to remember, the task force, the Medicaid Task Forces are under MAP. So we fall under MAP. So we follow all of the rules of MAP, and we have to, after you all make your recommendations, we have to report to the Coordinating Committee, and they have to bless our recommendations, so we are definitely under MAP.

CHAIR GESTEN: Gets to your question. David, do you want to introduce yourself?

PARTICIPANT: Your microphone.

: Usually volume is never an issue. It's always a content problem with me. I am David Hunt. I am from the Office of the National Coordinator. And I mentioned earlier on Wednesday that you can sort of think of me as a very downgraded version of Kevin Larsen.

CHAIR GESTEN: I am already endeared

to you by your comments, so I wouldn't -- I wouldn't say you're downgraded at all. So thank you, and welcome.

Somebody had a quick -- Andrea?

MEMBER BENIN: I think, you know, I was under the impression and have been from the beginning that we can most certainly recommend things that are not NQF-endorsed. It is up to us to frame the recommendation that way. But I mean, I think that over time, this process has sort of narrowed into this -- there used to be more choices when we voted, and now it's just yes and no, and it means conditional if it is not endorsed. Like that has really changed, and that's not how it -- it's not how it always was.

So it has evolved into that categorization, but I do think that we should feel free if we have metrics that are not NQF-endorsed to advocate for them to the extent to which we think they have appropriate scientific validity.

I do think that, you know, Shaconna

and Nadine may be limited in their ability to accrue metrics that aren't NQF-endorsed because how do you find them? I mean, they aren't in the database, because that's hard sometimes unless people are submitting them, and that is just reality.

And I do understand that. It may be that a number of the metrics, and I don't recall the timing of this, that are on the list that are not NQF-endorsed, some of those may predate the MAP process because prior to the MAP process, wasn't there like a SNAC? Or there was some other committee that originally set up this list, and so I don't know if that -- some of those are legacy things.

But I just think we should be a little bit -- I think that NQF endorsement reflects a level of rigor and testing, and that's important, but to your point, it doesn't -- if we have an opinion about it, we should feel free.

CHAIR GESTEN: Yes. I think the preference for all of us around the table is that

folks, if they have ideas, that they present it to us, you know, in time so that we can do the -- so that we or they can do the necessary background to answer the questions that the committee will have about exclusions, denominators, testing, methodology, has it been shown to improve care, and so.

So I think we've -- we've created that opportunity for folks to bring those forward, but have also said that if you're going to bring it forward, you have some responsibility to bring that information forward as well so that the group can make an intelligent decision about the measures. So I, you know, agree with you that the process has evolved over time, but the door is always -- remains open around measures that fall under the categories that you -- you describe.

Kamila?

DR. MISTRY: I just have a quick -- so the other issue is that I think prioritizing things that are important, you know, and

listening to this group, the measure developers can also think if I've got ten measures that are completed, which ones should I prioritize to think about with regard to the measure endorsement process? Because resources are limited, and so what would those be? So that is also an important function here, I think.

CHAIR GESTEN: So with the indulgence of the group, I think we'll move on in the agenda, and the other answer to your question Rich about, you know, what's working I think neglected to mention that we have two folks from two states who are going to talk a little bit about what they're doing.

So it is my pleasure to introduce first Jeff Schiff, who is the Medical Director at Minnesota Department of Human Services. He also has been very involved, as he has mentioned, in the organization and the leadership of the Medicaid Medical Directors nationally, and somebody just mentioned the SNAC. You were an early SNACer, right?

So I think Jeff -- Jeff actually probably has some direct and indirect responsibility for the predecessor of the list that we have currently when this was -- this process was under a different organizational heading, so it is fitting that you're here. So Jeff, coming from the state where everyone is above average, can you -- I'll turn it over to you.

DR. SCHIFF: Yes, I will --

CHAIR GESTEN: And just for process, we're going to -- there are some questions at the end. We're going to have both Jeff and -- and Charles present, and then we'll go through some of the questions and -- and so on. Go ahead.

DR. SCHIFF: So I will try to fly through this in 15 minutes or so and then leave room for questions.

And I think I have -- I showed this to the staff I work with who does the actual measurement calculation, and he said, with 40-some slides, he said what about parsimony? And I

said okay. Point well taken.

So I want to -- I'm going to go ahead and go through this a little bit, and I have -- I think I have an overarching theme, which is that there's a lot of measurement, and the quality of the measurement process that we're talking about here, but I am going to talk probably a little bit more about how that relates to quality improvement and how we in states see -- I'll talk mostly about Minnesota, but also some other examples about how states see quality improvement because I think that -- I'm going to go here first -- I think the thing we're trying to impact we all want to say is okay, at the end of the day, we have less premature babies born, less moms addicted who deliver babies unsuccessfully, this is all obvious.

But I think -- I think we have to really think about it because we've really funded the measurement development enterprise way better than we've funded the measurement improvement enterprise, and the states are anemically funded

around -- around measurement improvement, and the -- I can tell you stories that won't take -- I can't do in this 15 minutes about how we scrapped together to do quality improvement.

But I want to -- my -- my theme, because Garrison is about ready to exit his role on Prairie Home Companion, I decided I'd pick up a -- a Prairie Home Companion theme because -- but I tell you, this is my theme about quality improvement. To do quality improvement, you need Powdermilk Biscuits because they give shy people the strength to stand up and do what needs to be done.

(Laughter.)

DR. SCHIFF: And so I think this is really around -- I really want to say this because I think it's really important: quality improvement is around having data and stories that go together well and then being able to go to people and having what I call turning conversations where you actually can say to the doc who is inducing your babies under 37 weeks

that we can't do that anymore, and what our job at the state is is to stand up to people who can do that at the local level because we've given them the Powdermilk Biscuits to do that, you know, the strength to say there's somebody behind you that stands up for something.

So it is really about how do we do these turning conversations? So I want to -- I am going to go into measurement a little bit. I'm going to talk about what we're doing around measurement and parsimony and the IOM report in Minnesota. Then I'm going to talk about quality improvement.

So our decisions around measurement are -- are guided by the purpose of the measurement. It's interesting that we have in the past in these conversations talked about accountability at the state and health plan level, and then we talk about quality improvement as if that's not accountability, but it is accountability.

So I think accountability at the

state, MCO, accountable care organization levels, one level accountability for quality improvement at the provider and community level is where I think it's worth spending a lot of time. We have measurement to compare populations to identify disparities and do a lot of work on that, and then measurement to develop policy, that story plus the data that I can go to the legislature with and create a fiscal note.

So the traditional Medicaid levers for changing behavior are MCO contracting, changes to payment models to providers, and then focused policy and payment initiatives, and I'll talk a little about each of these.

But I think these are the real levers, and I want to talk -- look at these for a minute. Financials are a real lever, though not the most successful I would argue. We are starting a level around opiate use, around disenrollment of providers, so you get to wear a scarlet letter and stop being a provider if you really are out of line, but we give you a long time to get in

line.

Competitive spirit is the one we don't use enough. We -- people do not want to be below average, even outside of Lake Wobegon. So I think that's important.

We have used reporting burden as a lever in a very significant way when we did our Early Elective Delivery Project and said you cannot be part of this project, but then you have to tell us about every delivery, and the -- you know, reporting burden is an issue. Maybe we should use that with the Office of the National Coordinator. No.

(Laughter.)

DR. SCHIFF: But anyhow, and then the last thing, which I don't think we should underestimate, is people have said to me very directly, Jeff, we do things not just because you tell us to, but because we do it for our patients, so I think it's important to keep that in mind, and that -- the last one gets into where our gaps are and whether we have the courage to

look at our gaping holes and leave them there.

So measurement for accountability at the health plan level, these are our withhold measures that are financial measures for PMAP, which is our Prepaid Medical Assistance. The first three are measures that the legislator put in. I have talked to this legislator a long time and asked him to mend his ways because they're really hard to get to. And the last three are measures that -- that are -- two of which are measures from -- from this set, but they're not -- there aren't 25 on there. We have tried to be selective.

I want to talk just about the legislative ones because they are so out of reality. A reduction in plan's emergency room utilization rate by five percent. The managed care or accounting purchasing plan must achieve a reduction of no less than 10 percent per year of ER use, and it's like the only way you can do that is to change the way you counted ER visits, you know? But it's -- and you need to get to --

they were supposed to get to a 25 percent reduction, and it was supposed to be five percent of the health plan's cap rate.

Well, that was just fiction, you know, because it was not going to happen. Here is the real reality, is we have a five percent withhold for quality. The health plans are guaranteed to get back all but one percent of that. They get partial credit for any of those six goals, so they have to decide how much effort they're going to put into something that's going to be at most one-sixth of one percent, and then they get partial credit for moving towards the goal, so the financial incentive is tiny. It's the embarrassment incentive for the health plants that I would argue is a bigger deal, and they -- they want to get these incentives because one percent of a few billion dollars is still some money, but some of them are hard to get to, and they just don't -- they don't necessarily have that effort.

And other states put way more measures

into the withhold, but I think it's -- I think we have to be careful about expecting too much out of the withholds from the health plans. I think there are better ways to do it.

So we -- one of the better ways we've done, and this is about something that is not related to this, what's being endorsed today -- today is around quality improvement, we developed an opioid quality improvement program where we create -- where the -- we had a process to create guidelines and communication tools. We're actually creating internal measures, and this is something that I think we have to think a lot about nationally, is we created our own internal measures of acute use, post-acute -- and post-acute use, and now we're working on measures of chronic use because we don't really have -- we have to get these done. We don't have an opportunity to bring them through a big process because opioids are a gigantic deal in every state, and we need to figure out what we're going to do.

And then we have new leverage in this process by which we're really saying to providers we're going to tell you where you're at compared to your peers. If you stay out of compliance with where you are and you're way on the far end of the bell curve, we're going to tap you on the shoulder privately first and say you're not in compliance, and we're going to ask you to give us quality improvement processes you're going to use, and then if you stay out of line, we're going to tell you you can't be a -- a provider for our public programs.

And in that way, we have really sort of politely but firmly twisted the arm of some of our providers to say we don't want to disenroll anybody, but we want to tell you that we will if we have to. And so we've used -- we've created leverage around quality improvement that are strong enough to move -- to move it.

And the important thing for us at Medicaid is we got the Medical Association to agree to this because we said this is your

problem as physicians, or our problem as physicians, and we have to do it, and the Steve Rummler Foundation is a foundation that looks at -- from the -- from the folks who have been affected by overdoses.

No financial incentive: I talked about this already. Anyhow, so we want healthy birth -- this is my little advertisement for the state bird.

So to the core set, I want to talk a little about what we report, and then about burden, and then what we're doing in Minnesota around this and what I think other states are thinking about.

So we have -- we have committed internally to reporting on 12 measures, which is a -- a doubling of what we report in our core set for children in Minnesota, and these are the access and preventative care ones. These are the maternity and perinatal health, behavioral health, chronic conditions, and oral health ones.

So we are trying to -- to bump these

up. But every one of these measures requires an analyst to spend a week or more to pull out the data to know what the specs are, and the analysts are -- are doing other things around managed care rates and other projects that we have for them, and they -- we get this estimate from our data people about how long it takes to do these measures, so we have to really justify that there's a reason to do this that's important besides -- you know, that's important for quality within our programs, not just -- and part of it is being part of a good national player, but -- but part of it is what are we going to do about the information?

So I asked my data people what they thought of what could be done to improve reporting, and they said here's what we came out with. Find the right people in the state responsible for -- for doing this, not -- because you can get to me, but I'm not the right person. Technical assistance must be proactive and not reactive if possible. Respect the effort of

state reporting. Provide -- and I think precise is really important, technical specifications, it's really a problem if the tech specs aren't out, and people start looking at these.

And then people want a return on the reporting investment, so one of the things I will just say about that is if their return could be more timely about where we are compared to other states, that can sometimes drive policy. And even if it's not perfect, it might be good to do that sooner.

So Minnesota is unique a little bit because we've always had the state reporting system that -- that parallels the national one, and we have the State Quality Measurement and Reporting System just to say that we're living in two worlds. We have one foot in trying to match up our work with what other parts of the state are doing in the private sector, and another part of our world in trying to match up what's happening in Minnesota with the rest of Medicaid.

So I want to talk about burden for a

little bit. This I think I -- I used this slide last year when you guys asked me to come, and I just wanted to show it again. Doctor burnout is something that we talk about, and how do we prevent that? There was an article in -- in Health Affairs that looked at this and just said the average physician spends 2.6 hours per week, and their staff spends 12.5 hours per week, on quality measurement and reporting.

I don't know if those numbers are right or exaggerated, but I think they are certainly representing some disgruntlement, I guess. And this is the dollar amount, if that is true.

And the last -- just a couple points, here is that 28 percent use quality scores to focus their quality improvement efforts. So that's -- that could be going up and a good thing, or it could be going -- or we could look at that and say we have a long way to go before our measures are relevant.

So I want to go deeper and talk about

what we're doing in Minnesota around measurement. We were pretty excited about the IOM report. It came out at the same time that we were looking at what about measurement burden in Minnesota, and we developed our own report, which I think you guys have seen, called Too Many & Not Enough: What Matters Most on Care Quality Measures.

And we looked at two things. First thing I want to talk about really quickly is looking at what measures we want to -- we want to put an effort into, and we're trying to do a state effort around how -- what's important in Minnesota around -- around measures, and really trying to say there are places where there are too many, and we're going to try to create some room. And we figure we can build some social capital by decreasing the amount of measures that people feel obligated about.

This, if you -- if you don't have a -- don't recognize this grid, is what came out of the IOM report, and there are domains of healthy people, care quality, care cost, and I think the

-- the last one is engaged people, I think.

We looked at those and said here's the ones we can affect in Medicaid, in healthy people, and in care quality. Then we took those and we looked at -- at what we have in there, and then we matched those to the last two columns, what's in the core set right now and what's in the Minnesota set.

And what we're really using with this stuff is we're going out to a number of different communities now. We're going out to our managed care medical directors, we're going out to our -- our hospital association, we're going out to our medical association and saying what of these really matter that you want us to focus on with you? And then something that I am really excited about is we have an intern coming for a year, and we're going to go out to our racial and ethnic communities and ask them what's important to them to measure.

And we expect that with that, we're going to actually create a parsimonious set that

we're going to come back to you all and say this is what we want to spend our time reporting on and improving, and we hope that you'll give us the -- what's the -- Marsha, what's the quality version, the state version of the -- of the quality reporting for managed -- on the managed care rule that we're allowed to apply for? I forget the initials.

PARTICIPANT: The Quality Rating System?

DR. SCHIFF: The Quality Rating System, yes. So we're hoping that -- I think I'm going to push for us to have our own version.

So these are the things that are important to measure, obviously access, quality, satisfaction, and then what we use for change and improvement. And this is the grid that we created around that just -- and you have this, you can see it, but you can see that some of -- a lot of access measures, a fair number of quality measures, a little bit on satisfaction, and the change and improvement are the ones where we

actually have programmatic efforts around quality improvement on.

So that's really quickly on the burden, and then the aspirational stuff, which is what we don't have enough of, we don't have enough patient-reported outcomes, patient-reported experience of care, EMR-derived measures, and then I've already talked about the other stuff.

So projects we'd like better measures on, I talked about this before, I think a lot of these are things you know. There -- I think there's some exciting work here and with the Center of Excellence that was sponsored by AHRQ on care coordination and case management, and then Rich's work on that. I think we have some interesting opportunities there, but then we have to figure out the collection burden as well.

And then just a couple other things really quickly: we want to look at -- we've done some interesting work, in a lot of states, there's a lot of interest on family and social

risk factors among the Medicaid Medical Directors. We had a webinar with Christie Patel on this and had incredible attendance and very excited about that.

So I think there's -- people are really trying to look at family and social risk factors in Medicaid and get under the hood and not just report a few major ethnic group categories and then not -- and then report on -- on outcomes based on that, but really say what's under that? What do -- what are the issues for us that -- that are -- create multi-generational poverty that we can impact in the healthcare system? Because that's really where the -- you know, that's the gold ring I think right now for us, is to say what can we really do to impact that?

One of the things that was exciting from our State Improvement Model, our SIM grant, is that a group got together and talked about things we could commonly measure across the sectors of the social service sector and the

healthcare sector, and what are the priorities that we need to measure?

And these are the six things that that group now looked at, and if the folks who are here nationally would look at these and think about helping us measure these the same way between the social service sector and the medical sector, I think we will have really, you know, gone light years towards our journey about -- about addressing this on both sides.

Mental health and substance use disorder, how we define that between different sectors; race, ethnicity, and language is something I know there has been some good work on; transportation came up; social services already being received; housing, and I think that's not just homelessness, but it's housing insecurity, did you miss your rent payment, or are you going -- are you worried about that; and then food insecurity, and that's what our group in Minnesota looked at, and these are factors we're going to work on standardizing collection

and reporting across sectors on.

The other thing we got a little money from the feds for is social risk -- not from the feds, from the legislature, the -- our FQHCs came and said we want to get paid more for social risk factors, and we said how are you going to do that and what do you do? So we're working on a little bit of money on a payment structure that asks and answers these questions: what are the social risk factors that impact health? Which of these factors can be impacted effectively by the healthcare system? And how much should it cost to provide this intervention? So a lot of -- a lot of opportunity for cross-sector work as well.

And then some other things that you guys know, measurement infrastructure, we would love to get more EMR personal health record information. We would love to figure out text app reported health outcome measures and totally think about different ways of reporting. The whole rest of the world does that, but we don't, and I think there's ways that that can happen.

And then I think feedback to providers in a more timely way really has changed our equation for our accountable healthcare organizations. They love the feedback. It's actionable because they get it a month later.

So -- and this is just me making the point that you shouldn't go 167, but -- but people get feedback, you change your behavior, and we change our behavior when we see these speed things, so I just really want to emphasize that.

So opportunities I want to talk about at the state level, I think there really needs to be some effort at assessing capacity at the state level, and capacity in three areas: capacity to report, and the AQM did some of that; capacity to do quality improvement, again, the AQM did that, but we need more sustained efforts, as well as the CHIPRA quality efforts; and then to sustain systems.

All of us at -- when we get together as Medical Directors talk about how hard it is to

sustain these systems, and I think that is really important to keep that in mind, that asking to report more without having sustainable models in states is really a challenge.

And the value proposition for legislators and policymakers is really where it comes down to. I can get money for an opiate program because I can both -- because they both know the story of how that's important and I can provide a fiscal note that shows savings over a four-year cycle if I -- if I produce that, but some of these are harder to do, but that's what they really are reacting to, so you need to -- we need to think about that at the national level when we think about how to sell this at the state level.

And people, there's a guy from Alabama who has been at a lot of our meetings who talks about the ROI on a measure, so what's the ROI on -- on actually getting a measure implemented in the field and -- and measuring it, and I think we have to be conscious of that, and that's where

we're at at the state level. What are we going to do with this, and is there an ROI on reporting it?

My last slide, and then I'll be done, is we at the Medicaid -- I want to -- I am -- this is an unabashed advertisement. The Medicaid Medical Director Network is this group that has been around for ten years. We have had a few iterations. We now reside at Academy Health. 65 percent of us in a survey of 37 of us ran or participated in the quality improvement and performance structure.

We don't have a good enough infrastructure of ourselves at a national level, or as I've been saying all along, at the states, to develop this, but we could. You know, we can be the drivers of quality improvement. We need to -- we need -- we know both the measurement and the improvement, and I tell people that if the Medicaid Medical Directors have a superhero, it's Elasti-Girl because we're the people who talk to you guys and the policymakers, and then we also

are the people who get yelled at at retirement parties by our -- by our colleagues who say what's that BMI measure for? That has no relevance to me.

So we're living in this gigantic space that spans everything, and I think you need to think of us as -- as colleagues that can be -- that could use a little more resource. And we're competitive too. We want to be above average for all of our states, and we could lever other partners. We're working right now, trying to work with the National Academy of Pediatrics to develop a -- some sort of quality improvement project.

So my last nod to Lake Wobegon is that -- is that Lake Wobegon, where all the women are strong, all the men are good looking, thank you, and all the children are -- and all the children are above average, and I think that this is -- I love this because it's the great statistical paradox, you know, that we -- we all want that, but -- but I think we can do it if we work

together in a better way. So thank you for the time.

CHAIR GESTEN: Jeff, thank you so much. Thanks for going quick and condensing it and hitting really I think a lot of the points that we're, you know, constantly grappling with about the utility and the implementation of measures in a real context.

There's a set of questions that the next slide shows, and these are the questions I think we should probably wait to discuss after we hear Charles as well, if that's okay with the group, but if -- if there are clarifying questions that people want to ask Jeff right now, feel free, and then otherwise we'll move on to hear from Oregon, and hearing from two state experiences I think and then having a discussion might be a good way to -- to bring out issues and differences and similarities.

But any clarifying questions for Jeff? Meg?

(No audible response.)

DR. SCHIFF: It's not -- I mean, I agree, it's relatively small, but for the states, it's -- it created the opportunity for an infrastructure. Yes.

CHAIR GESTEN: Susan?

MEMBER LACEY: You -- and that was in -- I was looking at something, that was in reference to what?

(No audible response.)

MEMBER LACEY: Okay. I was just Googling the network, and it's not a lot of money, but what are you -- what's the PCORI money going to be helping you do?

DR. SCHIFF: So PCORI gives us a grant to do really two things: one is they want our input into what things should be -- they should be doing comparative effectiveness research on, so we give them a report every year and say these are the issues that are important to Medicaid; and then they also want us to -- we comment or work on their products with them, so we will talk about how we can -- how -- how we can use their

products, a lot like when AHRQ was our funder, the -- very similar kind of input.

But it is also -- the network really has I think three goals. One is it gives us the opportunity to meet as colleagues and to compare notes and -- and go back to our states and do it for another year or another six months, you know. And then the other thing is to -- we -- you know, some of us have been on committees like this nationally because we represent the network. And then the last thing is these quality -- these projects, and I think there's a lot of -- there's a lot of opportunity if we can get -- because we can pull together state resources and compare states on projects is the other thing we're -- we'd like to work on.

CHAIR GESTEN: So why don't we move to the next speaker? Again, welcome, delighted to have Charles Gallia. He is the Senior Policy Advisor for Research and Evaluation at Oregon Health Authority. Like Minnesota, Oregon is one of those states that -- or it's known on the East

Coast, Oregon, is one of those states that we -- that -- that at least we in New York often look to as sort of often ahead of the curve doing interesting things, states worth -- state worth watching in terms of the development of their programs.

So Charles, thanks so much for -- thank you both for taking the time and traveling to be here, but I'll turn things over to you.

DR. GALLIA: Thank you.

I feel like I am part of a legacy because I was also on the SNAC as co-chair with Charlie Irwin, so the second evolution of the reviews, so I have great empathy for the group that's here and how -- the challenge of reviewing those measures.

I am also kind of a little bit humbled following Jeff, and the way that he has articulated some of the areas and issues that face Medicaid programs, and the time and energy that he has spent on keeping a focus on population health and still has a clinical

perspective that drives change at a -- at a local level.

One of the things that the American Academy published recently in pediatrics is a really great policy statement on poverty and -- and childhood. I recommend those people take a look at it because it covers a broad array of issues that are relevant to the way that a state Medicaid program looks at the drivers and the causes of healthcare and healthcare disparities.

