

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

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

2 9:05 a.m.

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

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

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

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

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

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

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

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

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

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

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

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

1 Hospital Association.

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

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

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

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

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

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

22 CHAIR GESTEN: Foster Gesten, I work

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

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

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

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

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

16 MEMBER PELLEGRINI: Cindy Pellegrini,
17 March of Dimes.

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

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

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

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

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

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

19 DR. FOX: Renee Fox, CMS.

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

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

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

7 CHAIR GESTEN: Great, thank you.

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

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

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

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

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

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

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

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

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

16 CHAIR GESTEN: So this is yesterday,
17 yes?

18 PARTICIPANT: Yes.

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

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

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

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

18 (No response.)

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

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

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

7 MS. ALLEN: Hi, good morning again.

8 So I am going to provide a brief overview of the
9 meeting materials, and my colleague Shaconna will
10 be presenting the key points from staff review of
11 the -- the core set.

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

1 percent of all births on average across the
2 states.

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

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

1 risks are growing.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5 DR. LILLIE-BLANTON: Right.

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

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

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

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

18 DR. LILLIE-BLANTON: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

22 CHAIR GESTEN: You guys probably know

1 more about the -- and I know you know more about
2 the process than I do, but the measures come both
3 through committees where this might be relevant
4 as well as potentially proposed or brought up by
5 the coordinating committee, is that correct? But
6 --

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

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

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

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

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

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

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

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

7 Can we go to the next slide?

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

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

20 MS. ALLEN: Correct.

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

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

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

5 MEMBER LACEY: We are? Okay.

6 CHAIR GESTEN: Yes, right.

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

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

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

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

3 MS. GORHAM: Thank you, Nadine.

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

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

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

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

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

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

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

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

4 MEMBER PELLEGRINI: I am sorry --

5 MS. GORHAM: -- and most are --

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

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

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

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

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

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

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

14 CHAIR GESTEN: Thank you, Shaconna and
15 Nadine.

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

1 that?

2 DR. LILLIE-BLANTON: Only that it was
3 reported this year, and we will be publically
4 hopefully reporting that before the end of 2016,
5 so it's federal fiscal year 2015 reporting. So
6 you only have the results of federal fiscal year
7 2014 reporting data.

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

11 DR. LILLIE-BLANTON: I think --

12 CHAIR GESTEN: -- report this?

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

15 CHAIR GESTEN: Okay.

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

18 CHAIR GESTEN: Jail? Okay.

19 (Laughter.)

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

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

3 CHAIR GESTEN: Okay.

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

6 (Laughter.)

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

9 (Laughter.)

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

13 PARTICIPANT: That there's at least
14 one state.

15 CHAIR GESTEN: You know, and they say
16 --

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

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

1 they're talking about. Rich?

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

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

1 substantial. Is that -- ?

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

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

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

22 DR. ANTONELLI: Yes.

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

3 DR. ANTONELLI: Follow-up --

4 DR. LILLIE-BLANTON: -- backwards?

5 DR. ANTONELLI: -- question please?

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

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

1 that's where we'd like to go.

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

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

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

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

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

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

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

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

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

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

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

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

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

19 (No audible response.)

20 MEMBER LACEY: Okay. So in general,
21 when we're seeing a -- an average of -- or the
22 41, I remember one of your slides said on average

1 41 states are reporting that, for that snapshot
2 of that year, that's just whatever states are
3 reporting in that bucket of 41. If you looked at
4 the year before, it might say 41, but it might be
5 different states in the 41 number, right?

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

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

10 PARTICIPANT: Yes.

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

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

5 Other -- do we have somebody on the
6 phone?

7 PARTICIPANT: Yes.

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

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

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

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

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

21 DR. SINGH: Okay.

22 CHAIR GESTEN: -- thank you. Thank

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

8 (No response.)

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

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

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

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

12 I know Shaconna shared this with you
13 yesterday. I am just going to provide a brief
14 overview. The Pediatric Quality Measures Program
15 was established under CHIPRA and intended to
16 improve and strengthen this core set of measures,
17 specifically to generally expand the availability
18 of pediatric quality measures for use by all
19 sorts of public and private healthcare
20 purchasers, to advance development and innovation
21 around new and emerging quality measures, and to
22 increase the portfolio of evidence-based,

1 consensus-driven pediatric quality measures
2 available in the field.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14 DR. MISTRY: It has been --

15 MEMBER MURRAY: -- but it's --

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

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

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

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

9 CHAIR GESTEN: Yes.

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

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

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

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

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

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

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

8 DR. MISTRY: Yeah --

9 MEMBER MURRAY: But the --

10 DR. MISTRY: -- right.

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

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

15 MEMBER MURRAY: -- and they've --

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

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

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

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

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

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

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

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

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

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

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

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

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

1 Is that -- is that correct?

2 CHAIR GESTEN: Correct.

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

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

11 CHAIR GESTEN: Jeff?

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

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

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

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

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

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

22 MS. GORHAM: Yes.

1 CHAIR GESTEN: Okay. Rich and then
2 Kamila?

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

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

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

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

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

1 "project"?

2 MS. GORHAM: So a project is funded,
3 for example, a project would be funded by CMS, so
4 example, the Pulmonary and Critical Care Project
5 --

6 DR. ANTONELLI: Yes.

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

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

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

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

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

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

17 CHAIR GESTEN: Kamila and then Carol?

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

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

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

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

14 PARTICIPANT: Perinatal.

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

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

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

4 CHAIR GESTEN: Thank you. Carol?

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

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

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

22 MS. GORHAM: Yes.

1 MEMBER SAKALA: So that's --

2 MS. GORHAM: So CMS has --

3 MEMBER SAKALA: Yes.

4 MS. GORHAM: -- that option --

5 MEMBER SAKALA: Got it.

6 MS. GORHAM: -- too.

7 MEMBER SAKALA: Okay.

8 MS. GORHAM: We make the

9 recommendations, and they choose which measures
10 that they want.

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

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

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

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

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

15 PARTICIPANT: Your microphone.

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

22 CHAIR GESTEN: I am already endeared

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

4 Somebody had a quick -- Andrea?

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

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

22 I do think that, you know, Shaconna

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

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

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

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

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

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

19 Kamila?

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

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

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

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

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

10 DR. SCHIFF: Yes, I will --

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

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

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

1 said okay. Point well taken.

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

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

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

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

14 (Laughter.)

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

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

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

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

22 So I think accountability at the

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

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

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

1 line.

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

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

14 (Laughter.)

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

1 look at our gaping holes and leave them there.

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

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

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

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

22 And other states put way more measures

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

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

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

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

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

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

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

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

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

22 So we are trying to -- to bump these

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

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

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

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

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

22 So I want to talk about burden for a

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

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

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

22 So I want to go deeper and talk about

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

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

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

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

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

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

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

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

9 PARTICIPANT: The Quality Rating
10 System?

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

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

1 actually have programmatic efforts around quality
2 improvement on.

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

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

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

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

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

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

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

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

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

1 and reporting across sectors on.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20 But any clarifying questions for Jeff?
21 Meg?

22 (No audible response.)

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

5 CHAIR GESTEN: Susan?

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

9 (No audible response.)

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

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

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

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

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

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

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

10 DR. GALLIA: Thank you.

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

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

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

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

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

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

1 they generated different feel.

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

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

11 DR. GALLIA: Right.

12 CHAIR GESTEN: Thank you so much.

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

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

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

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

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

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

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

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

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

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

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

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

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

1 developmental screening rates. What it shows
2 here is 2012. What it doesn't show is that in
3 2009, we were at 9 percent. So between 2009 and
4 2014, we moved up to 42.6 -- 42 point -- now
5 we're at close to 50 percent of the population
6 being screened routinely for social and emotional
7 delays as well.

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

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

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

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

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

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

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

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

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

1 that's something to bear in mind.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 I am going to only focus in on two

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

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

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

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

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

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

1 appointments?

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

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

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

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

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

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

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

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

2 So when I turn in a --

3 PARTICIPANT: Say what SBIRT is.

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

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

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

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

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

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

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

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

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

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

1 that they didn't even know.

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

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

22 So what I am just saying is that when

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

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

22 I am -- this is the process that we

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

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

17 Now what we're doing frequently is
18 we're picking numbers out of the air. We'll say
19 5 percent or 10 percent, you know, or 25 percent
20 changes, but I don't know what's, you know,
21 possible, so -- so in -- in having the history of
22 performance improvement and testing them is

1 really important.

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

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

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

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

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

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

22 I am just going to list these here.

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

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

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

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

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

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

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

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

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

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

17 I mean, as far as I'm concerned
18 working in the ED department, I'm telling you it
19 means nothing to me whether it goes up or down,
20 and it's going to continue to go up as far as I'm
21 concerned, since it has been over my 25 years of
22 --

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

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

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

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

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

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

1 CHAIR GESTEN: Karen?

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

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

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

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

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

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

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

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

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

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

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

1 level.

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

20 CHAIR GESTEN: Thank you. Rich?

21 DR. ANTONELLI: That was awesome.

22 Thank you, Karen.

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

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

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

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

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

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

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

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

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

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

22 If I think I am integrated because I

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

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

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

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

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

6 CHAIR GESTEN: Thanks, Rich. Jeff?

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

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

1 infrastructure?

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

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

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

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

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

12 CHAIR GESTEN: Thank you, Jeff.

13 Susan?

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

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

22 And you know, there's amazing progress

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

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

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

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

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

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

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

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

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

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

18 CHAIR GESTEN: Yes, Jeff, quick?

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

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

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

19 CHAIR GESTEN: Thank you. Marsha?

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

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

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

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

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

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

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

9 CHAIR GESTEN: Thanks, Marsha.

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

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

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

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

1 areas should be worked on?

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

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

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

1 is a place where we need to work on.

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

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

19 CHAIR GESTEN: Do you have a thought
20 about it?

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

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

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

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

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

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

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

18 (No audible response.)

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

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

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

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

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

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

1 wanted to share that with you.

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

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

11 (No response.)

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

15 (Laughter.)

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

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

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

7 MS. ALLEN: Thanks, Foster.

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

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

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

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

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

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

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

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

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

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

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

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

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

1 medical records.

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

9 31 states did not report this measure.
10 Most common reasons for not reporting was data
11 were not available, recorded by 22 states. Other
12 reasons for not reporting have also been listed,
13 and that's at the bottom of your screen, so
14 information was not collected because of budget
15 constraints, data inconsistency or accuracy
16 required medical record review, and information
17 not collected by provider, and other.

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

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

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

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

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

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

1 DR. LILLIE-BLANTON: Oh, okay --

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

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

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

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

1 more about our outreach efforts with states?

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

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

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

1 was reliable measure reporting. So Rich?

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

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

18 DR. ANTONELLI: Yes.

19 CHAIR GESTEN: Okay. Oh, Charles,
20 Jeff?

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

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

3 MS. ALLEN: It was 18 --

4 DR. GALLIA: Yes.

5 MS. ALLEN: -- 12 states in 2012, and
6 it increased from 12 states to 20 states 2013 and
7 2014.

8 DR. GALLIA: Right.

9 CHAIR GESTEN: 18 reporting the
10 measure as specified.

11 MS. ALLEN: Yes.

12 CHAIR GESTEN: Two states reporting
13 something else.

14 Jeff, did you have something?

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

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

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

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

19 12 states reported this measure in
20 2012, 17 states in 2013, and it decreased to 16
21 states in 2014. 10 states reported the measure
22 using the Child Core Set specifications, which

1 was based on Joint Commission's 2014
2 specifications.

3 35 states reported reasons for not
4 reporting this measure. The most common reason
5 was data not available. Three TA requests were
6 submitted by three states. TA requests were
7 about calculations of the denominator, measure
8 coding, and data linkage. There was no
9 additional support provided to states on this
10 measure.

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

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

1 specifications.

2 47 states did not report this measure.
3 The most common reasons for not reporting were
4 that the data were not available. One TA request
5 was submitted for this measure regarding
6 clarification on measure specification version.
7 CMS TA Team provided additional support to the
8 states by updating the resource manual.

9 So --

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

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

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

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

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

17 MEMBER ADIRIM: I have a point of
18 clarification --

19 CHAIR GESTEN: Sure.

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

1 measures? I was --

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

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

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

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

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

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

10 (No response.)

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

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

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

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

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

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

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

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

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

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

4 CHAIR GESTEN: So let me --

5 MEMBER LACEY: -- in that regard.

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

13 MEMBER LACEY: Yes --

14 CHAIR GESTEN: Okay.

15 MEMBER LACEY: -- that would be right.

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

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

1 know what's going to happen with that.

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

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

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

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

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

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

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

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

19 CHAIR GESTEN: Sure.

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

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

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

10 CHAIR GESTEN: Charles?

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

19 CHAIR GESTEN: Rich?

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

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

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

12 CHAIR GESTEN: Yes --

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

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

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

3 CHAIR GESTEN: Any other comments?

4 (No response.)

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

7 PARTICIPANT: I'll second.

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

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

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

20 CHAIR GESTEN: Yes, Kathryn?

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

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

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

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

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

12 CHAIR GESTEN: Well this is -- Table
13 2 just gives the performance. You want -- she is
14 looking for the measure description?

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

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

20 CHAIR GESTEN: Yes.

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

1 PARTICIPANT: Yes. Give us one
2 minute.

3 (Pause.)

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

8 MS. GORHAM: I found it.

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

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

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

22 (Whereupon, the above-entitled matter

1 went off the record at 12:11 p.m. and resumed at
2 12:45 p.m.)

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

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

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

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

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

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

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

12 (Voting.)

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

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

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

22 I am not recused from this one. There

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

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

7 CHAIR GESTEN: There was no list
8 proposed for --

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

11 CHAIR GESTEN: Staff had proposed zero
12 for removal.

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

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

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

1 If you can take us back to slide 365?

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

7 Comments? Discussion? Proposals?
8 Jokes?

9 (No response.)

10 CHAIR GESTEN: Is that okay, Andrea?

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

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

22 MS. GORHAM: So, the measures that

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

7 CHAIR GESTEN: Go ahead, Nadine.

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

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

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

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

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

1 statistical significant result.

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

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

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

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

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

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

19 MS. MUKHERJEE: Right.

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

22 CHAIR GESTEN: I just want to jump in

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

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

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

11 Rich?

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

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

1 island?

2 (Laughter.)

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

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

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

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

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

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

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

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

12 But in our data that we reported from
13 2015 we didn't have a concern about reliability
14 for Medicaid plans. There does continue to be a
15 concern about commercial plans. And so, we will
16 be observing that. The 2015 data were the first
17 year of reporting to NCQA, and the first year is
18 not public. It is reported again this year. It
19 will be publicly-reported for Medicaid plans; for
20 commercial plans it will not be because we are
21 going to be looking to see about that, and the
22 result is going to be based on -- it is the

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

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

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

15 So, Charles I think was next.

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

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

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

13 MEMBER SAKALA: Andrea?

14 MEMBER BENIN: I am just confused on
15 the process. This metric is on the list for the
16 2016?

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

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

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

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

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

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

12 MEMBER BENIN: Yes, in the 2106 core
13 set.

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

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

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

1 don't know if it is good, better, indifferent.

