

NATIONAL QUALITY FORUM

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IN-PERSON MEETING
MAP MEDICAID CHILD TASK FORCE

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TUESDAY
JUNE 9, 2015

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

PRESENT:

FOSTER GESTEN, MD, FACP, Chair

TERRY ADIRIM, MD, MPH, FAAP, American Academy of
Pediatrics

ANDREA BENIN, MD, Children's Hospital Association

LUTHER CLARK, MD

ANNE COHEN, MPH

JEFF CONVISSAR, MD, Kaiser Permanente

DENISE CUNILL, MD, FAAP, America's Essential
Hospitals

CAROLE FLAMM, MD, MPH, Blue Cross and Blue Shield
Association

ASHLEY HIRAI, PhD, Health Resources and Services
Administration

SUSAN LACEY, RN, PhD, FAAN, American Nurses
Association

KEVIN LARSEN, Office of the National Coordinator
for Health IT

MARC LEIB, MD, JD

MARSHA LILLIE-BLANTON, DrPH, CMS

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

ALVIA SIDDIQI, MD, FFAFP, American Academy of
Family Physicians

SANDRA WHITE, MD, MBA, Aetna

NQF STAFF:

MARCIA WILSON, PhD, MBA, Senior Vice President,
Quality Measurement
NADINE ALLEN, Project Manager
SEVERA CHAVEZ, Project Analyst
SHACONNA GORHAM, Senior Project Manager
SARAH LASH, Senior Director

ALSO PRESENT:

SANDRA BLAKE, PhD, University of Louisiana at
Monroe *
SEPHEEN BYRON, MHS, NCQA
WOODY EISENBERG, MD, Pharmacy Quality Alliance
REBEKAH GEE, MD, MPH, MS, Medical Director,
Louisiana Medicaid
LAWRENCE KLEINMAN, MD, The Mount Sinai Hospital *
EDDY MYERS, University of Louisiana at Monroe *
JEFF SCHIFF, Medical Director, Minnesota Health
Care Programs *
MARK SCHUSTER, MD, PhD, Boston Children's
Hospital*
SALLY TURBYVILLE, Children's Hospital Association

* present by teleconference

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

2 (9:03 a.m.)

3 MS. LASH: Good morning, everyone, and
4 welcome. This is the Measure Applications
5 Partnership meeting of the Medicaid Child Task
6 Force. Tomorrow we will be joined by the
7 Medicaid Adult Task Force, and then a few of you
8 all get a chance to go home. The Adult Task Force
9 will continue their deliberations for a third
10 day.

11 I am Sarah Lash, and I have the
12 pleasure of standing in temporarily for our
13 chair, Dr. Foster Gesten, who woke up very early
14 this morning to find out that his flight had been
15 canceled. He is on a train from Albany,
16 connecting through to New York City, and due to
17 arrive at NQF about 1:30 this afternoon.

18 We spoke this morning. He is going to
19 set up in the café car, try to stream the meeting
20 as best he can to follow the conversation. He
21 might be able to pipe in periodically, but for
22 ease of facilitation, you have the NQF staff to

1 step in and lead you through this morning's
2 deliberations, at least. A lot of the important
3 decision making about considering measures that
4 MAP might want to support for addition to the
5 child core set comes this afternoon. Hopefully
6 Foster will be here by that point in the meeting.
7 We just want to be somewhat apologetic and very
8 transparent that this is unusual. Normally, we
9 really do try to be neutral in NQF's role in
10 meeting facilitation and have chairpersons for
11 exactly this reason. Actually, wanted to offer
12 the opportunity for anyone to ask any questions
13 or make any comments about the change in plans.

14 (No audible response.)

15 MS. LASH: Hearing no objections,
16 we'll just assume everyone's pretty comfortable
17 with that approach, and you can bear with us if
18 we're just a little bit discombobulated this
19 morning. I first want to introduce our senior
20 vice president, Marcia Wilson, to offer some
21 welcoming remarks on behalf of NQF, and then
22 we'll have Dr. Marsha Lillie-Blanton add any

1 additional thoughts from CMS.

2 WELCOME, INTRODUCTIONS, AND REVIEW OF MEETING

3 OBJECTIVES

4 DR. WILSON: Thanks so much, Sarah,
5 and thank you all for your forbearance in us
6 temporarily re-arranging who's leading this
7 meeting for this morning. I leave you in very
8 capable hands, of course, with Sarah, who will be
9 taking over for Foster until he arrives. I just
10 wanted to say thank you for joining us today.
11 The one thing about NQF that never fails to
12 impress me is the caliber of people who come
13 forward for the Major Applications Partnership
14 work, or also our measure endorsement work.

15 We know you do this as volunteers, but
16 the brain power that collectively ends up in the
17 room is pretty amazing, so I'd like to thank you
18 in advance for spending this time with us, and
19 we're really looking forward to this discussion.
20 Marsha?

21 MS. LILLIE-BLANTON: Thank you. I
22 just also want to echo those remarks. I want to

1 thank all of you for joining us. I especially
2 want to thank the National Quality Forum for
3 convening this body and of course wanted to thank
4 our co-chair, Foster Gesten, in his absence,
5 because without the work of either NQF or the co-
6 chairs, I think we would not be where we are
7 today. I especially want to thank all of you
8 because we have made, I think, incredible
9 progress at CMS in developing a quality
10 measurement and reporting program that provides
11 our stakeholders, both at the federal and the
12 state level, and other stakeholders, with
13 standardized quality measures to help us gauge
14 where we are and to help us better identify where
15 we need to improve.

16 We could not have gotten to where we
17 are now without your efforts. We rely on our
18 partners in the clinical community, in the
19 measurement community, in the academic community,
20 and our other federal partners in helping us to
21 chart a course forward. I have to say our
22 technical assistance and analytic support

1 contractor, Mathematica, is here today. They are
2 also key to this process. So I want to thank all
3 of you for joining with us and helping us get to
4 where we are today.

5 I want to also just mention that a
6 three-day meeting is a lot, so I know that it is
7 a big chunk of your time, for those of you who
8 will stay here either two days, or those of you
9 who will be here for three days. This is not a
10 sprint. We definitely view this as a marathon.
11 This is a leg of our work, but this three-day
12 meeting helps us to do something that we have
13 talked about a long time and that is, how do we
14 better coordinate across the core sets? We find,
15 at previous meetings, that there's been some
16 discussion about, "Why aren't you collecting this
17 measure for adults?" or conversely, when you're
18 looking at the adult core set, "Why aren't you
19 collecting this measure for children?"

20 This meeting, with the day in between,
21 helps us to better link the two and have a broad
22 overview of what we consider the child and adult

1 core sets to help us understand performance. I
2 want to say thank you to all of you who are
3 taking the time to either spend the two days or
4 the three days with us and understand that that
5 helps us to move along the pathway of something
6 we think it's important for us to do. With that,
7 I'll turn it back over to Sarah.

8 MS. LASH: Thank you so much, Marsha.
9 We're very grateful for CMS's support of this
10 work and asking us all to be here today to work
11 in partnership with you. I'll do a few
12 housekeeping announcements now, and then we'll
13 move on to some introductions of our participants
14 today. There is Wi-Fi available in the room.
15 The login and password have been flashing on the
16 screen. There's a handout, as well. I guess,
17 why don't I say it out loud for the benefit of
18 everyone? The login is guest, lowercase, and the
19 password is NQF in capital letters and guest in
20 lowercase. Everyone will be asked to use their
21 microphone when participating in today's meeting.

22 This is important for two reasons.

1 First, we have a transcriptionist in the corner
2 taking careful record of today's conversation.
3 Second, we have a number of participants who are
4 listening to this remotely, including our chair.
5 They will not be able to follow the conversation
6 if it's not broadcast through the microphone.
7 It's push to talk. If the light is red, somewhat
8 counterintuitively, that means you're live.

9 If it is flashing green, that means
10 that too many other people in the room have their
11 microphone on. Only three can be turned on at a
12 time, so we will wave at the person who has left
13 theirs on and operate that way. Should you wish
14 to make a comment or ask a question during
15 discussion, the easiest way to signal to myself
16 or Foster that you'd like to do so is to take
17 your tent card and prop it up on its side, like
18 this. That helps us keep track of who has
19 something to say and the order in which they put
20 themselves in the queue. For members of the
21 public who are joining us in the room, welcome.
22 Please help yourself to beverages. The food is

1 for the benefit of the task force members, but
2 we'd be happy to direct you to a local restaurant
3 for lunch at the time we get to that part of the
4 day.

5 We will also be stopping at multiple
6 points throughout today's conversation to take
7 comments from the public as part of the
8 committee's deliberations. I do encourage the
9 task force members to stop us at any time and ask
10 questions, to really speak honestly and
11 informally with one another, so that we can have
12 a very authentic dialogue. We have, I think,
13 plenty of time on today's agenda to accomplish
14 what we need to.

15 There's no reason to rush through any
16 deliberations. Want this to be a very
17 purposeful, consensus building process. We have
18 a brief pause for some disclosures of interest
19 and general introductions of the task force
20 members. Most of you completed your disclosure
21 of interest on the web meeting that was held
22 several weeks ago to introduce and kick off this

1 work, but we do need to revisit that for a
2 handful of committee members who did not complete
3 their disclosure at the time. Sandra White and
4 Marc Leib, specifically looking at you. I don't
5 think Cyndi Pellegrini's in the room yet. Give
6 me just a second to run through this, per our
7 general counsel's advice, and we'll quickly move
8 on.

9 There are three types of MAP members.
10 Most of you are organizational members, which
11 means that you are representing the interest of
12 that organization. We expect you to come to the
13 MAP table representing those interests, and
14 that's why you have been selected to participate.
15 In light of that, that there is interest, we ask
16 a very limited question, for purposes of
17 disclosure.

18 That is we ask you to disclose if you
19 have a personal financial interest of \$10,000 or
20 more in an entity that is related to the work of
21 this committee? You can tell us who you
22 represent and if you have anything to disclose.

1 Sandra?

2 DR. WHITE: I have nothing to
3 disclose.

4 MS. LASH: Thank you. Is there anyone
5 on the phone, perhaps Cyndi is joining us
6 remotely this morning, who's an organizational
7 member that needs to -- thank you so much for
8 that. We'll come back to Cyndi tomorrow. Now
9 we'll move on to disclosure for our subject
10 matter experts who have not yet disclosed?

11 Our subject matter experts sit as
12 individuals. There was a more detailed form to
13 understand all of your professional activities.
14 We don't need you to review your whole resume for
15 us, but we are interested in hearing about
16 activities related to the subject matter of the
17 committee's work, specifically grants,
18 consulting, or paid speaking arrangements that
19 are relevant to the committee's work.

20 So you are sitting on this group as an
21 individual. You are not representing the
22 interest of your employer or anyone who may have

1 nominated you for the committee. We are only
2 interested in your disclosures of activities that
3 are paid. For example, if you volunteered for a
4 committee like this one, that is relevant -- you
5 may have participated as a volunteer on a
6 committee where the work is relevant to the work
7 of this task force. We would look for you to
8 disclose that type of activity, as well. Just
9 because you disclose does not mean you have a
10 conflict of interest. We do these oral
11 disclosures in the interest of openness and
12 transparency. Dr. Leib, if you could tell us
13 your name, again, who you're with, and if you
14 have anything to disclose?

15 DR. LEIB: I'm Marc Leib --

16 MS. LASH: Your microphone.

17 DR. LEIB: Sorry, Marc Leib. I'm here
18 as an individual, subject matter expert. I
19 occasionally participate in discussions with the
20 American Society of Anesthesiologists for
21 physician quality measures, particularly
22 anesthesia measures, but none of those overlap

1 anything to do with Medicaid, adult or child
2 measures.

3 MS. LASH: Thank you very much. In
4 general, I'd like to remind all of you that if
5 you believe you might have a conflict of interest
6 at any time during the meeting, please speak up.
7 You can do so in real time. You can approach the
8 chair, once he gets here, or any member of the
9 NQF staff. If you believe that a fellow
10 committee member is acting in a biased manner or
11 has a conflict of interest, you may point this
12 out in a similar fashion. We certainly don't
13 want anyone to sit in silence if you believe
14 there are any irregularities due to conflict of
15 interest.

16 We will now go around the room, in a
17 circle, and you can say your name and who you're
18 representing today as a way to break the ice and
19 all start the process of getting to know one
20 another. I'll ask Sandra to kick us off again.

21 DR. WHITE: Good morning. My name is
22 Sandra White, Dr. Sandra White. I work for Aetna

1 as the executive director of healthcare quality.
2 I'm an internist and rheumatologist by training,
3 and I've been in managed care for a number of
4 years. I currently lead the healthcare quality
5 efforts for our national Medicaid plans.

6 MS. SAKALA: Good morning. My name is
7 Carol Sakala. I am with the National Partnership
8 for Women and Families, and I'm the director of
9 Childbirth Connection programs there.

10 DR. CONVISSAR: Hi, everyone. I'm
11 Jeff Convissar from Kaiser Permanente. I'm
12 medical director at our Care Management
13 Institute. Nice to be here.

14 DR. LEIB: Marc Leib. I am recently
15 retired from the Arizona Medicaid program. I
16 spent ten years as their Chief Medical Officer --
17 ten years and one month, and recently retired and
18 am just doing some independent work now.

19 DR. SIDDIQI: Hi, I'm Alvia Siddiqi.
20 I'm representing the American Academy of Family
21 Physicians. I serve on their Commission on
22 Quality and Practice. In my day job, I'm the

1 medical director for Illinois Health Connect,
2 which is the PCCM fee-for-service, essentially,
3 program, with some managed care elements for the
4 State of Illinois. Thank you.

5 DR. CUNILL: Good morning. I'm Denise
6 Cunill. I'm representing America's Essential
7 Hospitals. I'm a pediatrician, associate medical
8 director of M3 Pediatrics of the Cook County
9 Health and Hospital Systems. Thank you.

10 DR. ADIRIM: Hi, I'm Terry Adirim.
11 I'm here representing the American Academy of
12 Pediatrics, who are representing children and
13 pediatricians. I am on the executive committee
14 of their Council on Quality Improvement and
15 Patient Safety, and I am a pediatric emergency
16 physician, working at St. Christopher's Hospital
17 for Children. Thank you.

18 DR. LARSEN: I'm Kevin Larsen, the
19 Medical Director of Meaningful Use at the Office
20 of the National Coordinator for Health IT.
21 There, I'm responsible for the quality portfolio
22 for the coordination of the quality measures for

1 EHR systems and working very closely with CMS,
2 both on the Medicare and Medicaid side. I'm an
3 internist by training. Before I was at ONC, I
4 was chief medical information officer of a county
5 hospital system in Minnesota, where I also had a
6 research portfolio studying care outcomes of
7 Medicaid patients.