So that's not part of my planned presentation. This was, and I -- what I am sharing with you is the fact that I actually was a PI on our CHIPRA Quality Demonstration Grant too, and that was a three-state project with West Virginia, Alaska, and Oregon.

And the reason I show this slide is not just because it's from Alaska, but I wanted to show -- it's the -- it's the impact of having perspective, and this was -- that one shot was obviously a close-up, and the second one is the shot of me from a distance, and -- and I think

they generated different feel.

And so similarly with a national perspective or a multi-state perspective or a state plan and clinic level, what you look at and the level of detail actually can make a lot of difference in what you see.

CHAIR GESTEN: Charles, can you -- you're a soft-spoken guy, but can you move closer to the mic so that folks can hear you a little bit better?

DR. GALLIA: Right.

CHAIR GESTEN: Thank you so much.

DR. GALLIA: Is that better? A little better? All right. We are getting some nods.

Okay, so as I mentioned, this national perspective, and part of the drivers that led some of the review work and our CHIPRA Quality Demonstration Grant work, and I'm going to point to it a little later, is that there was a charge that was put in the CHIPRA legislation. This is preceding the revisions that it -- of MACRA now.

And it -- the core set was to be --

the type of measures, and I've listed it here, that taken together can be used to estimate the national quality of healthcare. And there's some specific sub-components of that that I wanted to call out. One is children with special healthcare needs; do comparative analysis on healthcare quality; racial, ethnic, and socioeconomic disparities in health and healthcare. And they make a distinction between health and healthcare, too, so I want to make those important points.

Some of this work is still underway through the AHRQ's efforts, but I think this is something that I think is unfinished, and it still needs attention for us to address and look at measures that are being produced and selected with this lens behind them.

And when I -- I mentioned already that I participated in that previous SNAC, and so I understand the challenges that you face when reviewing a lot of work, a lot of great energy, important topics, and then have to make this

essentially political-economic choice between what is going to be preferred in this core set versus what's not.

So when -- Alaska, Oregon, and West Virginia were the participants in our Three-State CHIPRA Demonstration Grant. We produced measures over time. Some of them we used for quality improvement, and when I say some, we narrowed it down to five. And -- and it wasn't simply because we were reporting across each group, but it was because, and I'm glad that the person from HRSA is on, because some of them were driven by choices, but about what I call measurement inversion. They were already being produced, so that it wasn't really a selection that was being made, it was because they were part of a uniform data set, the reporting FQHCs or some other standard, that they were already in place, so that gave considerable weight to why they were included.

Part of the responsibility that Oregon assumed in -- in the CHIPRA Demonstration Grant

was to report all 24 of the core measures, and we did that in some cases knowing that the end result following the specifications may result in information that wasn't reflective of -- it didn't have face validity.

And a good example of that is using the administrative data, we have BMI rates, and if it were that way in Oregon that we had 0.8 percent of our population being obese or overweight, you know, it would be okay. But I know it's not true. And part of the reason that I know it's not true is because we triangulate with other sources of information.

It is more accurate in West Virginia because we also checked it at a clinic level. So the reason that I am presenting this is that that helped us make the determination which sources of information we would use, which are most reliable and valid and how.

We did show I think probably one of the most remarkable changes that I have ever seen -- well, I am happy, and -- and that was in our

developmental screening rates. What it shows here is 2012. What it doesn't show is that in 2009, we were at 9 percent. So between 2009 and 2014, we moved up to 42.6 -- 42 point -- now we're at close to 50 percent of the population being screened routinely for social and emotional delays as well.

And this was supported through the grant and our Pediatric Improvement Partnership, and it was really -- it was on the groundwork, and it wasn't really necessarily the measures that did it, they complemented it. The driver was performance, but we didn't have one in place. We started that work because of the National Children's Survey, and it showed where we were, so we had at least a gauge of where there was problem areas, and that helped set our priorities in emphasizing QI.

So -- and I highlighted a couple others, and I -- we discovered how the ADHD medication in West Virginia performed so well. It's because they PA all of the scrips. So

there's a -- there is a visit that's set at the time of the scrip so I know how that works. And we started to move towards that area. It's a little tough in a managed care setting.

What's great about this particular contrast is that Alaska, and you need to be very mindful of this when you do your reviews, Alaska is a Medicaid expansion state. It is not a CHIP state alone. What that means is that there is not any distinction programmatically when you apply.

Oregon is a hybrid state. We have managed care, but it covers both CHIP and Medicaid. So that means some of the reporting components are applicable to both populations.

West Virginia has a freestanding CHIP state. That means that they contract with managed care organizations for CHIP services for CHIP children. So when we make some comparisons at a national level between those programs, you can actually be looking at significantly different delivery systems, populations,

continuity, and the ability to influence or effect changes at those levels.

And I know that in the reporting system that we have, you make -- the MACRA and the previous one, the CARTS system, both were able to parse out which populations were included in those sub-groups. But I just think it is important, we -- when -- to bear in mind that the delivery system is going to have an influence on the ability of the state to produce information. West Virginia for example has to submit a request to the MMIS or have a contractual obligation with their managed care organizations to generate the information.

A state like Oregon that has an integrated system can rely principally on its own Medicaid managed -- its MMIS to produce the information with staffing that's available. And similarly with Alaska, but Alaska also had the challenge of during the course of the end of this implementation, going through a transition in the vendor and the operating system of their MMIS, so

that's something to bear in mind.

So when things shift on a medical record, you introduce an EMR at a clinic, it's very disruptive. At a state level, it can stop everything.

So I am -- I am not going to go into these specifically, but I am going to make them available for the members afterwards. But there are some high-level lessons that I -- I just want to point to. One is that going back to that initial charge of the core set, talking about stratification, almost every single measure that we have, with the exception of those broad-based population ones, for example the access to -- access to primary care, are almost impossible to stratify with anything -- and do anything meaningful about them. Over one year, it's the -- the ns are simply insufficient to do that.

And then if we try to translate that back down to a practice level or a clinic level or a managed care level, you will see in a second how difficult it is to make something actionable.

What I mean by actionable is like this is where the root of the problem is.

So that's where they want to focus, but this is one of the core set lessons here. These are challenges, just kind of generic challenges, with the measures. One of them, I think the most important one, is the very last one that's listed here. The age segmentation in measures that exist like the adult and versus child in part does not correspond, obviously. You've already encountered this, that we have measures that span -- we have issues and areas of concern that span age groups that don't quit or start necessarily at age 18 or 21, and they -- and they can move across programs.

So part of the reason that we have a children and adult set basically is partially from federal funding drives, if I am -- I am -- I don't want to make people down at the other end of the table uncomfortable, but in part, it is because of the way we implemented it. We have CHIP and -- and kids in Medicaid and then adults

followed afterwards, and so the initiative or impetus to start this in that segmented way was driven primarily by the levers of payment and -- and what was -- what was possible through federal legislation and regulation.

But they don't always make clinical or -- or even population health sense. To make a distinction, like in a CAHPS survey, it doesn't have questions about smoking for kids. It's -- it's -- the -- the -- it does in the adult survey, there is a question that's embedded with -- because of NCQA accreditation of smoking cessation and benefits, but it doesn't say anything to that about -- for the child version that's part of the Children's Core Set. Or alcohol and drug use, pregnancy intention, and a number of other areas that are equally relevant at -- particularly at transitioning.

And again, the population characteristics are something that I think that are important to understand about the Medicaid population. What I mean by that is that the -- I

am following on the housing stability insecurity question, some of the food-related insecurity questions. Imagine trying to do the BMI and the -- and the counseling that follows with someone who is on SNAP or -- and living in a car, or even in the, you know, their family's basement.

Those are particularly challenging characteristics to have a different standard or bar, but really, I think they are important considerations when you -- when you look at a population, so it is not -- while I think that Medicaid benchmarks ought to be the same as commercial, there are some things to understand about the dynamics that are potentially influencing some of the outcomes and the measurement levels that exist.

I am going to kind of jump to this last one, that part of the challenge is we can produce a lot of measures, we could even report them, and then one of the first times we went, I've turned in some CARTS information after the CHIPRA started. Karen Llanos said well why

didn't you report this one? And I -- I -- she said I know you produced it, and I said well, because it asked for goals, and -- and I -- we haven't really thought through that, you know, as a state, so I don't want to be disingenuous about putting something out where I don't have a reasonable target and the resources committed operationally to say that this is what we're going to do.

So it's thinking through, I mentioned this on Tuesday, that -- thinking through the -- the whole process of the implications of having a measure. It's knowing that -- being willing to address those underlying concerns if they're identified, and having the resources to do it.

And sometimes, it is to get the resources that you need to do it. But nonetheless, thinking through that these are not just measures to produce change. I -- I -- you'll -- you may never see this, but I bristle sometimes when people say that we're going to use measures to drive change. It's not measures that

do that. It's actually those people that are involved that know that there's a concern or issues.

Measures help reinforce the leadership that is demonstrated in states, organizations, health plans, and clinics. They're -- they're a communication vehicle. They are not by themselves the driver.

I had a colleague, and I'm going to give him credit for it, RJ Gillespie, he said would you refrain from using that phrase? He said you might think you're in the driver's seat, but if you look in the rearview mirror and you're thinking that I'm going to be there, I may or may not be, so be careful about who you think you're driving.

And so I keep that in mind when we're moving forwards with some of the measures that we select. We don't do it in isolation.

One of the areas that -- that we made some modifications, and these are kind of like the other organizational operational barriers

that were addressed I'd say in the Adult Quality Grant about the infrastructure that I say that parallels both what Jeff said and what was somewhat addressed in the Adult Quality Measures Grant.

When I say infrastructure, it's not just an appeal for the resources that are there. It's really because there's a -- kind of like an intellectual capital to say this is what's going on with this measure, to do the analysis, to do the breakdowns, to see if there's some problems that exist within those. So producing them is one thing. Looking at and trying to do a QI conversion is another. And having that capacity to make the shift between the measures and actions and operations is really one of the things that's particularly challenging. And translating the state-level information back to a practice level also has its own unique set of challenges.

I was going to say, I didn't use the term "burden," unlike you did, and part of the

reason is because it's a perception, and if there's value that's perceived in what's produced, and it demonstrates meaningful results, even if it is the same steps that are involved in producing the measure -- you'll see one measure that doesn't seem to be burdensome even though it incorporates hybrid measures or multiple data sources incorporating vital records -- you'll see that there is not -- that is not considered -- that's not a consideration.

It is when the -- when the communication of the results aren't made meaningful and aren't made relevant that it becomes perceived as -- as being burdensome. That's not all cases, but in -- in large part, that's one of the things that we've been mindful of when we produce measures. We're going to use it, and we're going to provide feedback to you to show you the utility of it, and when those two things are done, then it is not perceived as burdensome.

I am going to only focus in on two

parts of the two examples that I have here, and they're basically graphic. So one of the things we wanted to do was develop a framework because we don't have a measure of disparities in the state, and I wish we did. I wish we had them nationally.

So there was a push to create an index. In order to create this index, what we did was identify areas from earlier IOM and -- and some other NQF reports that said these are the points at which disparities start to happen. There's -- in getting -- obtaining coverage, the question that you asked earlier about the continuity measure, those -- those would go into this first stage. Do people have coverage? Is it continuous? Or are there administrative barriers?

But being able to break that information down by race and ethnicity or disability or serious persistent mental illness is one of -- an important part for at least the state to make a potential intervention, to say

okay, we're creating some administrative barriers and putting disproportionate burdens on a population by language or access and some other ways.

And then you can go evolutionary into access to care, general preventative services, are those uniform, are they in stable patient-centered care medical homes? So it's the setting that exists. And then the specific kind of quality of care measures, once that service is obtained, the -- the coverage is provided, what's happening in the clinic?

And then making one step further is understanding that -- and that's where I -- where I believe we are, at least in Oregon, is then the need or the risk-based kind of care difference -- differences that we should be considering. So are the practices trauma-informed? Do they -- do they make accommodations for children with autism in appointment setting? Do they anticipate the needs of children with other -- children with special healthcare needs in setting up those

appointments?

So part of that is being able to understand the specific needs of populations and -- and convening the expectation that those differences be accommodated. And then we always kind of need some kind of anchoring point to determine whether or not all of this -- all of these measures do kind of create a picture of a whole, and I am going back again to that first slide.

And one of the things that I think is probably a good indicator is the patient's experience of care using CAHPS or BRFSS for adults about self-reported health status, and the other component is about assessment of the quality of care. Both of those are potentially good indicators. So this is a cumulative kind of framework that we're constructing to make sure that we can address a wide range of disparities in different populations.

This, the -- this is the criteria -- I was -- I -- I skipped past this, but this is

the criteria that we use for selection of measures to be included in that index, which I think are also relevant to the selection of measures from the pediatric -- for your work. And this is also in the -- in the deck.

We anticipate issues dealing with small numbers. Sometimes we just have to go with what we've got. It's not going to be perfect. It's progress. And we have some underlying issues that we always feel like we have to address.

I am conscientious of my time, and I'm going to try to -- there's -- I am going to focus on one example and then address the care coordination questions and integrations that were -- the ones that we're supposed to pose to the group as a discussion item.

So this is what -- when -- when you see the -- at the national level, those measures at a state level, I am going to turn in something, this is the SBIRT, it's -- we use it across the -- it's actually 15 years old and

older, and it's not part of either set.

So when I turn in a --

PARTICIPANT: Say what SBIRT is.

DR. GALLIA: Screening and Brief Intervention Referral and Treatment. It is primarily for alcohol. Can also be used for chemical and illicit drug use. So it's kind of a -- we use it as a marker of the level of integration with the physical and -- and behavioral health.

If -- when we -- when we produce a measure at a state level, it's an average. It's an average of 16 different coordinated care organizations. It's an average across race and ethnicity.

And I can -- and I -- aggregate -- if I -- if this were a national measure, I could turn this in and send it up to the national level. One of the things that you don't see until you unpack the measure is actually this is a huge difference between one coordinated care organization way onto the right and another one

way over to the left. These are ranked by their averages.

And then within that, just race and ethnicity for example, we see large disparities in one organization, and very small in another. So when we start talking about measures and averages and so on, a lot of the story that really is some of the drivers of this differences and variation gets lost.

And even picking a benchmark, in this particular process, what's a good measure? What -- if we picked the highest standard, that's potentially possible, but I don't know that that's achievable for all populations. Is it reasonable to expect a coordinated care organization to move their entire population, or just a small population, or -- you know, I mean, this -- it starts to trigger a whole series of issues in terms of implementation.

So producing the measure by itself might -- we could rerun this in a year and -- and hope that it looks, if we did just the state's

average, but it's the segmentation that's actually going to facilitate some of the important focus on disparities and differences within the populations.

We made a -- we ended up using some of the NQF's report on disparity-sensitive measures to isolate the ones that we might use for that index that I mentioned, but even those are anchored to the access component on our either preceding or succeeding elements about differential treatment, so we can -- these are having -- will have more weight in our review of selection in the future.

The CAHPS survey, and I'm -- the -- exists at a -- at a -- that's part of the core set, has incredibly valuable information in terms of access and meeting that second kind of element of that developmental stage, but -- but it doesn't translate back down to a practice. Very seldom do you see in any of the states that we worked with that managed care level information getting converted back to a practice, so they say

that they didn't even know.

And part of that is because the Medicaid population is just one component of most practices, so it -- it doesn't resonate to take actions and completely turn your practice upside down because you have 26 children that are on Medicaid that -- and -- and that's -- that's why you're going to do a conversion.

So what we did was this combination hybrid. So we timed the -- a practice-level survey along with the health-plan or state-level survey, so the health plan had information the same time that the state had information, and then we did the clinician and groups version at that practice level, and then we added in some questions and children with chronic conditions, the screeners, the expanded -- the question about needing additional care coordination, like with schools, and then added the shared decision-making to the clinician and groups which don't exist.

So what I am just saying is that when

I mentioned the burden idea before, this is an incredibly long survey now. I mean, the children with chronic conditions screener module by itself is huge. So you add those, and guess what? We still -- we're still having relatively good response rates, but the -- but the information that results from them is meaningful to the practices and to the health plans, and they can work in concert with the states in order to facilitate change because they can be literally on the same page.

And I think that that notion about it being too complicated can be dispelled if you -- there are some creative solutions that you can use. The only problem is that this is not sustainable. The funding for it was produced in part through the CHIPRA and the Adult Quality Grants, and that enabled us to support that method of -- of fielding. But we can't do that now, and so we're, I don't know, thinking through different options that might be able to help us.

I am -- this is the process that we

used that -- to go through the sample selection and why it -- we think it has some value, because we're taking into consideration the national perspective and the information that's required for CMS to meet that one CHIPRA demonstration or CHIPRA legislation requirement.

Some of the things that I think that's missing is that I think there's enough data to -- already, and history, is that I am not certain that -- about the sensitivity of -- to -- of measures to change over time. So if you do have concerted effort, there's kind of an ecological influence in the beginning that will push numbers because they're presented, you know. But how -- what kind of -- which measures can move? How much? What's a reasonable expectation?

Now what we're doing frequently is we're picking numbers out of the air. We'll say 5 percent or 10 percent, you know, or 25 percent changes, but I don't know what's, you know, possible, so -- so in -- in having the history of performance improvement and testing them is

really important.

The other recommendation that I have is that -- that -- make sure that the measures themselves have what I call added value. I think it's a little bit of a buzzword, but mostly I mean that they serve more than one purpose: that they really do have relevance to the population characteristics of a Medicaid program, that they have an impact on disparities reduction, reflect populations across the board, but probably one of the most important things in terms of implementation is converting the measures into quality improvement activities on the ground, and that's why I said that they're scalable and they have multiple purposes.

And you're going to get into this, but the care coordination component I think needs to be kind of reframed a little bit because there's real distinctions, almost a cultural breakdown in what it means in a pediatric population and in an adult population. One is the handoff to another clinician or provider, and another one is care

coordination with other organizations or institutions that are in the community.

And so that -- that level of measurement is -- it's a big gap, and -- and I am also going to suggest that we rethink the notion of integration because it should come from the patient's perspective and not colocation in a physical facility meeting a specific criteria.

And integrated service can mean all kinds of things. It can mean if I go to a community mental health center once a week or once every two weeks, that might be my best medical home, and so the concept of reverse integration may be something that -- to rethink. So the place of service may not be the sole reason to think about integration.

And so that's kind of like -- I don't -- I know you can't address these. I am just laying them out as concerns or considerations when -- for future work, and I hope that they have some sense of direction or value for you.

I am just going to list these here.

There's some other suggestions that -- that are really more aspirational, but -- and the last one is when -- when thinking about that measure set as a whole, and I know that there's some background work that has already been done initially when we identified the core set, including the work that you continue to do in your state Jeff about the -- it's a kind of a life course perspective to make sure that -- that the span of one's life and not just the pediatric level is taken into consideration when you think about the completeness and adequacy of the core set.

So take the Adult Core Set and the -- and the Child Core Set, put them together, and see, do you have the span of one's life covered? And that includes living with diseases and end of life and starting healthy.

And I think with that, I am going to end.

CHAIR GESTEN: Charles, thank you so much. Between, you know -- brought out some

really great issues, problems, but also I think some really interesting directions for solutions, so I really appreciate that comprehensive presentation.

We have a limited amount of time for some conversation. If you can tee up the next slide, there's some suggested sort of questions. I don't think we need to feel like these are the only questions that we can discuss. Let me just open things up to the group for any items or observations or questions you might have. Terry?

MEMBER ADIRIM: Yes, just quickly, thanks to both of you for your presentations. I think they have given us a lot to think about, and we can spend the next week talking about all of those issues. But we're not going to.

So one thing that I thought of, Jeff, while you were giving your presentation, was whether or not the measures that we currently have in the set from a national standpoint really get at what it is that we're trying to accomplish, and one of the things that you had

mentioned was about what your state is doing around ED visits measure that is in our core set, and it made me wonder whether or not that particular measure should remain in the core set or whether it needs to come out, and here's why based on what you're saying.

Whether or not ED visits go up or down, there really -- I mean, we don't know if that's good or bad. I mean, you know, in states that expanded Medicaid, we know already that visits have gone up, and it's really an indicator of problems with infrastructure and processes in our healthcare system, so maybe it should stay in as kind of that kind of indicator, or it's just too much of a big measure that -- that really doesn't tell us anything.

I mean, as far as I'm concerned working in the ED department, I'm telling you it means nothing to me whether it goes up or down, and it's going to continue to go up as far as I'm concerned, since it has been over my 25 years of --

CHAIR GESTEN: So before you answer, I've been in conversations about this issue and this measure that can last -- in fact, put them all together, it would probably be weeks, so be quick. Give your short answer.

DR. SCHIFF: I think that -- I think that some of these measures, I think we have to look at the process sort of organically. So I think it's really interesting to see what ED rates are and to see what they are comparatively, but I think that ED rates are a marker for a zillion other things.

Is there a primary care infrastructure? Is there a culture of using the EDs in a certain community, you know? All those sort of things. So what's the -- so I think that -- I think that some of these, if they are used in the right way, they're fine, you know, but I've often said to people since I'm with you, I'm a pediatric ED doc, so it's like -- it's like I don't want to -- you know, I don't want to be out of business. You know, I don't have much fear of

that, but I don't want -- but I think -- but I think that it's a -- you know, when people complain about ED rates, what they're really talking about is expensive ED care that then results in expensive admissions and workups because people are afraid to actually send the kids home.

And it's like well, you know, you can close the ED down, but somebody else is going to just admit the kid then because they're afraid, so you've got to get to better clinical care and better outcomes as far as that's concerned.

So I think -- I think it's -- I think one way to think about some of these measures, I think it's almost like you should endorse them for a different purpose, you know, to trend utilization in the system, or to use it as something to identify other areas of quality improvement, but don't try to just nail that thing, you know. It's -- you know, because that thing may not be the thing. In fact, it's probably not.

CHAIR GESTEN: Karen?

DR. MATSUOKA: So just to piggyback on that, I just thought this would be an interesting time to note some recurring themes that I've heard over the past three days and try to start to connect the dots, because it sounds like, and I'm very excited because I think what it's -- what it's telling me is that I think we're all kind of dovetailing towards the same endpoint.

So let me just talk about, and picking up some themes from our state partners, this issue of levels of measurement and why that's so important. And, you know, just a reminder that this -- this discussion is about our core measures, which are state-level measures.

We at CMS, I think we're very cognizant of the fact that if we want to see improvement on the state-level measure, to have national improvement, we are very much -- have to be in partnership with states. States in turn have to be very cognizant about what's happening at the local provider level because ultimately,

improvement on all these levels above them is very much dependent on quality improvement at the level of provider/patient delivery.

So I think this has implications for a lot of things, and I just want to put out a plug for this -- the next phase of the PQMP program, because I think it tries to get at many of these very issues.

So Kamila mentioned that we now have these measures, these new measures that have been developed, some of which have gone through endorsement, some not, but in this next phase of the funding opportunity that has recently gone out that Foster mentioned earlier, there is a deliberate play in there to start to see what these measures look like in a real world setting at these various levels of measurement.