2 It looks like there are some methodological
3 issues, but if there is some interest from the
4 states and we had some interest last year, and we
5 heard all this -- I mean, I remember last year we
6 had a lot of conversation about the mental
7 health, the need for some real mental health
8 stuff, et cetera, et cetera.

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

15 MEMBER SAKALA: Rich?

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

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

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

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

16 MEMBER SAKALA: Other comments?

17 (No response.)

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

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

1 (Pause.)

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

4 MEMBER SAKALA: From the room as well?

5 (No response.)

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

10 (No response.)

11 MEMBER SAKALA: Okay. Thank you.

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

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

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

22 But, first, I would like to remind you

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

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

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

12 Next slide.

13 And that is the comprehensive list.

14 Okay.

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

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

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

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

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

1 support.

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

8 Next slide.

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

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

17 MEMBER ADIRIM: Okay.

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

1 current multiple antipsychotic measure that you
2 all just heard about.

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

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

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

1 clinical practice guidelines and standards from
2 five organizations.

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

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

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

21 MS. GORHAM: Two or more.

22 MR. HUNT: But the scoring of 10

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

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

6 MR. HUNT: Okay.

7 MS. GORHAM: Okay. The next Measure
8 2797, this is the transcranial Doppler
9 ultrasonography screening among children with
10 sickle cell anemia.

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

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

1 sickle cell anemia.

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

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

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

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

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

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

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

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

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

1 administration.

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

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

9 DR. ANTONELLI: Thank you.

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

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

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

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

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

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

4 Thank you.

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

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

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

1 antibiotic prophylaxis as well.

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

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

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

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

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

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

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

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

15 MEMBER SAKALA: Andrea?

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

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

21 MS. REESE: Hello. This is Sarah
22 Reese from the University of Michigan.

1 MEMBER SAKALA: Thank you.

2 MEMBER BENIN: Hi, Sarah. Can you
3 comment on how you chose the ultrasound metric to
4 go to NQF before the antibiotic prophylaxis
5 metric and where your thinking is on the
6 prioritization of those?

7 MS. REESE: Absolutely. We actually
8 very much wanted to submit both to NQF in this
9 last round, but, frankly, lacked the capacity to
10 do two. And the TCD measure was still a little
11 further along. So, we chose to go ahead with
12 that one. We are very much looking forward to
13 submitting that for consideration during the next
14 call, however.

15 MEMBER SAKALA: Thank you.

16 Yes, please.

17 MEMBER BENIN: I don't want to
18 overstep my commenting time.

19 So, if I could just try to put a
20 little bit of a frame around the four metrics
21 that we have discussed so far.

22 The Children's Hospital Association

1 has a Committee on Metrics and Standards. We
2 actually have created a short set of metrics that
3 we suggest for children with chronic illness.
4 The sickle cell ultrasound Doppler metric is on
5 that list, and we got to that list through a very
6 comprehensive review of all of the possible
7 metrics out there. We had a pretty in-depth
8 peer-review process, not at the level of an NQF
9 endorsement level, but assuming some NQF
10 endorsement.

11 And so, I think that I would very much
12 support the sickle cell Doppler metric. I feel
13 as though the antibiotic prophylaxis metric is
14 super-important. I might want to just wait until
15 it went through the NQF process for the sort of
16 rigor around that.

17 I would prioritize those two metrics,
18 certainly the ultrasound, you know, the Doppler
19 ultrasound metric over the other two metrics that
20 were on that list, one of which is a survey
21 metric. I think in the spirit of not adding more
22 survey metrics when we kind of haven't figured

1 out the survey metrics that we have to the list,
2 I would suggest that we hold off on recommending
3 the survey metric.

4 And then, the first metric was a
5 relatively-new behavioral health metabolic
6 disease for metabolic screening around behavioral
7 health medication initiation. And so, to me, it
8 sounds like we already have a new behavioral
9 health metric. I would say, if we are looking at
10 our gaps and we want to get into the sickle cell
11 space, I might let us play out, have the measures
12 that play out the behavioral health metrics that
13 are already in there and start to get into the
14 sickle cell space and kind of bookmark those
15 other two for future evaluation. But, in the
16 spirit of not recommending a million things, I
17 would suggest that we could prioritize them in
18 that fashion.

19 Our Committee did put on the short
20 list the cranial Doppler.

21 MEMBER SAKALA: Thanks, Andrea. That
22 is very helpful.

1 We have two more measures to go
2 through in this series of new considerations, but
3 I want to ask -- I know there is a small window
4 for the developer.

5 Are there any more questions on the
6 measures from this developer while this woman is
7 on the line?

8 (No response.)

9 Okay. Thank you very much.

10 So, I think, Shaconna, finish with the
11 last two measures in this series.

12 MS. GORHAM: Okay. We are kind of
13 torn here. We have two more measures recommended
14 by Meg, and she asked us to kind of wait, but we
15 definitely can't hold the conversation for long.

16 So, I want to go to 2801, but I look
17 over and Terry just walked out of the room. But
18 we will go to 2801 because I know that Terry will
19 return shortly.

20 And she has recommended 2801 today,
21 the use of first-line psychosocial care for
22 children and adolescents on antipsychotics. The

1 steward is NCQA. This is an NQF-endorsed
2 measure.

3 And you can see on your screen the
4 description of the measure, percentage of
5 children and adolescents 1 through 17 years of
6 age with a new prescription for antipsychotic.
7 The numerator is children and adolescents from
8 the denominator who have psychosocial care at
9 first-line treatment. And it is a process
10 measure, and the data source is administrative
11 claims.

12 Any questions about this measure?

13 (No response.)

14 MS. GORHAM: Okay. So, we will move
15 on to the churning measures.

16 Okay, so the informed coverage
17 measure. Yes, scroll down.

18 Terry, I briefly introduced the
19 Measure 2801. If you want to elaborate a little
20 more, just in time.

21 MEMBER ADIRIM: Yes. No, this didn't
22 come to our attention until I think it was

1 earlier today or yesterday. I thought it was an
2 important issue, especially since states had told
3 us last year that this was a huge issue, an
4 appropriate prescription of antipsychotics. I
5 think there have been recent guidelines that just
6 came out within the last few weeks regarding use
7 of psychosocial interventions first, especially
8 in younger children, as opposed to medication.

9 So, I had only briefly looked at this,
10 and I don't know if this gets at it, but it is an
11 endorsed measure. I think pairing on this with
12 the measure that is already in the set would be,
13 I thought, useful.

14 MS. GORHAM: Thank you.

15 Okay. So, the informed coverage
16 measure, again, a Task Force recommendation. I
17 will at least say the rationale that she gave me.
18 She recommended this measure as well as the next
19 measure, the duration of first-observed
20 involvement, as a set to address the turning on
21 and off of Medicaid.

22 It has not been submitted to NQF. It

1 is, again, a PQMP measure, and CHOP is the
2 steward for this measure.

3 So this, along with the duration of
4 first-observed enrollment, again, CHOP is the
5 steward. It has not been submitted to NQF. So,
6 therefore, we pulled this information from the
7 website, the information that was submitted to
8 us. This is what we have on these measures.

9 She had to leave. She anticipated
10 being back by now, but --

11 DR. MISTRY: I just asked because Meg
12 actually spoke with the developer in detail about
13 these. And so, I think that would be valuable
14 since she was the one who put it forward.

15 I think the developer, CHOP, should be
16 on the phone a little later as well. They might
17 already be on, but I am not sure, if questions
18 come up.

19 MS. GORHAM: Let me see whether or
20 not, Sean, do we have anyone from CHOP on the
21 line?

22 Jeffrey, are you from CHOP? Would you

1 like to speak for these measures?

2 DR. SILBER: We had not originally, as
3 you know, submitted this to NQF. We are glad to
4 go through that process if NQF is interested.

5 These were measures to help the states
6 determine the enrollment of eligible children in
7 Medicaid. We have two kinds of measures.

8 Coverage is a point-in-time measure which is
9 informed by the event of appendicitis. We look
10 at a state's appendectomy patients or patients
11 that come down with appendicitis, and we look to
12 see when they developed their random event, which
13 isn't related to insurance, and they were
14 admitted to the hospital, whether they were
15 covered or not in those patients that were
16 eligible.

17 And that metric is the rate of the
18 random event of appendicitis patients having
19 insurance. It tells us about the state and it
20 informs us of the assumptions that are needed to
21 make an estimate of coverage or of having
22 insurance if you were eligible.

1 From that number, we, then, will
2 produce coverage metrics, but it is not just for
3 appendectomy patients. It is for all patients in
4 the state.

5 When we do that, then, in our analysis
6 we have compared this to survey results and to
7 other methods that are out there, rougher metrics
8 like the COO continuity metric. And ours
9 performs better and looks closer to the results
10 of the surveys. So, we think it is a good way to
11 look at whether a state is doing a good job at
12 making sure that their eligible kids have
13 insurance.

14 Secondly, and combined with that, is
15 the duration metric, which is a more common
16 metric that people use. Duration talks about
17 whether, once you have insurance, do you hang
18 onto your insurance and over what period of time.

19 What we have done is compare duration
20 to coverage and other metrics. What we find is
21 that they measure different things. Many kids
22 who have insurance from a continuous period of

1 time will not be in the duration metric because
2 duration has to start when you have been off
3 insurance and, then, go onto insurance. So, you
4 can lose 80 percent of the patients. The states
5 that do the best in terms of keeping people on
6 the rolls, those states won't get any benefit for
7 that because it won't show up in the duration
8 metric.

9 So, what we have decided is that you
10 really need both. You need a point-in-time
11 estimate to see if you are actually, for a random
12 point in time, are you covering the patients that
13 you need to cover that are eligible. And you
14 need a duration metric. They are not well-
15 correlated. The correlation is around .5, and at
16 the same time they give different bits of
17 information. The random point in time gives you
18 an overall assessment of how well a state is
19 doing in terms of making sure that their patients
20 are covered. And the duration metric is a select
21 population of those who had not been covered who,
22 then, become covered. It tells you how long that

1 new person would stay covered.

2 So, it has got problems; at the same
3 time, it has some useful information as well.
4 That is kind of a general overview of the
5 methods. These are developed for the states.

6 And then, in our analysis we also, and
7 in our algorithm, we also have ways to test
8 whether the data that the state is providing is
9 adequate. That is always a big issue.

10 It is developed to be used with MAACS
11 data, which is the kind of the data that the
12 states are supposed to be sending to the federal
13 government.

14 I guess I will stop there, but we are
15 delighted that people are interested in this. We
16 hadn't thought that it was what NQF would want,
17 but if you are interested, we are certainly
18 interested as well.

19 MEMBER LACEY: My only question to --
20 you said Kevin? -- whoever is on the phone --

21 DR. SILBER: Jeff Silber.

22 MEMBER LACEY: Okay. So, we have

1 talked a lot on different measures throughout
2 doing this work about events that don't happen
3 very often. So, I don't have any idea, any bias.
4 How often does it happen that this random event
5 is how you can capture these people and find out
6 if they are -- do you know what I mean?

7 DR. SILBER: Right. So, the
8 appendectomy is relatively rare, but, remember --
9 and I guess I want to make sure I am explaining
10 this right -- the metric uses all patients, not
11 just appendectomy patients. Appendectomy simply
12 tells us about one assumption in the metric. We
13 have to assume, when we first see a patient,
14 whether they are presumed to be eligible or
15 ineligible.

16 One of the main problems with all of
17 the ways that we estimate coverage for any of the
18 methods that are out there is that we never know
19 when a patient drops out of the system. We never
20 know whether they dropped out because they meant
21 to drop out because they were no longer eligible,
22 or whether they meant to drop out because they

1 were -- they didn't mean to drop out, but they
2 ended up not getting re-enrolled. So, we never
3 know that information, short of surveying
4 patients, which is very difficult and rarely
5 something that is available for the state
6 Medicaid systems.

7 For that one assumption, if we knew
8 whether someone who has dropped out was eligible
9 or not eligible when they dropped out, that is
10 what we use the appendectomy rate for. It is
11 just one part to refine the estimate of what is
12 the real coverage rate for a state's Medicaid
13 population.

14 Appendectomy is just common enough, so
15 that we can help with that assumption, but it is
16 not about appendectomy. Our coverage is about
17 the whole state's Medicaid insurance population.
18 It is just a useful tool to refine the estimate,
19 and then, we compare it to the survey data that
20 is available and we find that we do very well.

21 So, this is not about appendicitis.
22 We simply use appendicitis as a method to refine

1 the assumption about whether you count someone as
2 not being covered when they leave, whether they
3 were eligible or ineligible.

4 Is that clear? It is not about this
5 random event of appendicitis.

6 MEMBER LACEY: Yes, I don't think
7 anybody was thinking that.

8 DR. SILBER: Okay. I didn't
9 understand your question.

10 MEMBER LACEY: We were just thinking
11 about an infrequent versus a frequent event.

12 DR. SILBER: Right.

13 MEMBER LACEY: And that is all we were
14 asking.

15 DR. SILBER: Okay. So, we are talking
16 about a whole state's population with a
17 refinement that uses their patients who get
18 appendicitis, which is enough in most states to
19 give us reasonable confidence.

20 MS. GORHAM: Additional conversation
21 about the recommendations put forward? Just the
22 recommendations from Task Force members as well

1 as staff picks, so we have been discussing some
2 of the measures. I just wanted to see if there
3 is any other discussion.

4 MEMBER BENIN: Given the
5 opportunity --

6 CHAIR GESTEN: Go ahead, Andrea.

7 MEMBER BENIN: I mean, these seem like
8 great metrics for us to like go through the NQF
9 process and make sure that the kinks get worked
10 out. And then, I think the second phase of the
11 PQMP stuff, of actually having people work on
12 trying this, I mean, obviously, I don't have a
13 good handle on the extent to which the field
14 testing and all the other stuff. But it does
15 seem like this is potentially really valuable.
16 It may not be ready for primetime right this
17 year. So, that would be my assessment of this.
18 So, I would up this on a bookmark for next year
19 kind of list, not on a recommend list.

20 CHAIR GESTEN: So, Meg, we just went
21 through a list of measures that were recommended,
22 either a combination of staff, NQF staff

1 recommendations, and from the Task Force. And
2 these last two were recommended by you. We just
3 went through them. On the phone, folks from CHOP
4 talked a little bit about the development.

5 So, I don't know if there are any
6 questions or any statements you want to make
7 about why you suggested these or the importance
8 of these, whatever. And then, I think we will
9 move on to -- I think we are ready to start
10 considering voting on these measures.

11 I am being tapped on the back. Go
12 ahead. I will figure out what the tap is.

13 MEMBER MURRAY: Okay. Yes, just two
14 main points. One is that the legislation does
15 call for a continuity measure, although it does
16 say "existing," but I guess these measures are
17 existing now. And two, that all of these
18 measures, especially the HEDIS ones, you have to
19 be in for 12 months. And we know from research
20 that we have done that people are only in,
21 typically, for eight, nine, ten months. And so,
22 we need to do a better job on that. One of the

1 ways to do that is to measure it, so that we can
2 see improvements. Eventually, we would like to
3 see a policy change where people have to be on
4 for 12 months.