8 MS. DOUGHERTY: I'm Denise Dougherty
9 from the Agency for Healthcare Research and
10 Quality in the U.S. Department of Health and
11 Human Services. Since 2011, I've been the team
12 lead for the seven Centers of Excellent, the ARC,
13 CMS, CHIPRA, PQMP, Centers of Excellence who are,
14 or have been, developing, testing and submitting
15 measures to Arc and to CMS. Prior to that, I was
16 involved early on in the identification of the
17 initial child core set.

18 MS. HIRAI: Hi, I'm Ashley Hirai. I'm
19 with the Maternal and Child Health Bureau of the
20 Health Resources and Services Administration,
21 also part of Health and Human Services more
22 broadly. I'm a health scientist, and I'm excited

1 to be here to help foster alignment with a lot of
2 these measures across initiatives, and Medicaid
3 is a key partner to us for our Title V Block
4 Grant.

5 We just recently had a performance
6 measurement overhaul and transformation, and also
7 our Collaborative Opportunity Improvement and
8 Innovation Network to Reduce Infant Mortality,
9 which engages states around collaborative
10 learning and quality improvement to advance
11 outcomes through shared measures and tracking
12 progress on a real-time data dashboard, so
13 excited to be here and help foster that
14 alignment. Thanks.

15 DR. LACEY: Hi, I'm Susan Lacey. I am
16 representing, today, the American Nurses
17 Association. My background is measurement
18 development and testing for pediatric nursing
19 quality indicators with NDNQI. My day job is
20 over a large graduate program in south
21 Mississippi and faculty development.

22 DR. FLAMM: Hi, my name is Carole

1 Flamm. I'm here representing the Blue Cross Blue
2 Shield Association. I'm a physician in our
3 Office of Clinical Affairs. I'm the executive
4 medical director for the Center of Clinical
5 Value. I lead several national programs,
6 particularly focusing on collaborating with the
7 Blue plans and provider organizations to measure,
8 recognize and improve quality and value involved
9 in measurement, and very happy to be here today.

10 MS. COHEN: Hi, I'm Anne Cohen, and
11 I'm serving as your disability subject matter
12 expert on this MAP, and I'm also a member of the
13 Duals MAP. I have been involved in developing
14 disability programs for Medicaid health plans, as
15 well as a consultant, developed CAHPS and HEDIS-
16 like measures targeted to people with
17 disabilities via state governments and developing
18 tracking programs, including the State of
19 California and the Duals program. I work for the
20 Consumer Advocate Group, so I've done a little
21 bit of everything.

22 DR. BENIN: Hi, I'm Andrea Benin. I

1 am a pediatric infectious disease doctor, and I'm
2 the senior vice president for Quality and Patient
3 Safety at Connecticut Children's Medical Center
4 in Hartford. I am representing the Children's
5 Hospital Association.

6 MS. LILLIE-BLANTON: I'll tell you a
7 little bit about myself. I'm Marsha Lillie-
8 Blanton, and I am the chief quality officer for
9 Medicaid and CHIP, and I also direct the Division
10 of Quality Evaluation and Health Outcomes. We
11 organize the work in the division in three big,
12 broad buckets. One is quality in Medicaid
13 managed care.

14 We then have general responsibility
15 for performance measurement and improvement which
16 is largely, as you know, funded and supported
17 through both CHIPRA and the Affordable Care Act.
18 Then we have a number of improvement initiatives,
19 one on maternal and infant health, another one on
20 oral health.

21 We have a number of other newer ones
22 that we're starting on psychotropic drug use, as

1 one area, and one to try and improve our
2 reporting on developmental screening among young
3 children. So there are a number of smaller
4 efforts we have underway, but those are things
5 that we kind of identify as we see our need and
6 we have staff resources to do that. In terms of
7 my background, I've worked in academia both at
8 Hopkins and on the faculty of Hopkins and GW,
9 spent most of my time at the Kaiser Family
10 Foundation, about 13 years. Then I've also
11 worked in government prior to this at GAL for
12 about four years.

13 MS. GORHAM: Good morning. My name is
14 Shaconna Gorham, and I'm the senior project
15 manager for the two task forces, for the child
16 and adult task force. I have been with NQF now
17 for a whopping five months, and so far, I have
18 really enjoyed my time. Before coming here, I
19 was at Kennedy Krieger in Baltimore, working at
20 the Developmental Disabilities Administration
21 providing quality assurance for their projects.

22 MS. ALLEN: Good morning. I'm Nadine

1 Allen. I'm the project manager for this project
2 and Surgery Phase 2. Prior to this project, I've
3 worked on home and community-based services,
4 multiple chronic conditions, person and family
5 centered care, and I was also the project analyst
6 for the Child Medicaid project.

7 MS. LASH: Thank you. The final
8 member of our team is Severa Chavez, who doesn't
9 have a microphone, but is ably assisting us from
10 just outside the perimeter of the table. Thank,
11 Severa. As a final note on introductions, the
12 subject matter experts, the organizational
13 members and the chair are the voting members of
14 the MAP task force. The federal government
15 members and our state panelists, who will be
16 joining us later, won't be participating in any
17 specific voting, but we absolutely invite all of
18 you to engage in the discussion openly.

19 Today's objectives. First on this
20 list, but not first in time in which we will
21 accomplish these objectives, but very important
22 to grounding the conversation is to consider the

1 experiences of states in implementing the
2 Medicaid child core set. We have some aggregated
3 data that was reported to CMS regarding measures
4 that we'll be summarizing for you.

5 We'll also be hearing directly from
6 Minnesota and Louisiana representatives within
7 the meeting. Over the course of the late morning
8 and afternoon and into tomorrow, the group will
9 also be developing concrete, specific, actionable
10 recommendations for how MAP would suggest that
11 CMS continue to strengthen the Medicaid child
12 core set. The main mechanisms through which
13 you'll do that are to give voice to important
14 measure gaps that you perceive in the measure
15 set. We'll be specifically reviewing a number of
16 measures that are available and could address
17 gaps that have already been identified. We will
18 also take a look at the measures currently
19 reported to see if we find any of them to be
20 ineffective and potentially counter-productive,
21 and we might recommend that any of those such
22 measures be removed.

1 It would create additional capacity
2 for new measures to come in, as we would usher
3 others out. Then primarily tomorrow, the group
4 will formulate strategic items to CMS about
5 strengthening the measure set over time to meet
6 program goals. One of these areas of discussion
7 will be the relationship between the child core
8 set program and the adult core set program.

9 This task force charge will sound
10 familiar, as well. We went over both of these on
11 the web meeting. Essentially, your charge is to
12 review states' experiences, reporting measures,
13 refine previously identified gap areas, recommend
14 potential measures for addition, and then, again,
15 recommend measures for removal that are found to
16 be ineffective. This group is comprised of
17 current MAP members from across the coordinating
18 committee and standing work groups who have
19 relevant interest and expertise. You have a few
20 items at your place to assist you with that
21 charge. I just want to explain what some of that
22 paper is that we've put in front of you this

1 morning.

2 First, there is a list of measures in
3 the child core set. It's sort of a quick cheat
4 sheet. It looks like this. It lets you know the
5 NQF number, if the measure is endorsed, who the
6 developer or steward is, the name of the measure,
7 and essentially the condition category that CMS
8 has identified for each measure.

9 There's also a link-breaking table,
10 looks more like this, full of Xs. This shows the
11 MAP members, state by state, who reported which
12 individual measure at the end of federal fiscal
13 year 2014. There's a nice total column across
14 the top, as well, that will show you the volume
15 of the states reporting each measure. This
16 particular piece of information is for your eyes
17 only. It should not be distributed outside of
18 the MAP meeting today. I think you also have a
19 copy of the MAP measures selection criteria as a
20 reference. This is essentially the rubric that
21 the committee will use to guide its decision-
22 making. Nadine will be reviewing it in some

1 detail with you in just a few minutes. Any
2 questions or anyone needing further orientation
3 to the meeting materials?

4 DR. LARSEN: This is Kevin, and this
5 might be a question for Marsha. I don't know. I
6 know that a lot of our deliberation will be
7 around the core set. The meaningful use program
8 also contains measures of children that states
9 can get data on for under Medicaid. Can you talk
10 about the relationship between that reporting
11 program and the core set program?

12 MS. LILLIE-BLANTON: Unfortunately, I
13 probably can't say much, but what I can say is
14 that we have tried to align, as best we could.
15 We have measures in our core set that are also a
16 part of the meaningful use core set. We think
17 that there is an incentive for providers --
18 because there's a financial incentive for the
19 meaningful use; whereas, there's no other
20 financial incentive for reporting for our core
21 set. So it's in our interest to align with the
22 meaningful use core set. In terms of collection

1 of the data, to my knowledge, we are not
2 collecting -- we, meaning CMS does not have a
3 portal by which we receive the data that comes
4 from providers on the meaningful use measures.
5 That is something that we think is important
6 moving forward, but we've not worked out the
7 mechanics of how that happens. My understanding
8 is that states have created data repositories
9 where that information is being stored, but it's
10 not being channeled, at this point, to CMS.

11 DR. LARSEN: Thanks. I was just
12 looking for the scope of this committee. We're
13 really only thinking about the core set, it
14 sounds like to me. Is that correct?

15 MS. LILLIE-BLANTON: I would say that
16 has been our charge in the past, but going
17 forward, I do think that's something for us to
18 consider.

19 MS. LASH: There's a planned
20 discussion of alignment across programs tomorrow
21 morning, Kevin. I think that is absolutely the
22 right place to begin to unpack some of this with

1 the committee. Alvia?

2 DR. SIDDIQI: Just a quick question.
3 What are the total number of measures that
4 could've been reported, so when we're looking at
5 this graph of how many states have reported --

6 MS. LASH: I believe it's 24.

7 DR. SIDDIQI: Okay, thank you.

8 MS. LASH: As we get started today,
9 you will see items on the agenda that reflect the
10 discussion of the group at the web meeting. We
11 heard from you that you want to base MAP's
12 decision-making on a true understanding of how
13 states are using measures, the real-world
14 challenges that they're experiencing, and to get
15 clarity on the factors that influence their
16 ability and willingness to report on an annual
17 basis.

18 We're also encouraged to look for
19 potential measures to fill gaps that are the
20 result of the Arc CMS Pediatric Quality Measures
21 Program, affectionately known as the PQMP from
22 here on out. You also wanted the chance to look

1 back at the recommendations that MAP made last
2 year on the child core set and maybe re-interpret
3 those in the context of the actions that would be
4 recommended this year. One last piece of
5 orientation and grounding is to remind you of the
6 timeline for this work. We first met via web on
7 April 27th. You are here in June, at the in-
8 person meeting. We are anticipating our public
9 comments period of about 30 days on draft reports
10 would take place through most of July, and into
11 the very beginning of August, and that we would
12 have the opportunity to bring the recommendations
13 of the two task forces to the MAP Coordinating
14 Committee for their final approval in mid to late
15 August.

16 The reports, and there will be two of
17 them separately resulting from each task force,
18 are due to be complete at the end of August.
19 That will give CMS the time they need to work
20 internally and release the statutorily required
21 annual update to each of the core sets by the end
22 of the calendar year. I think we're ready to

1 dive in to some of the key points that the staff
2 discerned about the measure set in our review and
3 preparation for this meeting. I will introduce
4 to you -- re-introduce to you Nadine and
5 Shaconna, who will present this section.

6 OVERVIEW OF MEETING MATERIALS AND KEY POINTS

7 FROM STAFF REVIEW OF CORE SET

8 MS. ALLEN: Thank you. Good morning,
9 everyone, again. During our April 27th web
10 meeting, Karen and Marsha described CMS's goals
11 and that these goals should influence MAP's
12 choice of measures for the core set. CMS's
13 three-part goals for the child and adult core set
14 is to increase the number of states reporting
15 core set measures, increase the number of
16 measures reported by each state, and lastly,
17 increase the number of states using core set
18 measures to drive quality improvement.

19 Now we wanted to know a little bit
20 about how CMS uses the core set data. These are
21 some of the ways they use the core set data. The
22 core set data -- so CMS uses a snapshot of the

1 core set data to drive quality improvement. It's
2 published throughout several publications,
3 including the Annual Child Quality Report, the
4 Annual Adult Health Quality Report, chart packs
5 and other analyses.

6 Lastly, they use the core set to
7 inform policy and program decisions. I know
8 Sarah mentioned this earlier. This is the MAP's
9 measure selection criteria. It is used
10 throughout the work groups and task forces to
11 make the decisions on what measures to include in
12 a specific program set. They are not absolute
13 rules. Rather, they are meant to just provide
14 some general guidance on making the measure
15 selection decisions. The central focus should be
16 on the selection of high-quality measures that
17 address the National Quality Strategy. We have
18 here lists of the measure selection criteria,
19 starting with the NQF endorsement.

20 That shows that they have been through
21 that evaluation process, including importance to
22 measure and report, scientific acceptability of

1 measure properties -- that's more along the lines
2 of reliability and validity -- also feasibility,
3 usability and use and harmonization of competing
4 and relating measures. The second measure
5 selection criteria is, the program measure set
6 adequately addresses each of the national quality
7 strategy's three aims and their corresponding
8 priorities.

9 The third criteria is, the program
10 measure set is responsive to specific program
11 goals and requirements. Here we would like to
12 see a program measure set that is fit for purpose
13 for the particular program. Fourth, the program
14 measure set includes an appropriate mix of
15 measure types. So we would like to see here a
16 mixture of outcome measures, process measures,
17 structural measures, cost and resource use,
18 person- and family-centered care measures, things
19 along those lines. Fifth, on criteria, the
20 program measure set enables measurement of
21 person- and family-centered care and services.

22 We would like, here, to see a program

1 measure set that addresses access, choice, self-
2 determination and community integration. The
3 sixth criteria is, the program measure set
4 includes considerations for healthcare
5 disparities and cultural competencies. When we
6 talk about healthcare disparities, we would like
7 to include race, ethnicity, socioeconomic status,
8 language, gender, sexual orientation, age and
9 some of those things.

10 Also, the program measure set can
11 address populations at risk for health
12 disparities -- example, people with behavioral or
13 mental illnesses. Last criteria would be the
14 program measure set promotes parsimony and
15 alignment. For this last criteria, we would like
16 to see a program measure set that supports
17 efficient use of resources for data collection
18 and reporting and supports alignment across
19 program. The program measure set should balance
20 the degree of effort associated with measurement
21 and its opportunity to improve quality. As we
22 were looking through the core set for this year

1 and bringing this to your attention and what --
2 when we would make the decision on what measures
3 should be removed as a condition for a staff pick
4 or something along those lines, we looked to
5 these reasons why the task force may consider
6 removal of a measure.

7 Some measures might not be very
8 effective, such as consistently high levels of
9 performance, multiple years of very low numbers
10 of states reporting, change in clinical evidence
11 has made the measure obsolete, measure does not
12 provide actionable information for state,
13 superior measure on the same topic has become
14 available and other reasons why we would want to
15 remove a measure.