So implicit in that is, you know, the measures that are developed, I think there's an open question as to where those measures should land: are they appropriate as a state core measure, to our -- Jeff's point? Are they

actually better positioned at the provider/patient -- provider level? Is it better at a plan level?

And I will say, just to kind of bring it back to Debjani's issue about alignment, so the CCSQA core set activity, that's trying to get at alignment at the provider level. There is the QRS opportunity for Medicaid managed care. That's an opportunity for alignment at the plan level.

Then there's the core measures here, which is state level. How do we start to have a portfolio of measures that are slated at the appropriate level of measurement so that, taking into consideration all the issues of Charles's point, you know, what is the percentage of improvement over what time period?

You could imagine that that sensitivity to change and improvement really needs to be -- the sensitivity needs to be much more acute at the provider level than at the plan level than at the state level than at the federal

level.

So all of these things come into play, and this new round of funding is an opportunity to test all of those things with the bucket of measures that are newly developed for the pediatric population. So I just put that out there because I think this is an opportunity. There is funding attached to it. And I plug to do some matchmaking because I think we have some folks in the room between the measurement developers, the state partners, the health plan partners, the external quality review organization partners, FQHC partners, to really come together and really start to see what are the measures that matter, at what level, and how do we start to drive improvement at the provider level so that they eventually roll up to improvement at the plan level, the state level, and then the national level?

CHAIR GESTEN: Thank you. Rich?

DR. ANTONELLI: That was awesome. Thank you, Karen.

The -- I am on the Standing Committee of Care Coordination for the NQF, and a few months ago, the Office of the National Coordinator reached out and said before we start putting together some performance indicators for IT, we thought we would come to you to inform what care coordination is. And it was really wonderful to get something that proactive. I also am endeared to you for your introduction.

But it was really cool. It was the ONC saying we're not sure what care coordination is. Can you help us?

And so what I want to call out is an opportunity before us. So Karen, to that point, if you want to look at the performance of a delivery system or a state or a practice, we have to think about what are the implications around measurement? So the policy brief we did for the Commonwealth Fund a few years ago actually is -- there's a framework in there for what care coordination would be. It gets eventually to integration, but for care coordination.

But we also put in place potential performance indicators of what the state's responsibility would be, what the state Title V program would be, what -- what the individual practice responsibilities would be. And so this notion -- there's only so much that could come out of the NQF or that should come out of the NQF in terms of promulgating state-level measures.

That said, in my day job, we started a -- an intervention, a care integration intervention, for patients with a really complicated neurologic condition called Rhett Syndrome. These girls, it's only females affected, are cared for between a dozen and 18 different sub-specialties. So take my word for it, they're really complicated.

When those patients came into our clinic, we knew why they were there less than 10 percent of the time. So that's not a measure that I will ever bring to the National Quality Forum, but I can tell you at the level of a delivery system, I have a dashboard that has

almost 30 measures on it, and I'd probably say two of those I would ever want to bring into this environment.

And my suggestion is that they are both necessary, right? And so I think to the degree that CMS would be promulgating measures or that comes out of the PQMP and AHRQ, I just want to tip my hat to you. You guys have been a game-changer with that -- with those Centers of Excellence and what they've done.

But this notion of throw the spaghetti against the wall and see what sticks is so disheartening to me, because it is not just a matter of paying PCPs more and those medical homes are just going to start cranking out much more effectively.

So I want to end with an observation, because it -- called out. Charles, I totally agree that we need to rethink integration. I have. In fact, I -- I -- it is an experience measure of patients with families.

If I think I am integrated because I

have interoperability with her hospital, so what? What does this parent or this patient think about it? I totally understand that.

But I will push back a little bit on rethinking care coordination. The activities of -- of care coordination, and -- and I love the NQF definition of it. I didn't write that one. I did write one, but I like the NQF's one better. Mine is in the AAP's policy statement. The activities are actually age agnostic, and they're also agnostic to what the handoff is.

So it already encompasses a workplace. It encompasses a SNF. It encompasses a school. It encompasses a sub-specialty setting. So I guess I -- I love everything about the presentation. I'm a huge fan of the work in Oregon. But I don't want to keep defusing what care coordination is because I do think that that is a stopping point in all of these conversations.

So I will just end by saying it has to be a team sport. And Karen, that's my -- my

offer to you and to your team: how can we begin to look at these high-level measures but go down a couple of levels and say what would it look like in the community, in the ACO, in the housing provider? So thank you.

CHAIR GESTEN: Thanks, Rich. Jeff?

DR. SCHIFF: I just want to -- I want to put a plug in for a theme I am hearing here which I think is important, is that we can talk a lot about measures and how to make them more parsimonious or the right level. There's another parallel thing that goes on, which is what we need in terms of infrastructure to make all this happen.

And I think that in some ways, I was just thinking about it, the ONC in all the work on meaningful use has said we're going to set up this big infrastructure, and then it's going to -- it is going to be -- but then it's going to get infused with this -- these measures, and then on the other side, we have set up these measures and we say how are we going to get them into the

infrastructure?

In some ways, I think we need to almost take a step back and say what's the developmentally appropriate first step in this whole thing? Because we have done a lot of infrastructure that has been pretty detailed, chronic care record, those kind of things. I would be really ecstatic if in Minnesota I could get a BMI and a blood pressure out of my electronic record in a reliable way.

You know, I don't need the chronic care record, or, you know, I do, I'd like to have that, but I think we ought to think about where to put our money to develop the first parts of this infrastructure along with the first parts of the -- the coordination, and, you know, and not I guess, you know -- and just say, okay, we can make more measures, but we ought to figure out how we're going to make a few measures really work.

And also the last thing I'll say is, you know, when our communities, when we've gone

to communities and said what measures are really important for you, that's when we can start to get the buy-in, because if you -- the community members, the parents and the -- and the children and the -- and the elders in the Native communities say this is important to us, then they're going to drive the program.

So I just really want to put a plug in for at the national level thinking about those things in parallel to developmentally bring it up a little more incrementally. Thanks.

CHAIR GESTEN: Thank you, Jeff. Susan?

MEMBER LACEY: So I think that's connected to what I was going to talk about and what you were talking about.

So I was reviewing a grant about -- well, a while ago, because it was a January article in Wall Street Journal, and I didn't -- I thought well, that's kind of interesting, I will save it.

And you know, there's amazing progress

in many sectors, business and -- and political, I don't want to talk about political, but it's -- it's available to that sector, campaigns, on descriptive, analytical, and also diagnostic automated algorithms for, you know, deep diving the data.

It doesn't have anything to do with necessarily EHR or how the data is reported, but I think what I heard both of you say, and I think I heard the other state Medicaid Directors say in previous years, is that it might take a programmer a week to -- to do the appropriate level of specificity for an outcome, whereas other sectors of -- of the country and business have really pushed this notion of automated analytics.

Obviously there are a lot of things that have to go into that, and I was just curious where -- where people were for us about that. If that takes, you know, 15 weeks to do 15, you know, outcome measures, I mean, it seems like we're kind of behind in that regard.

CHAIR GESTEN: Charles, do you want to respond to that, or Jeff?

DR. GALLIA: Yes. The -- I think a week might be conservative, and -- and it -- it might -- it might take a week to set up the code initially.

And -- and it's not a deficiency on the part of states. The systems that states are operating, my -- we process about a million claims on a nightly basis of different types, that these are so complicated, and ours is actually relatively advanced in comparison to others.

We have a front end and a -- and two overlays that we've contracted with private entities that do help us produce measures. The -- the data that exists is supplied by our contractors, managed care organizations, fee-for-service pharmacy settings. It's probably one of the most complicated IT systems across every state in existence. I -- I can't -- I am actually -- the Indian Health Service or Medicare

will run close, but it's a single system.

Each one of them have differing benefits, screening possibilities on the front end, eligibility associations. And part of the reason is that they have to be auditable. That means that we can't go back and simply -- I mean, we have to be able to go back for each and every single claim and prove that this service is connected on the ground to a particular activity that can be documented in an EMR. That means that there's proof of it.

Now it's not a matter of supplying data. It's actually auditable payment-related transactions that are coded in there. And that -- and that is the function of that system. It was built as a paying system, not as a quality reporting system.

CHAIR GESTEN: Yes, Jeff, quick?

DR. SCHIFF: I just want to -- I just want to just further that by saying there is some -- I want to be -- I want to be a little optimistic in some things, like we did, in

Minnesota in the last three years, we have spent a lot of effort to get our encounter claims, which are the managed care claims, in in a timely manner that we can use for this data analysis, but that's a fundamental issue that other states need resources to do in order to -- I mean, you were still using the claims system. You can use the claims system in a -- in an effective way if you -- if you work on that.

And then in terms of timeliness, we have an ACO model. One of our successes has been using that encounter data, the claim -- from the managed care and our fee-for-service data to feed information back to the providers in near realtime, and I think that, again, the infrastructure is really important so you have a structure that will actually work to -- to give data for the measures.

CHAIR GESTEN: Thank you. Marsha?

DR. LILLIE-BLANTON: I am glad we're having this discussion about infrastructure at the state level and state capacity because I

think it is something that we oftentimes ignore or don't understand.

First, the most important thing to understand is that there's a lot of variability, that we have states that have more realtime access, greater capacity, capability, working with contractors that are experienced and can produce and generate the data from claims at a much faster rate than even what you're seeing in an advanced -- what we consider an advanced state such as Oregon or Washington or Minnesota.

But we have other states that are much, much further behind, much further behind, and part of it has to do with the fact that we in Medicaid are using a legacy system called the Medicaid Management Information System at the state level.

Now we have tried to make resources available to states, what we call a 90 percent enhanced match, so that they can update, upgrade, improve their systems. System update improving is still not staff capacity to analyze and manage

and operate those systems. So, you know, just -- just keep in mind, we have a system that has been under-resourced for almost the last 50 years.

It has only been in the last five to ten years that we are making these investments to improve the ability to really manage the -- to develop data-driven systems of management, so I just, you know, I just want to end with that.

CHAIR GESTEN: Thanks, Marsha.

So I have a question. Despite the variation and the challenges, I think it's clear that part of the goal of this is to create some standard way of evaluating care and create sort of national benchmarks and national goals to improve care for the country. Not all of this program is about states' needs, frankly, or providers' needs for improvement. I recognize that. For this program, there is a congressional need and a federal need to oversee what is a huge investment and try to understand what's going on.

So -- but thinking about the -- what the states can do in addition to the things that

you mentioned, one of the things that is always an assumption I think that rolls around is that having the ability to evaluate, to -- actually to be pushed to have to measure things that maybe have not been measured either for resource reasons or others, historically, and then, albeit imperfectly, being able for states to be able to see where they are relative to something nationally is -- can be productively, potentially, used as a way of generating attention and resources and/or prioritizing in a sea of need of things that you could do, what would be the thing that -- that states should work on.

So I just was curious about the two of your response to whether it actually plays out that way, that having this information, being compelled voluntarily to report, being able to see where you are nationally, if that jibes -- does that -- is that helpful in being able to get resources and/or prioritize and/or kind of see where you are, and see whether -- you know, which

areas should be worked on?

Because I think that one of the premises of doing evaluation across systems, whatever they are, is to be able to actually generate a notion of what's possible. You know, all these goals have 100 percent, but, you know, knowing that somebody got to 90 and you're at 20, after you go through the arguments about why it's not comparable and why, you know, all the various things, is supposed to be a motivating factor for improvement.

So do you see it playing out that way? And if -- if not, what's -- what's wrong with those assumptions, do you think? And is it not -- does it not play out that way in the state?

DR. SCHIFF: So I think -- so the answer -- the quick answer is yes, it does play out that way, and for example, our -- we were one of those red states in the dental presentation yesterday, and we're not proud of that. We know it is true, and -- or we know anecdotally it's true, and it does drive us to think, okay, this

is a place where we need to work on.

Same thing around some of our disparities. So the -- it absolutely drives the conversation. I think the challenge of it is getting to the right level of policymaker for the discussion, so -- so I think in some states that are perpetually not doing well, beating them up with data without tools or without getting to the policymaker is not going to make anybody happy. It's just -- they're just going to feel beat up again.

And it's -- you know, it's the psychology of how do you help them get on the road to do that? And that's going to be different by state. So I guess I would say that the measurement alone is -- is helpful and maybe sufficient in some states, but it's not -- I don't think it's sufficient everywhere.

CHAIR GESTEN: Do you have a thought about it?

DR. GALLIA: So the -- the comparison that -- example that I gave in that one slide

that showed where West Virginia was I think is a good example of what the comparative information brings to the state, and I -- the -- the -- knowing where the low-performing and the highest-performing and where we are relative to those is actually very incredible because it tells us it's possible to achieve a particular end at a state level with a Medicaid population.

So it has already kind of designed some parameters about creating expectations that are reasonable. The other thing that it -- well, there's a quality tag and some other communication vehicles that CMS has provided that make it so there are some tools that -- that can be used to understand well how do you -- how -- what are you doing? So it's like the best practices sort of thing at a state level.

And sometimes, they are easily transferrable, and sometimes, they are not. And I also agree that the data by itself does not determine changes, because frankly, if it's coming from CMS or Congress, in some states, it

doesn't matter. I mean, it's like that's them, you know, we know what's really going on here because it's our state. And so I think the audience and the constituencies and the stakeholder components that are within each state are probably a bigger driver than necessarily just the data itself.

CHAIR GESTEN: That's great. Thank you. So why don't we -- again, great presentations and discussions. Thank you both. Let's open things up on the telephone line for any public comment. We'll do the same for the room, and then we'll break for lunch. So Operator, any public comment?

THE OPERATOR: Okay. At this time, if you would like to make a public comment, please press star, then the number 1.

(No audible response.)

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

CHAIR GESTEN: Do we have public comment in the room? Sally?

DR. TURBYVILLE: Good morning. This is Sally Turbyville with the Children's Hospital Association.

I just wanted to share with all of you some exciting activities that we have going on at the association that we hope that we will be able to inform both our member hospitals and boards, but also committees such as yourself and our partners at CMS and AHRQ as well.

So we are currently finalizing a survey that we're going to be sending out to our members' children's hospitals, which is about 220 of them across the country, in which we're going to collect information on the types of accountability programs as well as the measures used in these programs that they're currently exposed to or will be in the short future, near term.

And we also want to understand which of these programs and measures are actually helping them drive improvement. So given the conversation that we've heard today, I just

wanted to share that with you.

And we'll also be looking at how many of them are using what types of measures, so for example, the Child HCAHPs measures, HEDIS measures, ED utilization, et cetera, and we will look to bring aggregate information back at some point to those who are interested. So thank you very much.

CHAIR GESTEN: Great. Thank you, Sally. Any other public comments in the room?

(No response.)

CHAIR GESTEN: So apparently I must have been hallucinating the smell of lunch, because lunch is not here.

(Laughter.)

CHAIR GESTEN: So it just tells you where my obsessions are. So I would say we should take advantage of this opportunity to move to the afternoon agenda and get through some slides which are overview slides. I don't think we'll do any voting yet because I think you need food before you vote, but we can at least set the

framework of the measures, the current measure sets and so on.

So I am going to turn things over to Nadine to -- to start that, and once again, thank you Charles and Jeff for both presentations. We really appreciate it. Nadine?

MS. ALLEN: Thanks, Foster.

So we don't want to -- so today -- actually, for the rest of this afternoon, we don't want to take too much time discussing the measures reported in fiscal year 2014, as they appear to be functioning very well. But we do want to focus some time on the three measures that were projected earlier in a presentation that were -- that had low levels of reporting.

We also want to focus on, you know, the 2015 recommendation, and one of those measures was the use of the multiple concurrent antipsychotics in children and adolescents. And then from there, we want to go through and look at the measures that are available and a good fit for -- for this program -- sorry -- that are a

good fit for this program based on the handful that relatively few states report.

So here, I wanted to share with you the MAP measure selection criteria. This identifies the characteristics that are associated with an ideal measure set, either for public reporting, like the Child Core Set, or payment programs. So these are consistent across all of MAP work groups and task forces.

They are not absolute rules. Rather, they are meant to just provide some general guidance on making the measure selection decisions. And the central focus should be on the selection of high-quality measures that address the National Quality Strategy.

Competing priorities often need to be weighed against one another, and these measure selection criteria can be used as a reference when you are evaluating the relative strengths and weaknesses of the program measure set and how the addition of an additional measure would contribute to that set.

So here is a rationale for -- reason for removing a measure from the core set. So if a measure has consistently high levels of performance, indicating little room for addition or improvement; multiple years of very low number of states reporting, indicating low feasibility or low priority of the topic; changing clinical evidence has made the measure obsolete; measure does not provide actionable information for state Medicaid program and/or its network of plans or providers; superior measure on the same topic has become available; et cetera, et cetera.

So this is -- the slide shows our decision logic as we consider these measures. So we use the -- the decision logic of support, and that's just saying, you know, it's for immediate use, so I would equate that to the traffic light as the green light saying go, CMS, you can go with that measure.

Conditional support, you know, gives you these pending endorsement by NQF, pending a -- a change by the measure steward, pending CMS

confirmation of feasibility, et cetera, and that's more on the lines of, you know, yellow -- yellow light at that point, to say, you know, wait a minute. We want it, but, you know, let's go through these different pending steps.

And then do not support. That's like -- that's a red light there that says stop, we don't need it in the core set, we can move forward.

So as Shaconna shared earlier, these are the measures that had low reporting. The behavioral health risk assessment measure, as Shaconna said, was added in fiscal year 2013, and that's the lowest-reported measure, where in -- sorry, we can talk about that in a little bit.

So Measure 1448, which is Developmental Screening: The First Three Years of Life, we -- we included pertinent information from QPS on this measure. This is an NQF-endorsed process measure. The measure uses multiple data sources, including administrative claims, electronic clinical data, and paper

medical records.

This is the number of states reporting. So 20 states reported this measure in both fiscal year 2013 and 2014, which is an increase from 12 states in fiscal year 2012. 18 states reported the measure using the Child Core Set specifications based on OHS use specifications.

31 states did not report this measure. Most common reasons for not reporting was data were not available, recorded by 22 states. Other reasons for not reporting have also been listed, and that's at the bottom of your screen, so information was not collected because of budget constraints, data inconsistency or accuracy required medical record review, and information not collected by provider, and other.

This measure received one technical assistance request, and CMS TA Team provided additional information to the state.

MEMBER ADIRIM: Point of clarification: for developmental screening, do we

know if pediatricians used an ICD-10 code for that or CPT code or something? Because it's hard for me to believe that data is not available if it's an administrative data point. Just wondering.

DR. GALLIA: Yes. I -- I am very familiar with the measure. It -- yes, it's -- there's a CPT ICD-9, you can use a modifier, it can make a distinction.

This is an ICD-9, and 10 is much more complicated, and we're going to have to refigure how it's going to be done in the future because the same developmental screening or screening, that coding doesn't translate. It's more general screening for almost any kind of disorder, so there's going to be a change that I don't -- I don't -- so it is available administratively, so I was actually kind of confused by that medical records review question because it's not necessary to -- it's not required.

CHAIR GESTEN: And go ahead, Marsha. I have something to say about this one too --

DR. LILLIE-BLANTON: Oh, okay --

CHAIR GESTEN: -- but maybe you're going to say this.

DR. LILLIE-BLANTON: No. Well, all I was going to say is that we have worked -- we issued what we call a -- a call to states and said we were willing to provide TA, so this is one of these proactive efforts. And there -- there are a number of challenges with this measure, but we are still working with the state partners to better collect it.

And some of it has to do with the fact that it's multiple screening instruments. It's not a simple -- it's just not a simple process. But we are working, and Oregon and Illinois are two of our states that have really helped us share with states how to conduct it, but it's costly because it's a screening instrument, so -- so I am not the most, you know -- is he's still here?

I don't know if you want -- I know time is limited, but do you want to say anything

more about our outreach efforts with states?

DR. FOX: No. We did targeted outreach. There is an issue about the -- whether you can discriminate between the M-CHAT, the autism screening, and the developmental screening, and in that, we're following up on that.

CHAIR GESTEN: You've got issues of payment where this may be included in an overall well child payment and not be coded. You have -- in our experience, you have major sensitivity and specificity issues about people who code for this, and you go in the chart to find evidence of it, and it's not there, and vice versa, and those are the -- it's not -- in some cases it's not coded. In some cases it's coded.

But you don't really know what you have, so we -- we're -- this is one of the few measures that we in New York don't -- don't report because we did a specific evaluation to look at some of these issues and found that it didn't meet our standards of what we thought that

was reliable measure reporting. So Rich?

DR. ANTONELLI: So I am thinking about EPSDT, and as a way of having that become a bit of a reporting vehicle. So this would fit in beautifully there as a mechanism of tracking it, and -- and then also one of the things that's missing with EPSDT explicitly is a tracking mechanism for care coordination. So do we have the ability to influence some of the -- the implementation, if you will, of EPSDT tracking to align with some of these other activities that we're trying to measure in -- at the practice level?

CHAIR GESTEN: It's a good question, but it's a little off topic. But maybe you can follow up with Rich about EPSDT tracking after. Is that okay, Rich?

DR. ANTONELLI: Yes.

CHAIR GESTEN: Okay. Oh, Charles, Jeff?

DR. GALLIA: Just one more comment, that this measure had six states -- five states

reporting I think in the first year, and I think we went to like 11 or 13, and then --

MS. ALLEN: It was 18 --

DR. GALLIA: Yes.

MS. ALLEN: -- 12 states in 2012, and it increased from 12 states to 20 states 2013 and 2014.

DR. GALLIA: Right.

CHAIR GESTEN: 18 reporting the measure as specified.

MS. ALLEN: Yes.

CHAIR GESTEN: Two states reporting something else.

Jeff, did you have something?

DR. SCHIFF: Well I just -- I just wanted to say that I think the difficulty of reporting, I think that as opposed to what we -- what you guys voted on with the perinatal, the prenatal measure, where there were really problems with the measure, the quality of the measure itself, even though that issue is super important, I think this is a situation where I'm

not sure if it's the quality of the measure as much as not having the infrastructure to report it, and the issue is also really important. So it seems -- it seems like it would be a mistake to take it off because it needs more infrastructure work.

CHAIR GESTEN: Okay. So just in terms of our process point, we're not yet at the point where we're going to -- we're going to have a discussion I think about these when we go through where folks can weigh in on, you know, does this information compel you to remove or not? So Nadine, do you want to go back?

MS. ALLEN: Okay. So this is another measure with low levels of reporting. This is an NQF-endorsed measure. It's an outcome measure, administrative claims, and paper medical record measure.

12 states reported this measure in 2012, 17 states in 2013, and it decreased to 16 states in 2014. 10 states reported the measure using the Child Core Set specifications, which

was based on Joint Commission's 2014 specifications.

35 states reported reasons for not reporting this measure. The most common reason was data not available. Three TA requests were submitted by three states. TA requests were about calculations of the denominator, measure coding, and data linkage. There was no additional support provided to states on this measure.

This measure is not NQF-endorsed. It hasn't gone through the NQF process at all, so it was not submitted to NQF. This is -- this is a process measure. Data is retrieved from electronic health records.