5 So, those are the reasons that we are
6 pushing it. It is because, without the good
7 data, it is hard to make the argument, as people
8 have said, that we need to make a change.

9 DR. SILBER: Yes, this is Jeff Silber
10 again.

11 Well, I appreciate your interest, and
12 we are certainly willing to work with you to go
13 forward on this, if you are interested.

14 CHAIR GESTEN: Any other questions,
15 comments?

16 (No response.)

17 CHAIR GESTEN: We do have one other.
18 This is, I think, all of the measures with one
19 exception. There was a request to reconsider the
20 measure that we talked about yesterday on healthy
21 newborns by a Task Force member. And so, we will
22 be, with some new information, responsive to some

1 of the questions or issues that came up
2 yesterday. Again, that is allowed under the
3 rules, but staff at NQF are busy putting the
4 information together. They are not quite ready
5 yet.

6 So, my suggestion is that we wait, and
7 when Reva and folks are ready, we will present
8 that as well. But we can go back to the measures
9 that were presented, starting with the staff
10 picks.

11 MEMBER BENIN: Just one process
12 question. I hate to obsess over this. Wasn't
13 the readmission metric on the orange? Wasn't
14 that in one of the orange ones? Were we coming
15 back to that later? Is that at the end still?
16 Okay. I mean, I will sit tight.

17 MS. GORHAM: So, I will throw it out
18 as a recommendation. We have those measures
19 teed-up. So that, if someone wants to make a
20 motion, they can do so. If you would like,
21 before we start voting on these, to make a motion
22 on 2015, whether or not we want to re-vote on

1 those this year, we can do that now.

2 So, bullet No. 4 are measures
3 recommended in 2014 and 2015, the NQF 2393,
4 pediatric all-condition readmission measure, and
5 then, 2509, prevention dental sealants for 10- to
6 14-year-old children at elevated caries risk.
7 And then, we just put the caps measures back up
8 there.

9 But, if you want to see the
10 specifications for those measures again, we can
11 pull that up as well. But that is the list with
12 the measures and bullet No. 3.

13 CHAIR GESTEN: So, I need a
14 clarification. If we do nothing, I mean, there
15 is always, I assume, an ability for folks to re-
16 vote and take something off the island. But
17 there is no obligation. Measures that were
18 recommended that were not taken up by CMS, from a
19 process point of view, is there a need to re-vote
20 on them, unless there is somebody who wants to?
21 Is there a need to restate the recommendation or
22 is the only discussion item whether or not

1 somebody in the group wants to remove them?

2 MS. GORHAM: So, that is up to you
3 all. From what I understand -- and, Marsha,
4 please correct me -- I don't think that CMS keeps
5 a list, a running list of all of the
6 recommendations from year to year.

7 CHAIR GESTEN: Why not?

8 DR. LILLIE-BLANTON: Well, we keep a
9 list, but we have not in the past been
10 reconsidering them. So, the only way you will
11 keep it is for us to keep bringing it up.

12 CHAIR GESTEN: Is that right?

13 DR. LILLIE-BLANTON: So, we would have
14 to add it to the list of recommendations each
15 year.

16 CHAIR GESTEN: Okay. All right. So,
17 that answers my question. If you want it --
18 okay, so that answers my question. Okay.

19 MEMBER BENIN: Can I make a motion,
20 then, that we suggest the readmission metric for
21 inclusion?

22 (Second.)

1 DR. ANTONELLI: Marsha, can you tell
2 us why the measures wouldn't have gotten
3 implemented, and is there something we should
4 know from CMS's perspective about these, if they
5 were recommended last year?

6 DR. LILLIE-BLANTON: So, the decision
7 about each measure varies. And I remembering I
8 discussed this at the adult and not the child.

9 We reached out to our stakeholders.
10 And by "stakeholders," I mean we consulted with
11 CMS internally. So, internally, we have
12 different sectors, both disabled and elderly
13 group, and the Duals Office, different sectors.
14 So, we met with them, discussed with them,
15 actually did some voting internally. We reached
16 out to our quality technical advisory group and,
17 for each of the measures, discussed the measures
18 and also voted with them. And then, for the
19 adult measures, we reached out to our adult
20 quality grantees.

21 So, we listen to the input and
22 feedback from our stakeholders about all of the

1 measures and made an assessment based on the
2 results from those efforts to communicate with
3 our different stakeholders.

4 The measures varied in terms of
5 reasons and explanations. As we talked about, we
6 try to make, we are making incremental changes.
7 And so, we really tried to take the measures that
8 we thought really helped us fill some gaps, would
9 address our ability to measure and monitor care
10 where we weren't doing it well, and we thought
11 could actually be implemented by our state
12 partners.

13 I would have to go back to look at the
14 specifics on the readmission measure, but I think
15 in some cases it is about problems. For example,
16 with antipsychotic use, it was clear that we had
17 a big problem in Medicaid and we needed to do
18 something for the hearing measure. It was clear
19 we have gotten a lot of concern about -- I mean,
20 this is something we can fix. I mean, there is
21 no reason for a child who is identified with a
22 hearing problem to leave, who is identified with

1 a hearing problem not to be referred for
2 treatment and have that addressed. I mean, it is
3 just the long-term consequences were too great.

4 So, there could be other measures like
5 that, but there were things that we thought we
6 should really be able to fix, even though we knew
7 it would add to a burden, even though we knew it
8 would be problematic to collect. And we think
9 that measure, the audiological measure, was going
10 to be problematic to collect, but we didn't want
11 to risk not trying, given we think that that is a
12 problem that we should be able to fix easily.

13 So, there are lots of tradeoffs, but
14 the main thing is we tried to be systematic and
15 thoughtful. I would have to go back to look at
16 the concretes on the readmission measure.

17 DR. ANTONELLI: So, thank you for the
18 candor. The genesis of my question, though, is,
19 is it productive for this group to once again
20 endorse something that was endorsed last year
21 without possibly knowing what that --

22 DR. LILLIE-BLANTON: She actually

1 pulled up the specifics.

2 DR. ANTONELLI: Okay. Because it
3 would be helpful for us to know what your
4 concerns were.

5 DR. LILLIE-BLANTON: Right.

6 DR. ANTONELLI: If you are able to
7 share that with us, it will certainly inform my
8 thinking about the vote.

9 DR. MATSUOKA: So, specifically on the
10 pediatric all-condition readmission measure, is
11 that the one? The overarching consideration, I
12 think, was this notion of parsimony. But, then,
13 with regard to this particular one, in addition,
14 there was a sense that readmissions are rare for
15 children. Maybe for children with particular
16 kinds of conditions that might be different, but
17 for the child population overall we thought that
18 the numbers would be relatively small.

19 And to get to the question about is it
20 worthwhile, I think yes. Because I think looking
21 back on our notes, it looks that there are some
22 that we did end up declining where MAP supported.

1 But we have a note here that we would like to
2 consider adding this in future years. So, I
3 think, in general, especially for measures where
4 we were kind of on the fence, I think it would be
5 helpful to hear whether the Committee still
6 thinks that it is worth recommending.

7 MEMBER BENIN: I do know that through
8 -- oh, sorry, go ahead, Terry. Through SBS, we
9 do know that pediatric readmissions in general
10 are in the vicinity of something like -- it
11 depends on the place and there is a lot of
12 variation, and the metric that people are using
13 around is a mixed bag. But it is something like
14 6 to 11 percent. You know, it is in that range.
15 So, it is in the kind of 10-percent-ish range.
16 That is the data that we often see. A lot of
17 places are a lot lower; some places are in that,
18 for whatever that is worth for people.

19 MS. GORHAM: I just want to make a
20 statement for the record, so that we have it on
21 the transcript that Foster is recusing himself
22 from discussion of the readmission measure.

1 MEMBER ADIRIM: And just to say I
2 pulled up two articles, because I know there have
3 been recent publications on this particular
4 issue, and it is an exceedingly small problem.
5 It is not like it is in the adult population with
6 readmissions being very high and good reasons to
7 lower them.

8 I think, in pediatrics, kids who get
9 readmission, they are probably more often than
10 not related to their particular condition and
11 would be a good reason for readmission. So, I
12 think in pediatrics my feeling would be that it
13 could be harmful to these kids with certain
14 medical conditions.

15 And the one article was 6.5 percent
16 that came out of Boston Children's, and it did
17 describe variability amongst institutions.
18 Another article said the numbers are just too
19 small to even report. So, those were the two
20 that I picked up.

21 MEMBER SAKALA: (presiding) Rich?

22 DR. ANTONELLI: So, it depends on how

1 you define the population. The IOM had a
2 Symposium on Kids with Special Healthcare Needs.
3 So, if you look at the so-called children with
4 medical complexity, in fact, their rates of 30-
5 day all-cause readmissions are comparable to
6 Medicare rates, so 22 percent and above.

7 So, for those entities that are
8 thinking about taking on accountability, it is
9 really important. Now, having said what I just
10 said, that is the science and the epidemiologic
11 data. If providers of care for children with
12 medical complexity aren't going to be held
13 "accountable" -- air quotes, for those of you on
14 the phone -- for 30-day all-cause readmissions,
15 then do we need this measure?

16 But I can tell you for somebody that
17 is actually doing this work, we watch the data
18 very carefully. So, once again, it is the
19 comparability of what does the utilization look
20 like and where are the opportunities to
21 ameliorate excessive cost versus what is an
22 accountability measure.

1 But I do want the group to know,
2 children with medical complexity are readmitted
3 at the same rate as Medicare beneficiaries.

4 MEMBER SAKALA: Bo?

5 (No response.)

6 MEMBER SAKALA: Are there any other
7 comments on the readmission measure?

8 MEMBER BENIN: Would it be helpful to
9 hear from the measure developer? Is the measure
10 developer on the phone? Or is that valuable to
11 people?

12 DR. TOOMEY: This is Sara Toomey from
13 Boston Children's. I would be happy to talk, if
14 that would be okay.

15 MEMBER SAKALA: Thank you.

16 DR. TOOMEY: Okay. Great.

17 And so, I think I will just make a
18 couple of points. In terms of the prevalence
19 overall, what has been cited is about right,
20 which is about, actually, the prevalence of
21 readmissions among the young adults and sort of
22 up through middle-aged populations. But I agree,

1 overall, it is less than sort of the Medicare
2 population that often gets cited.

3 In regards to, I think, though, key
4 points to remember, one is there is definitely
5 measurable variability among hospitals in regards
6 to performance on readmission measures. As such,
7 it really does speak to the point that there are
8 probably differences in care that is being
9 provided, because there is, once again, this
10 ability to see these differences.

11 We have just had accepted a paper that
12 hasn't come out yet that looked at one hospital
13 in a pretty extensive manner. What we were able
14 to show is that the potentially preventable
15 readmissions was somewhere around 25 to 30
16 percent of the readmissions that we were able to
17 find across the board.

18 And I should also say that, when we
19 developed this measure, we really developed it to
20 harmonize very closely with the CMS-approved
21 measure that is used for the adults. In doing
22 so, we think it is actually a really important

1 complement for children. As I said, we were able
2 to demonstrate that you can look, in particular,
3 at higher levels at differences among hospitals
4 and, therefore, among states in performance.

5 I am happy to answer any questions
6 anybody might have about the measure itself.

7 MEMBER SAKALA: Thank you.

8 Other comments or questions?

9 Terry?

10 MEMBER ADIRIM: Yes. I would just
11 want to ask about the utility of having a
12 measure. I mean, I agree with you, there are
13 certain diagnoses that have highest rates of
14 readmission, sickle cell disease, other ones that
15 don't come to me. Because I am in the ER, I
16 admit them to the hospital. So, I see them
17 bouncing back all the time.

18 The question that I have is, what is
19 the utility of having this measure in the core
20 set, so that there is aggregate data in a state,
21 small numbers, as opposed to being a measure that
22 is useful for a state Medicaid program to assess

1 the hospitals that are caring for children? For
2 me, I think it is a very useful measure for the
3 latter as opposed to the former, in my opinion.

4 DR. TOOMEY: Yes. No. Thank you.

5 I think it is valuable in both
6 settings. I mean, even though the readmissions
7 itself is a small number, the numbers of kids
8 that are being admitted in every state is
9 actually quite large. So, if you think of it
10 even in terms of what I think are really
11 wonderful measures that are much more targeted
12 populations, the population for which it is
13 evaluating is actually quite small also.

14 I should also say the nice thing about
15 the readmissions measure is it is based using
16 administrative claims data. So, in regards to
17 the issue around being a burden to states, this
18 is a measure that is pretty actually
19 straightforward, most likely to integrate into
20 their measurement plan, since they are already
21 collecting the claims data and would just need to
22 be providing -- we actually have a staff program

1 for them, but just being able to run the program
2 that we have to be able to give the right
3 readmission measure rates for their hospitals in
4 their state.

5 MEMBER SAKALA: Thank you.

6 Other questions or comments on this
7 measure?

8 Yes?

9 DR. GALLIA: I wonder why many of the
10 children that have special healthcare needs would
11 be covered by Medicare. That kind of gets lost.
12 I am wondering why the Medicare measure doesn't
13 extend its age as opposed to --

14 DR. TOOMEY: So, I don't think -- the
15 Medicare measure doesn't right now, to my
16 knowledge. It is really 18 and over.

17 See, one thing that would be hard in
18 doing so, I work for a state level, but if you
19 wanted to get down to hospital-level reporting,
20 if you only looked at Medicare beneficiaries, it
21 would be such a small component, that it would be
22 very hard to demonstrate variability.

1 So, at least in this instance when you
2 are looking at the population of all Medicaid
3 patients within a hospital, you are much better
4 able to look at sort of differences across
5 hospitals or across states.

6 MEMBER SAKALA: Thank you.

7 Other comments on this?

8 MEMBER BENIN: I will make one
9 comment, not to negate any other comments. But
10 one of the things that I think is potentially
11 valuable about us putting this metric forward is
12 that it, then, will go into the process that
13 Karen and Marsha just described, because I think
14 that there is some value to having the states
15 evaluate the feasibility of it.

16 Because I am not actually 100 percent
17 sure that I really understand the feasibility of
18 it. And so, I think that getting it into this
19 metric needs to happen eventually. It is sort of
20 an essential part of what we are going to end up
21 doing at some point here.

22 But how the data really gets linked,

1 whether you get readmitted in the same state
2 where you got admitted, and all that kind of
3 jazz, has to get sorted out a little bit. And
4 so, I think that there is a lot of value to
5 getting it put into the process of us
6 recommending it, so that there is a mechanism for
7 it to go forward and get evaluated in that way,
8 and to have the states really have to have this
9 iterative process around whether there is any
10 actual feasibility to it.

11 So, not to put any damper on it, but,
12 to me, that is the real kicker here, is how does
13 it actually play out. And I don't think that we
14 know that. I know that that usually is not the
15 type of metric I am in favor of, not to like
16 completely go counter to type. But I do think it
17 is an important piece of us moving these things
18 forward, and it is a PQMP metric, which also
19 makes it important.

20 CHAIR GESTEN: (presiding) Great.
21 So, the other measures, let's just go through the
22 measures here and, then, we will go back to

1 measures and see if there is a motion to vote to
2 include.