16 Staff looked for these in our review
17 of the measure core set, as I said before. Along
18 with the measure selection criteria, we also
19 would like to consider some decision categories.
20 MAP uses these decision categories within their
21 work groups, as well as their task forces. The
22 decision categories are used to provide

1 consistency and clear direction to HHS. Then in
2 addition to decision categories, there's usually
3 a statement providing the rationale behind a
4 decision. For this particular review, the two
5 categories that we would be focusing on would be
6 the support and conditional support.

7 Support, which would be used in the
8 case of measures that are ready for immediate use
9 and address the identified gaps, and then the
10 condition support is appropriate for measures
11 that are either still going through the NQF
12 endorsement process and are pending endorsement,
13 there is something that needs to be changed or
14 addressed by either the measure steward or
15 working with CMS to confirm feasibility before it
16 can be incorporated into the child core set.

17 "Do Not Support" decision is unlikely
18 to come up in this review, but it would be how
19 MAP signals a measure was inappropriate or a bad
20 fit for use in the child core set. Think of
21 these in terms of a traffic light. For support,
22 we would look at a green light and say that CMS

1 could move forward with this recommendation. The
2 conditional support, we would look at that more,
3 a yellow light. CMS may want to pause, proceed
4 slowly and with caution with this recommendation,
5 and then the do not support, that's a red light,
6 where stop, we're not going any further with
7 this.

8 The reason we're seeking to understand
9 the health-related needs of this population is so
10 that we can select measures that correspond to
11 what is most important for Medicaid and CHIP
12 enrollees. We have noted primary care access and
13 preventative care, perinatal health, management
14 of acute and complex condition, behavioral
15 health, dental and oral health. Some of these
16 measures already is in the core set. We may need
17 to add some additional measures.

18 That's going to be some discussion
19 later on today about that. This slide
20 illustrates how child health is different from
21 adult health. Just to remind everyone, the
22 nature of pediatric benefits in Medicaid are a

1 little bit different than in adult-oriented
2 healthcare. Less of attention needs to be paid
3 to development risk, as opposed to acute
4 conditions. Acute health conditions in children
5 have declined over the past several decades, but
6 the relative importance of chronic health
7 conditions in those risks are growing. So today,
8 as opposed to historically, a significant portion
9 of children are living with chronic illnesses,
10 like asthma, autism, sickle cell disease, CF,
11 obesity and birth conditions that need to be
12 managed in an ongoing way.

13 Thinking about the epidemiology
14 picture, it influences the way healthcare
15 expenditures is allotted towards pediatric
16 populations and the healthcare system needs to
17 continue to improve its capacity to detect, then
18 treat, then manage, and then reduce the impact of
19 physical and mental conditions that affect
20 development.

21 That information and these
22 recommendations are from the CHCS paper on EPSDT

1 benefits. They had highlighted some domains in
2 preventative care and significant implications
3 for long-term outcomes. These might correspond
4 with the task force gap areas and opportunities
5 for measurement. Domains in preventative care
6 with implications for long-term physical,
7 emotional, social, educational and functional
8 outcomes include giving parents guidance about
9 what to anticipate in their children's
10 development, immunizations, preventative dental
11 care, vision and hearing screening at an early
12 age, lead screening, mental health screening,
13 development screening and body mass index.

14 Again, some of these topics are
15 already covered in measures, and others are not.
16 We're bringing this to the task force's attention
17 because last year MAP discussion highlighted
18 premature birth and behavioral health as a high-
19 impact condition for children in Medicaid and
20 CHIP. This is more prevalent in the Medicaid
21 population than in the commercial insurance. In
22 2009, one of every eight babies in the U.S. was

1 born prematurely, defined as birth before 37
2 weeks gestation.

3 About 75 percent of the infants who
4 use a NICU do so because they're premature. As
5 you know, NICUs are very costly services, and
6 it's very stressful for parents. The other 25
7 percent have other medical problems. Later
8 today, the committee will be discussing measures
9 related to psychotropic medications during the
10 measure review and measure selection
11 recommendation sessions. I wanted to provide
12 some additional information about this issue to
13 assist you with your deliberations. This is just
14 a brief background of what's going on in mental
15 health and behavioral health for this population.
16 Children with behavioral health issues are among
17 the country's most vulnerable population, and
18 there are concerns about whether they have access
19 to the most appropriate kind of care for this
20 condition.

21 Early detection and treatment of
22 childhood behavioral health issues can improve a

1 child's symptoms and reduce potential harmful
2 effects on a child. Children with behavioral
3 health issues, such as ADHD or depression, can be
4 treated with psychosocial therapies, psychotropic
5 medications, and a combination of both.

6 Many of these children, however, lack
7 access to the treatment they need to help them
8 manage or overcome their emotional or behavioral
9 problems. In addition, child advocates,
10 providers, and researchers have expressed
11 concerns about the increased prescribing of
12 psychotropic medications for children, in part
13 because there's limited evidence about the side
14 effects for these medications, especially the
15 combination of medications. In my research, I
16 also found that psychotropic medications are
17 often being prescribed to the Medicaid and CHIP
18 population, as well as children within foster
19 care systems, as opposed to children with
20 commercial insurance, which is very high.

21 Concerns about access to appropriate
22 behavioral health services and the increased

1 prescribing of psychotropic medication can be
2 multiplied for children within this population.
3 This slide talks about some of the findings, and
4 6.2 percent of non-institutionalized children
5 with Medicaid took psychotropic medications
6 during a calendar year, and 21 percent of those
7 children took an anti-psychotic medication.

8 It's estimated that anti-psychotic use
9 increased from 8.9 percent in 2002 to 11.8
10 percent in 2007. State-specific rates of any
11 anti-psychotic use were significantly increased
12 in 45 states from 2002 to 2007. This slide
13 showed MAP's recommendations last year and what
14 CMS has done since then. It also shows that CMS
15 was very responsive to MAP's recommendation.
16 That was exemplified by their updates to the 2015
17 child core set. They retired the percentage of
18 eligibles that received dental health services
19 and added two measures, which was the Dental
20 Sealants for Six to Nine-Year-Old Children at
21 Elevated Caries Risk, the Child and Adolescent
22 Major Depressive Disorder: Suicide Risk

1 Assessment.

2 MAP also recommended the addition of
3 the child HCAHPS, but before that was possible to
4 get done, CMS had to do some work before
5 incorporating it into the core set, just to make
6 sure that it's feasible. This was mostly used
7 within the hospital-based pediatric care, so CMS
8 wanted to make sure that it was good for state-
9 level reporting. This recommendation helped to
10 address gaps in three areas. That was inpatient
11 care, patient experience and care coordination.

12 This is the 2015 child core set. As
13 you can see, they added the Suicide Risk
14 Assessment Measure. CMS added that this year.
15 The next slide shows that they also added the
16 Dental Sealants for Six to Nine-Year-Old Children
17 at Elevated Caries Risk. The NA on this slide
18 implies that it's not an NQF-endorsed measure.
19 This is MAP's six recommendations last year for
20 phase additions to the core set. As you know,
21 CMS added two, and one they're pilot testing.
22 The ones in the orange are still up for grabs and

1 will be discussed later this afternoon and will
2 be discussed along with the new measures for your
3 consideration. Now I'm turning it over to my
4 colleague, Shaconna. Thank you.

5 MS. GORHAM: Okay, we just learned
6 that Foster is on the line. Welcome, Foster.

7 CHAIR GESTEN: Hi, can you guys hear
8 me?

9 MS. GORHAM: Yes, we can.

10 CHAIR GESTEN: Okay, I'm sorry to not
11 be there in person, but I just joined and
12 followed along on the slides. Again, my
13 apologies for not being there in person.

14 MS. GORHAM: All right. Before I
15 begin, that was a lot of information that Nadine
16 shared, so let me just take a minute and see if
17 you all have any questions or comments? No?
18 Okay.

19 MS. COHEN: This is Anne. This is
20 really -- it's kind of gap areas. I don't know
21 whether this is appropriate to discuss now, or
22 you want to discuss it later?

1 MS. GORHAM: We have a section a
2 little later where we'll focus on gaps.

3 MS. COHEN: Okay.

4 MS. GORHAM: Don't forget your
5 question, though.

6 MS. COHEN: I won't.

7 MS. GORHAM: As you can tell, the
8 staff, we want to make sure that you are well
9 prepared, so you received a lot of information in
10 your bundle of materials. The information that I
11 will review now is basically a good review of the
12 FY 2014 Child Charts report. We glean
13 information from what CMS affectionately calls
14 the one-pagers of the measures. That was given
15 to you not to share for public, but definitely
16 for your use during the time of the meeting.

17 The CART reports or one-pagers include
18 information about the levels of reporting. We,
19 as a staff, glean information about the states'
20 uptake of measures in the patterns of apparent
21 and technical assistance requests. The data also
22 helps us to identify any measures for potential

1 removal and revisit priority measure gap areas.
2 That's basically what we are using the
3 information for, but it was really good
4 information. From the one-pagers, we understand
5 that there is room for improvement, but overall,
6 the child core set participation is pretty
7 strong. All 22 measures were reported by at
8 least four states. So just a bit of
9 clarification, Alvia.

10 The 2015 child core set for use in
11 2015, there's 24 measures, but today we'll
12 discuss the 2014 reporting, and there's 22
13 measures in the child core set. Most frequently
14 reported measures include the well-child visits,
15 the adolescent well-care visits, and access to
16 primary care practitioners. If we move to the
17 next slide, you will see just the 2014 child core
18 set compared to the 2013 reporting by states for
19 the core set.

20 You can see the way we have the chart
21 arranged, we have the measure with the lowest
22 number of states reporting at the top and the

1 measure with the highest number of states
2 reporting at the bottom. So participation is
3 generally increasing. We'll give you all a
4 couple of seconds just to kind of review. You
5 have to cut your mic on.

6 DR. ADIRIM: Some of those measures
7 stopped being reported in 2014. The most glaring
8 one is the percentage of eligibles who received
9 preventive dental services. Do we know why?

10 MS. GORHAM: Give me a couple of
11 minutes and we'll go into that, as well. The
12 next slide we have measures with high levels of
13 reporting. The five measures on the chart have
14 remained high throughout 2013 and 2014, with at
15 least 41 states reporting the measures. They
16 tend to be claims-based. Most of the states
17 reported using the child core set specifications,
18 which were based on the HEDIS 2014
19 specifications, and most are reflective of
20 primary care encounters.

21 The measure at the top listed the
22 CLABSI. The number of states for which

1 standardized infectious ratios were calculated
2 increased from 40 states in 2012 to 41 states in
3 2013 and 2014 reporting.

4 MS. DOUGHERTY: Could I ask a
5 question? Is that CLABSI measure -- and maybe
6 this is for Marsha -- I think this is one that
7 states reporting is kind of misleading because
8 it's CMS staff that works with CDC to get that
9 data, so that's why -- one reason it's so high, I
10 think.

11 SPEAKER: Which measure is that?

12 MS. DOUGHERTY: The CLABSI measure,
13 the top one. The states don't have to go and get
14 hospital data on CLABSI.

15 MS. GORHAM: Thank you, Denise.

16 DR. BENIN: Not all of the states
17 mandate pediatric reporting, I don't think, for
18 CLABSI. Connecticut does, but I don't know that
19 all of them do. For the adult side they do. I'm
20 not sure for the pediatric side.

21 MS. GORHAM: Thank you. The well-
22 child visits, in the first 15 months of life, 44

1 states in 2013 reported and decreased to 42
2 states in 2014, but 46 states reported the
3 measure at least once during the three years.
4 The CHAP measure, states reported the measure
5 increased from 43 states in 2012 to 45 states in
6 FY 2013, and then decreased to 43 states in FY
7 2014. Forty-six states reported the measure at
8 least once during the three years. The AWC
9 measure, 43 states for 2013. It increased to 44
10 states for 2014, and then there was a total of 46
11 states that reported the measure at least once
12 during the three years. The W34 measure, 47
13 states for 2013. It decreased to 46 states in
14 2014. Forty-eight states reported the measure at
15 least once during the three years. And so I went
16 through that just to give you an idea how the
17 different states reported over the different
18 years.

19 So those were measures with high
20 levels of reporting. Then we want to move to
21 measures reported more frequently in FY 2014. We
22 took a chunk of the measures in the middle. They

1 were 14 measures. Measures with 24 to 39 states
2 reporting experienced the most uptake from 2013
3 to 2014. All of the measures experienced an
4 increase except for the chlamydia measure.

5 The chlamydia measure remained the
6 same. The CHAPs measure decreased from 41 states
7 to 39 states in 2014, and then hopefully, Terry,
8 this will answer your question. The peanut
9 measure experienced the greatest decrease. CMS
10 noted, in their one-pagers, the state challenges
11 in reporting this measure. As of April 16, 2015,
12 23 states had not completed reporting data for
13 the measure in 2014. CMS is actively working
14 with these states to finalize that reporting.
15 I'm not sure, Marsha, if the handout that we
16 received today, is that the -- so that's been
17 updated. Did that answer your question?

18 (No audible response.)

19 MS. GORHAM: Okay. It's important to
20 note that the medication management for people
21 with asthma and the HPV measure were all added in
22 2013. The measures with relatively low levels of

1 reporting, there were three measures reflected on
2 the chart that show the fewest number of
3 reporting states. The VHRA, of course, is the
4 lowest reporting measure. It's relatively new in
5 the core set, and it was reported for the first
6 time in 2013. There was a slight increase from
7 two states in 2013 to four states in 2014.

8 Reasons given for not reporting in
9 measures for potential removal. The most common
10 reason for not reporting was data was not
11 available. There were no more than three TA
12 requests per measure. A low number of TA
13 requests reflects the states are generally
14 comfortable with the specifications. Additional
15 support was provided by two states by CMS' TA
16 team. For example, the TA team conducted a
17 webinar. The resource manual was updated for
18 several of the measures, etc. Those are just
19 some of the reasons. While a few measures were
20 pointed out as having relatively low levels of
21 reporting, they were reported and in use by a
22 good number of states, so the staff did not

1 identify any measures for removal. Plus we know
2 that stability in the measure set is desirable,
3 so we didn't notice any significant problems with
4 the current measures. Are there any general
5 questions or comments about the current measures?

6 Yes, ma'am?

7 MS. DOUGHERTY: I just wanted to
8 mention that on the behavioral risk factors in
9 prenatal care, that measure was introduced, I
10 think, in January 2013, as an update, so it came
11 later than the other measures, which is -- as you
12 can see, reporting increases with every year.

13 MS. GORHAM: Yes, thank you.

14 DR. ADIRIM: I think I might know the
15 answer to this, but do any of the measures top
16 out, are any of them --

17 MS. LASH: No, we didn't observe that
18 consistently high performance level at that high
19 90s cut point.

20 DR. ADIRIM: Even access to primary
21 care --

22 MS. LILLIE-BLANTON: Yes, actually, it

1 does.