This measure was first introduced to the core set in 2013. Two states reported on this measure in 2013, four states in 2014. Five states reported the measure at least once during the two years. In fiscal year 2014, three of the four states reported the measure using the Child Core Set specifications based on AMA PCPI

specifications.

47 states did not report this measure. The most common reasons for not reporting were that the data were not available. One TA request was submitted for this measure regarding clarification on measure specification version. CMS TA Team provided additional support to the states by updating the resource manual.

So --

CHAIR GESTEN: It's me? Okay. So here is the point where folks can weigh in and comment about whether -- you see what the staff thought, whether any of the measures that were presented, or I assume any other measures you think meet the criteria that were presented previously about potential removals.

As Nadine went through, some of these measures in terms of their reporting are -- are still pretty early experience, so I think there has been a collective desire to not prematurely pull the plug, as, you know, states are getting experience, and as Charles, maybe you were

hinting at, some of these measures really, over the past number of years, you can see a real increase in uptake despite some of the challenges of the measures.

Or some areas are important. Jeff, I think your point about the developmental screening, that despite challenges or reporting issues, perhaps it's a -- it's an issue on which the field of -- and the -- the mechanics of being able to record the information is the problem, not the measure, and some optimism that maybe that's a solvable problem.

So we'll just open up the floor to comments about removal or non-removal of the measures, responding to the staff -- staff evaluation. Go ahead.

MEMBER ADIRIM: I have a point of clarification --

CHAIR GESTEN: Sure.

MEMBER ADIRIM: -- I suppose I could have looked this up myself, but are the last two measures on the Adult Core Set the pregnancy

measures? I was --

MS. ALLEN: They're only in the Child Core Set.

CHAIR GESTEN: So not hearing anything, I am going to assume that hearing nothing means that folks agree with the staff assessment that there -- none of these measures met criteria for removal, unless I hear otherwise.

And as you're thinking about that, as an interpretation, I just want to -- you know, as I went through the CMS report on measures, and I'm looking at Table 2, which is the reported measures from fiscal year 2014, you know, there are four access to primary care measures, and I just want to preface this by saying, yes, I think access to primary care is a really important thing.

But as I look at the overall median, which is in the 90s in some cases, the high 90s, but more importantly, look at the differential between the 25th and the 75th percentile, I am

wondering whether there are -- and it's a high level of states reporting, somewhere around 40 plus states -- I just wonder if -- what folks think about whether those are measures that meet the criteria of does this really continue to be meaningful? Is there an opportunity for improvement? Is the variation significant?

When I look at that, I guess my conclusions are not so much. But other folks?

(No response.)

CHAIR GESTEN: So this report, it's -- I don't know what SharePoint page it's on. In this report, it's referred to as Table 2, and there are four measures which are access to primary care stratified by four different one -- five different age groups -- four different.

MS. MUKHERJEE: It's the committee's SharePoint page.

CHAIR GESTEN: The measure? The name of the report, the Department of Health and Human Services 2015 Annual Report on the Quality of Care for Children in Medicaid and CHIP. It --

MS. GORHAM: So that is how it's referenced on SharePoint, by that title.

MS. ALLEN: So this is under -- under general documents.

CHAIR GESTEN: And the measure is with the percentage of -- of individuals at different age stratifications that had a PCP visit in the past year.

PARTICIPANT: Are you talking about child with access to primary care, well child visits --

CHAIR GESTEN: No, I am talking about access to primary care, 12 to 24 months; access to primary care, 25 months to 6 years; access to primary care, 7 to 11 years; access to primary care, 12 to 19 years.

MEMBER LACEY: Do you think that's going to be influenced by additional children that may likely be part of the program? You know, I -- it doesn't look like it's a problem now, but we're talking about, you know, kind of -- should we just kind of give it a little bit of

a window of time because we'll really probably not until after the election, to be perfectly blunt, know really what might happen --

CHAIR GESTEN: So let me --

MEMBER LACEY: -- in that regard.

CHAIR GESTEN: So let me translate what you said into -- so your question would be this may be true that performance is high and not much variability, but you think with new enrollment related to -- that's happening this year or next year, that it could change, and so it should be kept in? Is that --

MEMBER LACEY: Yes --

CHAIR GESTEN: Okay.

MEMBER LACEY: -- that would be right.

CHAIR GESTEN: Any other comments about -- about removal, or about this or any other measures?

MEMBER PELLEGRINI: Just a quick one, actually, I think that is an especially good point given that CHIP is coming up for reauthorization next year, and we really don't

know what's going to happen with that.

CHAIR GESTEN: So I am -- I am going to -- I am going to take a different view. You're going to have to help me with the process point, particularly since I am the chair here. Am I allowed to make a motion relative to removal? Yes? The answer is yes.

And before -- before I make a motion, again, what I would say is there's probably always a concern that things could change and that there may be a need to measure things periodically. As I think about our overall desire to expand the set and think about the comments I heard from colleagues in other states and think about our own experience, no measure reporting has zero resource use or cost or implications to it.

And so my personal reason for suggesting this is I think it does meet the criteria. I am not -- I am not -- when I look at the variation, I don't see meaningful variation. I think access can be measured probably more --

better in other ways, including things like patient experience, and more directly in terms of services that -- that kids receive.

The well child visits, as you mentioned Terry, still remain as a part of the set. This happens to be a very easy one to do because it's just kind of counting visits, so the -- the burden level is low. But I am not sure that the value level is high, even if the burden level is low.

So I am going to propose that we vote to eliminate the four access to primary care measures. And I'll look for a second.

There are four: access to primary care, 12 to 24 months; 25 to 6; 7 to 11; 12 to 19. One measure stratified by four age groups.

MEMBER SALAM: Can I actually just make a comment first?

CHAIR GESTEN: Sure.

MEMBER SALAM: Yeah. I think it's also interesting if you look at the report, what struck me when I read it was that despite the

overall -- despite the overall high rates of access, the well child visit, it wasn't correlated or comparable, so something is going on there which makes me, even though the organization that I am representing, primary care, I mean that to me makes sense.

Like if there's -- where is the linkage between the two if it's not showing where to improve? Then nobody is in that habit.

CHAIR GESTEN: Charles?

DR. GALLIA: One of the things, I actually specifically mentioned this as an example of a measure that is really so broad that it makes it, I mean, like well, okay, here we go. And we're going to turn it in and look at it kind of to make sure that it's, you know, the decimals are in the right place, but that's it. I mean, it's not going to go anywhere.

CHAIR GESTEN: Rich?

DR. ANTONELLI: So Fatema, I want to make sure I understand, are you saying looking at the -- what is the message that's coming through

in the well child visit versus the access to primary care? And so in the kids with special healthcare needs literature for quite some time, these patients ironically have -- have an exuberant amount of access to primary care, but it's all urgent care.

And they often in fact are underserved in terms of the activities around primary and secondary prevention, so that is why there is a bit of a dichotomous theme that's coming from -- from those measures.

CHAIR GESTEN: Yes --

MEMBER ADIRIM: Yes, well I think though -- I agree with you that some of the other measures capture really what we're looking for, the well child visit, first 15 months of life, and the population which in general tends to not have as much access to primary care would be the adolescents, and that's there, adolescent well visit.

So I agree. If that -- I think we wouldn't lose much, and it may help states, if we

were to drop the child and adolescent access to primary care, so --

CHAIR GESTEN: Any other comments?

(No response.)

CHAIR GESTEN: So it's a -- it's a proposal without a second, also.

PARTICIPANT: I'll second.

CHAIR GESTEN: Okay. That's a second. So is Alexandra -- are we able to set up a vote?

MS. GORHAM: Yes. So Donna will help us to set up the vote, but just to be clear for records and for Donna, the measure that we -- that you all have proposed for removal is the non-endorsed Child and Adolescent Access to Primary Care Practitioners, an NCQA measure? Yes.

No, this does not have a number. It is not endorsed. Is that the correct measure? Okay. So let's give her a minute to tee up.

CHAIR GESTEN: Yes, Kathryn?

MEMBER BEATTIE: Sorry, I am still looking for it to know what we're voting on, so I

can't vote until I can find it. I think I've gotten to the correct document, but can you give me direction again?

CHAIR GESTEN: Are you looking for the document of the measure description, or are you looking for --

MEMBER BEATTIE: I am looking to find the content that we're voting on to say we're removing it.

MEMBER SAKALA: Table 2 if you have the document open.

CHAIR GESTEN: Well this is -- Table 2 just gives the performance. You want -- she is looking for the measure description?

DR. ANTONELLI: Table 2 is on page 39 of the pdf of that document, but it's just the measures.

But are you -- are you looking for the measure itself --

CHAIR GESTEN: Yes.

DR. ANTONELLI: -- or -- yeah. Could the staff put that on the screen please?

PARTICIPANT: Yes. Give us one minute.

(Pause.)

CHAIR GESTEN: Would it be -- Shaconna, would it make sense to break now, since we have -- we're having some trouble finding the measure, and we'd have to set up the vote?

MS. GORHAM: I found it.

CHAIR GESTEN: So why don't we -- sorry to -- sorry to cause this confusion right before lunch. We're going to see if we can work out the logistics so you can actually see the measure that you're voting to.

Well, apparently they have better computers, I guess. Write down the name of their computer.

So -- so we'll give -- we'll give folks a chance to do that. Why don't we break for lunch? We will -- we will come back at quarter to one. We're breaking right now, and we're going to come back at quarter to one.

(Whereupon, the above-entitled matter

went off the record at 12:11 p.m. and resumed at 12:45 p.m.)

CHAIR GESTEN: We are at the point of voting. Again, just to ground us, we would be voting to remove this measure which has age stratifications from the recommended set. A yes vote would be for removal of this measure; a no vote would be a vote to retain it.

We do also have some departures, right? We have Meg and Cindy are both not here. We don't have a quorum issue, do we? What's that? Do we have a quorum? We still do? Okay, great.

So, everybody remember the voting rules here. Alexandria and others, you guys could tell us when we are ready to vote.

MS. GORHAM: In the meanwhile, you all wanted information. So, we have screen-shared the Excel sheet. But, if you want to scroll over, because I think they are busy working with the voting slide, you can find it on the 2016 Child Core Set tab, and it is line 23.

CHAIR GESTEN: We have two gone. Cindy and Meg are gone.

Okay. So, are we ready to vote? Okay. We are voting on whether the measure should be removed from the Child Core Set. It is the Child and Adolescence Access to Primary Care. A yes vote is to remove; a no vote would be to retain.

So, yes? I'm just looking for a head nod. We can vote? You guys are ready? Yes. Okay.

(Voting.)

CHAIR GESTEN: Okay. So, it looks like that will be recommended to remove. Just to be clear, looking at numbers, Cindy gave you a proxy, gave us a proxy to vote?

MS. GORHAM: Yes, I am voting for Cindy Pellegrini.

CHAIR GESTEN: Okay. Can we go back to where we are in sort of our slide set measures?

I am not recused from this one. There

are 10 because Meg is gone. We have 11 otherwise. She is voting for Cindy. Cindy gave a proxy vote, yes.

MEMBER BENIN: There was a list that you had proposed for removal. Do you want to show that list, so we could --

CHAIR GESTEN: There was no list proposed for --

MEMBER BENIN: The staff had proposed three metrics, I thought.

CHAIR GESTEN: Staff had proposed zero for removal.

MS. GORHAM: Staff proposed zero for removal. We showed you three measures that had the least numbers of states reporting on those measures.

CHAIR GESTEN: Is that what you want to go back to or no?

MS. GORHAM: PCO-2 and the behavioral health one were the two then. Yes, we can go back to that slide if you would like. Would you like? Okay.

If you can take us back to slide 365?

CHAIR GESTEN: Okay. So, these are the three slides that were reported, developmental screening, C-section, and behavioral health risk assessment for pregnant women.

Comments? Discussion? Proposals? Jokes?

(No response.)

CHAIR GESTEN: Is that okay, Andrea?

So, if we can go, I think, past the discussion slide and go to the slide that starts to introduce measures that are being suggested for addition?

MEMBER BENIN: While you are doing that, can we just get some clarification on the metrics that were orange on that other slide that I think we had recommended in the past? Then, do those stand as recommended or are we going to re-discuss those, the orange ones on that other slide?

MS. GORHAM: So, the measures that

were recommended last year, 2015 recommendations that CMS did not include into the core set, you have the option to put a motion in to re-vote on those measures, but we will not automatically move them forward. You would have to make a motion.

CHAIR GESTEN: Go ahead, Nadine.

MS. ALLEN: Okay. So, 2015 review, MAP recommended that CMS add the non-NQF-endorsed use of multiple concurrent antipsychotic in children and adolescent measure to the Child Core Set upon completion of NQF endorsement.

For 2016 Child Core Set updates, CMS added the use of multiple concurrent antipsychotics in children and adolescents measure to the 2106 core set. This measure was later submitted. What is now considered NQF Measure No. 2799 was submitted for the NQF endorsement project under pediatrics. This was submitted on September 2015.

The next slide is telling you what was the Committee's deliberation in the final

decision for this measure. So, this measure was not endorsed. The rationale for not endorsing was, while the Committee agreed on the importance of the measure, overuse of antipsychotic medication, but they noted the lack of empirical evidence to support this measure, particularly the specification of two antipsychotic medications versus more than two antipsychotic medications. In some cases, two antipsychotic medications may be appropriate.

No evidence-based threshold or goal for percent of patients on two or more antipsychotics exists, only that percentage should be low. So, the Committee moved it forward with insufficient evidence with exception. They did not reach consensus on the reliability criterion, stating that the measure was not as reliable for Medicaid plans except those that are large. It was not reliable at the commercial plan level because the measure assesses a relatively-rare event. A large sample size or population is needed to produce the

statistical significant result.

Concern about the consistency of the measure validity. So, the specifications do not measure appropriate prescribing of the antipsychotic medications, but use quantity as a proxy. Since the measure did not assess inappropriate prescribing, the Committee agreed that this measure did not meet the validity criteria. So, overall, this was a decision for not endorsing this measure.

MEMBER LACEY: I just want some clarification. I don't have a dog in the fight per se.

One of the pieces of information that you just read of why it was not endorsed is that it is a relatively-rare event. Now what I remember last year was the person who gave us the report on the number of antipsychotic drugs for kids in the Medicaid population, that person indicated it was huge. It was a huge issue. And so, were they saying it would be small in the individual plans or were they saying it was a

low-level event occurring? Because I don't think that is what we heard last year at all.

MS. MUKHERJEE: Yes. So, I think what we heard was that in some states there are a large number of children who are on antipsychotic medications, perhaps inappropriately. I didn't recall that what she said was that they are on multiple antipsychotics. I mean, it does happen, and that is inappropriate. But I think last year I don't think we had access to a lot of measures around this particular topic. And if I recall the conversation correctly, this was a huge issue, yes, because that is what we heard, but this was the only measure that I think we had at the time. So, that is why we recommended it. Somebody correct me if I am wrong.

MEMBER LACEY: And it was particularly problematic for kids in foster care.

MS. MUKHERJEE: Right.

MEMBER LACEY: So, I don't know. I am just trying to clarify what we heard.

CHAIR GESTEN: I just want to jump in

and let you know that I am turning the facilitation of the Chair over to Carol because this is a measure I need to recuse myself from.

MEMBER SAKALA: Since CMS has recommended it to states, we have the option of a conversation that helps continue to inform their work or the option of picking this up as an officially-recommended measure within this set.

When we are done, I think, with our comments, then we will open it up. Thank you.

Rich?

DR. ANTONELLI: I just need a little bit of context here. I know that this is proposed as a measure of quality, but, in fact, is that the intent or is it of interest to track the percent of the pediatric population that is on concurrent antipsychotics? If it is the latter, I assume that that data will be collected at some level anyway. It just won't be labeled necessarily as a quality indicator.

So, can somebody comment on that? Do we lose that data stream if we vote this off the

island?

(Laughter.)

MEMBER SAKALA: I think it is not voted on the island.

DR. HUDSON SCHOLLE: May I speak to the questions?

MEMBER SAKALA: Yes. I'm sorry, you're going to answer the specific question? Great.

DR. HUDSON SCHOLLE: I could try to answer those questions. I am Sarah Scholle from NCQA.

And we did develop this measure along with a suite of measures on antipsychotic medication management through our Center of Excellence.

And so, this is intended as a quality measure, not a utilization measure. It is based on multiple guidelines that caution against the use of multiple antipsychotics because of the risk of the antipsychotic medication and its side effects for children and youth.

And so, the measure is specified very clearly to look at children who are on multiple antipsychotics for a period of time, not just as a point in time when they are shifting medications, but over a period of time.

The measure reliability -- and I am not sure the information that is reported here is up-to-date -- this measure is reported by health plans and HEDIS. We will have new data in about two weeks. Unfortunately, I don't have the full data today.

But in our data that we reported from 2015 we didn't have a concern about reliability for Medicaid plans. There does continue to be a concern about commercial plans. And so, we will be observing that. The 2015 data were the first year of reporting to NCQA, and the first year is not public. It is reported again this year. It will be publicly-reported for Medicaid plans; for commercial plans it will not be because we are going to be looking to see about that, and the result is going to be based on -- it is the

number of kids eligible for the denominator does influence the reliability, and commercial plans just tend to have fewer kids.

We did find evidence of the validity of the measure. We are also looking. We see that this is a measure where the use of multiple antipsychotics is more common among children in foster care and children who are disabled compared to children in poverty. So, that is why we think it is important for this high-risk population.

MEMBER SAKALA: Rich, are you done? Are you done? You do have another comment? Okay.

So, Charles I think was next.

DR. GALLIA: I wanted to say, topically, this is probably one of the more important subject matter areas from a state Medicaid program. The shared responsibility for children in foster care is one part of it, but the polypharmacy use and management. And, then, across in the other states that I was working

with, the prescribing provider and knowing who that is in one setting but not in another, it is important information to facilitate the discussion about care coordination. I don't know another more vulnerable point and potential influence than the use of antipsychotics inappropriately.

Even though the threshold is not clinically-determined, if we get to the point where we can have some comparative information, I can see if there is a higher proportion of my population that is exposed to having two or more.

MEMBER SAKALA: Andrea?

MEMBER BENIN: I am just confused on the process. This metric is on the list for the 2016?

MS. GORHAM: That is just what I am trying to clarify.

MEMBER BENIN: I guess, then, my question is, did anybody collect data on it this year and were there any lessons from that? So, if we say no, then we are taking it off, having

given it one year's worth of a chance. We are recommending taking it off, having given it only one year's worth of a chance.

MEMBER SAKALA: So, let me just ask this: but it was conditional upon NQF endorsement? You have recommended it, but NQF is not recommending endorsing it.

MEMBER BENIN: But it is on the list that went to the states?

MS. GORHAM: It is on the 2016 core set?

MEMBER BENIN: Yes, in the 2106 core set.

MS. GORHAM: This measure has been included in the 2016 core set.

MEMBER SAKALA: So, I just need to correct that it can be voted off, but it is already on. I'm sorry.

MEMBER BENIN: I guess, then, I would say give it a couple of years. I mean, if it got voted on last year, maybe we should just give it a little bit of time and see if there is any -- I

don't know if it is good, better, indifferent. It looks like there are some methodological issues, but if there is some interest from the states and we had some interest last year, and we heard all this -- I mean, I remember last year we had a lot of conversation about the mental health, the need for some real mental health stuff, et cetera, et cetera.

So, personally, I like metrics that have hard goals. I don't like metrics where you don't know what the goal is. But, since there was, obviously, some interest in it and we put it on for a year, it seems a little vague, you know, a little wind-blown just putting it on and off.

MEMBER SAKALA: Rich?

DR. ANTONELLI: I would like to make an observation, as somebody in the clinical trenches. That is why, Sarah, thank you for the clarification. Because I am of a mixed mind about, while I recognize that it is a quality measure, I also see it as a utilization measure. And here is what it looks like to provide care in

the trenches for especially patients with significant behavioral health needs in Medicaid.

Getting access to non-pharmacologic interventions can sometimes be a protean task, right? So, the way I would look at this data is not necessarily, well, those prescribing physicians are just totally off the planet. They are not following best practice guidelines because it may be their only contingency option. And so, I just want to call that out.

That is why I would actually say get rid of this one if it was purely a quality measure. But, being somebody who practices every day in the frontline, it is easy for me to see it as both.

MEMBER SAKALA: Other comments?

(No response.)

MEMBER SAKALA: So, I think we open this up to public comment.

OPERATOR: Okay. At this time, if you would like to make a public comment, please press star, then the number 1.

(Pause.)

OPERATOR: There are no public comments from the phone lines at this time.

MEMBER SAKALA: From the room as well?

(No response.)

MEMBER SAKALA: So, I think what we would entertain is a motion to take it off, if anyone is proposing that. Otherwise, it will stand as we decided last year.

(No response.)

MEMBER SAKALA: Okay. Thank you.

MS. GORHAM: Just for the record, there was no motion to remove the measure from the core set.

CHAIR GESTEN: Is this Shaconna? I think this is you going through a little bit of information about gaps and your idea about filling gaps.

MS. GORHAM: These are additions or potential recommendations from both staff and the Task Force.

But, first, I would like to remind you

of the gap areas identified by MAP during last year's review. The Task Force identified gaps in the measure areas listed on your slide.

There are some measures included in the core set that pertain to some of these topics, but you all did not perceive them as comprehensive. So, those are the measures that are listed.

The measures with the asterisk next to them indicate those measures that were introduced as of 2015.

Next slide.

And that is the comprehensive list. Okay.

The next list is the Excel sheet, basically, that we compiled. Again, as we discussed earlier, the measures that we pulled to address the gap areas that you identified in 2015 as well as 2014, we took measures from NQF's repository; we took measures from PQMP; we took measures from Task Force members, and we compiled the number of measures.

So, perinatal/maternity care measures were discussed yesterday. Asthma was discussed yesterday.

Care coordination, there were nine measures on your Excel sheet, three measures of injury and trauma, 12 measures in mental and behavioral health, and then, there were six in overuse, 18 in sickle cell, 10 in patient-reported outcomes, and then, 10 in dental.

So, if we move on, because I know that we have the Centers of Excellence, and we are going to discuss a couple of sickle cell measures and they are only on the line at 1:30 or so. So, I want to make sure we have enough time to have sufficient conversation about those measures.

Just to remind you -- if we go back one slide, please -- just the decision category. So, support and conditional support are usually the ones that we follow. Conditional support pending NQF endorsement, pending a change by the measure steward, pending CMS confirmation of feasibility are your reasons for conditional

support.

But, again, support would be a green light; conditional support would be a yellow light saying, yes, you know, we support this measure, but we would like a little bit more information, if you will, through the NQF endorsement process, for example.

Next slide.

MEMBER ADIRIM: Just quickly, I wonder if this is the time I can ask if we could add a measure for discussion, just the 2801, the one I had mentioned.

MS. GORHAM: So, that will give Nadine time. So, hold that information up while I go through the rest of what has already been recommended.

MEMBER ADIRIM: Okay.

MS. GORHAM: So, first to discuss, this is a staff pick, as well as a Task Force member recommendation, Measure 2800, Metabolic Screening for Children and Adolescents Newly on Antipsychotics, suggested as a complement to the

current multiple antipsychotic measure that you all just heard about.