3 Just for clarity, the No. 3 on this
4 list, effective postpartum contraceptive access,
5 did not pass yesterday. This was a measure that
6 we voted on yesterday.

7 The measure on contraceptive -- I'm
8 sorry -- postpartum past use of contraceptive
9 methods, by within 15-to-20, did not pass.

10 So, No. 3 is currently in the set.
11 Four is not.

12 And No. 1 there, NQF 0477, under 1500-
13 gram infants not delivered at an appropriate
14 level of care, my understanding is that the
15 measure developer is not continuing stewardship
16 of this measure.

17 Shaconna, maybe you can clarify that
18 and see what we want to do about that.

19 MS. GORHAM: So, the measure developer
20 did not submit this measure for maintenance
21 review for the following reasons: too much work
22 -- and this is me stating the reasons given by

1 the developer -- too much work for a measure that
2 we, ourselves, are not using; uncertainty that
3 others were truly using it as a quality measure.
4 Its best role seemed to be at a population level
5 rather than a hospital-level measure, which are
6 their main interests. The hospital-level
7 measures are their main interest.

8 So, the measure was not submitted for
9 maintenance review. Therefore, it would lose
10 endorsement.

11 CHAIR GESTEN: So, again, we have
12 confronted some measures that don't have
13 endorsement, lost endorsement, are on their way
14 to endorsement. This one will not get endorsed
15 because it is not going to go through the measure
16 review process. This was not taken up by CMS as
17 a measure to include for state reporting.

18 So, the question for the Committee,
19 just like the previous measures are, do we want
20 to continue to recommend this going forward as a
21 measure that should be put into the measure set?

22 Discussion?

1 (No response.)

2 CHAIR GESTEN: Is there any motion to
3 vote to decide whether this should be included
4 going forward?

5 MEMBER SALAM: I guess maybe I am not
6 sure I am understanding. Because if the measure
7 isn't going to be maintained and, then, there is
8 going to be errors in it, and there is no one
9 monitoring the quality of the measure, actually,
10 it shouldn't even be a vote. Like it can't be a
11 measure because no one is maintaining it.

12 CHAIR GESTEN: Some people would
13 believe that the universe should run that way,
14 but as far as I know, there is no rule that says
15 it must. So, that is why.

16 Carol?

17 MEMBER SALAM: If I made the rules, it
18 would happen that way.

19 (Laughter.)

20 CHAIR GESTEN: We got it.

21 Carol?

22 MEMBER SAKALA: So, the measures that

1 come out of Elliott Main and the California
2 Maternal Quality Care Collaborative are, in
3 general, top-notch. They are focused on
4 hospital-level quality improvement. So, I can
5 understand why he didn't want to go through the
6 effort of continuing to be the steward.

7 As a population-level measure, it
8 could be of value here. My feeling is that the
9 perinatal measures that we have already put forth
10 in our short list are probably more impactful for
11 a larger segment of the population. So, I would
12 personally prioritize those, even though I have a
13 lot of confidence in this measure.

14 CHAIR GESTEN: Thank you, Carol.

15 So, can we go back to the slide that
16 has the individual measures, starting with the
17 three that were recommended by staff?

18 MEMBER SAKALA: Are we going to ask
19 whether people want to put them up to a vote?

20 CHAIR GESTEN: Uh-hum.

21 MEMBER SAKALA: But without doing that
22 one with complication because that is

1 different --

2 CHAIR GESTEN: We are waiting for it.
3 We are still waiting for Reva to get that
4 together.

5 MEMBER SAKALA: Okay.

6 CHAIR GESTEN: We are doing to delay
7 on that.

8 So, without getting into the
9 individual measures -- I will need to recuse
10 myself -- but just in terms of a process point
11 going forward, I think we should see whether
12 there is a motion include this one, a second, if
13 there is any discussion, and then, we would vote.
14 That would be the progression of things. And
15 then, we need to decide about public comment
16 relative to this.

17 No, how about this? Can we get public
18 comment now on any of the measures that we have
19 just spent some time talking about? Why don't we
20 do that? Does that make sense?

21 So, Operator, can we open up lines for
22 any public comment on any of the measures that we

1 have just talked about that we may consider for a
2 vote?

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

6 (Pause.)

7 OPERATOR: There are no public
8 comments at this time.

9 CHAIR GESTEN: Great. Thank you. In
10 the room, any public comments on any of the
11 measures that we have just talked about?

12 (No response.)

13 CHAIR GESTEN: Okey-doke.

14 DR. KLEINMAN: Can you all hear?

15 CHAIR GESTEN: Yes, now I can. Go
16 ahead.

17 DR. KLEINMAN: Okay. They never said
18 to go ahead.

19 This is Larry Kleinman from CAPQuaM.
20 I wanted to make a couple of comments.

21 One is I have seen the measure that
22 Jeff Silber was discussing as it was being

1 developed and as it was tested. I think it is a
2 superb measure.

3 I think it is interesting because,
4 like any number of the CAPQuaM measures, it
5 challenges some of the paradigms about when we
6 think about quality -- I'm sorry -- the PQMP
7 measures, in that it doesn't line itself up well
8 to, for example, the NQF framework in which the
9 algorithm doesn't distinguish good care from bad
10 care. Often, that is not actually the relevant
11 question. It is, can it systematically,
12 reliably, and validly measure something that is
13 happening and important?

14 So, whether it rises to the level of
15 importance to be on the core set, I would leave
16 to the Committee to decide, but I just want to
17 say that, as someone who watched it grow up, I
18 think it is scientifically-superb and it reflects
19 a lot of the challenges.

20 I also want to say I have heard
21 several times the statement about Elliott Main.
22 I am not sure it was made by the same person or

1 others or various people. And I agree, Elliott
2 is terrific and his measures are terrific.

3 But I just want to point out that I
4 would say the same of all the PQMP measures,
5 which I don't think a number of them got a fair
6 hearing. I hope there will be an opportunity to
7 discuss some of that at some point in the public
8 comments for this call, because I think there are
9 measures that were available that were responsive
10 to questions asked yesterday that were not
11 brought up by staff or others and might have
12 impacted the direction of conversation and/or
13 decision-making, had they been pointed out. I
14 mean, I don't know; that is an unknowable. But,
15 certainly, the Committee deserved to be aware of
16 the measures as the discussions were taking
17 place.

18 Thank you.

19 CHAIR GESTEN: Thank you, Larry, for
20 that comment. It is Foster.

21 Hopefully, if there is some time,
22 there may be an opportunity to raise that as an

1 issue. I hope there is.

2 But can you just clarify the first
3 question? The first measure that you were
4 talking about, that you were referring to, was
5 which measure exactly?

6 DR. KLEINMAN: I don't remember the
7 name of the measure. It was about continuity,
8 the one Jeff Silber was discussing from CHOP.

9 CHAIR GESTEN: Oh, the CHOP measure on
10 continuity of coverage? Okay. Thank you.

11 DR. KLEINMAN: Right. Yes. Okay,
12 good. Thank you.

13 CHAIR GESTEN: Thank you much.

14 There is another public comment, I
15 hear, on the phone?

16 OPERATOR: Yes, sir. You have a
17 public comment on from Sean Currigan.

18 MR. CURRIGAN: This is Sean from ACOG.

19 I just wanted to express my concern
20 that measures that have gone through the
21 perinatal and reproductive health panel which are
22 recommended for endorsement have been voted down

1 by this panel or by the combined panel, but you
2 are in the process of potentially considering a
3 measure that did not even seek endorsement. And
4 I am just concerned that there has been another
5 panel that has expressed the recommendation that
6 contraception measures and even the unexpected
7 complications in newborns go forward for
8 endorsement, and then, not be included in the
9 Medicaid MAP.

10 CHAIR GESTEN: Sean, thank you for
11 that concern.

12 Do you have any response or anything?

13 MS. MUNTHALI: Well, Sean, this is
14 Elisa from NQF.

15 One of the things we are doing right
16 after the Task Force votes on the measures that
17 are in front of them today is to reconsider one
18 of those measures you brought up. But I just
19 wanted to remind you, while endorsement is a
20 strong preference by Medicaid, it is not a
21 requirement for the measures that may go into the
22 core set.

1 CHAIR GESTEN: Rich, was there a
2 question?

3 DR. ANTONELLI: Just a procedural
4 question. Will we have an opportunity to comment
5 as we go measure-by-measure for each of the
6 votes? Yes? Okay. Thank you.

7 CHAIR GESTEN: That would be my
8 suggestion --

9 DR. ANTONELLI: Yes.

10 CHAIR GESTEN: -- to see whether there
11 is a motion and second, conversation, vote.

12 MEMBER SAKALA: (presiding) Okay.
13 So, for 2800, metabolic screening for -- oh, I am
14 sorry, Marsha.

15 DR. LILLIE-BLANTON: Before you vote,
16 I just want to ask, is there data somewhere on
17 the continuity-of-coverage measure, just so we
18 can get a sense? So, I could get a sense of how
19 it has been tested and what we have learned
20 from -- you all would have sent it to the NQF
21 members, right?

22 CHAIR GESTEN: I believe this measure

1 would be in the spreadsheet, the CHOP measure,
2 the PQMP CHOP measure on consent and --

3 MEMBER SAKALA: Continuity of
4 coverage.

5 CHAIR GESTEN: Continuity of coverage.
6 But it would be information about the
7 description, not detailed information about the
8 testing of the measure.

9 MS. GORHAM: We don't have this
10 information, but we have the Excel sheet that the
11 members receive.

12 MEMBER SAKALA: Okay. So, is there
13 anyone here who would like to propose that we
14 have a vote on 2800 and including that, our
15 recommendation to include that in this core
16 measure set?

17 (No response.)

18 MEMBER SAKALA: Okay. Seeing no
19 interest in that one, let's move on to 2797,
20 which is transcranial Doppler ultrasonography
21 screening among children with sickle cell anemia,
22 an NQF-endorsed measure. Is someone here

1 interested in a vote?

2 Andrea, yes. Is there a second?

3 MEMBER ADIRIM: I second.

4 MR. CURRIGAN: Terry. Okay. Now here
5 is another opportunity have comments and
6 questions about this measure before we vote.

7 (No response.)

8 MR. CURRIGAN: Okay. No comments or
9 questions. Can we open it for voting, please?

10 MS. OGUNGBEMI: The voting is open.

11 MS. GORHAM: And we are looking for 10
12 votes. I do not have a proxy vote for Cindy.

13 MEMBER SAKALA: Okay. So, 1 is, yes,
14 we recommend it be included in the set, and 2 is
15 no.

16 (Voting.)

17 MEMBER SAKALA: We are looking for one
18 more vote.

19 MS. GORHAM: For the record, I don't
20 have a proxy vote for Cindy and Foster is
21 recusing himself from vote for this measure.

22 MEMBER SAKALA: Okay. Okay. Seventy-

1 eight percent support this. So, we are adding
2 that to our list of recommended measures.

3 CHAIR GESTEN: (presiding) Cool.
4 What is the next one?

5 MEMBER SAKALA: 2789.

6 CHAIR GESTEN: 2789 is the adolescent
7 assessment in preparation for transition to
8 adult-focused healthcare. This is NQF-endorsed.
9 It comes from one of the centers. It is a
10 patient-reported survey of young adults 16 to 17
11 years old. We had a conversation about it.

12 Is there anyone who would like to
13 propose adding this to the measure set?

14 Rich?

15 DR. ANTONELLI: I will make a motion.

16 CHAIR GESTEN: Okay. Is there a
17 second?

18 (Second.)

19 CHAIR GESTEN: There is a second. Any
20 discussion?

21 (No response.)

22 CHAIR GESTEN: So, I have some

1 discussion. I think this is a gap area. I think
2 it is a gap age population. I think it is an
3 important issue.

4 My fear about this measure is that it
5 is not going to get much uptake, and that may not
6 be a reason to vote it down. But I would say,
7 based on we have done, or tried to do, adolescent
8 surveys by mail in the past, and there are a huge
9 number of implementation challenges to doing
10 this. That doesn't make it not worthy, and maybe
11 it is a new day. But I have real concerns about
12 states' ability to actually implement this.

13 On the other hand, you know, we
14 certainly have -- what are you guys doing over
15 there? Susan is on the ground.

16 (Laughter.)

17 CHAIR GESTEN: So, we have measures
18 that are aspirational, and it would be great to
19 be wrong in my assessment of this, but that is my
20 concern about this relative to the burden of
21 cost, prioritization, and so on, despite what I
22 think is a really important area.

1 I am not sure whose card -- but yours
2 is on the ground, Susan. I will let you go
3 first. Go ahead.

4 MEMBER LACEY: So, I think traditional
5 surveys would be really -- you know, nobody would
6 do those in that age bracket. But apps, YouTube
7 slides, some other like innovative way to get
8 this information would make a whole lot of sense.
9 It is sort of like we can't keep teaching tiger
10 clubbing in an age where we don't also go around
11 clubbing tigers. So, we need to find the right
12 way to get information, not necessarily a survey.

13 CHAIR GESTEN: I have to follow up
14 with you on that analogy. Is that a southern
15 thing?

16 (Laughter.)

17 CHAIR GESTEN: Tiger clubbing, I have
18 never heard that one before.

19 MEMBER LACEY: Have you never read The
20 Saber Tooth Curriculum?

21 CHAIR GESTEN: Apparently not.

22 MEMBER LACEY: It is a classic. It is

1 about teaching things we don't do anymore because
2 we have always done it.

3 CHAIR GESTEN: It sounds great.

4 Bo?

5 MEMBER RIEWERTS: I am not going to
6 say much, but I agree totally with you that we
7 have been totally unsuccessful at doing this in
8 our organization, trying to reach out to teens to
9 get information from them by mail.

10 CHAIR GESTEN: Rich? You were just
11 busy knocking down Susan's card? Is that it?

12 (Laughter.)

13 CHAIR GESTEN: We would let you speak.
14 You don't have to knock down other people's
15 cards.

16 (Laughter.)

17 CHAIR GESTEN: Any other comments
18 before we vote? Kathryn?

19 MEMBER BEATTIE: I think there is
20 inherent bias in the methodology proposed and
21 that a patient who would be compliant and follow
22 up and going to a visit might be more likely to

1 respond to a survey. And so, then, the actual
2 value of the data gotten back in response to that
3 survey may represent the bias of those who would
4 participate in that program. So, I think it
5 would be challenging to implement.

6 CHAIR GESTEN: Thank you.

7 Charles?

8 Good interesting point.

9 DR. GALLIA: I could be making this up
10 because it is convenient. But I think that there
11 was some work through AHRQ on a pediatric EMR
12 criteria, modules, recommendations. And one of
13 the components, I believe, is the ability of the
14 system to report exactly this piece of
15 information. So, where that is in development
16 and implementation, I am not exactly sure.

17 CHAIR GESTEN: Is there anyone around
18 the table who has any insight on that? No?
19 Okay.

20 So, why don't we move to a vote. It
21 looks like we have teed-up. So, we are voting on
22 whether to include this measure, 2789, recommend

1 it to be included to the core set. It is
2 adolescent assessment of preparation for
3 transition to adult-focused healthcare.