2 DR. ADIRIM: Okay.

3 MS. LILLIE-BLANTON: The access to
4 care does, except when you look at the
5 adolescents.

6 DR. ADIRIM: Right, but they're two
7 separate measures, right?

8 MS. LILLIE-BLANTON: I think they're
9 three sub-groups for that measure, so it's age
10 groups -- not sub-groups, but age groups for that
11 measure. For the younger children, we're at
12 above 90 percent, but when you go to the 12 to 19
13 year olds, we're not.

14 DR. ADIRIM: Right, and that's an
15 important measure.

16 MS. LILLIE-BLANTON: Yes, absolutely.

17 DR. ADIRIM: The reason why I bring
18 this up is because access to behavioral health
19 services is increasingly a very important
20 measure. I would prefer seeing something like
21 that in the set, rather than -- because at least
22 in Pennsylvania, or Philadelphia, where I

1 practice, every single kid -- infant has a
2 primary care provider.

3 MS. DOUGHERTY: I think it's also true
4 of the well-child visits for the younger age
5 groups. It's probably in the 90s. Not on
6 average? No? Okay. Not for adolescents, I
7 know.

8 MS. LILLIE-BLANTON: The third,
9 fourth, fifth and sixth grade is high, but we're
10 not topping out at the 90s.

11 MS. DOUGHERTY: Okay, thanks.

12 MS. LILLIE-BLANTON: It would be nice
13 if we were, but we're not. Let me look. No.

14 DR. CUNILL: Question.

15 MS. LILLIE-BLANTON: Our 75th
16 percentile is 76 percent, 50th percentile is 67
17 percent. That's the one we're doing the best,
18 third, fourth and fifth.

19 DR. CUNILL: Question. How often are
20 the states required to report? Is this on a
21 quarterly basis, monthly basis?

22 MS. LASH: There's one annual

1 submission.

2 DR. CUNILL: Just one? Okay, thank
3 you.

4 DR. LACEY: But I think you clarified
5 at the last face-to-face meeting, some states
6 rotate what they report. Say, for example -- I
7 don't know, but say, for example, Alabama says
8 they report 21 of the 22 on here, they may rotate
9 and do ten one year, ten the next, or some, I
10 think you guys said last time, may only report
11 every three, so highly variable, which I guess
12 leads into my question.

13 I know one criterion for potentially
14 removing an outcome or indicator is that -- a
15 measure -- the states are not able to report it.
16 I just would want to beg the question is should
17 that be our criterion for rejection if it's an
18 important health measure for children? Should we
19 not maybe, on the flip side, provide more
20 technical assistance or support in reporting the
21 measure or finding ways to actually gather
22 credible information? I just wanted to put that

1 out there.

2 MS. LASH: I think it's something to
3 balance that feasibility versus the importance of
4 trying to spur progress in an important area.
5 That is probably -- you'll want to speak --
6 that's the philosophy about the behavioral health
7 risk assessment for pregnant women, very few
8 states sending in data at the present time, but
9 hopeful that we would be able to build the
10 capacity for more states to engage on that really
11 important issue.

12 DR. BENIN: Is there any discussion
13 about the metrics on here that are not NQF
14 approved and why they're not and whether or not
15 we need to take that into consideration, or have
16 we discussed that at length and I'm just not --
17 it looks to me like there's one, two, three, four
18 -- six that are not -- that say NA for NQF
19 approval. Do we need to understand better the
20 reasons why those are not NQF approved? Maybe
21 they just haven't come up for approval, but
22 they're pretty straightforward sounding things,

1 so I don't know.

2 MS. LASH: Sure. I believe that the
3 majority of the measures that are not endorsed
4 have not been submitted to NQF for endorsement
5 review, which is a somewhat different category
6 than if it had been submitted and failed an
7 endorsement review. That would have more
8 concern, I think, for this panel, if a measure
9 was not able to pass endorsement versus the
10 steward, for whatever reason -- or there hadn't
11 been a timely endorsement project available to
12 look at the measure.

13 DR. LACEY: So is that a resource
14 issue, in terms of getting the data available,
15 together, to get on the table?

16 MS. LASH: That's one factor.

17 DR. LACEY: Okay.

18 MS. LASH: It's the decision of the
19 individual measure stewards to submit for
20 endorsement. It can't be required by NQF. But
21 something to consider when we look at measures
22 for addition, where we might be looking at

1 measures that are not endorsed, you might want to
2 put the condition on it that it complete that
3 review before CMS implements it.

4 DR. BENIN: Do you think that given
5 the fact that we're not really in a position, in
6 this room, to do a full technical review of the
7 measures that it seems prudent for us to, in some
8 way, shape, or form, request that if we're going
9 to ask this question again next year or whatever
10 the thing is that these get more of a technical
11 evaluation, so that we can feel confident that
12 they're measuring what we think they're measuring
13 if we're going to say that. I don't know that --
14 I don't think ---

15 (Simultaneous speaking.)

16 CHAIR GESTEN: Can I (telephonic
17 interference.)

18 MS. LASH: Sure, Foster.

19 CHAIR GESTEN: I have three comments
20 (telephonic interference.)

21 MS. LASH: Foster, we were -- the
22 background noise made a little difficult to hear

1 you. I think we have the gist, but we might have
2 to have you clarify some of your thinking later
3 today.

4 DR. BENIN: And I would doubt that
5 these have gone through a rigorous development
6 process, etc., etc., but I think that if we're
7 going to -- if the purpose of this is to expand
8 and formalize this program over time, then we
9 should take all of these things into
10 consideration.

11 MS. GORHAM: Okay, so we touched on it
12 just briefly, but I just want to throw the
13 question out to the task force. Are there any
14 proposals to remove a measure? If so, can we
15 explain why we would like to do so? Like I said,
16 we talked just briefly on it, but just for
17 clarification.

18 DR. BENIN: I did notice that the
19 immunization metric performance is different than
20 the immunization metric performance on the NIS
21 measures, which are the CDC immunization
22 measures. Those have a different methodology,

1 and those are not just limited to the Medicaid
2 population.

3 I guess I do -- I wouldn't necessarily
4 put this, I guess, in the reason to take them
5 out, but I would want to know, in an ongoing
6 fashion, do we need to understand better why
7 there are such discrepancies, in part because I'm
8 struck by how low the performance is -- really
9 struck by that, and sort of saddened.

10 I think that understanding a little
11 bit better -- and maybe this is the work that
12 your team is working on -- understanding a little
13 bit better does one or the other of those metrics
14 have some idiosyncrasies, or is there some cross
15 matching, or is there a way to sub-set out the
16 NIS data? I'm not super facile with that.

17 DR. LACEY: To follow up on that, I
18 think it will be helpful maybe, potentially, to
19 come back to that question when we start looking
20 at alignment, you know, the crosswalk with the
21 different measure groups that are out there, so
22 we're not doing work twice or having states

1 report things differently, so maybe ask again
2 later?

3 MS. GORHAM: Thanks, good
4 recommendation. Thank you.

5 MS. LILLIE-BLANTON: So let me just
6 say we had CDC present to us on a webinar some of
7 the NIS data that compared Medicaid and private
8 insurance immunization rates. We're still not
9 comparable to private insurance, but we're
10 certainly far better than what we are getting
11 from our state reporting. We have asked our
12 technical assistance and analytic support
13 contractor to support us in working with our
14 state partners to improve reporting.

15 We think a part of what's happening is
16 that data on immunizations is either going to a
17 registry or not -- claims aren't being submitted,
18 and many states are running their claims data to
19 provide us with this data. Because Medicaid uses
20 the Vaccines for Children Program, the state
21 claims records oftentimes don't capture the
22 information on the immunizations because they

1 only -- they're not being required to charge for
2 the actual vaccine. We do think we have a
3 reporting challenge with claims data for this
4 measure. I am very open to seeing whether we
5 think it's the measure that we should replace,
6 rather than do TA to get better reporting from
7 states. Because we are concerned, too, that this
8 does not reflect what's happening in Medicaid, so
9 we welcome your input.

10 DR. BENIN: Thank you. That is very
11 reassuring, obviously, that -- I guess I have
12 felt strongly for a long time that one of the
13 most -- there's so many really base-level things
14 that we can do for children, and the
15 immunizations is really one of them. We should
16 be able to figure out -- it's a nice opportunity
17 for us to be able to iterate through how to
18 properly measure that and get a -- thank you.

19 MS. LASH: Anne, go ahead.

20 MS. COHEN: Actually, I had -- along
21 the same lines, it was kind of a reporting
22 question about 0471, the Cesarean section

1 measure. It looked like only 16 states reported,
2 which, as we all know, there's a higher rate of
3 unnecessary C-sections. That concerned me, and I
4 wanted to kind of delve into maybe why, and
5 whether -- is it the appropriate measure? What's
6 going on --

7 MS. LILLIE-BLANTON: That's another
8 measure where we think data availability is the
9 challenge, but I think we're still open to
10 hearing your thoughts on whether or not there's a
11 more appropriate measure. Let me just tell you
12 what we have done to help improve reporting. We
13 have, through a contract with -- or working with
14 CDC in a contract with AcademyHealth, developed a
15 data linkage training program for states.

16 Because the challenge with this
17 measure is linking with vital records. Some
18 states have the capacity to do that and have been
19 doing it for many years and do well at reporting,
20 and other states don't. The first year of the
21 data linkage training, we had ten states
22 participate. The second year we have -- I think

1 there's even or eight states. I'm not sure if
2 Lakisha's on the phone and could tell us more.

3 In other words, we are working to
4 improve state reporting on that measure. We're
5 still not at our threshold of 25 states reporting
6 this year, but we have -- I can tell you that
7 training targeted both the low birth weight
8 measure and the CD-section measure, and early
9 elected delivery measure, measures which require
10 linkage. At least for the 2014 reporting, we
11 have met our threshold of having 25 states
12 reporting for the low birth weight measure, so
13 that training helped us in that respect. But
14 still, there are just so many challenges for
15 state Medicaid agencies that are not now linking
16 to learn how to do it, to develop the staff
17 capacity and infrastructure.

18 I don't know that there is another
19 better measure, but if there is and you all want
20 to suggest that, we're open to it, but we think
21 this probably is the best measure. We think it's
22 an important measure.

1 MS. COHEN: I'm just curious, from
2 sort of a data-driven perspective -- and maybe
3 this is a hospital association question -- I
4 thought C-section rates were reporting issue at
5 the hospital level, overall, for quality
6 measures, not just Medicaid, but that's a big
7 emphasis on the C-section rates. Is there
8 something that we can get the data from that
9 angle and not have to burden the states so much?
10 I could be totally off base. I'm not a hospital-
11 based person.

12 MS. LASH: Alvia?

13 DR. SIDDIQI: Oh, I wasn't going to
14 respond to that, but I was just going to throw
15 out there that the behavioral risk assessment,
16 when I looked more in detail with the one-pagers,
17 it looks like most states actually required or
18 asked for technical assistance on this one, and
19 that at least 11 states said that this one would
20 require medical reviews.

21 I kind of went into the details of
22 what does this require? Because it sounds like a

1 great measure, but when you talk about health
2 risk assessment as saying pre-natal screening in
3 multiple categories, intimate partner violence,
4 drug/alcohol/tobacco use, I'm thinking I don't
5 think there's any good code that providers use or
6 that states are using that would help support
7 that one.

8 I would just suggest that if we don't
9 -- if there's another measure that maybe is more
10 specific that states could report on, based on a
11 code, on something that they could use claims
12 data on, that we at least consider that,
13 especially for adding more measures to the set.
14 This is one that even though it's very important,
15 it may need to be tweaked to find one that could
16 be easier to report for states.

17 MS. LASH: I want to just go back to
18 the previous point about the use of pCO2, the C-
19 section measure. That is a very widely used
20 Joint Commission measure in the inpatient
21 hospital reporting program. So in terms of
22 alignment and having everyone working towards the

1 same measure, that really is, I think, the best
2 choice. Carol knows certainly better than me.

3 MS. SAKALA: Sure, I was going to say
4 that there's a lot of consensus that that's a
5 very good measure in maternity care. Also, I
6 think it's important to recognize that early
7 elective delivery was a huge success, in terms of
8 getting people on board with quality improvement.

9 I feel that Cesarean rates are the
10 next big thing that there's a lot of consensus
11 about, to the point of the joint commission, it's
12 now requiring that all hospitals with 1,100 or
13 more births per year report this measure, with a
14 hope that it will be expanding that to others, as
15 well. I think things are moving together, and
16 it's a good measure to keep and support states in
17 reporting.

18 DR. BENIN: It's a joint commission
19 measure, but not a CMS measure, or is it also a
20 CMS measure?

21 MS. LILLIE-BLANTON: What do you mean
22 by CMS measure? You mean --

1 DR. BENIN: Yeah.

2 MS. LILLIE-BLANTON: It's a part of
3 the core set.

4 DR. CONVISSAR: Just a question about
5 this. It sounds like the real issue here is
6 identifying Medicaid beneficiaries within this
7 already well-reported measure. So solving to
8 that is, I think, what really is in play. I
9 think this is the right measure for what we're
10 trying to accomplish here, and then it's really
11 an issue of how do we actually facilitate the
12 identification of the population, our Medicaid
13 beneficiaries, so that we know which one of these
14 results is theirs?

15 DR. WHITE: It is Sandra White. It's
16 fairly easy for the hospitals to determine
17 whether or not a member is paid by commercial
18 insurance or by Medicaid, so that should be --
19 they should be able to segment that data by the
20 payer.

21 MS. LILLIE-BLANTON: Good for you to
22 say that. Unfortunately, hospitals don't feel

1 that it's that easy for them to do. I agree. In
2 our training, we've been using the vital records
3 because the hospitals submit the data on vital
4 records, but they don't easily segment the data
5 by coverage type.

6 DR. LACEY: Just one last quick
7 question. Marsha, what exactly are you have
8 AcademyHealth analyze for you?

9 MS. LILLIE-BLANTON: They're not
10 analyzing. They're doing a training.

11 DR. LACEY: Oh, they're the trainers.

12 MS. LILLIE-BLANTON: They're the
13 training -- they have a training program for
14 states on data linkage. It's the linkage of the
15 claims data with the vital records data.

16 DR. LACEY: Okay, I just was --

17 MS. LILLIE-BLANTON: Because the
18 claims data has some of the information, and the
19 vital records has the other information about C-
20 sections.

21 DR. LACEY: All right, thanks.

22 MS. LASH: Marc?

1 DR. LEIB: It may be easier, starting
2 next year, to get some of this data on
3 deliveries, if state Medicaid programs want to
4 require it, because the ICD-10 codes are
5 expanding the information that will be available.

6 At least one state I know, and several
7 states, I believe, are now going to require an
8 ICD-10 code that identifies the gestational age,
9 by week, in order to get paid for deliveries at
10 either the hospital or the OB/GYN. So that data
11 should be rolling in, starting next year, and
12 they can start analyzing that.

13 MS. LASH: Important point, thank you.
14 I'll reflect back, I think, some of what we're
15 hearing. That is rather than suggesting any
16 individual measure be removed at this point in
17 the meeting, we would actually encourage just
18 continued focus on data fidelity, strategies to
19 improve the completeness of data reported by
20 states on an annual basis, specifically around a
21 few specific measures.