This measure was reviewed in a Pediatrics Performance Measures Project. The measure was recommended by the Steering Committee, and it has been ratified by the Board. So, this is an endorsed measure.

During last year's review, MAP explored, as we discussed, the issues of access to appropriate behavioral health services. Staff analysis favored this measure. Since this measure assesses the prescribing of two or more antipsychotics accompanied with metabolic monitoring, the coupling of the antipsychotic prescription with metabolic monitoring is a great start in potentially identifying and addressing the serious side effects -- for example, diabetes, rapid weight gain -- of prescribing these medications.

So, when the Steering Committee looked at this measure, they thought it had good evidence. It was based on 11 evidence-based

clinical practice guidelines and standards from five organizations.

There were some gaps. In examination of claims data from 17 Medicaid health plans in one state, the developer found the average percentage of children receiving baseline metabolic screening within 30 days of a new antipsychotic medication prescription among the general population of children in health plans was 10.3 percent, with a range of .2 to 17 percent.

The Standing Committee thought this measure had good specs, thought that it was precise and solid testing results, thought that this measure was usable and feasible. And so, they recommended this measure.

MR. HUNT: You just cited the 10.3 percent scoring on that measure. That was with only one antipsychotic, or was it, because this measure is two or more?

MS. GORHAM: Two or more.

MR. HUNT: But the scoring of 10

percent, they scored with the addition of one or two? It is not a big point, but I just wondered.

DR. SILBER: I think it is two more prescriptions -- so, it is some continuity -- not two or more drugs.

MR. HUNT: Okay.

MS. GORHAM: Okay. The next Measure 2797, this is the transcranial Doppler ultrasonography screening among children with sickle cell anemia.

This measure stood as a key metric, University of Michigan. This was a staff pick as well as a Task Force member recommendation. It was also reviewed in the Pediatric Project and was recommended and ratified by the Board.

The measure fills a gap area identified by MAP last year. Without intervention, 11 percent of children with sickle cell anemia will have a stroke by the age of 18. This measure aligns with the National Heart, Lung, and Blood Institute guidelines for annual transcranial Doppler screening of children with

sickle cell anemia.

The Committee agreed that the clinical evidence provided by the measure developer demonstrated that lack of annual screening is strongly associated with poor outcomes, that gaps exist. Most kids with SCA are covered under Medicaid.

The testing was fine. No feasibility or usability concerns. And overall, the Standing Committee thought this was a good measure. They recommended it.

The next Measure 2789, the ADAPT to Adult-Focused Healthcare, the Adolescent Assessment of Preparation for Transition to Adult-Focused Health Care. This is Measure 2789.

This was also reviewed in the Pediatrics Performance Measurement Project. It was recommended and ratified by the Board.

Last year, MAP identified PROs and care coordination as gap areas. The patient-reported outcome and coordination-of-care measure has three domains: counseling on transition to

self-management, counseling on prescription medication, and transfer planning. And it is reported as a single measure.

This measure addresses care coordination, and especially seamless care coordination between childhood and adulthood, which is important for population health improvement.

This is some just summary of the Standing Committee as they looked over the measure. Despite finding the measure conceptually-compelling and noting there is evidence that care transitions are not being done well, the Committee had some concerns that the process is focused on the domain's link to actual improved outcomes. However, it ultimately passed the evidence criteria.

The testing results were fine. And there is a male-only survey. So, there are some feasibility concerns, but, ultimately, the Standing Committee was okay with it. And the developer is looking into electronic

administration.

It is not in use, but there is a lot of interest. Overall, the Standing Committee endorsed or recommended this measure, and it was endorsed.

So, those are the three staff picks. I would invite Rich to speak about the measures that he recommended.

DR. ANTONELLI: Thank you.

I would like to bring to people's attention consideration of appropriate antibiotic prophylaxis for children with sickle cell disease. A couple of years ago, I sat in this room. I was the child health subject matter expert for a Task Force that was designed to populate the exchange plans for quality portfolios. I noticed after six hours or so that there were really no measures for vulnerable and disparate populations. And so, I said, you know what? Let's think about sickle cell disease and what would be a really straightforward thing to do for sickle cell.

Interestingly, the NQF staff said, "That's a really good idea." They did a quick search of the archive, and there were no sickle cell measures.

So, I am excited that there finally are some sickle cell measures of quality. However, this one has the opportunity literally to be lifesaving. It is essential for children who are diagnosed with sickle cell disease, starting them on a daily dose of penicillin, a very inexpensive drug. Up through about the fifth birthday, it has very positive evidence for outcomes.

I know that it is not NQF-endorsed yet, but it is a disparate outcome that I feel is something that we can make an impact on by putting it forward.

The transcranial ultrasound is looking for problems. That is really important. But this measure has the ability to prevent problems. So, I would really like to appeal to the Committee's sensibilities to do something for a

population that for many, many years has been at the level of receiving disparate outcomes. It is simple. It is evidence-based.

Thank you.

MS. GORHAM: And so, for the folks on the phone, and apparently us since we can't see this slide deck right now, but Rich is referring to the appropriate antibiotic prophylaxis for children with sickle cell disease measure. In one minute we will be able to see the description, numerator statement, denominator statement, and exclusions.

As he said, this measure has not actually been submitted to NQF, and it is in the PQM pipeline and it is ready. But we have not formally received it.

CHAIR GESTEN: So, while we are waiting, I guess I will do my recusals. I am, for the record, recusing myself from discussion on 2800, metabolic screening; 2797, the transcranial Doppler ultrasonography, and the measure that Rich just talked about regarding

antibiotic prophylaxis as well.

So, I am turning things over to my trusty Co-Chair.

MS. GORHAM: I am sorry. On your screen you have the description and numerator statement for the measure that was just discussed, the appropriate antibiotic prophylaxis for children with sickle cell disease.

We have two more measures that a Task Force member recommended. But, before we lose our developers, I would just invite conversation about especially the sickle cell measures. Because, if we have any questions about specifications, now would be the time.

MEMBER ADIRIM: Point of clarification. Rich, the appropriate antibiotic prophylaxis in children, is there any data that demonstrates that children with sickle cell disease are not getting appropriate -- like what is the rate of that?

DR. ANTONELLI: First of all, there is solid evidence that it makes a difference. So,

it is a quality/safety -- but you are looking at the obverse of that. Because it is not a broadly-used performance measure, we can only report anecdotally, based on published literature, that there are significant gaps of children going without antibiotic prophylaxis.

A part of that is not knowing who is on point. Is it the primary care provider? Is it the hematology and/or sickle cell specialist? So, some of that is actually the result of fragmentation. Others are the result, I think, of just people not following clinical guidelines.

Just to be clear, this is not going to change best practice. This is best practice.

MEMBER SAKALA: Andrea?

MEMBER BENIN: Do we know why the sickle cell metric was not in the first round to go to NQF?

MS. GORHAM: Sean, can you open Kevin's line?

MS. REESE: Hello. This is Sarah Reese from the University of Michigan.

MEMBER SAKALA: Thank you.

MEMBER BENIN: Hi, Sarah. Can you comment on how you chose the ultrasound metric to go to NQF before the antibiotic prophylaxis metric and where your thinking is on the prioritization of those?

MS. REESE: Absolutely. We actually very much wanted to submit both to NQF in this last round, but, frankly, lacked the capacity to do two. And the TCD measure was still a little further along. So, we chose to go ahead with that one. We are very much looking forward to submitting that for consideration during the next call, however.

MEMBER SAKALA: Thank you.

Yes, please.

MEMBER BENIN: I don't want to overstep my commenting time.

So, if I could just try to put a little bit of a frame around the four metrics that we have discussed so far.

The Children's Hospital Association

has a Committee on Metrics and Standards. We actually have created a short set of metrics that we suggest for children with chronic illness. The sickle cell ultrasound Doppler metric is on that list, and we got to that list through a very comprehensive review of all of the possible metrics out there. We had a pretty in-depth peer-review process, not at the level of an NQF endorsement level, but assuming some NQF endorsement.

And so, I think that I would very much support the sickle cell Doppler metric. I feel as though the antibiotic prophylaxis metric is super-important. I might want to just wait until it went through the NQF process for the sort of rigor around that.

I would prioritize those two metrics, certainly the ultrasound, you know, the Doppler ultrasound metric over the other two metrics that were on that list, one of which is a survey metric. I think in the spirit of not adding more survey metrics when we kind of haven't figured

out the survey metrics that we have to the list, I would suggest that we hold off on recommending the survey metric.

And then, the first metric was a relatively-new behavioral health metabolic disease for metabolic screening around behavioral health medication initiation. And so, to me, it sounds like we already have a new behavioral health metric. I would say, if we are looking at our gaps and we want to get into the sickle cell space, I might let us play out, have the measures that play out the behavioral health metrics that are already in there and start to get into the sickle cell space and kind of bookmark those other two for future evaluation. But, in the spirit of not recommending a million things, I would suggest that we could prioritize them in that fashion.

Our Committee did put on the short list the cranial Doppler.

MEMBER SAKALA: Thanks, Andrea. That is very helpful.

We have two more measures to go through in this series of new considerations, but I want to ask -- I know there is a small window for the developer.

Are there any more questions on the measures from this developer while this woman is on the line?

(No response.)

Okay. Thank you very much.

So, I think, Shaconna, finish with the last two measures in this series.

MS. GORHAM: Okay. We are kind of torn here. We have two more measures recommended by Meg, and she asked us to kind of wait, but we definitely can't hold the conversation for long.

So, I want to go to 2801, but I look over and Terry just walked out of the room. But we will go to 2801 because I know that Terry will return shortly.

And she has recommended 2801 today, the use of first-line psychosocial care for children and adolescents on antipsychotics. The

steward is NCQA. This is an NQF-endorsed measure.

And you can see on your screen the description of the measure, percentage of children and adolescents 1 through 17 years of age with a new prescription for antipsychotic. The numerator is children and adolescents from the denominator who have psychosocial care at first-line treatment. And it is a process measure, and the data source is administrative claims.

Any questions about this measure?

(No response.)

MS. GORHAM: Okay. So, we will move on to the churning measures.

Okay, so the informed coverage measure. Yes, scroll down.

Terry, I briefly introduced the Measure 2801. If you want to elaborate a little more, just in time.

MEMBER ADIRIM: Yes. No, this didn't come to our attention until I think it was

earlier today or yesterday. I thought it was an important issue, especially since states had told us last year that this was a huge issue, an appropriate prescription of antipsychotics. I think there have been recent guidelines that just came out within the last few weeks regarding use of psychosocial interventions first, especially in younger children, as opposed to medication.

So, I had only briefly looked at this, and I don't know if this gets at it, but it is an endorsed measure. I think pairing on this with the measure that is already in the set would be, I thought, useful.

MS. GORHAM: Thank you.

Okay. So, the informed coverage measure, again, a Task Force recommendation. I will at least say the rationale that she gave me. She recommended this measure as well as the next measure, the duration of first-observed involvement, as a set to address the turning on and off of Medicaid.

It has not been submitted to NQF. It

is, again, a PQMP measure, and CHOP is the steward for this measure.

So this, along with the duration of first-observed enrollment, again, CHOP is the steward. It has not been submitted to NQF. So, therefore, we pulled this information from the website, the information that was submitted to us. This is what we have on these measures.

She had to leave. She anticipated being back by now, but --

DR. MISTRY: I just asked because Meg actually spoke with the developer in detail about these. And so, I think that would be valuable since she was the one who put it forward.

I think the developer, CHOP, should be on the phone a little later as well. They might already be on, but I am not sure, if questions come up.

MS. GORHAM: Let me see whether or not, Sean, do we have anyone from CHOP on the line?

Jeffrey, are you from CHOP? Would you

like to speak for these measures?

DR. SILBER: We had not originally, as you know, submitted this to NQF. We are glad to go through that process if NQF is interested.

These were measures to help the states determine the enrollment of eligible children in Medicaid. We have two kinds of measures. Coverage is a point-in-time measure which is informed by the event of appendicitis. We look at a state's appendectomy patients or patients that come down with appendicitis, and we look to see when they developed their random event, which isn't related to insurance, and they were admitted to the hospital, whether they were covered or not in those patients that were eligible.

And that metric is the rate of the random event of appendicitis patients having insurance. It tells us about the state and it informs us of the assumptions that are needed to make an estimate of coverage or of having insurance if you were eligible.

From that number, we, then, will produce coverage metrics, but it is not just for appendectomy patients. It is for all patients in the state.

When we do that, then, in our analysis we have compared this to survey results and to other methods that are out there, rougher metrics like the COO continuity metric. And ours performs better and looks closer to the results of the surveys. So, we think it is a good way to look at whether a state is doing a good job at making sure that their eligible kids have insurance.

Secondly, and combined with that, is the duration metric, which is a more common metric that people use. Duration talks about whether, once you have insurance, do you hang onto your insurance and over what period of time.

What we have done is compare duration to coverage and other metrics. What we find is that they measure different things. Many kids who have insurance from a continuous period of

time will not be in the duration metric because duration has to start when you have been off insurance and, then, go onto insurance. So, you can lose 80 percent of the patients. The states that do the best in terms of keeping people on the rolls, those states won't get any benefit for that because it won't show up in the duration metric.

So, what we have decided is that you really need both. You need a point-in-time estimate to see if you are actually, for a random point in time, are you covering the patients that you need to cover that are eligible. And you need a duration metric. They are not well-correlated. The correlation is around .5, and at the same time they give different bits of information. The random point in time gives you an overall assessment of how well a state is doing in terms of making sure that their patients are covered. And the duration metric is a select population of those who had not been covered who, then, become covered. It tells you how long that

new person would stay covered.

So, it has got problems; at the same time, it has some useful information as well. That is kind of a general overview of the methods. These are developed for the states.

And then, in our analysis we also, and in our algorithm, we also have ways to test whether the data that the state is providing is adequate. That is always a big issue.

It is developed to be used with MAACS data, which is the kind of the data that the states are supposed to be sending to the federal government.

I guess I will stop there, but we are delighted that people are interested in this. We hadn't thought that it was what NQF would want, but if you are interested, we are certainly interested as well.

MEMBER LACEY: My only question to -- you said Kevin? -- whoever is on the phone --

DR. SILBER: Jeff Silber.

MEMBER LACEY: Okay. So, we have

talked a lot on different measures throughout doing this work about events that don't happen very often. So, I don't have any idea, any bias. How often does it happen that this random event is how you can capture these people and find out if they are -- do you know what I mean?

DR. SILBER: Right. So, the appendectomy is relatively rare, but, remember -- and I guess I want to make sure I am explaining this right -- the metric uses all patients, not just appendectomy patients. Appendectomy simply tells us about one assumption in the metric. We have to assume, when we first see a patient, whether they are presumed to be eligible or ineligible.

One of the main problems with all of the ways that we estimate coverage for any of the methods that are out there is that we never know when a patient drops out of the system. We never know whether they dropped out because they meant to drop out because they were no longer eligible, or whether they meant to drop out because they

were -- they didn't mean to drop out, but they ended up not getting re-enrolled. So, we never know that information, short of surveying patients, which is very difficult and rarely something that is available for the state Medicaid systems.

For that one assumption, if we knew whether someone who has dropped out was eligible or not eligible when they dropped out, that is what we use the appendectomy rate for. It is just one part to refine the estimate of what is the real coverage rate for a state's Medicaid population.

Appendectomy is just common enough, so that we can help with that assumption, but it is not about appendectomy. Our coverage is about the whole state's Medicaid insurance population. It is just a useful tool to refine the estimate, and then, we compare it to the survey data that is available and we find that we do very well.

So, this is not about appendicitis. We simply use appendicitis as a method to refine

the assumption about whether you count someone as not being covered when they leave, whether they were eligible or ineligible.

Is that clear? It is not about this random event of appendicitis.

MEMBER LACEY: Yes, I don't think anybody was thinking that.

DR. SILBER: Okay. I didn't understand your question.

MEMBER LACEY: We were just thinking about an infrequent versus a frequent event.

DR. SILBER: Right.

MEMBER LACEY: And that is all we were asking.

DR. SILBER: Okay. So, we are talking about a whole state's population with a refinement that uses their patients who get appendicitis, which is enough in most states to give us reasonable confidence.

MS. GORHAM: Additional conversation about the recommendations put forward? Just the recommendations from Task Force members as well

as staff picks, so we have been discussing some of the measures. I just wanted to see if there is any other discussion.

MEMBER BENIN: Given the opportunity --

CHAIR GESTEN: Go ahead, Andrea.

MEMBER BENIN: I mean, these seem like great metrics for us to like go through the NQF process and make sure that the kinks get worked out. And then, I think the second phase of the PQMP stuff, of actually having people work on trying this, I mean, obviously, I don't have a good handle on the extent to which the field testing and all the other stuff. But it does seem like this is potentially really valuable. It may not be ready for primetime right this year. So, that would be my assessment of this. So, I would up this on a bookmark for next year kind of list, not on a recommend list.

CHAIR GESTEN: So, Meg, we just went through a list of measures that were recommended, either a combination of staff, NQF staff

recommendations, and from the Task Force. And these last two were recommended by you. We just went through them. On the phone, folks from CHOP talked a little bit about the development.

So, I don't know if there are any questions or any statements you want to make about why you suggested these or the importance of these, whatever. And then, I think we will move on to -- I think we are ready to start considering voting on these measures.

I am being tapped on the back. Go ahead. I will figure out what the tap is.

MEMBER MURRAY: Okay. Yes, just two main points. One is that the legislation does call for a continuity measure, although it does say "existing," but I guess these measures are existing now. And two, that all of these measures, especially the HEDIS ones, you have to be in for 12 months. And we know from research that we have done that people are only in, typically, for eight, nine, ten months. And so, we need to do a better job on that. One of the

ways to do that is to measure it, so that we can see improvements. Eventually, we would like to see a policy change where people have to be on for 12 months.

So, those are the reasons that we are pushing it. It is because, without the good data, it is hard to make the argument, as people have said, that we need to make a change.

DR. SILBER: Yes, this is Jeff Silber again.

Well, I appreciate your interest, and we are certainly willing to work with you to go forward on this, if you are interested.

CHAIR GESTEN: Any other questions, comments?

(No response.)

CHAIR GESTEN: We do have one other. This is, I think, all of the measures with one exception. There was a request to reconsider the measure that we talked about yesterday on healthy newborns by a Task Force member. And so, we will be, with some new information, responsive to some

of the questions or issues that came up yesterday. Again, that is allowed under the rules, but staff at NQF are busy putting the information together. They are not quite ready yet.

So, my suggestion is that we wait, and when Reva and folks are ready, we will present that as well. But we can go back to the measures that were presented, starting with the staff picks.

MEMBER BENIN: Just one process question. I hate to obsess over this. Wasn't the readmission metric on the orange? Wasn't that in one of the orange ones? Were we coming back to that later? Is that at the end still? Okay. I mean, I will sit tight.

MS. GORHAM: So, I will throw it out as a recommendation. We have those measures teed-up. So that, if someone wants to make a motion, they can do so. If you would like, before we start voting on these, to make a motion on 2015, whether or not we want to re-vote on

those this year, we can do that now.

So, bullet No. 4 are measures recommended in 2014 and 2015, the NQF 2393, pediatric all-condition readmission measure, and then, 2509, prevention dental sealants for 10- to 14-year-old children at elevated caries risk. And then, we just put the caps measures back up there.

But, if you want to see the specifications for those measures again, we can pull that up as well. But that is the list with the measures and bullet No. 3.

CHAIR GESTEN: So, I need a clarification. If we do nothing, I mean, there is always, I assume, an ability for folks to re-vote and take something off the island. But there is no obligation. Measures that were recommended that were not taken up by CMS, from a process point of view, is there a need to re-vote on them, unless there is somebody who wants to? Is there a need to restate the recommendation or is the only discussion item whether or not

somebody in the group wants to remove them?

MS. GORHAM: So, that is up to you all. From what I understand -- and, Marsha, please correct me -- I don't think that CMS keeps a list, a running list of all of the recommendations from year to year.

CHAIR GESTEN: Why not?

DR. LILLIE-BLANTON: Well, we keep a list, but we have not in the past been reconsidering them. So, the only way you will keep it is for us to keep bringing it up.

CHAIR GESTEN: Is that right?

DR. LILLIE-BLANTON: So, we would have to add it to the list of recommendations each year.

CHAIR GESTEN: Okay. All right. So, that answers my question. If you want it -- okay, so that answers my question. Okay.

MEMBER BENIN: Can I make a motion, then, that we suggest the readmission metric for inclusion?

(Second.)

DR. ANTONELLI: Marsha, can you tell us why the measures wouldn't have gotten implemented, and is there something we should know from CMS's perspective about these, if they were recommended last year?

DR. LILLIE-BLANTON: So, the decision about each measure varies. And I remembering I discussed this at the adult and not the child.

We reached out to our stakeholders. And by "stakeholders," I mean we consulted with CMS internally. So, internally, we have different sectors, both disabled and elderly group, and the Duals Office, different sectors. So, we met with them, discussed with them, actually did some voting internally. We reached out to our quality technical advisory group and, for each of the measures, discussed the measures and also voted with them. And then, for the adult measures, we reached out to our adult quality grantees.

So, we listen to the input and feedback from our stakeholders about all of the

measures and made an assessment based on the results from those efforts to communicate with our different stakeholders.

The measures varied in terms of reasons and explanations. As we talked about, we try to make, we are making incremental changes. And so, we really tried to take the measures that we thought really helped us fill some gaps, would address our ability to measure and monitor care where we weren't doing it well, and we thought could actually be implemented by our state partners.

I would have to go back to look at the specifics on the readmission measure, but I think in some cases it is about problems. For example, with antipsychotic use, it was clear that we had a big problem in Medicaid and we needed to do something for the hearing measure. It was clear we have gotten a lot of concern about -- I mean, this is something we can fix. I mean, there is no reason for a child who is identified with a hearing problem to leave, who is identified with

a hearing problem not to be referred for treatment and have that addressed. I mean, it is just the long-term consequences were too great.

So, there could be other measures like that, but there were things that we thought we should really be able to fix, even though we knew it would add to a burden, even though we knew it would be problematic to collect. And we think that measure, the audiological measure, was going to be problematic to collect, but we didn't want to risk not trying, given we think that that is a problem that we should be able to fix easily.

So, there are lots of tradeoffs, but the main thing is we tried to be systematic and thoughtful. I would have to go back to look at the concretes on the readmission measure.

DR. ANTONELLI: So, thank you for the candor. The genesis of my question, though, is, is it productive for this group to once again endorse something that was endorsed last year without possibly knowing what that --

DR. LILLIE-BLANTON: She actually

pulled up the specifics.

DR. ANTONELLI: Okay. Because it would be helpful for us to know what your concerns were.

DR. LILLIE-BLANTON: Right.

DR. ANTONELLI: If you are able to share that with us, it will certainly inform my thinking about the vote.

DR. MATSUOKA: So, specifically on the pediatric all-condition readmission measure, is that the one? The overarching consideration, I think, was this notion of parsimony. But, then, with regard to this particular one, in addition, there was a sense that readmissions are rare for children. Maybe for children with particular kinds of conditions that might be different, but for the child population overall we thought that the numbers would be relatively small.