4 A yes vote would be to include it; a
5 no vote would be to not include it.

6 Are we all ready?

7 MS. OGUNGBEMI: Yes, voting is open.

8 (Vote.)

9 CHAIR GESTEN: Okay. So, 90 percent
10 no. So, this was not recommended to be added to
11 the core set.

12 What is the next item that we have?
13 Sure. So, we can do this one. I will have to
14 recuse myself, and you will have to do this one.
15 Sorry.

16 MEMBER SAKALA: (presiding) So, the
17 next up for consideration is 2801, use of first-
18 line psychosocial care for children and
19 adolescents on antipsychotics.

20 And we will first ask if anyone has
21 any questions or comments before we find out
22 whether you want to make a vote on it.

1 CHAIR GESTEN: Do you have a question
2 that you would like to ask? Okay.

3 MEMBER SAKALA: Okay.

4 (No response.)

5 MEMBER SAKALA: Hi, Sarah. Not to put
6 you on the spot, but there has been a request
7 that we consider 2801, use of first-line
8 psychosocial care for children and adolescents on
9 antipsychotics. Do you have any comments on this
10 measure?

11 DR. HUDSON SCHOLLE: Sure. Actually,
12 this is a measure that was, when we asked
13 stakeholders to prioritize, this was often the
14 most important priority. It is the most
15 important.

16 This measure really came out of our
17 desire to try to reduce the use of antipsychotics
18 among children and adolescents because our
19 research showed us that children and adolescents,
20 like over half of the kids that get
21 antipsychotics actually have behavioral
22 disorders, and they don't have the conditions for

1 which antipsychotics have an FDA indication,
2 which suggests that they are being used more to
3 address a behavior, rather than to treat a
4 problem.

5 And so, that is the origin of the
6 logic here, that the measure is looking to see
7 whether children and adolescents, whether there
8 is a trial really, some attempt to provide
9 psychosocial care either in the month before the
10 prescription -- I'm sorry -- is it the month or
11 -- you know, in the time before the prescription
12 or within 30 days afterwards.

13 We wanted to take into account whether
14 in an acute situation a child might be given an
15 antipsychotic at the same time that you are
16 arranging psychosocial intervention. But the
17 real concern was that, often, the children have
18 ADHD, and where evidence-based psychosocial
19 interventions exist, and we wanted to make sure
20 that that happens.

21 In our data, the performance rates are
22 around, the median performance rate is around 50

1 percent. So, it shows that there is an awful lot
2 of room for improvement on this measure.

3 MEMBER ADIRIM: Could I ask -- this
4 seems like a strong candidate for some of the
5 things that we are looking for -- and why this
6 wasn't a staff pick, if you have any comments on
7 that?

8 MS. GORHAM: We didn't choose it as a
9 staff pick. No particular reason. We didn't
10 want to choose too many measures as a staff pick
11 and really leave it up to the Task Force members.
12 So, no, I can't give you a solid reason.

13 MEMBER SAKALA: Other questions or
14 comments on 2801?

15 Yes, Rich?

16 DR. ANTONELLI: Sarah, psychosocial
17 care, is that a generic term for counseling?

18 DR. HUDSON SCHOLLE: Okay. This
19 measure is reported using claims data. And so,
20 the claims that count as a psychosocial
21 intervention are individual, family, and group
22 therapy. While we would prefer to have something

1 that was more specific to evidence-based
2 psychotherapy, as you know, that is not
3 documented in any obtainable dataset today.

4 DR. ANTONELLI: Then, just a follow-up
5 observation. Not having an FDA primary
6 indication does not necessarily mean that it is
7 not appropriate care. There is a gap there in
8 terms of pharmacologic interventions finding
9 their way into the pediatric population. That is
10 not to push back on the measure. It is just an
11 observation to the degree that one would consider
12 that the gold standard, but in terms of pediatric
13 indications.

14 MEMBER ADIRIM: I agree, and I think
15 the thing that made a big impression on me, I
16 think it was two years ago -- I'm not sure if it
17 was last year -- was that the State Medicaid
18 Director from Louisiana said 40 percent of their
19 kids on Medicaid were on antipsychotics, and she
20 said that there are a lot of southern states
21 where that happens. So, this is a widespread
22 problem, and certainly 40 percent of children

1 should not be on antipsychotics. So, that is why
2 I think we should put this in the core set.

3 MEMBER SAKALA: Susan?

4 MEMBER LACEY: More for you in terms
5 of claims data, so I am not a provider, so I
6 don't like chart ICD-9s or codes, or whatever.
7 You would have to get the code that you
8 recommended the counseling or that they have gone
9 to counseling. I mean, how do you get that? It
10 is not just one piece of information. It will be
11 several pieces. Because won't you need the date,
12 several dates?

13 DR. HUDSON SCHOLLE: We are actually
14 looking at whether the counseling service
15 occurred, not whether it was recommended. So,
16 this is based on claims data. This is a health
17 plan measure. So, health plans, we have tested
18 it for both health plans and for states.

19 Really what we are trying to encourage
20 is access to psychosocial services for children's
21 behavioral health needs and to meet the gap in
22 providing psychosocial services that leads people

1 to prescribing medications instead of
2 psychosocial care. And so, that is why we think
3 it is appropriate at the state and health plan
4 level where states and where health plans are
5 responsible for both the general medical,
6 pharmacy, and mental health benefit. So, it is
7 that responsibility.

8 MEMBER LACEY: When you are saying it
9 is claims data, so if the patient or the family
10 goes to the counselor, that is how you would
11 capture it? And would you have a special way of
12 knowing if that was the first-line or after
13 medication failed? I mean, how do you get that?

14 DR. HUDSON SCHOLLE: That is a very
15 good question. So, the way that we identify that
16 is that we look for children who have a new
17 episode of a medication. And we do that from the
18 claims data. So, we look to see they haven't
19 been on an antipsychotic I think for six months.
20 So, they are continuously enrolled. We can tell
21 they haven't been on an antipsychotic. We see a
22 new prescription of an antipsychotic, and we look

1 to see, did they have psychosocial service in the
2 -- I'm not sure if it is three or six months. I
3 can't say that. And then, we also give kind of
4 this 30-day grace period. So, we are really
5 saying, did you try psychosocial service before
6 the antipsychotic prescription is filled?

7 In the claims, you are pulling all
8 those pieces of information from the claims data,
9 uh-hum.

10 MEMBER SAKALA: Thank you.

11 Other questions or comments?

12 Charles, did you have your card up?

13 DR. GALLIA: I was just going to say,
14 technically, this is similar to some other
15 measures that we have done. So, it is not
16 onerous in that sense that, I mean, the data
17 exists. It is mostly making certain that the
18 timing dates are accurate. And then, the other
19 part6 of it is that, as long as the coding is
20 updated routinely, then we can operationalize it
21 fairly easily.

22 The challenge will be that, if we find

1 discrepancies, then we can work those out with
2 managed care organization to say, no, actually,
3 they did and it was a claim that was submitted.
4 So, it could not only improve, have a focal point
5 for the subject matter, but it might be able to
6 improve our data quality, too.

7 MEMBER SAKALA: Okay. Any more on
8 this one?

9 (No response.)

10 MEMBER SAKALA: So, is there a motion
11 that we recommend addition of this Measure 2801
12 to our recommendations for addition to the child
13 core set?

14 MEMBER ADIRIM: I move that we add
15 this to the core set.

16 MEMBER SAKALA: A second?

17 Meg seconds.

18 Thank you.

19 So, could we open voting, please?

20 A 1 will be yes and a 2 will be no.

21 MS. OGUNGBEMI: Voting is open.

22 MS. GORHAM: And we are looking for

1 nine votes.

2 (Vote.)

3 MEMBER SAKALA: Okay. So, this one,
4 it gets added to our list with 78 percent yes.

5 Next, we will move on to -- there is
6 no number, but it is from the PQM pipeline,
7 appropriate antibiotic prophylaxis for children
8 with sickle cell disease.

9 Now is an opportunity any additional
10 comments or questions on this measure.

11 Rich?

12 DR. ANTONELLI: Thank you.

13 I don't know whether the measure
14 developer is still on the line or not. But
15 recall that the reason that her team decided not
16 to put this one forward had nothing to do with
17 the validity of the measure. It is because of
18 limitation of resources.

19 So, once again, I see this as a pure
20 and simple measure of disparity. The American
21 Academy of Pediatrics, this is a care guideline.
22 There is an evidence base for this. I am fully

1 in support of doing the transcranial ultrasound.
2 It costs about a dollar a day for penicillin. It
3 will cost more than that to do an ultrasound
4 looking for problems. This prevents problems.
5 So, it is a prevention strategy. It is
6 inexpensive. This has the hallmarks of a
7 disparate outcome for a vulnerable population.

8 Please don't make this a "Sophie's
9 choice" for the sake of the population. Well,
10 no, I am concerned because she said -- well, the
11 fact that Sara had to say, "We didn't have the
12 resources to do both." I decided it wasn't going
13 to be appropriate for me to say, "Well, why did
14 you choose that one?" But, as a pediatrician, I
15 tend to think prophylactically or preventively as
16 much as possible. So, I really want to appeal to
17 people to think about this because she clearly
18 said, if they had the resources, this would have
19 come before us.

20 MR. OLKOWSKI: This is Kevin Olkowski
21 at the University of Michigan.

22 MEMBER SAKALA: Yes. Thank you.

1 MR. OLKOWSKI: So, just to amplify on
2 that, we, in fact, just did not have the
3 bandwidth to put both measures through
4 successfully, and our Center was in the process
5 of finishing up 52 separate measures in different
6 areas. And it just was simply impossible to move
7 these forward. It is our full intent, though, to
8 submit that at the next opportunity to seek NQF
9 endorsement.

10 MEMBER SAKALA: Okay. Thank you.

11 Any other comments or questions?

12 Terry?

13 MEMBER ADIRIM: Yes, just a
14 clarification, since the measure developer is on
15 the phone. So, in your developing of this
16 measure, do you have any data of how large a
17 problem this is? I mean, what percent of kids
18 with sickle cell disease are not on antibiotics?

19 MR. OLKOWSKI: Yes. Of course, Sara,
20 who is the true expert on that, had to leave.
21 But my understanding is that there is actually a
22 fairly low compliance. I don't have the numbers

1 in front of me. I wish I could send it to you,
2 but I believe 15 percent is the number I recall.
3 But I don't have that right in front of me.

4 DR. ANTONELLI: That is compliance as
5 opposed to non-compliance.

6 MEMBER SAKALA: Rich, do you want to
7 turn your microphone on and say that?

8 DR. ANTONELLI: Kevin, that 15 percent
9 was the compliance rate or the failure rate?
10 Kevin?

11 MR. OLKOWSKI: Oh, I'm sorry.

12 DR. ANTONELLI: Fifteen percent was
13 the rate of adherence to the guideline?

14 MR. OLKOWSKI: Correct.

15 DR. ANTONELLI: Yes.

16 MEMBER ADIRIM: But does this measure
17 measure adherence or prescriptions? Because it
18 looks to me like it is administrative claims
19 data, so it would look at prescriptions as
20 opposed to actual adherence. No, I know, but I
21 am saying every single kid that comes to the
22 emergency department with sickle cell disease, it

1 says they are on penicillin, whether or not they
2 take it or not. I mean, that is what I am trying
3 to get at, whether or not this measure is going
4 to really help with improvement.

5 MR. OLKOWSKI: Right. And so, the
6 measure actually recognizes the fact that we are
7 using administrative claims data, which certainly
8 has its strengths which are well-documented and
9 known to you all, but it also is not a full
10 representation. It is a proxy for actual use
11 of the medications. However, we are looking at
12 it over a one-year time period using that proxy,
13 you know, those refills, and whatnot, to indicate
14 continued use, as best as claims can support.

15 MEMBER SAKALA: Thank you. Any other
16 comments or questions on this one?

17 (No response.)

18 MEMBER SAKALA: Okay. Okay. So, we
19 are interested in knowing whether there is a
20 motion to add this one to our list.

21 DR. ANTONELLI: I will make that
22 motion.

1 MEMBER SAKALA: Is there a second?

2 MEMBER RIEWERTS: I will second it.

3 MEMBER SAKALA: Okay. We have a
4 motion and a second. Could we vote, please?

5 We are voting to discuss whether
6 appropriate antibiotic prophylaxis for children
7 with sickle cell disease should be added to our
8 list of recommended measures for the child core
9 set.

10 One is yes and 2 is no.

11 MS. OGUNGBEMI: The voting is open.

12 (Voting.)

13 MEMBER SAKALA: We are looking for one
14 more, I believe.

15 Okay. All right. So, we are out of
16 a total of eight. Since we don't have 60
17 percent, we can't pass this. Okay. Thank you.

18 All right. So, I think we go on to
19 the two CHOP measures next.

20 CHAIR GESTEN: (presiding) So, we
21 will do these one at a time, though. Informed
22 consent, this is a measure from CHOP around --

1 I'm sorry -- informed coverage. And the measure
2 we talked about is the measure looking at
3 summation of covered months of coverage. This
4 was, again, developed by CHOP under the Pediatric
5 Quality Measurement Program. It is an
6 administrative measure.

7 CHAIR GESTEN: We had some discussion
8 about it previously. Let me just see if there is
9 any conversation or questions that did come for
10 you that people want to bring out.

11 (No response.)

12 CHAIR GESTEN: And if not, is there a
13 motion to take a vote, a proposal to take a vote
14 to see whether this measure should be added to
15 the core set?

16 Okay, Meg, yes. Is there a second?

17 (No response.)

18 CHAIR GESTEN: Okay. I am not seeing
19 a second. Sorry, Meg.

20 Let's go to the next one. The next
21 measure is the duration of first-observed
22 enrollment, again, a measure developed by CHOP

1 looking at issues of continuity of coverage.

2 Meg, can you just say two words,
3 rather than me read through that, what this
4 measure does versus the one that folks didn't
5 vote on. Use your microphone, please.

6 MEMBER MURRAY: This one looks at how
7 many of the kids that were on on day one are
8 still on at six months, at 12 months, at 18
9 months. And so, it gives a sense of the
10 continuity. You know, the trail goes down.

11 And I should say that last sickle cell
12 measure was looking at kids who are continuously
13 enrolled. So, my point is so many of these
14 measures are dependent on people being enrolled,
15 and if we don't know what the enrollment levels
16 are, it undermines the quality issues.

17 CHAIR GESTEN: Okay. Thanks. Any
18 questions or comments about this measure?

19 (No response.)

20 CHAIR GESTEN: Is there a motion to
21 consider voting on adding this measure?

22 Meg. Is there a second? A second.

1 Okay. Can we set up the vote? We are voting on
2 whether this measure, the duration of first-
3 observed enrollment should be added to the child
4 core set.

5 A yes vote would be for addition; a no
6 vote would be not to add.

7 And I think, what is the magic number
8 we are looking for now? Would it be nine? Nine,
9 yes. Okay.

10 So, are we ready to vote? Okay. We
11 are ready to vote.

12 MS. OGUNGBEMI: Yes, voting is open.

13 CHAIR GESTEN: Great. Thanks.

14 (Vote.)