22 STATUS OF PQMP MEASURE DEVELOPMENT AND

ENDORSEMENT

MS. LASH: Let's continue to move on. We wanted to bring you just a few more slides, so that we can understand the question of what other measures are out there that could be used in this reporting program. In MAP's last look at this measure set, it was commented many times that there are lots of activity taking place under the PQMP. It has been transformative to the pipeline of performance measures available for pediatric care.

When development and testing of those measures are complete -- they've sort of been rolling in -- it would be likely that NQF would receive many of them for endorsement review. There are a small number that have already completed endorsement review, and many more still going through the final stages of development.

This program was established under CHIPRA and intended to improve and strengthen this core set of measures, specifically, to generally expand the availability of pediatric

1 quality measures for use by all sorts of public
2 and private healthcare purchasers to advance
3 development and innovation around new and
4 emerging quality measures and to increase the
5 portfolio of evidence-based, consensus-driven
6 pediatric quality measures available to the
7 field. As Denise already mentioned, there are
8 seven CHIPRA funded Pediatric Centers of
9 Excellence. They have been supported by
10 cooperative agreement grants with Arc, funded by
11 CMS, in a multi-level partnership that's been
12 very strong. There is also a coordinating and
13 technical assistance center available to those
14 grantees under contract with RTI International
15 and other CHIPRA quality demonstration project
16 grantees funded by CMS also working on measure
17 development as part of their demonstrations.

18 In terms of a breakdown of what has
19 been endorsed and what has not, to date, this is
20 a moving target. We have two NQF endorsed
21 measures that we'll be specifically reviewing
22 later today, the pediatric all-condition

1 readmission measure and pediatric lower
2 respiratory infection readmission.

3 Not listed on this slide, but the
4 development of the Child HCAHPS tool also took
5 place under the PQMP, but since MAP already has
6 the standing recommendation that that be part of
7 the child core set, it's not listed here. There
8 are an additional 76 or so measures available on
9 a variety of other high-impact topics, including
10 preventive services, patient-reported outcomes,
11 measures of enrollment and coverage, service
12 availability, medication reconciliation and
13 others a little farther upstream in development
14 on perinatal care, and some on management of
15 specific acute and chronic conditions. Denise, I
16 don't want to put you on the spot, but if you
17 have anything else to add, in terms of an update
18 on your work with the grantees, any other current
19 priorities?

20 MS. DOUGHERTY: I think we could maybe
21 give the rest of the group the link to the list
22 of measures that are available and the link to

1 the topics in development. I do want to say I
2 think that there is one very interesting measure
3 about the availability of specialty services, or
4 the perceived availability, that was developed by
5 Gary Freed's group.

6 What they did was take a CAHPS measure
7 and use that language, but the actual measure
8 that they're proposing -- or they submitted.
9 They're not proposing -- they submitted is
10 whether or not the state reports publicly on that
11 access to specialty care services. It's one of
12 the few, actually, that is a state-level measure,
13 so that might be something to consider about the
14 availability of specialty services. This is for
15 chronic physical illness, mostly, is a really
16 high-importance topic. I could talk about each
17 of these measures. They're all my grandchildren.
18 They're not my children. That's the COEs.
19 They're children of the COEs. But as discussions
20 happen, maybe I can say more --

21 (Simultaneous speaking)

22 MS. LASH: Wonderful, thanks so much.

1 Just so we can be sure we're on the same page
2 about the measure you just mentioned, I'm
3 picturing it as somewhat nested, that there is a
4 CAHPS-driven data collection about the access,
5 and then an additional structural measure of
6 whether the state is making that publicly
7 available?

8 (No audible response.)

9 MS. LASH: Okay, that's interesting.
10 It's creative. Alvia?

11 DR. SIDDIQI: I was just going to add
12 recently, we've known about the CMS proposed
13 rules to Medicaid managed care. As states have
14 continued to expand in Medicaid managed care, I
15 think that measure will be really important, in
16 terms of alignment, so that's exciting.

17 MS. GORHAM: I just wanted to say, as
18 Denise mentioned about the links, if you actually
19 -- in your slide deck, if you click on the 76
20 measures available, or 24 measures in
21 development, it will link you right to the
22 information.

1 MS. LASH: Thank you, Shaconna. We're
2 next scheduled on the agenda to hear from Jeff
3 Schiff, who's going to be presenting by phone
4 about Minnesota's measurement experience. We had
5 asked him to call in at 10:45. He is on the
6 line? Great. Dr. Schiff?

7 DR. SCHIFF: Here I am.

8 MS. LASH: Oh, glad to have you with
9 us this morning. We're going to pull up your
10 slides here in the room, and you can begin
11 whenever you're ready.

12 DR. SCHIFF: Oh, great, thank you.

13 STATE PERSPECTIVES PANEL -- PART 1

14 DR. SCHIFF: Thanks you. While you're
15 pulling them up, it's nice to hear some familiar
16 voices over there. It's hard to listen to
17 somebody who's a disembodied voice. I hope I'll
18 keep your interest, at least as much as I can. I
19 want to first thank you all for inviting me to
20 talk about our experience. I thought I would --
21 some of this is reframing, and then trying to
22 link the reframing back into the work that you're

1 trying to do today, so I appreciate the
2 opportunity, and I'll just get started.

3 What I want to do is I want to talk a
4 little about Minnesota's experience -- a little
5 bit about how this whole measurement program
6 links into what we try to do in our state
7 Medicaid program, and then a little bit, maybe,
8 about where we want to go, in Minnesota, and
9 maybe this -- I hope this will help guide some of
10 the efforts or some of the decision making.

11 Just as an example, it was very nice
12 just to hear this small conversation about the
13 state-level reporting of the availability of
14 specialty services because that kind of
15 infrastructure measure, I think, is something
16 that actually may have a lot of relevance and
17 may, then, bring up some more granular work
18 inside the states. I think I'm going to just ask
19 you to say -- I'll just say next and ask you to
20 move the slide. Anyhow, I just wanted to spend a
21 few minutes talking, if I could, about
22 Minnesota's measurement journey. We are a

1 measurement rich -- or maybe some people might --
2 they would say a measurement-beleaguered state.
3 We adopted managed care very early on. When I
4 hear states moving to managed care, I think we're
5 almost in the -- we're in managed care at least
6 Version 2.0, probably more like 4.0, as far as
7 how we tried to work with managed care.

8 About 15 years ago, Minnesota
9 developed an organization called Minnesota
10 Community Measurement, which basically took the
11 issue of measurement away from just a managed
12 care organization, because so many of our
13 providers were in multiple managed care
14 organizations, and put it into a provider group
15 level. This organization, Minnesota Community
16 Measurement, exists -- it's funded partly by
17 state funds.

18 It's got a board that includes state
19 folks and funded, in large part, by the managed
20 care organizations, as well. I think it's done a
21 lot to create a culture where providers know that
22 there's some measuring going on and are

1 relatively -- I guess relatively accepting of
2 that, although I'll get to that in a minute, as
3 well. I think it also has helped move the
4 needle. 2008, we had healthcare reform
5 legislation that included our healthcare home
6 program, but also included this state quality
7 measurement and reporting system, which is known
8 inside Minnesota as SQ RMS, which has -- a large
9 number of measures can be put into the system,
10 and a small number are required for state
11 reporting that actually then contracts back to
12 community measurements.

13 They tried to do something called
14 provider peer grouping. It looked at cost over
15 quality and was not very successful and was
16 actually abandoned from the 2008 legislation. I
17 would say that there's an effectiveness of
18 shifting to the provider group level reporting,
19 although, as I said -- although it's not without
20 stress. You can go to the next slide.

21 Okay, there you go, thanks. The
22 question really comes up a lot in Minnesota is

1 can we measure value, if value is cost over
2 quality, and what's the role of quality in new
3 payment mechanisms, I think, is the other part of
4 this. We, in 2009, had implementation of the
5 patient-centered medical home and have quality
6 metrics associated with that. In 2012, we
7 started what are called integrated health
8 partnerships, which is our Medicaid ACOs. In
9 both of those programs, there's quality
10 measurement as part of the program, but I would
11 argue that the quality measurement is not the
12 strongest part of the program. If I can go to
13 the next slide.

14 I had to put this in here because this
15 is the thing I think we all want to be aware of.
16 In the StarTribune, which is our major state
17 newspaper, on May 24th, there was this article
18 about doctor burnout. We all worry, in
19 Minnesota, as a lot of places do, about workforce
20 issues, especially in primary care. This showed
21 up, so -- next slide -- the issue was, then, what
22 is causing doctor burnout?

1 Forty-eight percent of the physicians
2 surveyed said healthcare reform, and 43 percent
3 said paperwork and administrative burden, and
4 then there's other issues here, as well. Next
5 slide. One of the things that was cited in the
6 article was payment reforms that judge doctors by
7 their patients' health. I think this is getting
8 to be an interesting issue because in Minnesota,
9 we look at some of these health outcomes and
10 people are looking further and further upstream
11 and saying, "How much can our providers actually
12 impact the health of our patients?" I think
13 there's an interesting conversation happening
14 here as we work to integrate care coordination
15 and integrate, actually, care coordination with
16 social services in our state. Next slide.

17 I wanted to talk for a few minutes
18 about what levers we can use to improve the
19 quality of care in our state. I wanted to --
20 I've broken down by what I think -- what I see
21 we, in Medicaid, are able to do. I think you'll
22 see, in each of these, that quality measuring

1 plays some part of a role. So the levers are
2 really around managed care contracting, around
3 changes in payment models.

4 The word over there is just a
5 placeholder for me -- but changes in payment
6 models across fee-for-service and managed care,
7 direct provider relationships, like patient-
8 centered medical home and accountable care
9 organization, and then focused policy on payment
10 initiatives. There's a couple of examples on
11 this slide, but I'll get to that in more detail.
12 Within managed care contracting, we have a couple
13 -- I think a lot of people really think of this
14 as one of the major ways we can manage quality.
15 I think it is a major way, and one that I think
16 we have been okay at, but not nearly as good as
17 states like New York or Pennsylvania, in terms of
18 what's in our withholds and incentives to these?

19 We have found that within our
20 relationship with our managed care organizations,
21 there's some bandwidth to impact clinical care,
22 but there's a lot more interest in things like

1 denials, terminations and appeals, and other
2 technical things that's a better mechanism for
3 access issues. There's certainly some access
4 measures that are very prominent that we look to
5 our managed care organizations to improve, things
6 like dental sealant rates and dental visits and
7 primary care rates are where they have a bigger
8 impact than on some of the issues that get into
9 the specifics of quality of care.

10 Managed care organizations give,
11 sometimes, subtly different messages that's
12 better with community measurement, but sometimes
13 their incentives are just subtly different. That
14 sometimes is an issue that we hear from providers
15 about. Providers question the importance
16 sometimes of some of the measures and are
17 concerned, sometimes, about -- Keep going. I
18 wanted to talk a little bit about the direct
19 changes in payment that we sometimes get through
20 fee-for-service and managed care that we try to
21 see if they'll improve rates.

22 One of them that we're working on and

1 did not get through the legislature as we wanted
2 to this session was an increase in dental payment
3 rates as a mechanism to improve access. Some of
4 these things are determined by factors that are
5 outside of provider behavior and much more at the
6 program level, and sometimes it's affected by
7 what the legislature decides to do.

8 We have a small rate increase to
9 improve access in our rural areas for our dental
10 programs because we know the access is worse
11 there, but we didn't get the rate increase that
12 we had proposed as a mechanism to improve dental
13 access. We also sometimes will change rates to
14 drive behavior. We, for a while, had a blended
15 rate for Cesarean sections and vaginal deliveries
16 that was designed to encourage hospitals to move
17 towards more vaginal deliveries. That was
18 actually not effective, over time, because the
19 rate was not necessarily passed through from the
20 managed care organizations, so it was an
21 interesting thing. These are just ways in which
22 we tried to get to the same quality outcomes that

1 are in the quality measure set. You could keep
2 going.

3 This is where I think there's an
4 interesting opportunity for Medicaid is we have
5 some direct-to-provider relationships through our
6 patient-centered medical homes, our accountable
7 care organization, and now through a State
8 Innovation Model testing grant through
9 accountable communities. In those situations,
10 it's more likely that the outcomes are going to
11 be jointly decided as to what's effective.

12 We had some broad outcomes, but they
13 can be more specific, and they allow for some
14 provider-level innovation. I'm going to go to
15 the next slide, but can you guys hear me okay
16 over there?

17 MS. LASH: Yes, we are, thanks.

18 DR. SCHIFF: Okay, great, thanks. The
19 last way in which we leverage the improvement is
20 through what I called focused payment policy
21 initiatives. I think this is really where I just
22 want to make the point that as a Medicaid

1 program, any of the initiatives -- any of the
2 quality measures in the quality measure set can
3 lead to a topic-specific focused initiative.
4 It's really a question of both bandwidth and
5 importance inside the state as to where we put
6 our energy.

7 They're often topic specific. The one
8 I'll talk about a little bit is early elective
9 delivery in a minute. They engaged the provider
10 community and really looked to the provider
11 community for leadership. I think one of the big
12 issues here that is really, really relevant is
13 there's got to be acceptance of the relevance of
14 the measure.

15 One of the things -- just one moment,
16 please -- one of the things that's really
17 important is that the measure get a foothold in
18 the community as being relevant. I know, for
19 example, that the early elective delivery measure
20 is something that providers thought was relevant
21 and doable. On the other hand, I was at a
22 retirement party for one of our pediatric

1 surgeons when I was -- I wouldn't say accosted,
2 it's too strong a word, but one of the
3 pediatricians suggested that a measurement of
4 body mass index wasn't going to get him very far
5 in improving the obesity rate and sort of said,
6 "Why are you making us do that?" So we hear
7 about it at our level on both the good and the
8 bad side of this.

9 The acceptance of the measure is
10 really important. There's always a process or a
11 program that underlies measure improvements that
12 includes what I just said, community agreement on
13 importance, that the measure is either a health
14 outcome or it's a big process and a step to get
15 there, that there's established evidence, that
16 there's relevance for the population, so the
17 providers think it's worth doing, that the
18 healthcare system is able to impact it, so it's
19 not something outside of the scope of what can be
20 done, and that it's a solvable system or process
21 issue, so there's actual steps to make it happen.

22 You could go on to the next slide. I

1 think the best things that are measured are seen
2 as sensible, that there's acceptance that there's
3 multiple steps underneath the measure to get
4 there, and that the state can be a good convener
5 to establish consensus to support a process or
6 infrastructure and support practice change,
7 either financially or through technical support.
8 Keep going. There's a few of these that I'll
9 work on. Some of you who have heard me talk may
10 be tired of this example, but you'll hopefully
11 indulge me, and then I'll go into another one for
12 a second.