And to get to the question about is it worthwhile, I think yes. Because I think looking back on our notes, it looks that there are some that we did end up declining where MAP supported.

But we have a note here that we would like to consider adding this in future years. So, I think, in general, especially for measures where we were kind of on the fence, I think it would be helpful to hear whether the Committee still thinks that it is worth recommending.

MEMBER BENIN: I do know that through -- oh, sorry, go ahead, Terry. Through SBS, we do know that pediatric readmissions in general are in the vicinity of something like -- it depends on the place and there is a lot of variation, and the metric that people are using around is a mixed bag. But it is something like 6 to 11 percent. You know, it is in that range. So, it is in the kind of 10-percent-ish range. That is the data that we often see. A lot of places are a lot lower; some places are in that, for whatever that is worth for people.

MS. GORHAM: I just want to make a statement for the record, so that we have it on the transcript that Foster is recusing himself from discussion of the readmission measure.

MEMBER ADIRIM: And just to say I pulled up two articles, because I know there have been recent publications on this particular issue, and it is an exceedingly small problem. It is not like it is in the adult population with readmissions being very high and good reasons to lower them.

I think, in pediatrics, kids who get readmission, they are probably more often than not related to their particular condition and would be a good reason for readmission. So, I think in pediatrics my feeling would be that it could be harmful to these kids with certain medical conditions.

And the one article was 6.5 percent that came out of Boston Children's, and it did describe variability amongst institutions. Another article said the numbers are just too small to even report. So, those were the two that I picked up.

MEMBER SAKALA: (presiding) Rich?

DR. ANTONELLI: So, it depends on how

you define the population. The IOM had a Symposium on Kids with Special Healthcare Needs. So, if you look at the so-called children with medical complexity, in fact, their rates of 30-day all-cause readmissions are comparable to Medicare rates, so 22 percent and above.

So, for those entities that are thinking about taking on accountability, it is really important. Now, having said what I just said, that is the science and the epidemiologic data. If providers of care for children with medical complexity aren't going to be held "accountable" -- air quotes, for those of you on the phone -- for 30-day all-cause readmissions, then do we need this measure?

But I can tell you for somebody that is actually doing this work, we watch the data very carefully. So, once again, it is the comparability of what does the utilization look like and where are the opportunities to ameliorate excessive cost versus what is an accountability measure.

But I do want the group to know, children with medical complexity are readmitted at the same rate as Medicare beneficiaries.

MEMBER SAKALA: Bo?

(No response.)

MEMBER SAKALA: Are there any other comments on the readmission measure?

MEMBER BENIN: Would it be helpful to hear from the measure developer? Is the measure developer on the phone? Or is that valuable to people?

DR. TOOMEY: This is Sara Toomey from Boston Children's. I would be happy to talk, if that would be okay.

MEMBER SAKALA: Thank you.

DR. TOOMEY: Okay. Great.

And so, I think I will just make a couple of points. In terms of the prevalence overall, what has been cited is about right, which is about, actually, the prevalence of readmissions among the young adults and sort of up through middle-aged populations. But I agree,

overall, it is less than sort of the Medicare population that often gets cited.

In regards to, I think, though, key points to remember, one is there is definitely measurable variability among hospitals in regards to performance on readmission measures. As such, it really does speak to the point that there are probably differences in care that is being provided, because there is, once again, this ability to see these differences.

We have just had accepted a paper that hasn't come out yet that looked at one hospital in a pretty extensive manner. What we were able to show is that the potentially preventable readmissions was somewhere around 25 to 30 percent of the readmissions that we were able to find across the board.

And I should also say that, when we developed this measure, we really developed it to harmonize very closely with the CMS-approved measure that is used for the adults. In doing so, we think it is actually a really important

complement for children. As I said, we were able to demonstrate that you can look, in particular, at higher levels at differences among hospitals and, therefore, among states in performance.

I am happy to answer any questions anybody might have about the measure itself.

MEMBER SAKALA: Thank you.

Other comments or questions?

Terry?

MEMBER ADIRIM: Yes. I would just want to ask about the utility of having a measure. I mean, I agree with you, there are certain diagnoses that have highest rates of readmission, sickle cell disease, other ones that don't come to me. Because I am in the ER, I admit them to the hospital. So, I see them bouncing back all the time.

The question that I have is, what is the utility of having this measure in the core set, so that there is aggregate data in a state, small numbers, as opposed to being a measure that is useful for a state Medicaid program to assess

the hospitals that are caring for children? For me, I think it is a very useful measure for the latter as opposed to the former, in my opinion.

DR. TOOMEY: Yes. No. Thank you.

I think it is valuable in both settings. I mean, even though the readmissions itself is a small number, the numbers of kids that are being admitted in every state is actually quite large. So, if you think of it even in terms of what I think are really wonderful measures that are much more targeted populations, the population for which it is evaluating is actually quite small also.

I should also say the nice thing about the readmissions measure is it is based using administrative claims data. So, in regards to the issue around being a burden to states, this is a measure that is pretty actually straightforward, most likely to integrate into their measurement plan, since they are already collecting the claims data and would just need to be providing -- we actually have a staff program

for them, but just being able to run the program that we have to be able to give the right readmission measure rates for their hospitals in their state.

MEMBER SAKALA: Thank you.

Other questions or comments on this measure?

Yes?

DR. GALLIA: I wonder why many of the children that have special healthcare needs would be covered by Medicare. That kind of gets lost. I am wondering why the Medicare measure doesn't extend its age as opposed to --

DR. TOOMEY: So, I don't think -- the Medicare measure doesn't right now, to my knowledge. It is really 18 and over.

See, one thing that would be hard in doing so, I work for a state level, but if you wanted to get down to hospital-level reporting, if you only looked at Medicare beneficiaries, it would be such a small component, that it would be very hard to demonstrate variability.

So, at least in this instance when you are looking at the population of all Medicaid patients within a hospital, you are much better able to look at sort of differences across hospitals or across states.

MEMBER SAKALA: Thank you.

Other comments on this?

MEMBER BENIN: I will make one comment, not to negate any other comments. But one of the things that I think is potentially valuable about us putting this metric forward is that it, then, will go into the process that Karen and Marsha just described, because I think that there is some value to having the states evaluate the feasibility of it.

Because I am not actually 100 percent sure that I really understand the feasibility of it. And so, I think that getting it into this metric needs to happen eventually. It is sort of an essential part of what we are going to end up doing at some point here.

But how the data really gets linked,

whether you get readmitted in the same state where you got admitted, and all that kind of jazz, has to get sorted out a little bit. And so, I think that there is a lot of value to getting it put into the process of us recommending it, so that there is a mechanism for it to go forward and get evaluated in that way, and to have the states really have to have this iterative process around whether there is any actual feasibility to it.

So, not to put any damper on it, but, to me, that is the real kicker here, is how does it actually play out. And I don't think that we know that. I know that that usually is not the type of metric I am in favor of, not to like completely go counter to type. But I do think it is an important piece of us moving these things forward, and it is a PQMP metric, which also makes it important.

CHAIR GESTEN: (presiding) Great. So, the other measures, let's just go through the measures here and, then, we will go back to

measures and see if there is a motion to vote to include.

Just for clarity, the No. 3 on this list, effective postpartum contraceptive access, did not pass yesterday. This was a measure that we voted on yesterday.

The measure on contraceptive -- I'm sorry -- postpartum past use of contraceptive methods, by within 15-to-20, did not pass.

So, No. 3 is currently in the set. Four is not.

And No. 1 there, NQF 0477, under 1500-gram infants not delivered at an appropriate level of care, my understanding is that the measure developer is not continuing stewardship of this measure.

Shaconna, maybe you can clarify that and see what we want to do about that.

MS. GORHAM: So, the measure developer did not submit this measure for maintenance review for the following reasons: too much work -- and this is me stating the reasons given by

the developer -- too much work for a measure that we, ourselves, are not using; uncertainty that others were truly using it as a quality measure. Its best role seemed to be at a population level rather than a hospital-level measure, which are their main interests. The hospital-level measures are their main interest.

So, the measure was not submitted for maintenance review. Therefore, it would lose endorsement.

CHAIR GESTEN: So, again, we have confronted some measures that don't have endorsement, lost endorsement, are on their way to endorsement. This one will not get endorsed because it is not going to go through the measure review process. This was not taken up by CMS as a measure to include for state reporting.

So, the question for the Committee, just like the previous measures are, do we want to continue to recommend this going forward as a measure that should be put into the measure set?

Discussion?

(No response.)

CHAIR GESTEN: Is there any motion to vote to decide whether this should be included going forward?

MEMBER SALAM: I guess maybe I am not sure I am understanding. Because if the measure isn't going to be maintained and, then, there is going to be errors in it, and there is no one monitoring the quality of the measure, actually, it shouldn't even be a vote. Like it can't be a measure because no one is maintaining it.

CHAIR GESTEN: Some people would believe that the universe should run that way, but as far as I know, there is no rule that says it must. So, that is why.

Carol?

MEMBER SALAM: If I made the rules, it would happen that way.

(Laughter.)

CHAIR GESTEN: We got it.

Carol?

MEMBER SAKALA: So, the measures that

come out of Elliott Main and the California Maternal Quality Care Collaborative are, in general, top-notch. They are focused on hospital-level quality improvement. So, I can understand why he didn't want to go through the effort of continuing to be the steward.

As a population-level measure, it could be of value here. My feeling is that the perinatal measures that we have already put forth in our short list are probably more impactful for a larger segment of the population. So, I would personally prioritize those, even though I have a lot of confidence in this measure.

CHAIR GESTEN: Thank you, Carol.

So, can we go back to the slide that has the individual measures, starting with the three that were recommended by staff?

MEMBER SAKALA: Are we going to ask whether people want to put them up to a vote?

CHAIR GESTEN: Uh-hum.

MEMBER SAKALA: But without doing that one with complication because that is

different --

CHAIR GESTEN: We are waiting for it. We are still waiting for Reva to get that together.

MEMBER SAKALA: Okay.

CHAIR GESTEN: We are doing to delay on that.

So, without getting into the individual measures -- I will need to recuse myself -- but just in terms of a process point going forward, I think we should see whether there is a motion include this one, a second, if there is any discussion, and then, we would vote. That would be the progression of things. And then, we need to decide about public comment relative to this.

No, how about this? Can we get public comment now on any of the measures that we have just spent some time talking about? Why don't we do that? Does that make sense?

So, Operator, can we open up lines for any public comment on any of the measures that we

have just talked about that we may consider for a vote?

OPERATOR: Yes. At this time, if you would like to make a public comment, please press star, then the number 1.

(Pause.)

OPERATOR: There are no public comments at this time.

CHAIR GESTEN: Great. Thank you. In the room, any public comments on any of the measures that we have just talked about?

(No response.)

CHAIR GESTEN: Okey-doke.

DR. KLEINMAN: Can you all hear?

CHAIR GESTEN: Yes, now I can. Go ahead.

DR. KLEINMAN: Okay. They never said to go ahead.

This is Larry Kleinman from CAPQuaM. I wanted to make a couple of comments.

One is I have seen the measure that Jeff Silber was discussing as it was being

developed and as it was tested. I think it is a superb measure.

I think it is interesting because, like any number of the CAPQuaM measures, it challenges some of the paradigms about when we think about quality -- I'm sorry -- the PQMP measures, in that it doesn't line itself up well to, for example, the NQF framework in which the algorithm doesn't distinguish good care from bad care. Often, that is not actually the relevant question. It is, can it systematically, reliably, and validly measure something that is happening and important?

So, whether it rises to the level of importance to be on the core set, I would leave to the Committee to decide, but I just want to say that, as someone who watched it grow up, I think it is scientifically-superb and it reflects a lot of the challenges.

I also want to say I have heard several times the statement about Elliott Main. I am not sure it was made by the same person or

others or various people. And I agree, Elliott is terrific and his measures are terrific.

But I just want to point out that I would say the same of all the PQMP measures, which I don't think a number of them got a fair hearing. I hope there will be an opportunity to discuss some of that at some point in the public comments for this call, because I think there are measures that were available that were responsive to questions asked yesterday that were not brought up by staff or others and might have impacted the direction of conversation and/or decision-making, had they been pointed out. I mean, I don't know; that is an unknowable. But, certainly, the Committee deserved to be aware of the measures as the discussions were taking place.

Thank you.

CHAIR GESTEN: Thank you, Larry, for that comment. It is Foster.

Hopefully, if there is some time, there may be an opportunity to raise that as an

issue. I hope there is.

But can you just clarify the first question? The first measure that you were talking about, that you were referring to, was which measure exactly?

DR. KLEINMAN: I don't remember the name of the measure. It was about continuity, the one Jeff Silber was discussing from CHOP.

CHAIR GESTEN: Oh, the CHOP measure on continuity of coverage? Okay. Thank you.

DR. KLEINMAN: Right. Yes. Okay, good. Thank you.

CHAIR GESTEN: Thank you much.

There is another public comment, I hear, on the phone?

OPERATOR: Yes, sir. You have a public comment on from Sean Currigan.

MR. CURRIGAN: This is Sean from ACOG.

I just wanted to express my concern that measures that have gone through the perinatal and reproductive health panel which are recommended for endorsement have been voted down

by this panel or by the combined panel, but you are in the process of potentially considering a measure that did not even seek endorsement. And I am just concerned that there has been another panel that has expressed the recommendation that contraception measures and even the unexpected complications in newborns go forward for endorsement, and then, not be included in the Medicaid MAP.

CHAIR GESTEN: Sean, thank you for that concern.

Do you have any response or anything?

MS. MUNTHALI: Well, Sean, this is Elisa from NQF.

One of the things we are doing right after the Task Force votes on the measures that are in front of them today is to reconsider one of those measures you brought up. But I just wanted to remind you, while endorsement is a strong preference by Medicaid, it is not a requirement for the measures that may go into the core set.

CHAIR GESTEN: Rich, was there a question?

DR. ANTONELLI: Just a procedural question. Will we have an opportunity to comment as we go measure-by-measure for each of the votes? Yes? Okay. Thank you.

CHAIR GESTEN: That would be my suggestion --

DR. ANTONELLI: Yes.

CHAIR GESTEN: -- to see whether there is a motion and second, conversation, vote.

MEMBER SAKALA: (presiding) Okay. So, for 2800, metabolic screening for -- oh, I am sorry, Marsha.

DR. LILLIE-BLANTON: Before you vote, I just want to ask, is there data somewhere on the continuity-of-coverage measure, just so we can get a sense? So, I could get a sense of how it has been tested and what we have learned from -- you all would have sent it to the NQF members, right?

CHAIR GESTEN: I believe this measure

would be in the spreadsheet, the CHOP measure, the PQMP CHOP measure on consent and --

MEMBER SAKALA: Continuity of coverage.

CHAIR GESTEN: Continuity of coverage. But it would be information about the description, not detailed information about the testing of the measure.

MS. GORHAM: We don't have this information, but we have the Excel sheet that the members receive.

MEMBER SAKALA: Okay. So, is there anyone here who would like to propose that we have a vote on 2800 and including that, our recommendation to include that in this core measure set?

(No response.)

MEMBER SAKALA: Okay. Seeing no interest in that one, let's move on to 2797, which is transcranial Doppler ultrasonography screening among children with sickle cell anemia, an NQF-endorsed measure. Is someone here

interested in a vote?

Andrea, yes. Is there a second?

MEMBER ADIRIM: I second.

MR. CURRIGAN: Terry. Okay. Now here is another opportunity have comments and questions about this measure before we vote.

(No response.)

MR. CURRIGAN: Okay. No comments or questions. Can we open it for voting, please?

MS. OGUNGBEMI: The voting is open.

MS. GORHAM: And we are looking for 10 votes. I do not have a proxy vote for Cindy.

MEMBER SAKALA: Okay. So, 1 is, yes, we recommend it be included in the set, and 2 is no.

(Voting.)

MEMBER SAKALA: We are looking for one more vote.

MS. GORHAM: For the record, I don't have a proxy vote for Cindy and Foster is recusing himself from vote for this measure.

MEMBER SAKALA: Okay. Okay. Seventy-

eight percent support this. So, we are adding that to our list of recommended measures.

CHAIR GESTEN: (presiding) Cool. What is the next one?

MEMBER SAKALA: 2789.

CHAIR GESTEN: 2789 is the adolescent assessment in preparation for transition to adult-focused healthcare. This is NQF-endorsed. It comes from one of the centers. It is a patient-reported survey of young adults 16 to 17 years old. We had a conversation about it.

Is there anyone who would like to propose adding this to the measure set?

Rich?

DR. ANTONELLI: I will make a motion.

CHAIR GESTEN: Okay. Is there a second?

(Second.)

CHAIR GESTEN: There is a second. Any discussion?

(No response.)

CHAIR GESTEN: So, I have some

discussion. I think this is a gap area. I think it is a gap age population. I think it is an important issue.

My fear about this measure is that it is not going to get much uptake, and that may not be a reason to vote it down. But I would say, based on we have done, or tried to do, adolescent surveys by mail in the past, and there are a huge number of implementation challenges to doing this. That doesn't make it not worthy, and maybe it is a new day. But I have real concerns about states' ability to actually implement this.

On the other hand, you know, we certainly have -- what are you guys doing over there? Susan is on the ground.

(Laughter.)

CHAIR GESTEN: So, we have measures that are aspirational, and it would be great to be wrong in my assessment of this, but that is my concern about this relative to the burden of cost, prioritization, and so on, despite what I think is a really important area.

I am not sure whose card -- but yours is on the ground, Susan. I will let you go first. Go ahead.

MEMBER LACEY: So, I think traditional surveys would be really -- you know, nobody would do those in that age bracket. But apps, YouTube slides, some other like innovative way to get this information would make a whole lot of sense. It is sort of like we can't keep teaching tiger clubbing in an age where we don't also go around clubbing tigers. So, we need to find the right way to get information, not necessarily a survey.

CHAIR GESTEN: I have to follow up with you on that analogy. Is that a southern thing?

(Laughter.)

CHAIR GESTEN: Tiger clubbing, I have never heard that one before.

MEMBER LACEY: Have you never read The Saber Tooth Curriculum?

CHAIR GESTEN: Apparently not.

MEMBER LACEY: It is a classic. It is

about teaching things we don't do anymore because we have always done it.

CHAIR GESTEN: It sounds great.

Bo?

MEMBER RIEWERTS: I am not going to say much, but I agree totally with you that we have been totally unsuccessful at doing this in our organization, trying to reach out to teens to get information from them by mail.

CHAIR GESTEN: Rich? You were just busy knocking down Susan's card? Is that it?

(Laughter.)

CHAIR GESTEN: We would let you speak. You don't have to knock down other people's cards.

(Laughter.)

CHAIR GESTEN: Any other comments before we vote? Kathryn?

MEMBER BEATTIE: I think there is inherent bias in the methodology proposed and that a patient who would be compliant and follow up and going to a visit might be more likely to

respond to a survey. And so, then, the actual value of the data gotten back in response to that survey may represent the bias of those who would participate in that program. So, I think it would be challenging to implement.

CHAIR GESTEN: Thank you.

Charles?

Good interesting point.

DR. GALLIA: I could be making this up because it is convenient. But I think that there was some work through AHRQ on a pediatric EMR criteria, modules, recommendations. And one of the components, I believe, is the ability of the system to report exactly this piece of information. So, where that is in development and implementation, I am not exactly sure.

CHAIR GESTEN: Is there anyone around the table who has any insight on that? No? Okay.

So, why don't we move to a vote. It looks like we have teed-up. So, we are voting on whether to include this measure, 2789, recommend

it to be included to the core set. It is adolescent assessment of preparation for transition to adult-focused healthcare.

A yes vote would be to include it; a no vote would be to not include it.

Are we all ready?

MS. OGUNGBEMI: Yes, voting is open.

(Vote.)

CHAIR GESTEN: Okay. So, 90 percent no. So, this was not recommended to be added to the core set.

What is the next item that we have? Sure. So, we can do this one. I will have to recuse myself, and you will have to do this one. Sorry.

MEMBER SAKALA: (presiding) So, the next up for consideration is 2801, use of first-line psychosocial care for children and adolescents on antipsychotics.

And we will first ask if anyone has any questions or comments before we find out whether you want to make a vote on it.

CHAIR GESTEN: Do you have a question that you would like to ask? Okay.

MEMBER SAKALA: Okay.

(No response.)

MEMBER SAKALA: Hi, Sarah. Not to put you on the spot, but there has been a request that we consider 2801, use of first-line psychosocial care for children and adolescents on antipsychotics. Do you have any comments on this measure?

DR. HUDSON SCHOLLE: Sure. Actually, this is a measure that was, when we asked stakeholders to prioritize, this was often the most important priority. It is the most important.

This measure really came out of our desire to try to reduce the use of antipsychotics among children and adolescents because our research showed us that children and adolescents, like over half of the kids that get antipsychotics actually have behavioral disorders, and they don't have the conditions for

which antipsychotics have an FDA indication, which suggests that they are being used more to address a behavior, rather than to treat a problem.

And so, that is the origin of the logic here, that the measure is looking to see whether children and adolescents, whether there is a trial really, some attempt to provide psychosocial care either in the month before the prescription -- I'm sorry -- is it the month or -- you know, in the time before the prescription or within 30 days afterwards.

We wanted to take into account whether in an acute situation a child might be given an antipsychotic at the same time that you are arranging psychosocial intervention. But the real concern was that, often, the children have ADHD, and where evidence-based psychosocial interventions exist, and we wanted to make sure that that happens.

In our data, the performance rates are around, the median performance rate is around 50

percent. So, it shows that there is an awful lot of room for improvement on this measure.

MEMBER ADIRIM: Could I ask -- this seems like a strong candidate for some of the things that we are looking for -- and why this wasn't a staff pick, if you have any comments on that?

MS. GORHAM: We didn't choose it as a staff pick. No particular reason. We didn't want to choose too many measures as a staff pick and really leave it up to the Task Force members. So, no, I can't give you a solid reason.

MEMBER SAKALA: Other questions or comments on 2801?

Yes, Rich?

DR. ANTONELLI: Sarah, psychosocial care, is that a generic term for counseling?

DR. HUDSON SCHOLLE: Okay. This measure is reported using claims data. And so, the claims that count as a psychosocial intervention are individual, family, and group therapy. While we would prefer to have something

that was more specific to evidence-based psychotherapy, as you know, that is not documented in any obtainable dataset today.

DR. ANTONELLI: Then, just a follow-up observation. Not having an FDA primary indication does not necessarily mean that it is not appropriate care. There is a gap there in terms of pharmacologic interventions finding their way into the pediatric population. That is not to push back on the measure. It is just an observation to the degree that one would consider that the gold standard, but in terms of pediatric indications.

MEMBER ADIRIM: I agree, and I think the thing that made a big impression on me, I think it was two years ago -- I'm not sure if it was last year -- was that the State Medicaid Director from Louisiana said 40 percent of their kids on Medicaid were on antipsychotics, and she said that there are a lot of southern states where that happens. So, this is a widespread problem, and certainly 40 percent of children

should not be on antipsychotics. So, that is why I think we should put this in the core set.

MEMBER SAKALA: Susan?