15 CHAIR GESTEN: Nine is the right
16 number?

17 MS. GORHAM: We should have 10.

18 CHAIR GESTEN: We should have 10. Oh,
19 Rich stepped out. Was Rich not here?

20 MS. GORHAM: He voted first.

21 (Pause.)

22 MS. GORHAM: We still have a quorum,

1 so we are fine.

2 CHAIR GESTEN: I don't know. If Rich
3 were here, I suggest we re-vote, but he is not
4 here.

5 MS. GORHAM: We can hold off on the
6 re-vote.

7 CHAIR GESTEN: Let's do that. That is
8 my suggestion. I understand what you are saying,
9 but let's maybe re-vote.

10 Can we move on? Is there another one
11 to move on to?

12 Is Reva -- are we ready to tee-up?

13 MEMBER SAKALA: (presiding) So, I
14 would just like to say, Meg, that your colleague
15 mentioned you hadn't thought NQF might be
16 interested. And I think continuity and churn are
17 a huge issue for this population. So, we would
18 encourage you all to submit those measures
19 through this process, and then, they could be
20 really good candidates for us. It is just a
21 little hard to tell right now.

22 Thank you.

1 So now, we are going on to -- it was
2 recommended that we consider the readmission
3 measure -- where is it? -- from last year's list.
4 Okay. I'm sorry, where is the readmission --

5 MS. GORHAM: On the screen back, it
6 shows the voting slides. So, we are voting on
7 2393, pediatric all-condition readmissions
8 measure.

9 MEMBER SAKALA: I see. Got it. Okay.
10 So, we are not looking at any details on this?
11 We are just --

12 MS. GORHAM: They said they didn't
13 need to see them.

14 MEMBER SAKALA: Yes. Okay. So, is
15 there comment or questions?

16 Or you think the vote is up now
17 without any discussion?

18 MS. GORHAM: So, you all can discuss.
19 You said you didn't need to see the
20 specifications again because we looked at it and
21 discussed last year. If you need us to pull it
22 up, we can, or not. You all can have a

1 discussion, and we will vote. It will be nine
2 voters because Foster will recuse himself. So,
3 it is up to you. If you want to have discussion,
4 you can. We discussed it earlier, yes.

5 MEMBER SAKALA: Okay. So, we said we
6 would discuss as they came up for a vote. That
7 is what I was thinking.

8 And then, to further complicate
9 things, Rich, we are missing -- Rich, hi.

10 We are going to re-vote on the last
11 one. So, we wanted to try to get nine votes on
12 this CHOP duration of first-observed enrollment.
13 There is a request to re-vote when you came back,
14 and we are going to try to get nine votes.

15 So, once again, for duration of first-
16 observed enrollment, a yes would recommend this
17 for inclusion on our list of recommended new
18 measure, and a no would not include it on the
19 list.

20 MS. OGUNGBEMI: Voting is open.

21 (Voting.)

22 MEMBER SAKALA: Oh, now we have 10?

1 MS. GORHAM: Okay. Ten, got it, 10.

2 MEMBER SAKALA: Okay. So, this
3 measure does not pass with 40 percent yes. Thank
4 you for re-voting, everybody.

5 Okay. Now we are going to move to --
6 did we want to pull up details of this
7 readmission measure or are we prepared to vote?
8 Well, we have an opportunity to discuss, make any
9 additional comments, as we have for the other
10 ones we are running right now.

11 (No response.)

12 MEMBER SAKALA: Does anyone wish to
13 propose that we vote on inclusion of this
14 measure?

15 MEMBER BENIN: I think we already have
16 a motion that is an outstanding motion.

17 MEMBER SAKALA: Sorry.

18 MS. GORHAM: It is okay. We are now
19 going to open the vote for 2393, pediatric all-
20 condition readmissions measure.

21 One, we are recommending this measure
22 for addition in the core set; 2, we are not.

1 MS. OGUNGBEMI: The voting is open.

2 MS. GORHAM: We should have nine
3 votes, as Foster is recusing himself from the
4 vote.

5 (Vote.)

6 MEMBER SAKALA: So, this measure, at
7 44 percent yes, does not pass.

8 Okay. Now we will move on to one more
9 measure for this day.

10 CHAIR GESTEN: (presiding) Is the
11 next measure the healthy term or the unexpected
12 newborn complications?

13 Carol, did you describe sort of why we
14 are redoing this? Do you want to just refresh
15 folks' memory?

16 MEMBER SAKALA: Sure. So, after we
17 voted yesterday not to pass this measure, I think
18 not by a landslide, there was some surprised
19 response from people in the room and on the
20 phone. So, Helen was surprised. Reva was
21 surprised. Sean was surprised. And I was as
22 well, but I also recognized I shouldn't be too

1 greedy about maternity measures.

2 Anyway, the idea is that this measure
3 was supported by 100 percent of the members of
4 the Perinatal and Reproductive Health Standing
5 Committee earlier this month. As Sean pointed
6 out, it is a gift to the Medicaid population
7 because it is all based on administrative data.
8 It is also an outcome measure, where we are
9 looking toward moving away from process measures
10 and other low-bar measures. And it is considered
11 to be very well-done and, as I mentioned
12 yesterday, a balancing measure. So that, as we
13 move forward with quality improvement in areas
14 like Cesarean reduction, this would be a little
15 kind of canary in the coal mine, for example, if
16 we were getting too aggressive in some of those
17 areas.

18 So, there was the thought that
19 yesterday what we put up, the previous version of
20 this measure, there was some confusion at not
21 being able to see what is before now for 0716.
22 It is the same number. It was previously

1 endorsed.

2 The developer changed it in the course
3 of this four-year hiatus between the two
4 Perinatal Care Committee meetings, consensus
5 development process meetings. And it is well-
6 tested in its new rendition, which, as we have
7 been saying, is simply flipped. It is pretty
8 much the same measure, but a different way of
9 looking at it.

10 Now it is the number of babies that
11 aren't doing well as opposed to the number of
12 babies that are doing well, who would, in
13 general, be expected to be doing very well. And
14 it is a measure of things that happened around
15 the time of birth and for the rest of the stay in
16 the hospital.

17 CHAIR GESTEN: Thank you, Carol. That
18 is very helpful.

19 So, just as a process point, I just
20 want to point out, just frame this, that I think
21 we never want to have a vote depend a point of
22 confusion or clarification that we can clarify

1 before everyone leaves. And so, part of the
2 reason -- I mean, anyone at any time can ask for,
3 a Task Force member can ask for a re-vote.

4 In this particular case, the concern
5 was there were questions raised about what does
6 it mean that it is pretty much the same measure,
7 and what is the part that isn't pretty? And so,
8 staff have done some work to try to clarify that.
9 Again, I don't know if it will impact the vote or
10 not, but I think we collectively probably don't
11 want to have votes hinge on some misunderstanding
12 that we can clear up.

13 So, Andrea?

14 MEMBER BENIN: You know, I would just
15 like to comment, a question on the process,
16 Foster. I felt like the conversation yesterday
17 was pretty clear. You know, this is the inverse
18 metric that was well-supported by the group. I
19 am just not sure that if every time we vote and,
20 then, afterwards people don't like what we vote,
21 we are going to re-vote. That, to me, really
22 makes the whole process pretty suspect.

1 So, I am not going to object. If we
2 want to re-vote, we can re-vote, and my vote
3 won't change. But there is a real disconnect for
4 me on that, that really makes the whole process
5 highly suspect.

6 CHAIR GESTEN: So, I understand that
7 concern. I think that there will need to be a
8 second. And again, I don't know that anything
9 will change. But, again, I think, our view is,
10 first of all, from a process point of view,
11 people can ask for a re-vote if they want to.
12 There isn't anything that forbids that, but there
13 may or may not be support in the group to do
14 that.

15 I think we tried to explain what the
16 reasons were for this, which may accord with what
17 you think is a reasonable reason to re-vote or
18 not.

19 But, Terry? And then, Susan.

20 MEMBER ADIRIM: I was going to say
21 exactly what Andrea said, because it seemed very
22 clear to me yesterday what we were voting on.

1 So, I am not sure where the lack of clarity is
2 happening. And I agree fully that, once we have
3 a vote, I am not sure the utility in doing it
4 again, unless you wanted to re-litigate the whole
5 thing all over again.

6 CHAIR GESTEN: Susan?

7 MEMBER LACEY: So, the question I have
8 is, who can call another vote?

9 CHAIR GESTEN: Any Task Force member.

10 MEMBER LACEY: Right. So, we had a
11 Task Force member call? And you did that, absent
12 of any kind of -- I mean, you know, I am not --

13 MEMBER SAKALA: Right. I am willing
14 to do that now on the basis of the feedback from
15 people who are up in the helicopter around these
16 processes and consider this to be an excellent
17 measure that is moving in the direction of where
18 we want measures to be.

19 CHAIR GESTEN: So, to answer, just to
20 respond to the re-litigation, I would agree with
21 you. I think, again, that is why I framed it the
22 way I did. There were some concerns that there

1 were some questions that were unanswered or not
2 clear about the, quote/unquote, "inversion" of
3 the measure that we were looking at. So, I would
4 hope that -- and I think Reva is on the phone --
5 that discussion be limited to that the discussion
6 and the comment be around what is meant by the
7 inversion and what is pretty much the same. And
8 then, we will see if there is a second for this
9 proposal.

10 Bo?

11 MEMBER RIEWERTS: I would second it.

12 CHAIR GESTEN: Okay. Fatema, did
13 you --

14 MEMBER SALAM: Yes. I just wanted to
15 say I heard confusion as to what our task was in
16 terms of -- because today we looked at measures
17 that weren't endorsed; we didn't have the
18 specifications, but yesterday we were
19 formulating -- I heard people saying they had
20 trouble voting for this because, as you know, it
21 wasn't the same measure and they hadn't seen all
22 the details.

1 So, to me, the conversation that I
2 heard did have some confusion around the process.
3 But that is just what I heard, and my vote is not
4 going to change either way, anyway. But I am
5 kind of validating that, I guess.

6 CHAIR GESTEN: Okay. Thanks.

7 Reva, I know that you did some work
8 and you had some side-by-side -- at least I am
9 told there is some information, some other slides
10 that will be presented to try to clarify anything
11 that was at least perceived by some to be unclear
12 about what this inversion meant, ways in which
13 the numerator, denominator, or the exclusions --
14 I think, in particular, there were some questions
15 about whether the exclusions differed as the
16 measure was inverted.

17 So, Reva, are you on and can you --

18 MS. WINKLER: Yes, Foster, this is
19 Reva.

20 If they could show the slide of the
21 specs of the measure that is on the table? I
22 think everybody needs to forget the concept of

1 inversion and look at what is in front of you,
2 because this is the measure that is currently in
3 front NQF's consensus process for potential
4 endorsement.

5 The past history is interesting, but
6 probably not pertinent. And so, the measure you
7 want to be evaluating is the unexpected
8 complications in the term newborn. And I believe
9 you have a clear slide of the specifications of
10 that measure in front of you. And so, I think
11 that is really -- to me, I heard a lot of
12 confusion about what the measure actually is.
13 And so, we wanted to be clear what the measure
14 you would be considering, what the specifications
15 are, and have them in front of you.

16 CHAIR GESTEN: Great. Thank you,
17 Reva. That is very helpful.

18 So, I am giving people a chance to
19 kind of read through it. And we would open the
20 floor to any -- is the measure developer on the
21 phone?

22 MS. WINKLER: Foster, I tried to

1 contact him earlier today, and I didn't get a
2 response. I gave him the information.

3 CHAIR GESTEN: Okay.

4 MS. WINKLER: Operator, did Elliott
5 Main call into this call at all?

6 OPERATOR: I don't see him on the
7 line.

8 CHAIR GESTEN: Okay. I mean, I don't
9 know that we will have a question that we will
10 need to forward to him. Let's just see.

11 Are there any questions about this
12 measure, its specifications, the numerator,
13 denominator, or exclusions?

14 (No response.)

15 CHAIR GESTEN: Seeing no questions, we
16 have a proposal to consider adding this,
17 recommending this be added to the child core set.
18 It has been seconded. So, we are ready to vote.

19 This is for adding 0716, unexpected
20 complications in term newborns, to the core set.
21 A yes vote would be to add this measure; a no
22 vote would be not to.

1 MS. OGUNGBEMI: The voting is open.

2 (Vote.)

3 MS. GORHAM: Yes, I have a proxy vote
4 for Cindy. That is why we have 11 votes.

5 CHAIR GESTEN: Great. Thank you.

6 So, this measure does not pass, as it
7 was 55 percent yes, 45 percent no.

8 Thank you. Thank you, Reva, and thank
9 the indulgence of the group for a re-vote. Are
10 we through the gauntlet?

11 (Laughter.)

12 CHAIR GESTEN: First of all, thank
13 you. I thank everybody for this process. I know
14 it is to be a little grilling, a little confusing
15 sometimes. But, once again, thank you. It has
16 been great discussion.

17 The next step of this is prioritizing.
18 Again, just to re-ground folks, the reasons we
19 prioritize is to send a clearer signal/message to
20 CMS as they look at this list. While we have
21 approved each of them, whether there is more
22 weight or more concern about some measures versus

1 others.

2 And that is, in part, a recognition
3 that -- I don't know how many measures we have
4 currently that we have -- five. It is possible,
5 but not probable, that all five will be adopted.
6 So, this is, I guess, our way of putting a stamp
7 on this.

8 I think in the past we have given
9 folks a vote of a certain number of measures with
10 little stickies to decide which were most
11 important and kind of rank order them. When the
12 meeting started, we went through whether we
13 should digitalize this process and update it
14 using this or use stickies. Maybe based on my
15 age, I thought stickies would be easier.

16 What we are proposing is how many?
17 How many? Three? That folks get three votes to
18 stick on this.

19 I see, Terry, your question.

20 We, I think, landed. Do you want to
21 talk a little bit about the measure that has an
22 e-specification and how we are handling that?

1 Was that your question? I had a hunch.

2 MS. GORHAM: So, we had a little bit
3 of conversation behind the scenes. And so, we do
4 have the two measures, the breast milk measures.
5 One is a paper measure and the other is the
6 e-measure. The same measure, different data
7 sources. And you, as a Task Force, can recommend
8 and prioritize as you see. And then, if the
9 measures are recommended for the core set, then
10 it will be up to CMS to choose which measure they
11 think would be best for the states.

12 MEMBER ADIRIM: Let's say I consider
13 that No. 1. I consider both of them No. 1. I
14 want to use my 2 and 3 for two others. We can't
15 combine those?

16 (Laughter.)

17 MS. MUKHERJEE: We did combine the
18 voting because one is endorsed and the other is
19 going through the process. So, I think in a way,
20 if you are voting, you would be voting for both,
21 and maybe we should bracket it because we did
22 talk about that CMS should have the choice of

1 which data source. And hopefully, some states
2 will do the e-version and some states won't. So,
3 I think in that case, you know, we will put a
4 bracket. So, if you are choosing, you want to
5 use just one dot. Use one dot for the two.

6 CHAIR GESTEN: So, I am okay with
7 that. Is anyone not okay with that? But there
8 was a difference of opinion, at least earlier on,
9 about whether these are two measures or one
10 measure. So, I see it the way you see it, but
11 not everybody, including our colleagues at those
12 three initials, necessarily saw it that way. So,
13 I am good with a bracket.