13 The Evidence-based Childbirth Program
14 is what we did to try to get our early elective
15 deliveries lower. We knew that the sentinel
16 measure was the early elective delivery rates.
17 We looked for what was required underneath that.
18 What we asked the hospitals to do is to create an
19 infrastructure. The hospital infrastructure
20 included a hard-stop policy that made there be a
21 pause before there was any early elective
22 delivery or predetermined set of medical

1 indications we asked in that policy.

2 We asked that there be review for
3 other medical or non-medical interventions, so
4 that pre-determined medical indications weren't
5 the only exceptions, if there was something else
6 that wasn't on the list, and we asked that they
7 locally develop the set of indications. Then we
8 did an internal -- we did a review of these hard-
9 stop policies inside state government from their
10 attestations. We asked for an internal quality
11 review for all planned deliveries under 39 weeks,
12 and then consistent efforts to estimate
13 gestational age and patient and family education.
14 Hospitals only reported to us their aggregate
15 results.

16 Non-participating hospitals were
17 reported by patient. One of the things that --
18 there's an interesting article that came out in
19 our paper about this was Medicaid enforces early
20 elective delivery program by provider reporting
21 burden. I thought that was accurate, even though
22 it was kind of -- I don't know if I liked the

1 publicity that way, but it worked.

2 We didn't use a non-payment policy.
3 We, semi on purpose, created an annoyance to make
4 the hospitals want to do this. You can go on to
5 the next slide. This is an analysis by our
6 university. I wish all of our measure responses
7 could be this good, but the arrow is where we put
8 in our policy. You can see that even before a
9 policy gets put in place, people react. We got
10 down to a very, very low rate in these 69
11 hospitals of early elective delivery. Things
12 work when a process can be put in place, but
13 obviously, that's a lot of work. Go ahead, if
14 you can go to the next slide. The point I want
15 to make, though, is that what we all want is
16 improved outcomes for the patients.

17 The vertical linkage of NQF measures
18 to patients and providers is really dependent
19 upon local relevance, the ability to track the
20 measure as a sentinel outcome of performance, or
21 as a key structural or process step, and to be
22 supported with a defined performance improvement

1 effort. The other thing I wanted to put down
2 here in the bottom, which is, I think, what we
3 ask ourselves a lot, is what's the developmental
4 capacity of that part of the system to measure --
5 to improve care?

6 We have to really look at that in a
7 very critical way. Next slide, please. This is
8 to prove that Minnesota isn't flat entirely, and
9 that vertical integration is sometimes
10 achievable. This is our beautiful North Shore.
11 Anyhow, keep going. I wanted to talk a little
12 bit here because I think that one of the key
13 issues that I find is that we look at measurement
14 decisions that are guided by the purpose of the
15 measurement. A lot of the measurements in
16 community measurement is really measurement for
17 accountability. That's good, but I think we have
18 to really be honest with ourselves that
19 measurement for accountability isn't all that we
20 want, and that we can't always do it.

21 Because one of the things I think
22 happens is when measures become something for

1 accountability, there become big efforts to make
2 them happen, and there also become some efforts,
3 sometimes, to game the measure, especially if
4 there's finances associated with it. We think
5 about measurement in a number of other ways. One
6 is measurement for quality improvement.

7 So underneath an accountability
8 measure, or even separate from it, quality
9 improvement can be the key issue. We're
10 embarking on a big effort -- which is actually
11 where I'm at right now, so I'm not with you guys
12 -- on quality improvement around opioid
13 prescribing. We really feel like we have to give
14 the providers a chance to figure out a system
15 where quality improvement is the key, and we
16 measure some sentinel things on the accountable
17 level, but that the most of the work is done
18 around quality improvement. We also have
19 measurements to compare populations and identify
20 disparities. That's becoming an increasing
21 issue. Sometimes those things can highlight
22 significant disparities. We have a significant

1 disparity in our racial and ethnic populations
2 around neonatal abstinence syndrome, for example.

3 We use measurements for that. The
4 last thing, then, is sometimes we use measures to
5 develop policy. When we have measures that we
6 can use to change the story at the legislature,
7 that's not an insignificant issue. I think my
8 important point is the measurement world does not
9 live outside of these quality improvements or
10 policy conversations. We, at Medicaid, really
11 work hard to integrate all of those things.

12 Next slide, please. I wanted to talk
13 a little bit more to the core of what this
14 meeting is about. I'm talking about what we
15 measure and report, what we measure and don't
16 report, and maybe what we would like to measure.
17 So you can keep going. I'm not terribly proud of
18 the fact that Minnesota has a very low level of
19 reporting of measures. That has something to do
20 with the internal policies of some folks who have
21 been at DHS but aren't there right now. These
22 are what we report right now, the child and

1 adolescent access to primary care, well visits in
2 these two age ranges. Here's what we collect and
3 have not reported yet, but I'm going to try to --
4 if you go to the next slide, I'm hoping that we
5 get this going very soon and our numbers go way
6 up on that chart.

7 I'll be more proud and don't have to
8 hide my eyes so much when I see Lakisha and
9 Marsha. Here's what we have that is available
10 and collected. I think there's a lot of that
11 that actually we can look at and think about
12 improving. Then if you go to the next one,
13 here's the ones that we don't have available on
14 the next slot. I wanted to do one thing on this
15 first. I'm sorry.

16 One of the reasons -- no, you can go
17 back to that -- go forward. I want to just talk
18 about this because this is a postpartum visit,
19 which we're actually going to probably put into a
20 -- I'm working to put into a managed care
21 incentive. I just want to show that one of the
22 issues about measurement that's actually, I

1 think, important is that if we don't measure, we
2 sometimes start to slip. Here you could see
3 where we were at 49 percent for the postpartum
4 visit, and we've gone down to 42 percent, and
5 that we have a fairly big discrepancy by race and
6 ethnicity, as far as who we can get back for a
7 postpartum visit, depending on community.

8 So there's a lot of work to be done
9 here and work that we think can be done through
10 managed care. Next slide. Here's some things I
11 think would be really important for us to measure
12 that I'd like to work on from our state
13 perspective, that I think could actually change
14 the conversation in Minnesota, as well.

15 Live births under 2,500 grams, that's
16 an outcome measurement, and the process measures
17 about developmental screening, less than three
18 year olds, and the frequency of ongoing prenatal
19 care are things that, I think, I'd like to
20 measure because I think we could put programs in
21 place and are in the process of talking about
22 programs to actually improve them. You can keep

1 going. Here's the areas where I know you're
2 considering some measures, or the measures are in
3 development, that are really important.

4 Children's mental health outcomes, I think this
5 is one that we struggled with in 2009 when we did
6 the first core set, and I think we continue to
7 struggle with, is what are relevant outcomes in
8 children's mental health that we can actually
9 report. We have some interest there around
10 trying to reform care.

11 This may be sort of like the
12 conversation that we just had about an
13 infrastructure measure about whether or not we
14 look at the infrastructure there. We look at
15 integration of behavioral health and physical
16 health as a big issue to be able to measure how
17 well that's being done. Care coordination, which
18 I think of as really coordination in the medical
19 setting and in case management, which is the
20 broader coordination with social services.

21 We're in the process of doing some
22 work from one of the Centers of Excellence that

1 we were co-investigator with, so one of Denise's
2 children, on social determinants of health and
3 the link of social determinants to health
4 outcomes. That's not a measure we will use,
5 necessarily, for outcomes, but it's measures that
6 we are really -- actually, the legislature asked
7 us to use to develop some recognition in the
8 payment system around the difficulty of care
9 coordination for kids who have more social
10 complexity. Then some of the things we'd like to
11 work on or that we're already working on are
12 specific challenges, for example, opiate use I
13 already alluded to, and then we have challenges
14 around disparities by race and ethnicity for the
15 timeliness of autism diagnoses that we'd like to
16 get to, as well.

17 You can keep going. I want to talk
18 about measure depth. I thought a picture of one
19 of our state birds, who's nesting right now,
20 would be a good way to talk about depth. That's
21 the Minnesota loon. You can keep going. So
22 measure depth, I think we think about this in

1 terms of infrastructure process and health
2 outcomes.

3 There's some compelling to get to more
4 and more health outcomes. I think that's okay.
5 My point I'll get to a minute is really we have
6 to think about when the health outcomes is good
7 enough to spend the energy to get to. I added
8 something to the measure depth on the next slide
9 to really think about this. I don't know if I
10 have the terminology right, but there's some --
11 there are things to add on both sides of this
12 that I think are really relevant that are maybe a
13 little bit hard to get to sometimes at a group
14 like NQF, but I think they're important. One is
15 deep infrastructure on the one end, and then the
16 other is well-being on the other end.

17 In deep infrastructure, I think about
18 things like how well teams function and whether
19 providers are satisfied. Some of my colleagues
20 have suggested that the triple aim or the three-
21 part aim maybe should be the four-part aim.
22 Provider satisfaction's a really important

1 component to keep our workforce intact, and we
2 shouldn't neglect that. Team cohesion is really
3 important as we add more -- in Minnesota, we add
4 more lay health workers, like community health
5 workers, into the team.

6 Team cohesion is a really important
7 thing I think underlies some of the success on
8 things like healthcare homes. Then processes I
9 think we all know about. There's a lot of
10 process in the measure set we're considering
11 today, and then health outcomes, things like
12 early elective deliveries. But then on the other
13 side, which is where it gets a little tricky
14 because providers can't always impact this, but
15 it may be okay just to figure out where
16 communities are at, are things like well-being.
17 I have to confess that I'm not an expert on the
18 well-being -- I'm not up on the well-being
19 measures for children.

20 I think these are mostly for adults.
21 You can keep going. I wanted to challenge the
22 thinking a little bit here because I was invited

1 to speak. I want to tell you how we sometimes
2 think about this. Is a good measure of
3 infrastructure or an incomplete measure of
4 process or health outcome better? A good measure
5 of infrastructure may be something like -- and
6 something like we're considering now -- is how
7 much of our behavioral health is trauma-informed
8 care, which we think is a better way to look at
9 this, and how much is not trauma informed?

10 Because we know that trauma has a huge
11 effect on our young children -- all of our
12 children, but especially our young children. Is
13 that a better or worse thing than a follow-up
14 visit for ADHD? I think sometimes, we have to
15 say that a better, more holistic infrastructure
16 measure may be the way to go, and it may be
17 easier to move the system based on something like
18 that. You can keep going. A couple of
19 opportunities. I want to give credit to some of
20 the work that's been done with CMS through the
21 expert panel and Strong Start and the way the
22 Adult Quality Measure grants actually look for

1 quality improvement projects as a really
2 important link between quality improvement and
3 policy in measurement.

4 I think those things have really been
5 good catalysts in states to move things along. I
6 want to give a little plug here, just because I'm
7 finishing up as chair of the Medicaid Medical
8 Directors Network. Our group has really been
9 interested in doing comparisons across states.
10 States are natural experiments for how policy
11 links to measurement.

12 We did a project that was published in
13 December, with 22 states, on early elective
14 deliveries and showed both variation in states
15 that sometimes, based on their policies, as well
16 as the fact that overall, the rates were going
17 down. Things like that actually help us, as
18 Medicaid medical directors, move the needle by
19 being able to compare what we're doing. We'd
20 like to do future work like that, as well. Then
21 along with that, I think that there's -- I know I
22 saw in the list of attendees that Terry, from the

1 AAP, and some other folks -- I think that linkage
2 of this kind of work with the maintenance of
3 certification has a huge opportunity to align
4 where the provider community and the Medicaid
5 agency and the national organizations can
6 actually line up.

7 I'd love to be able to look and
8 explore the opportunities to improve some of
9 these measures based on that kind of linkage,
10 which we really haven't developed yet. I think
11 it would make the maintenance of certification,
12 which has been challenged of late, more relevant.
13 Next slide. I think I'm done. Thank you for
14 listening to me from afar. I hope this was
15 helpful framing and information.

16 MS. LASH: Thank you so much, Jeff.
17 It was a great presentation, really informative.
18 We're going to take questions and comments in the
19 room. As people are formulating their thoughts
20 for you, I do want to go to the next slide, which
21 has some discussion questions we pre-prepared.
22 Some of them might be questions to the presenter.

1 Some of them might be questions you all want to
2 ask of each other or share your opinions out
3 about. First, what are hearing as significant
4 challenges, and how might changes to the core set
5 actually be able to respond to those challenges?

6 Did you hear anything from Minnesota
7 about measure-specific feedback that we actually
8 need to take into the calculus of decision making
9 about what to be added or removed from the core
10 set? What policy-level issues are beginning to
11 float to the top that we need to be sure to
12 revisit in tomorrow's joint discussion? Then
13 finally, what are we hearing about successes
14 related to the use of measurement? How are
15 states able to capitalize on this opportunity? I
16 do see a couple cards up in the room. Alvia
17 first.

18 DR. SIDDIQI: Thank you so much, Jeff,
19 for that very insightful presentation. I just
20 had a couple of questions. First, when you
21 talked about patients that are medical home, ACO
22 integration within your Medicaid provider

1 network, do you actually incentivize practices
2 that do move towards the PCMH model, which
3 obviously helps with the alignment of quality
4 measures when you have a proactive healthcare
5 delivery system? That's one question, if you do
6 incentivize that as a state. The second, can you
7 speak a little bit more about the development of
8 the Minnesota Community Measurement?

9 I think that's a really interesting
10 concept and something where states could really
11 look to, in terms of trying to align all the
12 different managed care, non-managed care,
13 Medicaid plans to try and work together on
14 talking about quality. So just those two
15 questions for you.

16 DR. SCHIFF: Sure. First of all, our
17 patient-centered medical home, which we call
18 healthcare home in Minnesota, there's not an
19 incentive to move there, but there's actually
20 payment once you're there. We pay a per member,
21 per month in the fee-for-service Medicaid
22 program. The HMOs have some capacity to pay

1 differently for patient-centered medical home.
2 We think of it, quite honestly, as the core
3 infrastructure change in our system redesign in
4 Minnesota. We have over half of our primary care
5 practices and well over half of all of our
6 patients cared for in medical homes. We're
7 pretty proud of that. I would like to say that
8 the quality measures that are associated with
9 medical home are reported through the community
10 measurement, and they're decided by a quality
11 committee through the medical home program. They
12 don't have any teeth.

13 Originally, we had this idea, when we
14 started the medical home, that if your quality
15 was lousy, we would vote you off the island, but
16 the reality is we're too nice. And the measures
17 that we generally, actually, overall see
18 significant -- the medical home providers
19 generally do better than the other practices in
20 terms of the quality that they provide. And that
21 measure already happened.

22 So no specific payment for the

1 transformation effort, but payment once you
2 transform. That's been -- I shouldn't say that
3 entirely. We've given grants across time, small
4 grants, to get people to transform, but nothing
5 on an ongoing basis.

6 As far as community measurement's
7 concerned, community measurement, I think, was
8 conceptualized in sort of an agreement between
9 the HMOs -- and you should note that we have only
10 homegrown HMOs in Minnesota. We don't have the
11 for-profit corporations, even though one of them
12 has its headquarters in Minnesota, but doesn't
13 operate in Medicaid or in the state, as an HMO,
14 because all HMOs in Minnesota have to be not-for-
15 profit by state law.