MEMBER LACEY: More for you in terms of claims data, so I am not a provider, so I don't like chart ICD-9s or codes, or whatever. You would have to get the code that you recommended the counseling or that they have gone to counseling. I mean, how do you get that? It is not just one piece of information. It will be several pieces. Because won't you need the date, several dates?

DR. HUDSON SCHOLLE: We are actually looking at whether the counseling service occurred, not whether it was recommended. So, this is based on claims data. This is a health plan measure. So, health plans, we have tested it for both health plans and for states.

Really what we are trying to encourage is access to psychosocial services for children's behavioral health needs and to meet the gap in providing psychosocial services that leads people

to prescribing medications instead of psychosocial care. And so, that is why we think it is appropriate at the state and health plan level where states and where health plans are responsible for both the general medical, pharmacy, and mental health benefit. So, it is that responsibility.

MEMBER LACEY: When you are saying it is claims data, so if the patient or the family goes to the counselor, that is how you would capture it? And would you have a special way of knowing if that was the first-line or after medication failed? I mean, how do you get that?

DR. HUDSON SCHOLLE: That is a very good question. So, the way that we identify that is that we look for children who have a new episode of a medication. And we do that from the claims data. So, we look to see they haven't been on an antipsychotic I think for six months. So, they are continuously enrolled. We can tell they haven't been on an antipsychotic. We see a new prescription of an antipsychotic, and we look

to see, did they have psychosocial service in the -- I'm not sure if it is three or six months. I can't say that. And then, we also give kind of this 30-day grace period. So, we are really saying, did you try psychosocial service before the antipsychotic prescription is filled?

In the claims, you are pulling all those pieces of information from the claims data, uh-hum.

MEMBER SAKALA: Thank you.

Other questions or comments?

Charles, did you have your card up?

DR. GALLIA: I was just going to say, technically, this is similar to some other measures that we have done. So, it is not onerous in that sense that, I mean, the data exists. It is mostly making certain that the timing dates are accurate. And then, the other part6 of it is that, as long as the coding is updated routinely, then we can operationalize it fairly easily.

The challenge will be that, if we find

discrepancies, then we can work those out with managed care organization to say, no, actually, they did and it was a claim that was submitted. So, it could not only improve, have a focal point for the subject matter, but it might be able to improve our data quality, too.

MEMBER SAKALA: Okay. Any more on this one?

(No response.)

MEMBER SAKALA: So, is there a motion that we recommend addition of this Measure 2801 to our recommendations for addition to the child core set?

MEMBER ADIRIM: I move that we add this to the core set.

MEMBER SAKALA: A second?

Meg seconds.

Thank you.

So, could we open voting, please?

A 1 will be yes and a 2 will be no.

MS. OGUNGBEMI: Voting is open.

MS. GORHAM: And we are looking for

nine votes.

(Vote.)

MEMBER SAKALA: Okay. So, this one, it gets added to our list with 78 percent yes.

Next, we will move on to -- there is no number, but it is from the PQM pipeline, appropriate antibiotic prophylaxis for children with sickle cell disease.

Now is an opportunity any additional comments or questions on this measure.

Rich?

DR. ANTONELLI: Thank you.

I don't know whether the measure developer is still on the line or not. But recall that the reason that her team decided not to put this one forward had nothing to do with the validity of the measure. It is because of limitation of resources.

So, once again, I see this as a pure and simple measure of disparity. The American Academy of Pediatrics, this is a care guideline. There is an evidence base for this. I am fully

in support of doing the transcranial ultrasound. It costs about a dollar a day for penicillin. It will cost more than that to do an ultrasound looking for problems. This prevents problems. So, it is a prevention strategy. It is inexpensive. This has the hallmarks of a disparate outcome for a vulnerable population.

Please don't make this a "Sophie's choice" for the sake of the population. Well, no, I am concerned because she said -- well, the fact that Sara had to say, "We didn't have the resources to do both." I decided it wasn't going to be appropriate for me to say, "Well, why did you choose that one?" But, as a pediatrician, I tend to think prophylactically or preventively as much as possible. So, I really want to appeal to people to think about this because she clearly said, if they had the resources, this would have come before us.

MR. OLKOWSKI: This is Kevin Olkowski at the University of Michigan.

MEMBER SAKALA: Yes. Thank you.

MR. OLKOWSKI: So, just to amplify on that, we, in fact, just did not have the bandwidth to put both measures through successfully, and our Center was in the process of finishing up 52 separate measures in different areas. And it just was simply impossible to move these forward. It is our full intent, though, to submit that at the next opportunity to seek NQF endorsement.

MEMBER SAKALA: Okay. Thank you.

Any other comments or questions?

Terry?

MEMBER ADIRIM: Yes, just a clarification, since the measure developer is on the phone. So, in your developing of this measure, do you have any data of how large a problem this is? I mean, what percent of kids with sickle cell disease are not on antibiotics?

MR. OLKOWSKI: Yes. Of course, Sara, who is the true expert on that, had to leave. But my understanding is that there is actually a fairly low compliance. I don't have the numbers

in front of me. I wish I could send it to you, but I believe 15 percent is the number I recall. But I don't have that right in front of me.

DR. ANTONELLI: That is compliance as opposed to non-compliance.

MEMBER SAKALA: Rich, do you want to turn your microphone on and say that?

DR. ANTONELLI: Kevin, that 15 percent was the compliance rate or the failure rate? Kevin?

MR. OLKOWSKI: Oh, I'm sorry.

DR. ANTONELLI: Fifteen percent was the rate of adherence to the guideline?

MR. OLKOWSKI: Correct.

DR. ANTONELLI: Yes.

MEMBER ADIRIM: But does this measure measure adherence or prescriptions? Because it looks to me like it is administrative claims data, so it would look at prescriptions as opposed to actual adherence. No, I know, but I am saying every single kid that comes to the emergency department with sickle cell disease, it

says they are on penicillin, whether or not they take it or not. I mean, that is what I am trying to get at, whether or not this measure is going to really help with improvement.

MR. OLKOWSKI: Right. And so, the measure actually recognizes the fact that we are using administrative claims data, which certainly has it strengths which are well-documented and known to you all, but it also is not a full representation. It is a proxy for actually use of the medications. However, we are looking at it over a one-year time period using that proxy, you know, those refills, and whatnot, to indicate continued use, as best as claims can support.

MEMBER SAKALA: Thank you. Any other comments or questions on this one?

(No response.)

MEMBER SAKALA: Okay. Okay. So, we are interested in knowing whether there is a motion to add this one to our list.

DR. ANTONELLI: I will make that motion.

MEMBER SAKALA: Is there a second?

MEMBER RIEWERTS: I will second it.

MEMBER SAKALA: Okay. We have a motion and a second. Could we vote, please?

We are voting to discuss whether appropriate antibiotic prophylaxis for children with sickle cell disease should be added to our list of recommended measures for the child core set.

One is yes and 2 is no.

MS. OGUNGBEMI: The voting is open.

(Voting.)

MEMBER SAKALA: We are looking for one more, I believe.

Okay. All right. So, we are out of a total of eight. Since we don't have 60 percent, we can't pass this. Okay. Thank you.

All right. So, I think we go on to the two CHOP measures next.

CHAIR GESTEN: (presiding) So, we will do these one at a time, though. Informed consent, this is a measure from CHOP around --

I'm sorry -- informed coverage. And the measure we talked about is the measure looking at summation of covered months of coverage. This was, again, developed by CHOP under the Pediatric Quality Measurement Program. It is an administrative measure.

CHAIR GESTEN: We had some discussion about it previously. Let me just see if there is any conversation or questions that did come for you that people want to bring out.

(No response.)

CHAIR GESTEN: And if not, is there a motion to take a vote, a proposal to take a vote to see whether this measure should be added to the core set?

Okay, Meg, yes. Is there a second?

(No response.)

CHAIR GESTEN: Okay. I am not seeing a second. Sorry, Meg.

Let's go to the next one. The next measure is the duration of first-observed enrollment, again, a measure developed by CHOP

looking at issues of continuity of coverage.

Meg, can you just say two words, rather than me read through that, what this measure does versus the one that folks didn't vote on. Use your microphone, please.

MEMBER MURRAY: This one looks at how many of the kids that were on on day one are still on at six months, at 12 months, at 18 months. And so, it gives a sense of the continuity. You know, the trail goes down.

And I should say that last sickle cell measure was looking at kids who are continuously enrolled. So, my point is so many of these measures are dependent on people being enrolled, and if we don't know what the enrollment levels are, it undermines the quality issues.

CHAIR GESTEN: Okay. Thanks. Any questions or comments about this measure?

(No response.)

CHAIR GESTEN: Is there a motion to consider voting on adding this measure?

Meg. Is there a second? A second.

Okay. Can we set up the vote? We are voting on whether this measure, the duration of first-observed enrollment should be added to the child core set.

A yes vote would be for addition; a no vote would be not to add.

And I think, what is the magic number we are looking for now? Would it be nine? Nine, yes. Okay.

So, are we ready to vote? Okay. We are ready to vote.

MS. OGUNGBEMI: Yes, voting is open.

CHAIR GESTEN: Great. Thanks.

(Vote.)

CHAIR GESTEN: Nine is the right number?

MS. GORHAM: We should have 10.

CHAIR GESTEN: We should have 10. Oh, Rich stepped out. Was Rich not here?

MS. GORHAM: He voted first.

(Pause.)

MS. GORHAM: We still have a quorum,

so we are fine.

CHAIR GESTEN: I don't know. If Rich were here, I suggest we re-vote, but he is not here.

MS. GORHAM: We can hold off on the re-vote.

CHAIR GESTEN: Let's do that. That is my suggestion. I understand what you are saying, but let's maybe re-vote.

Can we move on? Is there another one to move on to?

Is Reva -- are we ready to tee-up?

MEMBER SAKALA: (presiding) So, I would just like to say, Meg, that your colleague mentioned you hadn't thought NQF might be interested. And I think continuity and churn are a huge issue for this population. So, we would encourage you all to submit those measures through this process, and then, they could be really good candidates for us. It is just a little hard to tell right now.

Thank you.

So now, we are going on to -- it was recommended that we consider the readmission measure -- where is it? -- from last year's list. Okay. I'm sorry, where is the readmission --

MS. GORHAM: On the screen back, it shows the voting slides. So, we are voting on 2393, pediatric all-condition readmissions measure.

MEMBER SAKALA: I see. Got it. Okay. So, we are not looking at any details on this? We are just --

MS. GORHAM: They said they didn't need to see them.

MEMBER SAKALA: Yes. Okay. So, is there comment or questions?

Or you think the vote is up now without any discussion?

MS. GORHAM: So, you all can discuss. You said you didn't need to see the specifications again because we looked at it and discussed last year. If you need us to pull it up, we can, or not. You all can have a

discussion, and we will vote. It will be nine voters because Foster will recuse himself. So, it is up to you. If you want to have discussion, you can. We discussed it earlier, yes.

MEMBER SAKALA: Okay. So, we said we would discuss as they came up for a vote. That is what I was thinking.

And then, to further complicate things, Rich, we are missing -- Rich, hi.

We are going to re-vote on the last one. So, we wanted to try to get nine votes on this CHOP duration of first-observed enrollment. There is a request to re-vote when you came back, and we are going to try to get nine votes.

So, once again, for duration of first-observed enrollment, a yes would recommend this for inclusion on our list of recommended new measure, and a no would not include it on the list.

MS. OGUNGBEMI: Voting is open.

(Voting.)

MEMBER SAKALA: Oh, now we have 10?

MS. GORHAM: Okay. Ten, got it, 10.

MEMBER SAKALA: Okay. So, this measure does not pass with 40 percent yes. Thank you for re-voting, everybody.

Okay. Now we are going to move to -- did we want to pull up details of this readmission measure or are we prepared to vote? Well, we have an opportunity to discuss, make any additional comments, as we have for the other ones we are running right now.

(No response.)

MEMBER SAKALA: Does anyone wish to propose that we vote on inclusion of this measure?

MEMBER BENIN: I think we already have a motion that is an outstanding motion.

MEMBER SAKALA: Sorry.

MS. GORHAM: It is okay. We are now going to open the vote for 2393, pediatric all-condition readmissions measure.

One, we are recommending this measure for addition in the core set; 2, we are not.

MS. OGUNGBEMI: The voting is open.

MS. GORHAM: We should have nine votes, as Foster is recusing himself from the vote.

(Vote.)

MEMBER SAKALA: So, this measure, at 44 percent yes, does not pass.

Okay. Now we will move on to one more measure for this day.

CHAIR GESTEN: (presiding) Is the next measure the healthy term or the unexpected newborn complications?

Carol, did you describe sort of why we are redoing this? Do you want to just refresh folks' memory?

MEMBER SAKALA: Sure. So, after we voted yesterday not to pass this measure, I think not by a landslide, there was some surprised response from people in the room and on the phone. So, Helen was surprised. Reva was surprised. Sean was surprised. And I was as well, but I also recognized I shouldn't be too

greedy about maternity measures.

Anyway, the idea is that this measure was supported by 100 percent of the members of the Perinatal and Reproductive Health Standing Committee earlier this month. As Sean pointed out, it is a gift to the Medicaid population because it is all based on administrative data. It is also an outcome measure, where we are looking toward moving away from process measures and other low-bar measures. And it is considered to be very well-done and, as I mentioned yesterday, a balancing measure. So that, as we move forward with quality improvement in areas like Cesarean reduction, this would be a little kind of canary in the coal mine, for example, if we were getting too aggressive in some of those areas.

So, there was the thought that yesterday what we put up, the previous version of this measure, there was some confusion at not being able to see what is before now for 0716. It is the same number. It was previously

endorsed.

The developer changed it in the course of this four-year hiatus between the two Perinatal Care Committee meetings, consensus development process meetings. And it is well-tested in its new rendition, which, as we have been saying, is simply flipped. It is pretty much the same measure, but a different way of looking at it.

Now it is the number of babies that aren't doing well as opposed to the number of babies that are doing well, who would, in general, be expected to be doing very well. And it is a measure of things that happened around the time of birth and for the rest of the stay in the hospital.

CHAIR GESTEN: Thank you, Carol. That is very helpful.

So, just as a process point, I just want to point out, just frame this, that I think we never want to have a vote depend a point of confusion or clarification that we can clarify

before everyone leaves. And so, part of the reason -- I mean, anyone at any time can ask for, a Task Force member can ask for a re-vote.

In this particular case, the concern was there were questions raised about what does it mean that it is pretty much the same measure, and what is the part that isn't pretty? And so, staff have done some work to try to clarify that. Again, I don't know if it will impact the vote or not, but I think we collectively probably don't want to have votes hinge on some misunderstanding that we can clear up.

So, Andrea?

MEMBER BENIN: You know, I would just like to comment, a question on the process, Foster. I felt like the conversation yesterday was pretty clear. You know, this is the inverse metric that was well-supported by the group. I am just not sure that if every time we vote and, then, afterwards people don't like what we vote, we are going to re-vote. That, to me, really makes the whole process pretty suspect.

So, I am not going to object. If we want to re-vote, we can re-vote, and my vote won't change. But there is a real disconnect for me on that, that really makes the whole process highly suspect.

CHAIR GESTEN: So, I understand that concern. I think that there will need to be a second. And again, I don't know that anything will change. But, again, I think, our view is, first of all, from a process point of view, people can ask for a re-vote if they want to. There isn't anything that forbids that, but there may or may not be support in the group to do that.

I think we tried to explain what the reasons were for this, which may accord with what you think is a reasonable reason to re-vote or not.

But, Terry? And then, Susan.

MEMBER ADIRIM: I was going to say exactly what Andrea said, because it seemed very clear to me yesterday what we were voting on.

So, I am not sure where the lack of clarity is happening. And I agree fully that, once we have a vote, I am not sure the utility in doing it again, unless you wanted to re-litigate the whole thing all over again.

CHAIR GESTEN: Susan?

MEMBER LACEY: So, the question I have is, who can call another vote?

CHAIR GESTEN: Any Task Force member.

MEMBER LACEY: Right. So, we had a Task Force member call? And you did that, absent of any kind of -- I mean, you know, I am not --

MEMBER SAKALA: Right. I am willing to do that now on the basis of the feedback from people who are up in the helicopter around these processes and consider this to be an excellent measure that is moving in the direction of where we want measures to be.

CHAIR GESTEN: So, to answer, just to respond to the re-litigation, I would agree with you. I think, again, that is why I framed it the way I did. There were some concerns that there

were some questions that were unanswered or not clear about the, quote/unquote, "inversion" of the measure that we were looking at. So, I would hope that -- and I think Reva is on the phone -- that discussion be limited to that the discussion and the comment be around what is meant by the inversion and what is pretty much the same. And then, we will see if there is a second for this proposal.

Bo?

MEMBER RIEWERTS: I would second it.

CHAIR GESTEN: Okay. Fatema, did you --

MEMBER SALAM: Yes. I just wanted to say I heard confusion as to what our task was in terms of -- because today we looked at measures that weren't endorsed; we didn't have the specifications, but yesterday we were formulating -- I heard people saying they had trouble voting for this because, as you know, it wasn't the same measure and they hadn't seen all the details.

So, to me, the conversation that I heard did have some confusion around the process. But that is just what I heard, and my vote is not going to change either way, anyway. But I am kind of validating that, I guess.

CHAIR GESTEN: Okay. Thanks.

Reva, I know that you did some work and you had some side-by-side -- at least I am told there is some information, some other slides that will be presented to try to clarify anything that was at least perceived by some to be unclear about what this inversion meant, ways in which the numerator, denominator, or the exclusions -- I think, in particular, there were some questions about whether the exclusions differed as the measure was inverted.

So, Reva, are you on and can you --

MS. WINKLER: Yes, Foster, this is Reva.

If they could show the slide of the specs of the measure that is on the table? I think everybody needs to forget the concept of

inversion and look at what is in front of you, because this is the measure that is currently in front NQF's consensus process for potential endorsement.

The past history is interesting, but probably not pertinent. And so, the measure you want to be evaluating is the unexpected complications in the term newborn. And I believe you have a clear slide of the specifications of that measure in front of you. And so, I think that is really -- to me, I heard a lot of confusion about what the measure actually is. And so, we wanted to be clear what the measure you would be considering, what the specifications are, and have them in front of you.

CHAIR GESTEN: Great. Thank you, Reva. That is very helpful.

So, I am giving people a chance to kind of read through it. And we would open the floor to any -- is the measure developer on the phone?

MS. WINKLER: Foster, I tried to

contact him earlier today, and I didn't get a response. I gave him the information.

CHAIR GESTEN: Okay.

MS. WINKLER: Operator, did Elliott Main call into this call at all?

OPERATOR: I don't see him on the line.

CHAIR GESTEN: Okay. I mean, I don't know that we will have a question that we will need to forward to him. Let's just see.

Are there any questions about this measure, its specifications, the numerator, denominator, or exclusions?

(No response.)

CHAIR GESTEN: Seeing no questions, we have a proposal to consider adding this, recommending this be added to the child core set. It has been seconded. So, we are ready to vote.

This is for adding 0716, unexpected complications in term newborns, to the core set. A yes vote would be to add this measure; a no vote would be not to.

MS. OGUNGBEMI: The voting is open.

(Vote.)

MS. GORHAM: Yes, I have a proxy vote for Cindy. That is why we have 11 votes.

CHAIR GESTEN: Great. Thank you.

So, this measure does not pass, as it was 55 percent yes, 45 percent no.

Thank you. Thank you, Reva, and thank the indulgence of the group for a re-vote. Are we through the gauntlet?

(Laughter.)

CHAIR GESTEN: First of all, thank you. I thank everybody for this process. I know it is to be a little grilling, a little confusing sometimes. But, once again, thank you. It has been great discussion.

The next step of this is prioritizing. Again, just to re-ground folks, the reasons we prioritize is to send a clearer signal/message to CMS as they look at this list. While we have approved each of them, whether there is more weight or more concern about some measures versus

others.

And that is, in part, a recognition that -- I don't know how many measures we have currently that we have -- five. It is possible, but not probable, that all five will be adopted. So, this is, I guess, our way of putting a stamp on this.

I think in the past we have given folks a vote of a certain number of measures with little stickies to decide which were most important and kind of rank order them. When the meeting started, we went through whether we should digitalize this process and update it using this or use stickies. Maybe based on my age, I thought stickies would be easier.

What we are proposing is how many? How many? Three? That folks get three votes to stick on this.

I see, Terry, your question.

We, I think, landed. Do you want to talk a little bit about the measure that has an e-specification and how we are handling that?

Was that your question? I had a hunch.

MS. GORHAM: So, we had a little bit of conversation behind the scenes. And so, we do have the two measures, the breast milk measures. One is a paper measure and the other is the e-measure. The same measure, different data sources. And you, as a Task Force, can recommend and prioritize as you see. And then, if the measures are recommended for the core set, then it will be up to CMS to choose which measure they think would be best for the states.

MEMBER ADIRIM: Let's say I consider that No. 1. I consider both of them No. 1. I want to use my 2 and 3 for two others. We can't combine those?

(Laughter.)

MS. MUKHERJEE: We did combine the voting because one is endorsed and the other is going through the process. So, I think in a way, if you are voting, you would be voting for both, and maybe we should bracket it because we did talk about that CMS should have the choice of

which data source. And hopefully, some states will do the e-version and some states won't. So, I think in that case, you know, we will put a bracket. So, if you are choosing, you want to use just one dot. Use one dot for the two.

CHAIR GESTEN: So, I am okay with that. Is anyone not okay with that? But there was a difference of opinion, at least earlier on, about whether these are two measures or one measure. So, I see it the way you see it, but not everybody, including our colleagues at those three initials, necessarily saw it that way. So, I am good with a bracket.

Okay. Rich?

DR. ANTONELLI: I was going to say I am confused, although I like where we just landed because the first measure includes electronic data. So, it actually is, if you will, the mother measure. So, the decision point, if we wanted to make one, would actually be, do we not care about any data sources other than electronic, in which case you should go with the

second one. And so, it was that concept yesterday that I was willing to vote them together.

Is that what we are really talking about? If we just put one sticky on those two and, then, CMS can decide?

CHAIR GESTEN: That is an approach.

DR. ANTONELLI: Yes, yes.

CHAIR GESTEN: Does anybody object to putting them together?

Carol?

MEMBER SAKALA: I don't object, but I just want to say that yesterday we handled the elective delivery that way. We didn't really vote on it. It was already in the set. So, we just said, oh, you also have an e-measure as an option.

CHAIR GESTEN: Both of those endorsed --

MEMBER SAKALA: So, I think elective delivery is already in the set, and then, we supported the e-measure for that.

MS. GORHAM: So, most importantly, CMS is shaking their head yes.

DR. ANTONELLI: I saw that.

CHAIR GESTEN: So, deal with the process. Three stickies, three dots.

Does anyone want to make any comments before you get your dots?

MEMBER LACEY: We have to put on three different ones or can we put all three of our dots on one?

(Laughter.)

MEMBER LACEY: I am not saying I want to do that. I am just saying I can't remember what we did last year.

CHAIR GESTEN: That is a great question.

MEMBER LACEY: Because we decided last year -- I can't remember what it was.

MS. GORHAM: We did that last year. So, you can, uh-hum. Yes.

CHAIR GESTEN: Yes? Okay.