14 Okay. Rich?

15 DR. ANTONELLI: I was going to say I
16 am confused, although I like where we just landed
17 because the first measure includes electronic
18 data. So, it actually is, if you will, the
19 mother measure. So, the decision point, if we
20 wanted to make one, would actually be, do we not
21 care about any data sources other than
22 electronic, in which case you should go with the

1 second one. And so, it was that concept
2 yesterday that I was willing to vote them
3 together.

4 Is that what we are really talking
5 about? If we just put one sticky on those two
6 and, then, CMS can decide?

7 CHAIR GESTEN: That is an approach.

8 DR. ANTONELLI: Yes, yes.

9 CHAIR GESTEN: Does anybody object to
10 putting them together?

11 Carol?

12 MEMBER SAKALA: I don't object, but I
13 just want to say that yesterday we handled the
14 elective delivery that way. We didn't really
15 vote on it. It was already in the set. So, we
16 just said, oh, you also have an e-measure as an
17 option.

18 CHAIR GESTEN: Both of those
19 endorsed --

20 MEMBER SAKALA: So, I think elective
21 delivery is already in the set, and then, we
22 supported the e-measure for that.

1 MS. GORHAM: So, most importantly, CMS
2 is shaking their head yes.

3 DR. ANTONELLI: I saw that.

4 CHAIR GESTEN: So, deal with the
5 process. Three stickies, three dots.

6 Does anyone want to make any comments
7 before you get your dots?

8 MEMBER LACEY: We have to put on three
9 different ones or can we put all three of our
10 dots on one?

11 (Laughter.)

12 MEMBER LACEY: I am not saying I want
13 to do that. I am just saying I can't remember
14 what we did last year.

15 CHAIR GESTEN: That is a great
16 question.

17 MEMBER LACEY: Because we decided last
18 year -- I can't remember what it was.

19 MS. GORHAM: We did that last year.
20 So, you can, uh-hum. Yes.

21 CHAIR GESTEN: Yes? Okay.

22 All right. So, feel free -- dots

1 away. Everybody get their dots. The dots are
2 for Task Force voting members, right?

3 MS. GORHAM: Yes.

4 So, just as a reminder, the measures
5 that were voted for conditional support are on
6 one wall, and the measures that were voted for to
7 support are listed on the other wall.

8 (Vote.)

9 CHAIR GESTEN: Why don't we take a
10 quick break. We will come back at 3:15 and
11 resume. We will talk a little bit more about cap
12 areas and some summary, next steps, timeline. A
13 lot of work is done, but don't leave yet unless
14 you have to. Thanks.

15 (Whereupon, the above-entitled matter
16 went off the record at 3:06 p.m. and resumed at
17 3:12 p.m.)

18 MS. MUKHERJEE: Okay. We're starting to
19 lose some people, so let's talk about gaps. Some
20 comments on the gap areas, today we did fill two
21 gap areas. We have a sickle cell measure and a
22 behavioral health measure, so we did make some

1 indentation in some of our gaps, even if it's
2 infinitesimally small, it's incremental changes,
3 it's all about scaling up. So, on that note,
4 other than that, our gap areas remain the same
5 from last year carry over, but we did sort of add
6 two measures. So with that, I will open up to
7 any comments about gaps that there are in the
8 room. And then with that, we'll follow up on the
9 phone and then we can let everybody go home. So,
10 we'll start with Charles.

11 DR. GALLIA: So, when the measures were
12 first reviewed in relationship to gaps, and I see
13 the tracking mechanism that was used to identify
14 particular areas, one of the components of it was
15 the ACEs and trauma behavioral healthcare, it's a
16 subcomponent. And when the different review
17 groups didn't have this was actually trauma-
18 informed, it's the preceding slide. Behavioral
19 health functional outcomes that stem from trauma-
20 informed care. I think it's important to
21 consider reframing this in a broader area, rather
22 than strictly mental health and look at a

1 population based, potentially consider there's
2 like the National Children's Health Survey and
3 the Maternal Child Health Bureau have trauma
4 rates as measures at a state level.

5 So, I would suggest reconsidering this
6 position as being more prominent and over time,
7 there were measures that were proposed that were
8 turned down because this gap wasn't used as a
9 contrast for that. In other words, we had
10 measures that considered in the first couple of
11 rounds of the versions that were submitted
12 through public comment over time, but they didn't
13 meet this threshold because the actual gap wasn't
14 identified either. So, what I'm suggesting is to
15 do a little bit of a reset on the subject and
16 consider it more prominent than what it is
17 positioned now. Does that make sense?

18 CHAIR GESTEN: So, I think so, but the
19 gap area as it's described right now under mental
20 health, initially when we were talking, I didn't
21 think it was there, but it's the behavioral
22 health functional outcome stemming from trauma-

1 informed care, is that what you're referring to
2 and is that what you're suggesting be
3 prioritized? Are those the two things that --

4 DR. GALLIA: This is narrowly
5 constructed, I think it needs to be expanded to
6 be reflected of ACEs more broadly and elevated
7 beyond mental health as it is as a category. So
8 the components --

9 CHAIR GESTEN: So have its own
10 category?

11 DR. GALLIA: -- of exposures -- right.
12 So that not just the consequences on the mental
13 health or even in the setting that's assessed
14 based on whether or not it's trauma-informed
15 care.

16 CHAIR GESTEN: Other comments about gap
17 areas? Terry?

18 MEMBER ADIRIM: Yes. And just to
19 extend on what you were just saying, I think
20 trauma, trauma period, injuries, trauma, in
21 adolescents is one of the leading causes of
22 death, so I think that is probably a gap area.

1 And I think too, just to expand on the behavioral
2 health, substance use. I think kids start
3 smoking during adolescence, so substances would
4 be something to consider too.

5 CHAIR GESTEN: Other comments? Meg?

6 MEMBER MURRAY: Yes. So, the coverage
7 issue, I don't know whether that will be
8 considered a gap, but certainly it's not
9 something that's on there now. So I think it
10 would be.

11 CHAIR GESTEN: Other thoughts or
12 comments about either gap areas that are either
13 not framed in the way you would frame them or
14 that you would add, subtract, or prioritize?
15 Terry?

16 MEMBER ADIRIM: I think too, we have
17 mentioned in past years about measures that
18 assess use or overuse. I believe that was
19 something that had been mentioned, not by me, but
20 I just recall that it was something that had been
21 mentioned. I don't want that to get lost.

22 CHAIR GESTEN: Kamila, microphone, you

1 were saying, overuse is on the list?

2 DR. MISTRY: I think overuse, because
3 I remember sorting measures by overuse. Is it on
4 there?

5 CHAIR GESTEN: Yes.

6 MS. MUKHERJEE: So there's misuse and
7 overuse. And a lot of overuse and misuse also
8 gets caught up in appropriate use criteria, which
9 is sort of a different look and it's sort of a
10 subset measurement.

11 CHAIR GESTEN: So I don't want to lose
12 folks on the phone who've, lord only knows how
13 they're able to hang in there all day over the
14 phone, having done that myself, it's a Herculean
15 task, so they need to be rewarded for hanging in.
16 So, Operator, if there are folks who want to make
17 public comment, I know Larry Kleinman wanted to
18 make a comment and I believe he's still on, but
19 if there are others who want to get in queue,
20 we'd be happy to take comments from folks on the
21 phone.

22 DR. KLEINMAN: Thank you, Foster. I'll

1 take that as an invitation to start. And I will
2 say it's the multiple antipsychotics that allow
3 us to hang in, in keeping with the measures. I
4 think that you all have a very difficult task.
5 And I want to suggest that there are a number of
6 -- I'm going to speak to CAPQM, the Collaboration
7 for Advancing Pediatric Quality Measures, which
8 is one of the PQMP Centers of Excellence
9 measures.

10 But I think there are other PQMP
11 measures that were not brought to your attention
12 that are excellent measures, some of which will
13 and some of which won't pass NQF's review process
14 because we were asked to move the science
15 forward, and we did. And the review criteria and
16 approaches have not caught up to the advances in
17 the science, and that's a problem. And in some
18 ways, as the one body that can make
19 recommendations or that has been formally asked
20 to make recommendations to CNS that is not NQF,
21 it becomes the responsibility in my view and the
22 opportunity for the MAP to help push that forward

1 by making recommendations.

2 So I want to suggest a few things.

3 One, the CAPQM has developed a really nice
4 framework on asthma ED overuse that includes a
5 better measure of the rate than the one that used
6 to be on the Core Set and was removed a couple of
7 years ago. This one is now going through the NQF
8 process, just went through the public comments
9 process where the CDC program strongly endorsed
10 it, or the CDC Asthma Control Program made public
11 comments strongly supporting it.

12 We also have an appropriateness
13 measure, and it's the combination of the count
14 measure and the appropriateness measure that
15 allow you to really get to the notion of overuse,
16 under use, et cetera. We also have measures that
17 look at the connection to primary care before and
18 after ED visits, thus looking at coordination in
19 a population that by its own behavior has
20 demonstrated itself to be at higher risk. So
21 it's targeted. That's one thing.

22 Also, in response to a question you

1 asked yesterday, Foster, about other prenatal
2 measures, the CAPQM actually does have several
3 measures of prenatal care, again targeted towards
4 higher risk. So, we had whether women who were
5 at higher risk had zero, one, or greater than one
6 visit with an appropriate specialist or an MFM
7 doc and we had that both as an overall measure
8 and then broken down by indications such as HIV,
9 heart disease, epilepsy, and other indications.
10 So that was one.

11 Secondly, we have a measure of whether
12 women at high risk receive multi-disciplinary
13 care, which is defined as services by three or
14 more different types of providers or clinicians
15 during the pregnancy. And a third is a proxy
16 measure for preconception care, looking at
17 whether women who are on teratogenic medication
18 continue to fill that prescription during their
19 pregnancy. So, there actually are three measures
20 that relate to prenatal care, with specific
21 content targeted to women who are at higher risk
22 on the basis of criteria developed by an expert

1 panel.

2 We also have other perinatal measures
3 that I think would have been useful for
4 discussion, including measures that relate to
5 ACOG's preferences regarding levels of care. We
6 have them as four individual measures that we
7 submitted to PQMP, looking at four different
8 aspects of the structural content or capacities
9 of the institutions in which women with high risk
10 deliver. These are intended to be index
11 measures, they're not supposed to be all 100
12 percent yes, but rather to reflect the
13 availability within a population of these
14 services, including 24/7 OB staffing, well, OB or
15 other staffing by a clinician capable of doing an
16 emergency C-section, 24/7 inpatient on the labor
17 and delivery anesthesiology, 24/7 blood banking
18 transfusion, and 24/7, well Level 3 or higher
19 NICU, so the NICU services.

20 We also have measures of temperature
21 for all low birth weight infants, because this is
22 a major source of mortality and morbidity, it's a

1 proximal outcomes measure. And we have a couple
2 of temperature taking measures that go with that.
3 And I think that this is really important,
4 because in the area of injury prevention as well
5 as safety, even in the very best NICUs, too many
6 infants get cold and die as a result of that.

7 And then, lastly to discuss, we have
8 mental health follow-up measures that we have
9 found in our work that children who have both a
10 primary care, well, who have primary care follow-
11 up following a mental health discharge,
12 controlling for whether or not they had mental
13 health follow-up, have lesser readmission rates
14 at 30, 60 or maybe 60, 90, and 180 days, I think
15 is what we looked at. So, this is really an
16 important component of it and we have a whole
17 series of measures that look at timely follow-up,
18 delays in follow-up, and also the establishment
19 of ongoing follow-up, looking at the time or
20 whether or not there was a second visit and the
21 time between the first and second visit.

22 So, I just want to say, I think there

1 are really wonderful measures, carefully
2 developed with the highest level of science to
3 try to fill some of these gaps and I feel sad, I
4 feel sad for the field, I feel sad for the
5 children who could potentially benefit, that I
6 don't think they're getting hearing because
7 they're developed outside of the framework that
8 NQF was designed to handle and I think that's
9 probably true for other measures.

10 Some of these have not gone through
11 NQF again, because of the resource issues you
12 heard about from other sectors. There are a
13 limited number of slots to submit for and a
14 limited amount of dollars to pay for our work to
15 do the submissions. I think this is an
16 opportunity for you all, I hope you will figure
17 out a way to address this opportunity. I think
18 CMS and our children will benefit if you can
19 figure that out. Thank you.

20 CHAIR GESTEN: Larry, thank you. And
21 just --

22 DR. WOODS: I'd like to follow up on

1 that.

2 CHAIR GESTEN: That would be great in
3 second. I need to recuse myself from
4 conversation about those measures, but, Shaconna,
5 do you want to maybe a clarifying comment about
6 process and -- I'm sorry? Yes, I know you do, I
7 know, I just wanted to respond to this directly
8 first. Okay.

9 MS. GORHAM: So, Larry, I just wanted
10 to thank you for that. Just a matter of
11 clarification as far as process, staff definitely
12 try to do our due diligence to get a list of all
13 of the measures that could possibly be in the
14 PQMP pipeline that are ready. And so we reached
15 out and Kamila did an excellent job, she was very
16 patient, worked with us, and got a list of PQMP
17 measures that are ready for development, but have
18 not been submitted to the NQF for endorsement
19 yet.

20 And so that list was put together, we
21 developed a spreadsheet, and submitted that to
22 our Task Force members so that they could see all

1 available measures, whether in the NQF repository
2 or other measures that are not aware of. So they
3 were -- the Task Force members did have an
4 opportunity to review the measures and recommend
5 those measures for potential discussion and vote.

6 DR. KLEINMAN: If I could just say
7 thank you, I appreciate that. I just think, as
8 you know and we all know, the work of actually
9 reviewing and going through that independent
10 critical thinking is very challenging for any of
11 us and certainly for the committee members. But
12 it's good to know and I appreciate your
13 clarifying that for the record.

14 DR. WOODS: This is Donna. Thank you,
15 Larry, for bringing that up, because I've been
16 sitting here thinking similar thoughts. And for
17 us, we also have perinatal measures, we have
18 measures of ADHD, we have PICU measures of
19 quality --

20 CHAIR GESTEN: Donna, could you just
21 introduce yourself so we know who you are?

22 DR. WOODS: Oh, okay. I'm Donna Woods.

1 I'm faculty at Feinberg School of Medicine at
2 Northwestern. I am a principal in the PMCOE
3 Center of Excellence, Pediatric Measures Center
4 of Excellence, for which Ramesh Sachdeva is the
5 PI and he asked me to sit in to be able to
6 comment as made sense.

7 CHAIR GESTEN: Thank you. Go ahead
8 with your comments. Thank you.

9 DR. WOODS: Right. So we have
10 additional PICU measures and dental measures as
11 well as a number of perinatal measures, different
12 than the ones that Larry just described. And one
13 of them was actually encouraged when there was
14 the SNAC, which was I guess an internal committee
15 to AHRQ, but I don't believe has been put forward
16 in this process. So, you might want to discuss
17 that. But also, we did submit two ADHD measures.
18 And one of them was very close, but needed a
19 tweak, but we had no funding to do that tweak.
20 And so, I fear that that one will be lost in this
21 process as well.