16 So they're homegrown and maybe made it
17 a little easier. The medical association, I
18 think everybody thought this is a better system
19 to have community measurement engagement. I
20 think overall it is. One of the jokes that I
21 think was early on in the initiation of community
22 measurement is they looked at their web hits once

1 they released their -- in October or November,
2 they released their annual ratings. They had
3 about 20,000 hits.

4 I would say that is 10,000 primary
5 care docs looking twice at their data because
6 everybody wants to know how they compare. I
7 think that's actually been a very effective part
8 of it is people want to know. They are pretty
9 good about looking in the community measurement,
10 just for those of us who are a little geeky, they
11 do confidence intervals. They put out people's
12 range and whether they're -- if you have a small
13 number, the range is larger, but I think that
14 helps so people don't feel like they're pushed
15 too hard. Then there's also one more thing is
16 that community measurement, a lot of folks in
17 Minnesota have electronic records, and community
18 measurement allows for electronic submission,
19 which gets the whole population, or they allow
20 for a sample for those practices that don't have
21 electronic submission.

22 MS. LASH: Thank you. Next question

1 from Anne.

2 MS. COHEN: Yes, I really appreciate
3 your comment about trauma-informed behavioral
4 health. I think that behavioral healthcare is
5 something that we're looking at, and we've looked
6 at the anti-psychotic use, but through a
7 different lens to inform the conversation, so I
8 thought that was important.

9 I thought your issue of opiate use was
10 a really critical one, and it's something that we
11 haven't really looked at either from the abuse
12 perspective or a pain-management perspective that
13 we might want to consider. Then the last one was
14 one of a question in your area of care
15 coordination in case management. Is there
16 something specific within that category that's a
17 need in your state? Is it around the home and
18 community-based services? Is it to a specific
19 measurement area we might want to work towards?

20 DR. SCHIFF: Thanks for the comments
21 about trauma-informed care and about opiates. I
22 don't have a specific case management care

1 coordination measure. I know that some of the
2 measures we developed through our Center of
3 Excellence may be worth doing, but I think that
4 they're a little hard because they're very chart
5 and medical record review intensive, but I think
6 one of the things I think about in some of the
7 care coordination and case management aspects is
8 maybe to look at whether or not there's an
9 infrastructure in place in states.

10 I know this isn't a specific measure
11 right now, but whether there's an infrastructure
12 in place to create that mechanism, either through
13 a medical home or through an integrated
14 behavioral health primary care system, and that
15 things like shared care plan between provider
16 organizations may be something to look at. Some
17 of the care coordination measures that we've
18 looked at in our center of excellence could be
19 the underlying base that you'd expect practices
20 to have in a situation like that. One of the
21 things that we did in Minnesota that could be a
22 state-level measure or could be a program-level

1 measure for our state innovation models. We
2 traded a matrix of the continuum of development
3 of integration across different systems.

4 We actually require all of our SIM
5 grantees to fill that out. It's not a measure by
6 standards of NQF. What it really does is it
7 creates a discussion so that our most integrated
8 models, where we really want community social
9 service to be integrated with medical care -- and
10 we have better success of that, quite honestly --
11 I shouldn't say better success -- some of our
12 best success of that is in rural areas, where
13 there's less providers.

14 We can actually track the governance
15 of those organizations and how they share care
16 plans and how they share records as a mechanism.
17 Those kind of things are things that I would
18 suggest that if we really want to push
19 integration, we look at that. I'll just say it
20 again, sometimes the hardest parts of that are to
21 figure out the governance issues, which I think
22 are not insignificant when you get organizations

1 together that commonly haven't talked to each
2 other.

3 MS. LASH: Thank you. I've been
4 trying to note the order in which people are
5 getting in the queue here, so we'll go to Luther,
6 then Terry, then Sandra, then Susan, then Kevin,
7 then Marc.

8 DR. SCHIFF: I guess I have some
9 questions. Good.

10 DR. CLARK: Thank you, that was a very
11 interesting and informative presentation. I have
12 two questions. Do you know how Minnesota
13 compares with other states in terms of the number
14 of measures reported and of late, have you been
15 adding or subtracting measures? The second
16 question, you commented a couple of times on the
17 issue of disparities. I was just wondering if
18 all of the measures that you're using considered
19 to be disparities-sensitive, and is it something
20 that is considered in selection of measures?

21 DR. SCHIFF: I'm going to take your
22 second question first. Community measurement, in

1 a contract from us, puts out a disparities
2 report. I guess I would say that it's really
3 good because it raises the question of
4 disparities. It looks at some of the most common
5 measures, and I think about it mostly in terms of
6 the adult population. It looks at the
7 disparities in things like cardiovascular care
8 and blood pressure management and diabetes and
9 things like that.

10 I'm going to say that because we
11 always have more questions, I think it could --
12 I'd like it to go further, so we don't -- I think
13 a lot of these measures we can look at by
14 disparities. We don't always look at them that
15 way. The other thing that we did in the
16 disparities world, which is, I think, important,
17 is we just released a report about a month ago
18 which looked at the social risk factors that our
19 kids are under. We have 440,000 kids.

20 We looked at, really, the demographics
21 of the social risk factors, how many of those
22 kids are homeless during a year? How many of

1 those kids are, have child protection? I think
2 in some respects, there's a lot of pressure,
3 which is really appropriate, and I'm excited
4 about, but it is to say what are the social risk
5 factors that cause disparity? One of the things
6 that's been very interesting about this, and
7 we're just starting to look at this, is to look
8 at whether the social risk factors, rather than
9 the race and ethnicity, explain variation.

10 That, I think, is an important thing
11 because it raises the question, really, of we
12 know that certain minority groups are more likely
13 to be poor and more likely to have health equity
14 issues. I think that that's a sort of an under-
15 the-hood kind of thing that I think can be really
16 helpful, as far as disparity. I think it's
17 important to look at all these measures by
18 disparity, but at some point, we have to look and
19 say what's under that that causes a disparity?

20 Homelessness causes disparities;
21 parental mental health does; parental substance
22 abuse does; involvement with child protection,

1 all those things really talk about chaos that are
2 maybe more of -- they do affect some of our
3 populations, our Native American population and
4 our African American population more, but it's
5 maybe -- we won't get to that by just calling it
6 out by race or ethnicity. That's the answer.
7 There's a big report on community measurement
8 about that, and then there's a report that we did
9 around what are the risk factors inside that? As
10 far as the number of measures go, that's a big
11 cry by the providers, and I think an appropriate
12 one as we keep on adding measures, and we don't
13 take measures away.

14 One of the things we've talked about,
15 partly because it's time for -- the SQRMS system
16 has been in place for a number of years and
17 people are saying what's next. I think we really
18 talked a little bit more, based on that and based
19 on the IOM vital signs report, about creating a
20 deeper strategy to more reflect some of the
21 things I was talking about and maybe abandoning
22 some of the measures that are outcome measures

1 for some more process and infrastructure type of
2 sentinel measures.

3 MS. LASH: Thank you. Terry.

4 DR. ADIRIM: Hi, Jeff, it's Terry.
5 Thank you so much. That was a really informative
6 presentation. Actually, your answer to the last
7 question was also very helpful, too, as well. My
8 question goes to gaps in the child core set. I
9 suppose wearing your Medicaid medical director
10 chair hat -- because again, this is a national
11 set. It's not necessarily reflective of the
12 needs of one specific state. Could you speak a
13 little bit about what you think is missing,
14 perhaps, that would be helpful in assessing -- so
15 what do you see as the gaps? Also, I figured I
16 might as well just ask, since you were talking
17 about cutting measures, is there anything on this
18 list that you think you might want to see cut?

19 DR. SCHIFF: It's kind of interesting
20 because I think some of the gaps are some of the
21 same things we identified in the 2009 set. I
22 have a slide that I don't know if you want to

1 pull up. I can give you a number. I think it's
2 maybe -- it's Slide 23. It's the one that says
3 projects we are working on where we'd liked
4 better measures.

5 That's the stuff I think we'd like
6 more on -- I think that the more is not
7 necessarily -- I think these are really tough
8 areas, so I don't think -- I think that the more
9 may be things like a state infrastructure measure
10 or a system infrastructure measure. I really do
11 think we're going to try to move to some sort of
12 a measure of how many kids who are getting mental
13 health services, the rate of diagnosis maybe at a
14 young age in mental health care, and then things
15 like the number of kids who are getting trauma-
16 informed care in that population, for example.
17 That may be something that we could look at. So
18 I think that there's some infrastructure and
19 process things we ought to think about building
20 first, which I think would be worthwhile.

21 Then integration of physical and
22 behavioral health is a big issue. Care

1 coordination, I think, is a really tough one, and
2 then social determinants, I don't think, as a
3 measure, that we should hold people accountable
4 for, but I think we ought to have a bigger
5 conversation about what should be in those
6 buckets.

7 We certainly have done some of that
8 with the Center of Excellence, but I think we
9 could do more. As far as what we could cut, I
10 didn't make a slide like that because I was
11 trying to be a little political, but I wrote down
12 the list of things that I think we should measure
13 in the future, and then the list of things that
14 we have, and the list of things that we already
15 report. There's a few that aren't on that list.
16 I have trouble with the -- the ones that aren't
17 on -- the ones that are on the core set that
18 aren't on those three lists are the ones that I
19 think I should cut. I won't look for the sheet
20 right now, but one of them is the follow up after
21 ADHD. I think that's not an unimportant thing,
22 but I don't think the juice is worth all the

1 squeeze on that, for example.

2 MS. LASH: Thank you. Before I take
3 the next question -- and I apologize -- I want to
4 insert a question of my own here, since we were
5 just talking about opiate use as a gap. Would
6 you see that as relevant for both the child core
7 program and the adult core? How prevalent would
8 the opioid use issue be in the pediatric
9 population?

10 DR. SCHIFF: I don't think it's as big
11 a deal with the kids, to be honest with you. We
12 haven't seen it as a -- there's a little bit of
13 adolescent issue around it, but it's -- I don't
14 think it's as much of an issue. The meeting I
15 was at, people just presented the data. I think
16 if we're going to do something on opioid use in
17 kids, we should -- I should've thought of this
18 earlier -- we should talk about NAS -- neonatal
19 abstinence syndrome and opioid exposure. That
20 would be, I think, a really important use on
21 things like early screening of moms, which we're
22 talking about implementing through some

1 legislation we just passed, so we can identify
2 folks early. But then again, you need to have a
3 continuum there, where you can do early
4 screening.

5 You need to have appropriate
6 treatment, medication-assisted treatment and
7 follow-up care. You maybe want to look at a
8 continuum of care in that regard. It's a big
9 deal in adults, and I want to say just one --
10 I'll put one plug in for you guys tomorrow when
11 you're with the adult folks. We want to look at
12 an inflection point in opioid use that we're
13 developing inside Minnesota.

14 We'd like NCQA to take this up, or
15 somebody that'd be the measure steward. That is
16 what we call new chronic users, so folks who have
17 -- you go, you break your leg. You go to the ER.
18 They give you a four or five-day supply. You go
19 to the orthopedic surgeon, they give you a 30-day
20 supply. Then all of a sudden, your physiology
21 changes and you're in trouble. Then your
22 genetics, as well, or your behavioral situation

1 is such that you ask for another refill. All of
2 a sudden, you're a chronic opioid user. We can
3 move upstream, I think, by saying that we want to
4 avoid new chronic users whenever possible by --
5 what we've done is we've looked at opioid-naive
6 individuals, who don't have any opioid on board
7 for six months, and then seen who, in the
8 following six months after an indexed
9 prescription, have 45 days or more, which is what
10 we're considering chronic.

11 We make over 3,000 of those folks
12 every year, and the million people in the
13 Minnesota Medicaid program. Those are the people
14 we get concerned about because a lot of them will
15 then go on to use heroin, not a lot, but most
16 heroin users start with pills. So we would like
17 to move upstream in that regard.

18 DR. ADIRIM: I have a quick follow-up.
19 Jeff, it's Terry again. With regard to trauma-
20 informed behavioral health measures, are you
21 aware of any that are in the pipeline or ways
22 that you all are considering measuring that?

1 DR. SCHIFF: I'm not an expert on
2 this, but one of our child health people -- there
3 are a set of measures that are used for younger
4 children, as far as outcomes. They're not
5 specifically whether the trauma-informed care is
6 being delivered, but they're actual functional
7 measures that are scored by the families, as far
8 as whether the kids' symptoms are better for
9 young kids in mental health.

10 Those measures may be -- I don't know
11 enough about them. I could certainly connect you
12 guys with our experts in Minnesota. I'd love to
13 do that. It may be a measure at the level of
14 NQF, maybe, about whether or not a tool like that
15 is being used in the state that actually measures
16 outcomes, rather than the specific improvements.
17 That would sort of get to that, so we could drive
18 to an infrastructure outcome around trauma.

19 MS. LASH: Thank you. Marsha?

20 MS. LILLIE-BLANTON: I have a quick
21 follow-up question, Jeff. Could you say more
22 about why you think the follow-up care for

1 children, prescribed medications for ADHD is not
2 of value, or at least worth our continuing to
3 report?

4 DR. SCHIFF: I think the issue is that
5 what I think happens is that if people are doing
6 this well, they can do that telephonically, for
7 example, and we won't get a claim on it. Some of
8 the measures where we'd like to move to more
9 integrated care where that could be done, that's
10 just an example of one where we want the kids to
11 have follow-up and make sure they're doing okay,
12 but I think I'm saying I guess that's the more
13 specific answer.

14 I think the other challenge is in the
15 spectrum of treating kids with ADHD, that's
16 something we can measure off of claims, so we
17 like it, but are there other things that are more
18 important, like measuring whether their
19 functional status has improved at school, some of
20 the other measures that we can't get at. I guess
21 that's really where my head goes with that one.

22 MS. LASH: Sandra, you're next.

1 DR. WHITE: Hi, Jeff, this is Sandra.
2 Thank you for that very comprehensive
3 presentation. I was also very interested in your
4 -- you touched on building infrastructure as a
5 way to improve and change the care delivery
6 system, as well as to drive outcomes on the
7 quality measures. One of those changes is that
8 you are actually reimbursing additional to your
9 fee-for-service providers if they have a patient-
10 centered medical home care delivery system. I'd
11 like to know whether or not the PCMH is
12 designated because they are a recognized PCMH, or
13 because there was attestation based upon the
14 state's criteria of being a PCMH? That's the
15 first part of my question. The second is I'd
16 like to hear a bit more about the recent
17 publication by the medical directors network.

18 DR. SCHIFF: Sure. Sandra, I'm sorry
19 I don't know you well, or I don't recognize you.
20 Can I just ask what organization you're from?

21 DR. WHITE: Sure. I'm Dr. Sandra
22 White. I'm the executive director of healthcare

1 quality for Aetna.