All right. So, feel free -- dots

away. Everybody get their dots. The dots are for Task Force voting members, right?

MS. GORHAM: Yes.

So, just as a reminder, the measures that were voted for conditional support are on one wall, and the measures that were voted for to support are listed on the other wall.

(Vote.)

CHAIR GESTEN: Why don't we take a quick break. We will come back at 3:15 and resume. We will talk a little bit more about cap areas and some summary, next steps, timeline. A lot of work is done, but don't leave yet unless you have to. Thanks.

(Whereupon, the above-entitled matter went off the record at 3:06 p.m. and resumed at 3:12 p.m.)

MS. MUKHERJEE: Okay. We're starting to lose some people, so let's talk about gaps. Some comments on the gap areas, today we did fill two gap areas. We have a sickle cell measure and a behavioral health measure, so we did make some

indentation in some of our gaps, even if it's infinitesimally small, it's incremental changes, it's all about scaling up. So, on that note, other than that, our gap areas remain the same from last year carry over, but we did sort of add two measures. So with that, I will open up to any comments about gaps that there are in the room. And then with that, we'll follow up on the phone and then we can let everybody go home. So, we'll start with Charles.

DR. GALLIA: So, when the measures were first reviewed in relationship to gaps, and I see the tracking mechanism that was used to identify particular areas, one of the components of it was the ACEs and trauma behavioral healthcare, it's a subcomponent. And when the different review groups didn't have this was actually trauma-informed, it's the preceding slide. Behavioral health functional outcomes that stem from trauma-informed care. I think it's important to consider reframing this in a broader area, rather than strictly mental health and look at a

population based, potentially consider there's like the National Children's Health Survey and the Maternal Child Health Bureau have trauma rates as measures at a state level.

So, I would suggest reconsidering this position as being more prominent and over time, there were measures that were proposed that were turned down because this gap wasn't used as a contrast for that. In other words, we had measures that considered in the first couple of rounds of the versions that were submitted through public comment over time, but they didn't meet this threshold because the actual gap wasn't identified either. So, what I'm suggesting is to do a little bit of a reset on the subject and consider it more prominent than what it is positioned now. Does that make sense?

CHAIR GESTEN: So, I think so, but the gap area as it's described right now under mental health, initially when we were talking, I didn't think it was there, but it's the behavioral health functional outcome stemming from trauma-

informed care, is that what you're referring to and is that what you're suggesting be prioritized? Are those the two things that --

DR. GALLIA: This is narrowly constructed, I think it needs to be expanded to be reflected of ACEs more broadly and elevated beyond mental health as it is as a category. So the components --

CHAIR GESTEN: So have its own category?

DR. GALLIA: -- of exposures -- right. So that not just the consequences on the mental health or even in the setting that's assessed based on whether or not it's trauma-informed care.

CHAIR GESTEN: Other comments about gap areas? Terry?

MEMBER ADIRIM: Yes. And just to extend on what you were just saying, I think trauma, trauma period, injuries, trauma, in adolescents is one of the leading causes of death, so I think that is probably a gap area.

And I think too, just to expand on the behavioral health, substance use. I think kids start smoking during adolescence, so substances would be something to consider too.

CHAIR GESTEN: Other comments? Meg?

MEMBER MURRAY: Yes. So, the coverage issue, I don't know whether that will be considered a gap, but certainly it's not something that's on there now. So I think it would be.

CHAIR GESTEN: Other thoughts or comments about either gap areas that are either not framed in the way you would frame them or that you would add, subtract, or prioritize? Terry?

MEMBER ADIRIM: I think too, we have mentioned in past years about measures that assess use or overuse. I believe that was something that had been mentioned, not by me, but I just recall that it was something that had been mentioned. I don't want that to get lost.

CHAIR GESTEN: Kamila, microphone, you

were saying, overuse is on the list?

DR. MISTRY: I think overuse, because I remember sorting measures by overuse. Is it on there?

CHAIR GESTEN: Yes.

MS. MUKHERJEE: So there's misuse and overuse. And a lot of overuse and misuse also gets caught up in appropriate use criteria, which is sort of a different look and it's sort of a subset measurement.

CHAIR GESTEN: So I don't want to lose folks on the phone who've, lord only knows how they're able to hang in there all day over the phone, having done that myself, it's a Herculean task, so they need to be rewarded for hanging in. So, Operator, if there are folks who want to make public comment, I know Larry Kleinman wanted to make a comment and I believe he's still on, but if there are others who want to get in queue, we'd be happy to take comments from folks on the phone.

DR. KLEINMAN: Thank you, Foster. I'll

take that as an invitation to start. And I will say it's the multiple antipsychotics that allow us to hang in, in keeping with the measures. I think that you all have a very difficult task. And I want to suggest that there are a number of -- I'm going to speak to CAPQM, the Collaboration for Advancing Pediatric Quality Measures, which is one of the PQMP Centers of Excellence measures.

But I think there are other PQMP measures that were not brought to your attention that are excellent measures, some of which will and some of which won't pass NQF's review process because we were asked to move the science forward, and we did. And the review criteria and approaches have not caught up to the advances in the science, and that's a problem. And in some ways, as the one body that can make recommendations or that has been formally asked to make recommendations to CNS that is not NQF, it becomes the responsibility in my view and the opportunity for the MAP to help push that forward

by making recommendations.

So I want to suggest a few things. One, the CAPQM has developed a really nice framework on asthma ED overuse that includes a better measure of the rate than the one that used to be on the Core Set and was removed a couple of years ago. This one is now going through the NQF process, just went through the public comments process where the CDC program strongly endorsed it, or the CDC Asthma Control Program made public comments strongly supporting it.

We also have an appropriateness measure, and it's the combination of the count measure and the appropriateness measure that allow you to really get to the notion of overuse, under use, et cetera. We also have measures that look at the connection to primary care before and after ED visits, thus looking at coordination in a population that by its own behavior has demonstrated itself to be at higher risk. So it's targeted. That's one thing.

Also, in response to a question you

asked yesterday, Foster, about other prenatal measures, the CAPQM actually does have several measures of prenatal care, again targeted towards higher risk. So, we had whether women who were at higher risk had zero, one, or greater than one visit with an appropriate specialist or an MFM doc and we had that both as an overall measure and then broken down by indications such as HIV, heart disease, epilepsy, and other indications. So that was one.

Secondly, we have a measure of whether women at high risk receive multi-disciplinary care, which is defined as services by three or more different types of providers or clinicians during the pregnancy. And a third is a proxy measure for preconception care, looking at whether women who are on teratogenic medication continue to fill that prescription during their pregnancy. So, there actually are three measures that relate to prenatal care, with specific content targeted to women who are at higher risk on the basis of criteria developed by an expert

panel.

We also have other perinatal measures that I think would have been useful for discussion, including measures that relate to ACOG's preferences regarding levels of care. We have them as four individual measures that we submitted to PQMP, looking at four different aspects of the structural content or capacities of the institutions in which women with high risk deliver. These are intended to be index measures, they're not supposed to be all 100 percent yes, but rather to reflect the availability within a population of these services, including 24/7 OB staffing, well, OB or other staffing by a clinician capable of doing an emergency C-section, 24/7 inpatient on the labor and delivery anesthesiology, 24/7 blood banking transfusion, and 24/7, well Level 3 or higher NICU, so the NICU services.

We also have measures of temperature for all low birth weight infants, because this is a major source of mortality and morbidity, it's a

proximal outcomes measure. And we have a couple of temperature taking measures that go with that. And I think that this is really important, because in the area of injury prevention as well as safety, even in the very best NICUs, too many infants get cold and die as a result of that.

And then, lastly to discuss, we have mental health follow-up measures that we have found in our work that children who have both a primary care, well, who have primary care follow-up following a mental health discharge, controlling for whether or not they had mental health follow-up, have lesser readmission rates at 30, 60 or maybe 60, 90, and 180 days, I think is what we looked at. So, this is really an important component of it and we have a whole series of measures that look at timely follow-up, delays in follow-up, and also the establishment of ongoing follow-up, looking at the time or whether or not there was a second visit and the time between the first and second visit.

So, I just want to say, I think there

are really wonderful measures, carefully developed with the highest level of science to try to fill some of these gaps and I feel sad, I feel sad for the field, I feel sad for the children who could potentially benefit, that I don't think they're getting hearing because they're developed outside of the framework that NQF was designed to handle and I think that's probably true for other measures.

Some of these have not gone through NQF again, because of the resource issues you heard about from other sectors. There are a limited number of slots to submit for and a limited amount of dollars to pay for our work to do the submissions. I think this is an opportunity for you all, I hope you will figure out a way to address this opportunity. I think CMS and our children will benefit if you can figure that out. Thank you.

CHAIR GESTEN: Larry, thank you. And just --

DR. WOODS: I'd like to follow up on

that.

CHAIR GESTEN: That would be great in second. I need to recuse myself from conversation about those measures, but, Shaconna, do you want to maybe a clarifying comment about process and -- I'm sorry? Yes, I know you do, I know, I just wanted to respond to this directly first. Okay.

MS. GORHAM: So, Larry, I just wanted to thank you for that. Just a matter of clarification as far as process, staff definitely try to do our due diligence to get a list of all of the measures that could possibly be in the PQMP pipeline that are ready. And so we reached out and Kamila did an excellent job, she was very patient, worked with us, and got a list of PQMP measures that are ready for development, but have not been submitted to the NQF for endorsement yet.

And so that list was put together, we developed a spreadsheet, and submitted that to our Task Force members so that they could see all

available measures, whether in the NQF repository or other measures that are not aware of. So they were -- the Task Force members did have an opportunity to review the measures and recommend those measures for potential discussion and vote.

DR. KLEINMAN: If I could just say thank you, I appreciate that. I just think, as you know and we all know, the work of actually reviewing and going through that independent critical thinking is very challenging for any of us and certainly for the committee members. But it's good to know and I appreciate your clarifying that for the record.

DR. WOODS: This is Donna. Thank you, Larry, for bringing that up, because I've been sitting here thinking similar thoughts. And for us, we also have perinatal measures, we have measures of ADHD, we have PICU measures of quality --

CHAIR GESTEN: Donna, could you just introduce yourself so we know who you are?

DR. WOODS: Oh, okay. I'm Donna Woods.

I'm faculty at Feinberg School of Medicine at Northwestern. I am a principal in the PMCOE Center of Excellence, Pediatric Measures Center of Excellence, for which Ramesh Sachdeva is the PI and he asked me to sit in to be able to comment as made sense.

CHAIR GESTEN: Thank you. Go ahead with your comments. Thank you.

DR. WOODS: Right. So we have additional PICU measures and dental measures as well as a number of perinatal measures, different than the ones that Larry just described. And one of them was actually encouraged when there was the SNAC, which was I guess an internal committee to AHRQ, but I don't believe has been put forward in this process. So, you might want to discuss that. But also, we did submit two ADHD measures. And one of them was very close, but needed a tweak, but we had no funding to do that tweak. And so, I fear that that one will be lost in this process as well.

And it's an important one because

we've interacted with Medicaid states and it's about the chronic care follow-up -- well, the current ADHD measure in the Core Set requires a DEA number and you may or may not know that Federally Qualified Health Centers when they prescribe don't use a DEA number because they consider the children to be covered by the entire Center. So all of the FQHC patients fall out of that measure and the state, particularly in the state of Illinois, they've been very frustrated with that and have really asked for an ADHD measure that they can use because it's a very prevalent problem. And we have -- it needed a tweak.

DR. MANGIONE-SMITH: Hello, this is Rita Mangione-Smith. Just wondering if I could make a comment?

MS. GORHAM: Yes.

DR. MANGIONE-SMITH: Thank you. So, my name is Rita Mangione-Smith. I am the principal investigator for the Center of Excellence located at Seattle Children's Research Institute, part of

the PQMP. And I just want to put a charge to the Committee moving forward in your work, and I don't envy your job, I think this is very difficult work. I know care coordination has been a gap area on your list for years and my fear is that it's going to continue to be a gap.

Having spent the last five years really diving into this topic area, developing rigorous quality measures around it through our FUCC Measure Set, having eight of those measures endorsed by NQF in this last round for measure calls, the resistance to survey measures is going to make this area of measurement remain problematic and a gap. Much of what the evidence supports in the realm of care coordination, successful transitions for adolescents, as we see in the ADAPT Measure, really depends on talking to families. It's the only way we can tell whether the things that the evidence show us will help with care coordination and help with outcomes actually happened.

So, I hope that moving forward, there

was mention of paper surveys are beating the tiger with a club, I really loved that analogy, and I'm hoping moving forward we can really start to think out of the box about collecting survey measures using smartphones, using other technologies that are now available so that these measures don't remain in a space where they can't be used. Because I really believe that's the only way we're ever going to learn about the quality of care coordination that children with special healthcare needs are receiving. Thank you for the chance to comment.

CHAIR GESTEN: Thank you very much. Other comments on the phone? So, we'll go to the room in a second, but I just --

DR. KLEINMAN: It's Larry. Can I make one more comment?

CHAIR GESTEN: Yes, go ahead.

DR. KLEINMAN: Thank you, Foster. I want to comment on the notion of harmonization. I struggle with this, because I appreciate the feasibility. But I looked up actually the word

harmony and it related to multiple sounds that together create something greater than any of them alone. And I think we need to remember that when we think about harmonization. It's not homogenization, it's not the same measures, because somebody commented yesterday that the adult and pediatric follow-up after mental health measure was harmonized because it was the same measure, but it wasn't optimized for children and it's not optimal for children, as someone who has spent two and a half years working on that specifically.

And so, I think that it also relates to the same kind of assumptions that we make that Rita was talking about, about survey measures hard, therefore probably shouldn't do, don't rise to the level. I think we need to figure out how to bring better critical thinking to understand what the marginal value of differences are, the marginal value of extra effort to create work, and how we can do those things efficiently, but also effectively. Thank you.

CHAIR GESTEN: So, I just want to thank Larry and Donna and Rita for your very thoughtful comments and input. And also just make one observation, which is that I think that those are good comments and things for us to think about going forward, both the staff and the Task Force and the MAP, and I think that we credit the tremendous reservoir of measures that have generated out of this program, and at least for me, I don't see this as a one time, one opportunity to consider them. I view many of these measures and these conversations as something that's going to continue.

And so, there's no question that, as a result of the work that all of you are involved in and engaged in, our ability to look at and have measures to pick from to look at gap areas or improve areas has made a huge difference over the past two to three years and I think it will continue to do that. So, I want to recognize how important that's been and recognize that there are measures that are making their way into the

set from that great work. But, Marsha, let me just, if you have a comment?

DR. LILLIE-BLANTON: I feel like you've already said pretty much what I wanted to say and that is, the Pediatric Quality Measures Program has really helped us to advance the science. And we are still evolving. I mean, we are evolving because we are learning from the researchers and the scientists and the clinicians in the field, but we're also evolving because as a quality measurement and reporting program, we're still pretty much, we're a little beyond our infancy, but we're not far beyond that. And so, we value the work you've done.

We continue to look for you because as I said, you are advancing the science and I would think as we move forward, more of the measures that have been developed will be considered as thoughtfully as they have, if not even more thoughtfully. So, we just want to thank you for being a part of this evolving team and look forward to continuing to work with you so that we

can do a better job at measuring and, in course, improving performance of children, both in Medicaid and in the nation overall.

CHAIR GESTEN: Thank you, Marsha. Charles, did you want to, before I go to the room, did you want to make a comment?

DR. GALLIA: And I'll make it brief. And just one time. So I'm going to make a couple recommendations. One is that you consider instead of just on or off in the set and reframe your voting to say that this one we could defer for future consideration, make a notation of that, that way you could have it marked and move forward instead of just having it set aside. Almost like a motion to defer it for future consideration, in addition to the options that you've presented.

That gives some future direction to any information to subsequent groups. So, like, On-Deck, so this is emerging, we think it should continue. We did this with some of the measures in the beginning, and this one is moving out

potentially, so it's on the edge, we think this might be retired at some point. So consider reframing how you're characterizing the measures.

The other is that go back to the charge of the Core Set, the characteristics of the Core Set included components related to children with special healthcare needs, race and ethnicity, and a number of other areas. And while these topically cover them in many ways, they really don't specifically address those disparities and I think that's important to identify those explicitly as a gap area.

And then finally, I think that the patient's experience of care component, the one that's caps, it's such a rich source of information, but the shortcoming is that it's not at a practice level, it's a state health plan level. So something needs to be done to translate back to primary care specifically and make it actionable. It's a big area of concern that I have and there's nothing in there that gives a state the impetus to go beyond that

health plan level. So, that's my last comments.

CHAIR GESTEN: Thank you. I just want to make sure I understand one of your recommendations. It sounds like it's a -- instead of saying no, it's kind of like this is promising if x, y, or z happened, as a communication to the measure developer. Is that what you meant?

DR. GALLIA: Yes. So, if it's --

CHAIR GESTEN: And is there --

DR. GALLIA: -- a work in progress --

CHAIR GESTEN: Hang on a second. Is there such a -- it's ringing some bell that there used to be, that the MAP has some category of sort of not yet ready, but promising, or something like that, and I can't remember. Does that category still --

MS. MUNTHALI: It's continued development.

CHAIR GESTEN: Continued development or --

MS. MUNTHALI: Yes.

CHAIR GESTEN: -- something like that? And so there are other context at NQF and other forums in which that category or that message, if you will, which is a little more positive or perhaps could create some gray is communicated to the developers. So I think that's an interesting suggestion. Terry?

MEMBER ADIRIM: Yes. Just two brief comments. The first one is, I mean, my heart is bleeding for the measure developers and all the hard work that went into developing the 79 measures, I think it was 79 measures, and obviously we know the issue with how many we could have in this particular Core Set. But my understanding of the program is not only to move the science along, but to create measures that are appropriate for children, not just for this Core Set, but population health is a growing field.

So these measures are so important to places and people, health plans, and so on, that are doing population health. And I'm sure there

are states that are, as had been mentioned by our state colleagues, that are creating dashboards that would need these measures. So I don't know if there is some kind of forum or place for the measure developers to present their measures so that they're being used and taken up. So that's one.

The second comment that I was going to make is, I agree with Rita, care coordination is a huge issue. And I would have liked to see more of those measures that we considered, but I understand the issues for states in their reporting of them. So I was just wondering if CMS had any thoughts about providing some resources to testing ways to, in a limited way, testing innovative methods for surveying, for example, adolescents or that kind of thing so that we can try and move the actual how we get that information so that the measure is a better measure for state Medicaid programs?

DR. MATSUOKA: I think, I mean, I think we're very interested in exploring different

options.

CHAIR GESTEN: Let me just say, because I failed to do it, because Bo asked me before he was leaving to make the point that on the Adolescent Transition Care Measure, I'm terrible with remembering the titles or names -- what? ADAPT measure, that it sort of falls under, I think, the category that Charles was mentioning, which was, want to send a signal that this was a really important area and a great sort of start, but concerns about the methodologic and implementation issues, but very much wanted a means to send a signal to the developer or to the field that this is really worthy to pursue and to try to deal head-on with some of the implementation issues. But I don't know, Kamila, did you want to -- I thought Terry's comments were important about this forum is not the only utility for measures that are developed for pediatric health. Did you want to add anything or respond to that?

DR. MISTRY: No. I mean, I think we do

know that more broadly. I think this was one of the main reasons and the main issue around the legislation. So this was a main target point. But I think that measure developers know more broadly. I mean, I can use Mark Schuster's group as an example, where they're thinking about things more broadly. They're working with vendors, they're trying to figure out how to get these measures used more broadly. I know Rita also and Larry, a lot of the folks have. So I know that they themselves, there's limited time, resources to be doing that, but I think we'll also, as a program, think through how we can think about this for private uses and for other public uses as well. So, thank you.

The other thing is, I think that gray area that Charles brought up I think is very important to the work that we do, because I think we very often with a limited resource set, we need to prioritize things. And so that's just another tool or another way for us to think about how to signal to, for instance, the Q-Metric team

learned today that the antibiotic, to prioritize that. And so, all these things kind of help to signal what goes first, second, or third. It's not to say that many of those measures aren't important, but it just allows us to be a little bit more pointed in the way that we do our work.

CHAIR GESTEN: Great. Thank you.

DR. MISTRY: Thank you.

CHAIR GESTEN: Didn't mean to shortchange the room, was there anyone in the room that wants to make public comment? Seeing nothing, so we just have a couple of, amazingly we are actually kind of on time, never seems like we will get there, but we want to just report on the prioritization. It looks like, in terms of the -- oops, that's what I'm looking at. So, the sticky dot war, we have a tie of the exclusive breast milk feeding, both those measures, which were counted together, as well as the transcranial Doppler ultrasonography screening among children with sickle cell, at the top of the list. And then rank order second was the use

of first line psycho-social care for children and adolescents on antipsychotics. And then third was the contraceptive care for postpartum women.

So, we have a timeline and some next steps. Maybe there's a slide, I'm guessing there is. Oh, wait, do you want to just go back to what we removed? We removed from the Core Set Measure 1391, frequency of ongoing prenatal care, we did that yesterday. And then today we removed the measure of Child and Adolescent Access to Primary Care Practitioners. So, we did that. Next steps.

So, the dates, July 6 to August 5 will be a 30 day public comment period on draft reports and recommendations. The process point is that the MAP Coordinating Committee will review draft reports and may have comments or suggestions or changes or whatever that happens as a result of that. And then, by August 31, which means vacations don't happen probably the last week of August for NQF staff, final reports are due to HHS and made available to the public.

And then during that fall-ish time, fall/early winter, I think you guys do seasonal time frames just like we do with the state, CMS makes a determination about what to do with the recommendations and makes that public to the world, right? Do I have that right?

So, let me just ask something I should know, which is, when people, either the public -- so the public comment period is this, if Task Force members have comments or things that they didn't mention or think of after the meeting, they're allowed to contact you guys, right?

MS. GORHAM: Yes. So, the Task Force members can definitely contact us. We will respond to your emails and consider or include your input as we write the draft report. But Task Force members are also, if you have comments to the draft report once it is online, then you can definitely make comments online as well.

CHAIR GESTEN: And we will also take process comments, like ways to make this better, clearer, faster, more productive, more efficient,

whatever. We're open to those comments as well. So I think, are we -- I want to thank my extemporaneous co-chair, Carol, who we drafted last minute to deal with all those recusals and facilitate. Thank you so much for stepping in to do that. And thanks staff, once again, and thank you all for participating and have safe journeys home. Anything else?

MS. GORHAM: I just want to echo what Foster said. I definitely thank Foster, he is always responsive and works very well with us. I mean, we appreciate you very much. And Carol was wonderful, I sent her an email probably like 8:30 last night and she was like, oh, sure, I can do that. So, I just want to thank all of the Task Force members just for your support and also your input and your hard work. You definitely did a wonderful job. You reviewed all of the information we sent you, so we just want to definitely thank you. As well as the staff, we had Alexandria and Donna help us and fill in with voting, so we definitely thank everyone.

CHAIR GESTEN: Bye, everyone. Bye, folks on the phone.

(Whereupon, the above-entitled matter went off the record at 3:47 p.m.)

Q

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: 05-26-16

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R. Gross

Court Reporter