22 And it's an important one because

1 we've interacted with Medicaid states and it's
2 about the chronic care follow-up -- well, the
3 current ADHD measure in the Core Set requires a
4 DEA number and you may or may not know that
5 Federally Qualified Health Centers when they
6 prescribe don't use a DEA number because they
7 consider the children to be covered by the entire
8 Center. So all of the FQHC patients fall out of
9 that measure and the state, particularly in the
10 state of Illinois, they've been very frustrated
11 with that and have really asked for an ADHD
12 measure that they can use because it's a very
13 prevalent problem. And we have -- it needed a
14 tweak.

15 DR. MANGIONE-SMITH: Hello, this is
16 Rita Mangione-Smith. Just wondering if I could
17 make a comment?

18 MS. GORHAM: Yes.

19 DR. MANGIONE-SMITH: Thank you. So, my
20 name is Rita Mangione-Smith. I am the principal
21 investigator for the Center of Excellence located
22 at Seattle Children's Research Institute, part of

1 the PQMP. And I just want to put a charge to the
2 Committee moving forward in your work, and I
3 don't envy your job, I think this is very
4 difficult work. I know care coordination has
5 been a gap area on your list for years and my
6 fear is that it's going to continue to be a gap.

7 Having spent the last five years
8 really diving into this topic area, developing
9 rigorous quality measures around it through our
10 FUCC Measure Set, having eight of those measures
11 endorsed by NQF in this last round for measure
12 calls, the resistance to survey measures is going
13 to make this area of measurement remain
14 problematic and a gap. Much of what the evidence
15 supports in the realm of care coordination,
16 successful transitions for adolescents, as we see
17 in the ADAPT Measure, really depends on talking
18 to families. It's the only way we can tell
19 whether the things that the evidence show us will
20 help with care coordination and help with
21 outcomes actually happened.

22 So, I hope that moving forward, there

1 was mention of paper surveys are beating the
2 tiger with a club, I really loved that analogy,
3 and I'm hoping moving forward we can really start
4 to think out of the box about collecting survey
5 measures using smartphones, using other
6 technologies that are now available so that these
7 measures don't remain in a space where they can't
8 be used. Because I really believe that's the
9 only way we're ever going to learn about the
10 quality of care coordination that children with
11 special healthcare needs are receiving. Thank
12 you for the chance to comment.

13 CHAIR GESTEN: Thank you very much.

14 Other comments on the phone? So, we'll go to the
15 room in a second, but I just --

16 DR. KLEINMAN: It's Larry. Can I make
17 one more comment?

18 CHAIR GESTEN: Yes, go ahead.

19 DR. KLEINMAN: Thank you, Foster. I
20 want to comment on the notion of harmonization.
21 I struggle with this, because I appreciate the
22 feasibility. But I looked up actually the word

1 harmony and it related to multiple sounds that
2 together create something greater than any of
3 them alone. And I think we need to remember that
4 when we think about harmonization. It's not
5 homogenization, it's not the same measures,
6 because somebody commented yesterday that the
7 adult and pediatric follow-up after mental health
8 measure was harmonized because it was the same
9 measure, but it wasn't optimized for children and
10 it's not optimal for children, as someone who has
11 spent two and a half years working on that
12 specifically.

13 And so, I think that it also relates
14 to the same kind of assumptions that we make that
15 Rita was talking about, about survey measures
16 hard, therefore probably shouldn't do, don't rise
17 to the level. I think we need to figure out how
18 to bring better critical thinking to understand
19 what the marginal value of differences are, the
20 marginal value of extra effort to create work,
21 and how we can do those things efficiently, but
22 also effectively. Thank you.

1 CHAIR GESTEN: So, I just want to thank
2 Larry and Donna and Rita for your very thoughtful
3 comments and input. And also just make one
4 observation, which is that I think that those are
5 good comments and things for us to think about
6 going forward, both the staff and the Task Force
7 and the MAP, and I think that we credit the
8 tremendous reservoir of measures that have
9 generated out of this program, and at least for
10 me, I don't see this as a one time, one
11 opportunity to consider them. I view many of
12 these measures and these conversations as
13 something that's going to continue.

14 And so, there's no question that, as
15 a result of the work that all of you are involved
16 in and engaged in, our ability to look at and
17 have measures to pick from to look at gap areas
18 or improve areas has made a huge difference over
19 the past two to three years and I think it will
20 continue to do that. So, I want to recognize how
21 important that's been and recognize that there
22 are measures that are making their way into the

1 set from that great work. But, Marsha, let me
2 just, if you have a comment?

3 DR. LILLIE-BLANTON: I feel like you've
4 already said pretty much what I wanted to say and
5 that is, the Pediatric Quality Measures Program
6 has really helped us to advance the science. And
7 we are still evolving. I mean, we are evolving
8 because we are learning from the researchers and
9 the scientists and the clinicians in the field,
10 but we're also evolving because as a quality
11 measurement and reporting program, we're still
12 pretty much, we're a little beyond our infancy,
13 but we're not far beyond that. And so, we value
14 the work you've done.

15 We continue to look for you because as
16 I said, you are advancing the science and I would
17 think as we move forward, more of the measures
18 that have been developed will be considered as
19 thoughtfully as they have, if not even more
20 thoughtfully. So, we just want to thank you for
21 being a part of this evolving team and look
22 forward to continuing to work with you so that we

1 can do a better job at measuring and, in course,
2 improving performance of children, both in
3 Medicaid and in the nation overall.

4 CHAIR GESTEN: Thank you, Marsha.
5 Charles, did you want to, before I go to the
6 room, did you want to make a comment?

7 DR. GALLIA: And I'll make it brief.
8 And just one time. So I'm going to make a couple
9 recommendations. One is that you consider
10 instead of just on or off in the set and reframe
11 your voting to say that this one we could defer
12 for future consideration, make a notation of
13 that, that way you could have it marked and move
14 forward instead of just having it set aside.
15 Almost like a motion to defer it for future
16 consideration, in addition to the options that
17 you've presented.

18 That gives some future direction to
19 any information to subsequent groups. So, like,
20 On-Deck, so this is emerging, we think it should
21 continue. We did this with some of the measures
22 in the beginning, and this one is moving out

1 potentially, so it's on the edge, we think this
2 might be retired at some point. So consider
3 reframing how you're characterizing the measures.

4 The other is that go back to the
5 charge of the Core Set, the characteristics of
6 the Core Set included components related to
7 children with special healthcare needs, race and
8 ethnicity, and a number of other areas. And
9 while these topically cover them in many ways,
10 they really don't specifically address those
11 disparities and I think that's important to
12 identify those explicitly as a gap area.

13 And then finally, I think that the
14 patient's experience of care component, the one
15 that's caps, it's such a rich source of
16 information, but the shortcoming is that it's not
17 at a practice level, it's a state health plan
18 level. So something needs to be done to
19 translate back to primary care specifically and
20 make it actionable. It's a big area of concern
21 that I have and there's nothing in there that
22 gives a state the impetus to go beyond that

1 health plan level. So, that's my last comments.

2 CHAIR GESTEN: Thank you. I just want
3 to make sure I understand one of your
4 recommendations. It sounds like it's a --
5 instead of saying no, it's kind of like this is
6 promising if x, y, or z happened, as a
7 communication to the measure developer. Is that
8 what you meant?

9 DR. GALLIA: Yes. So, if it's --

10 CHAIR GESTEN: And is there --

11 DR. GALLIA: -- a work in progress --

12 CHAIR GESTEN: Hang on a second. Is
13 there such a -- it's ringing some bell that there
14 used to be, that the MAP has some category of
15 sort of not yet ready, but promising, or
16 something like that, and I can't remember. Does
17 that category still --

18 MS. MUNTHALI: It's continued
19 development.

20 CHAIR GESTEN: Continued development or
21 --

22 MS. MUNTHALI: Yes.

1 CHAIR GESTEN: -- something like that?

2 And so there are other context at NQF and other
3 forums in which that category or that message, if
4 you will, which is a little more positive or
5 perhaps could create some gray is communicated to
6 the developers. So I think that's an interesting
7 suggestion. Terry?

8 MEMBER ADIRIM: Yes. Just two brief
9 comments. The first one is, I mean, my heart is
10 bleeding for the measure developers and all the
11 hard work that went into developing the 79
12 measures, I think it was 79 measures, and
13 obviously we know the issue with how many we
14 could have in this particular Core Set. But my
15 understanding of the program is not only to move
16 the science along, but to create measures that
17 are appropriate for children, not just for this
18 Core Set, but population health is a growing
19 field.

20 So these measures are so important to
21 places and people, health plans, and so on, that
22 are doing population health. And I'm sure there

1 are states that are, as had been mentioned by our
2 state colleagues, that are creating dashboards
3 that would need these measures. So I don't know
4 if there is some kind of forum or place for the
5 measure developers to present their measures so
6 that they're being used and taken up. So that's
7 one.

8 The second comment that I was going to
9 make is, I agree with Rita, care coordination is
10 a huge issue. And I would have liked to see more
11 of those measures that we considered, but I
12 understand the issues for states in their
13 reporting of them. So I was just wondering if
14 CMS had any thoughts about providing some
15 resources to testing ways to, in a limited way,
16 testing innovative methods for surveying, for
17 example, adolescents or that kind of thing so
18 that we can try and move the actual how we get
19 that information so that the measure is a better
20 measure for state Medicaid programs?

21 DR. MATSUOKA: I think, I mean, I think
22 we're very interested in exploring different

1 options.

2 CHAIR GESTEN: Let me just say, because
3 I failed to do it, because Bo asked me before he
4 was leaving to make the point that on the
5 Adolescent Transition Care Measure, I'm terrible
6 with remembering the titles or names -- what?
7 ADAPT measure, that it sort of falls under, I
8 think, the category that Charles was mentioning,
9 which was, want to send a signal that this was a
10 really important area and a great sort of start,
11 but concerns about the methodologic and
12 implementation issues, but very much wanted a
13 means to send a signal to the developer or to the
14 field that this is really worthy to pursue and to
15 try to deal head-on with some of the
16 implementation issues. But I don't know, Kamila,
17 did you want to -- I thought Terry's comments
18 were important about this forum is not the only
19 utility for measures that are developed for
20 pediatric health. Did you want to add anything
21 or respond to that?

22 DR. MISTRY: No. I mean, I think we do

1 know that more broadly. I think this was one of
2 the main reasons and the main issue around the
3 legislation. So this was a main target point.
4 But I think that measure developers know more
5 broadly. I mean, I can use Mark Schuster's group
6 as an example, where they're thinking about
7 things more broadly. They're working with
8 vendors, they're trying to figure out how to get
9 these measures used more broadly. I know Rita
10 also and Larry, a lot of the folks have. So I
11 know that they themselves, there's limited time,
12 resources to be doing that, but I think we'll
13 also, as a program, think through how we can
14 think about this for private uses and for other
15 public uses as well. So, thank you.

16 The other thing is, I think that gray
17 area that Charles brought up I think is very
18 important to the work that we do, because I think
19 we very often with a limited resource set, we
20 need to prioritize things. And so that's just
21 another tool or another way for us to think about
22 how to signal to, for instance, the Q-Metric team

1 learned today that the antibiotic, to prioritize
2 that. And so, all these things kind of help to
3 signal what goes first, second, or third. It's
4 not to say that many of those measures aren't
5 important, but it just allows us to be a little
6 bit more pointed in the way that we do our work.

7 CHAIR GESTEN: Great. Thank you.

8 DR. MISTRY: Thank you.

9 CHAIR GESTEN: Didn't mean to
10 shortchange the room, was there anyone in the
11 room that wants to make public comment? Seeing
12 nothing, so we just have a couple of, amazingly
13 we are actually kind of on time, never seems like
14 we will get there, but we want to just report on
15 the prioritization. It looks like, in terms of
16 the -- oops, that's what I'm looking at. So, the
17 sticky dot war, we have a tie of the exclusive
18 breast milk feeding, both those measures, which
19 were counted together, as well as the
20 transcranial Doppler ultrasonography screening
21 among children with sickle cell, at the top of
22 the list. And then rank order second was the use

1 of first line psycho-social care for children and
2 adolescents on antipsychotics. And then third
3 was the contraceptive care for postpartum women.

4 So, we have a timeline and some next
5 steps. Maybe there's a slide, I'm guessing there
6 is. Oh, wait, do you want to just go back to
7 what we removed? We removed from the Core Set
8 Measure 1391, frequency of ongoing prenatal care,
9 we did that yesterday. And then today we removed
10 the measure of Child and Adolescent Access to
11 Primary Care Practitioners. So, we did that.
12 Next steps.

13 So, the dates, July 6 to August 5 will
14 be a 30 day public comment period on draft
15 reports and recommendations. The process point
16 is that the MAP Coordinating Committee will
17 review draft reports and may have comments or
18 suggestions or changes or whatever that happens
19 as a result of that. And then, by August 31,
20 which means vacations don't happen probably the
21 last week of August for NQF staff, final reports
22 are due to HHS and made available to the public.

1 And then during that fall-ish time, fall/early
2 winter, I think you guys do seasonal time frames
3 just like we do with the state, CMS makes a
4 determination about what to do with the
5 recommendations and makes that public to the
6 world, right? Do I have that right?

7 So, let me just ask something I should
8 know, which is, when people, either the public --
9 so the public comment period is this, if Task
10 Force members have comments or things that they
11 didn't mention or think of after the meeting,
12 they're allowed to contact you guys, right?

13 MS. GORHAM: Yes. So, the Task Force
14 members can definitely contact us. We will
15 respond to your emails and consider or include
16 your input as we write the draft report. But
17 Task Force members are also, if you have comments
18 to the draft report once it is online, then you
19 can definitely make comments online as well.

20 CHAIR GESTEN: And we will also take
21 process comments, like ways to make this better,
22 clearer, faster, more productive, more efficient,

1 whatever. We're open to those comments as well.
2 So I think, are we -- I want to thank my
3 extemporaneous co-chair, Carol, who we drafted
4 last minute to deal with all those recusals and
5 facilitate. Thank you so much for stepping in to
6 do that. And thanks staff, once again, and thank
7 you all for participating and have safe journeys
8 home. Anything else?

9 MS. GORHAM: I just want to echo what
10 Foster said. I definitely thank Foster, he is
11 always responsive and works very well with us. I
12 mean, we appreciate you very much. And Carol was
13 wonderful, I sent her an email probably like 8:30
14 last night and she was like, oh, sure, I can do
15 that. So, I just want to thank all of the Task
16 Force members just for your support and also your
17 input and your hard work. You definitely did a
18 wonderful job. You reviewed all of the
19 information we sent you, so we just want to
20 definitely thank you. As well as the staff, we
21 had Alexandria and Donna help us and fill in with
22 voting, so we definitely thank everyone.

1 CHAIR GESTEN: Bye, everyone. Bye,
2 folks on the phone.

3 (Whereupon, the above-entitled matter
4 went off the record at 3:47 p.m.)
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This is to certify that the foregoing transcript

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Medicaid Child Task Force

Before: NQF

Date: 05-26-16

Place: Washington, DC

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