2 DR. SCHIFF: Oh, great, thanks. The
3 first question about PCMH, we have a state
4 program that sort of came into being around the
5 same time as NCQA. What we do, which makes it, I
6 think, really more effective, is we actually do
7 site visits for certification. People have to
8 first fill out the form that attests to all the
9 qualifications which are in Minnesota state rules
10 to become a patient-centered medical home. In
11 those criteria, they attest to that. They fill
12 in performance data or close enough or at the
13 point, wherever that's done, a site visit is
14 done, which includes a provider, which is often a
15 care coordinator, a member from the state
16 Department of Health, and then a patient or
17 family member, which is really a very crucial
18 thing.

19 Then the one thing I want to emphasize
20 in our patient-centered medical home is we push
21 the quality improvement process so that it's not
22 enough to have all the pieces in place. One of

1 the key pieces you have to have in place is a
2 functioning quality improvement system at the
3 site level, so that the medical home drives
4 infrastructure improvement.

5 Initially, people didn't like that, or
6 they were worried about it, but the reality is
7 that the site visit is really a learning thing
8 that people embrace, and they enjoy it. It's not
9 a punitive thing. There's very few times when we
10 say you can't belong. Sometimes we say you need
11 to change X, Y or Z, or here's how, so that's
12 been a very helpful thing. The second thing you
13 asked is about the Medicaid medical directors.
14 The report is in Health Affairs from December
15 2014. We, with the help of some technical
16 support from -- CMS provided support through PRI,
17 through Marsha and Lakisha, as well as
18 AcademyHealth, who really organized the project.
19 AHRQ provided funding, and then we got some
20 funding from HRSA and MCHB, as well.

21 We really, as Medicaid medical
22 directors, see if there's a value in doing

1 projects where there are cross-state comparisons
2 of policy. One of the reasons we wanted to do
3 this project was because it was in the core set.
4 It was something that we thought was a very
5 winnable battle because the evidence was clear.
6 Some of the processes to effect change were
7 already in the literature, and we thought that we
8 could look at it together.

9 States were already looking at it. It
10 was something that was a significant improvement
11 in health outcomes. The medical director process
12 was really more about collecting data and
13 collecting policies that compared how states did
14 things, rather than -- it wasn't that we all
15 decided we were going to go jump off the side of
16 the pool at the same time. It was more like what
17 are you doing, and has it been effective? States
18 were able to compare where they were at to other
19 states in a way that made them look and see which
20 policies were more effective or not. That's what
21 we did. The core data's in that article, and
22 then on the OHSU website, which is run by

1 Christina Bethell, but I can't think of the name
2 of the site exactly. We have all of the cross
3 tabulations available, as well, so it looks much
4 more specifically at the populations and some of
5 the ways we could analyze it.

6 MS. LASH: Just a few more questions.
7 Kevin.

8 DR. LARSEN: Thanks, Jeff. This is
9 Kevin Larsen. As we talk to a lot of states and
10 providers, they're really thinking about
11 alignment and how do we align beyond programs.
12 What would you say are your key successes and
13 challenges as you try to align your Medicaid
14 measurement to other state-based measurement
15 programs? I know in Minnesota, you mentioned
16 SQRMS. There's also the Minnesota Community
17 Measurement. How would you counsel us as we
18 think about that alignment question?

19 DR. SCHIFF: I know you'll always ask
20 great questions, not that they all weren't. I
21 think about this, and I think that's probably
22 what I tried to gear this towards. I think if we

1 can align about some of the measurement
2 infrastructure and it links to -- I guess the
3 biggest vertical alignment thing is the thing
4 that I say is the biggest deal.

5 I know whether a program's going to be
6 successful or not because I can go to the
7 providers who I know in the community and they'll
8 say, this is great. We think this is something
9 that needs to be done. Or I can tell it's going
10 to do really badly because they go, this is way
11 too focused on one part of the process, and we're
12 not going to get far enough.

13 I gave the example of body mass index,
14 where people weren't really very excited about it
15 because they said, what am I going to do once I
16 find somebody who's obese? I don't know what I'm
17 going to do and how I'm going to get them to
18 counseling. So much of that is outside my
19 purview, where the vertical alignment that we are
20 doing with opiates, for example, I have
21 anesthesiologists calling me up and saying at my
22 institution, the orthopedic surgeons and the ENT

1 docs and everybody automatically writes for 30
2 days of opiates because they don't want to be
3 bothered on the weekends. I'm sitting there
4 going, can you please help us. Even though not
5 all the medical community's going to like that,
6 they're all going to be willing to put that in
7 place. I think that I would say -- I guess what
8 I would say is first make sure their alignment
9 works with their provider community.

10 I would even go further and say it
11 makes sense for most patients. Then the second
12 thing, then, is I think the alignment at the
13 national or the state level is around what kind
14 of infrastructure could we put in place to
15 support that, that makes sense, that they'll buy
16 into, so we're not creating a burden, as much as
17 possible. Think more about measurement for
18 quality improvement and how to make that work,
19 and maybe a little less about measurement for
20 accountability.

21 MS. LASH: Next question from Marc
22 Leib.

1 DR. LEIB: Sorry. Jeff, this is Marc
2 Leib. Congratulations on finishing your year as
3 president of your medical directors there.

4 Question for you in follow up about the patient-
5 centered medical home. I applaud the efforts
6 that you have to not only just let them designate
7 themselves, but to actually go out and review
8 them, look at their processes, decide if they
9 really meet the criteria.

10 But once you are making these payments
11 per member, per month, on an ongoing basis, are
12 there any requirements, let's say two or three
13 years down the road, to show measurable
14 improvements in quality or decreases in cost,
15 either one of which will increase your value, in
16 order to continue getting those payments, or is
17 it just an ongoing, as long as they say they're a
18 PCMH and they met the criteria, they continue to
19 get that money?

20 DR. SCHIFF: I guess I would say the
21 short answer is the legislation allows us and
22 tells us to do that, and we haven't been very

1 good at it. We're working on it. They actually
2 have to re-certify every year, and that's a
3 pretty significant burden, so we really have a
4 biennial or triennial system by which we -- some
5 years are really almost a pass-through, and other
6 years are much more a report on quality. There's
7 just a very few -- less than ten -- programs that
8 have decided not to continue in the program and
9 continue to be certified. The vast majority, 150
10 or 200, have decided to be re-certified. In
11 terms of cost, one of the things that's pretty
12 interesting right now is we're really re-looking
13 at our payment structure for medical home. We
14 have a financial sustainability committee we're
15 starting that is going to kind of look at the
16 payment model.

17 I think one of the financial
18 sustainability options that I'm kind of excited
19 about is moving to a, I would say, more of on the
20 possibility of moving to a micro ACO model, where
21 actually there's some total cost of care analysis
22 in there. Bill Golden did that in his healthcare

1 home in Arkansas, and I think it's been an
2 effective way for people to be accountable in the
3 cost side. Then it's also an opportunity, as
4 well.

5 DR. LEIB: I have one other follow-up
6 comment. It's actually a quibble. Take it for
7 what it's worth. In your first slide or your
8 second slide, you had value equals cost over
9 quality. That should be value equals quality
10 over cost.

11 DR. SCHIFF: I couldn't remember.
12 Thank you.

13 DR. LEIB: I take every opportunity to
14 pick on you.

15 DR. SCHIFF: It's good to hear you.

16 MS. LASH: Andrea.

17 DR. BENIN: Hi, Jeff, this is Andrea
18 Benin. I have two questions. The first one, can
19 you comment a little bit on the relationship
20 between the Medicaid programs and the WIC
21 programs? Is there a gap area there around
22 metrics? At least in Connecticut, to get WIC,

1 there's certain things that happen at different
2 ages around lead screening and hemoglobins and
3 other types of metrics.

4 I don't know that I fully understand
5 the relationship between Medicaid and WIC and
6 whether there's an opportunity there when we
7 start to talk about alignment. My second
8 question is if you can -- I'm hoping, I guess,
9 that Denise is going to talk a little bit about
10 some of the new sickle cell metrics that are
11 coming out of the Centers of Excellence. It does
12 seem to me that the sickle cell metrics are a
13 potential gap that this group might want to go
14 into. I guess I'm interested in hearing some
15 commentary about your view on the epidemiological
16 and financial burden, if you will, around the
17 sickle cell population. It's a gap that I don't
18 think we've heard discussed.

19 DR. SCHIFF: Okay, thanks. The WIC,
20 that's an interesting question. We do a little
21 bit of work with WIC mostly around access to some
22 things like fluoride varnish and some dental

1 stuff, but we haven't really tried to align
2 measures with them in a really significant way.
3 So that's an opportunity we have not taken up,
4 and I don't know if other states have done more,
5 as far as that's concerned.

6 As far as sickle cell is concerned, we
7 haven't done that as -- that's an interesting
8 measure issue because I think it gets into the
9 whole hospital measure space, or at least ER
10 avoidance sort of thing. We haven't really
11 thought about that a ton in Minnesota. I think
12 the closest thing I would say is Children's is
13 one of our integrated health partnerships, our
14 ACOs. If they came to us and said, we're
15 interested in a measure on including quality of
16 our sickle cell care because we think we could
17 move that a little bit, we'd probably be
18 interested. We don't have a gigantic population
19 in Minnesota that -- or we haven't seen it as a
20 problem yet, and maybe we just haven't looked.

21 MS. LASH: Ashley.

22 MS. HIRAI: Hi, Dr. Schiff, this is

1 Ashley Hirai from the Maternal and Child Health
2 Bureau. I just wanted to follow up on one of
3 your possibilities for gaps in measures with the
4 opiate problem, specifically focusing on
5 children. You mentioned neonatal abstinence
6 syndrome, and that actually is a new national
7 outcome measure for the Title V Block grant, but
8 you also mentioned the need to focus more on
9 structural and process measures that drive those
10 outcomes in action.

11 I'm just wondering how you feel -- or
12 if you feel that the measure on the behavioral
13 risk assessment for pregnant women can help
14 capture screening and follow-up for addiction and
15 opiate use? I know it's a multi-item measure,
16 but we were also discussing challenges around
17 this measure because very few states are
18 reporting it and if maybe you could speak to that
19 more generally around the utility of that measure
20 or other barriers to reporting it.

21 DR. SCHIFF: I wasn't aware of the
22 neonatal outcome measure, so I'll be interested

1 in looking at it, first of all. The second thing
2 is around screening. I'll give you a little bit
3 of the story in Minnesota, so that you have sort
4 of the context of why infrastructure is really a
5 challenge.

6 This is probably a good example. We
7 have a rate of opioid use by pregnant women in
8 our native population of eight times as high as
9 our baseline population, so that's really a
10 crisis in some of our tribal communities. The
11 challenge is -- I think that tool could be
12 effective as far as screening is concerned.

13 Some of our hospitals, not necessarily
14 in those geographic areas, are looking at
15 universal screening, including questions, as well
16 as urine drug screening, so as specific -- I
17 think there's a link there. The challenge for
18 screening for us in this specific area is that
19 folks are more likely to be screened -- or come
20 in for prenatal care and then be available for
21 screening if they have some sense of what's going
22 on. There's a wide variety of two things. One

1 is there's a wide variety of how Child Protective
2 Services deals with women who are found to be
3 using. In some communities they won't come
4 forward because of this -- for screening because
5 they don't want to be found. We won't get that
6 fixed until we get to some unanimity about how
7 that works in different geographic areas of our
8 state.

9 Then the second thing is if folks are
10 screened, what's the services that are provided
11 for them and whether they're wrap-around.

12 Hennepin County, which is where Minneapolis is,
13 is our shining star. We have a program that does
14 screen and when moms are identified, they get
15 referred to this program. They have wrap-around
16 services.

17 They do medication-assisted treatment,
18 and they have a 95-plus percent success rate in
19 getting moms to healthy birth without using,
20 except for their assisted treatment. That's a
21 situation where I think screening might be an
22 interesting challenge and a good thing to do, but

1 as far as the substance abuse part of the
2 screening, I think just focusing on the screening
3 would miss all those other aspects that have to
4 be put in place to get to an effective and
5 healthy birth. We think of it as a three-legged
6 stool. We think of screening treatment and then
7 community support. So that's a situation where
8 the infrastructure's really important.

9 MS. LASH: Thank you, very thoughtful.
10 Do we have any follow-on? Ashley?

11 MS. HIRAI: Well, just in terms of
12 using that measure, I know that measure is just
13 the screening component -- the behavioral health
14 risk assessment. It doesn't capture the
15 treatment and follow-up. But just as a first
16 step, are you at all interested in exploring and
17 reporting that measure? What are the barriers
18 around that measure, specifically?

19 DR. SCHIFF: I think we'd be -- I
20 don't remember the exact numerator and
21 denominator in the measure, so I won't be able to
22 speak to the exact parts of it, but I think that

1 overall, we want that kind of screening to take
2 place. I think the challenge is if we look at
3 just the screening measure, and depending on how
4 it gets pushed, we may try to improve the
5 measure, but they won't -- it needs to be linked
6 to these other pieces. The question is, is it
7 better to do a screening measure like that, or is
8 it better to look at that screening linked to an
9 infrastructure that looks at how moms are treated
10 and whether or not there's appropriate support.
11 I guess I'm saying if you develop the
12 infrastructure, that measure should go up.

13 If there's too much emphasis on the
14 measure for accountability, then people will not
15 want to work just for that measure. It'll seem
16 like an effort that's too one-sided.

17 MS. LASH: All right, our last
18 question comes from our chair, Foster, who's
19 still en route to the meeting, so I'll read it
20 aloud for him. If you could expand on your
21 conversation about bandwidth, specifically how
22 many measures are, quote-unquote, enough or too

1 much to act on productively for a state, and then
2 I think you've already alluded to this a little
3 bit, but on the notion of importance or
4 relevance, are there any current measures that
5 don't meet your sniff test for being important?

6 DR. SCHIFF: I think I answered the
7 last one already. I don't want to inadvertently
8 pick on measures that people -- but I think that
9 there are some that I think we're more invested
10 than not. I guess it's an interesting question.
11 I guess there are -- what I'd say is we can
12 measure the amount of measures that are in the
13 sets. I think when it gets challenging is when,
14 on top of that, we have a set of state community
15 measures, or we have another set of measures from
16 a different organization and there's not
17 alignment.

18 I don't think that the number right
19 now is overwhelming in the core sets. I think
20 that number is pretty parsimonious and doesn't
21 even get to everything I think people want to get
22 to. I think the challenge is maybe what measures

1 do we put our full frontal assault effort into
2 and do much more of a quality improvement,
3 process improvement project on? I think that
4 number's much more limited.

5 I think we can do that in my Medicaid
6 program probably on maybe three or four at the
7 most. We do really one or two right now. I
8 think we're pretty resource-rich in Minnesota, so
9 there's not an ability to do that on too many --
10 I think the other side of that, though, I guess I
11 want to say, is I think that those process
12 quality improvement vertical integration efforts
13 are really worth it because they build momentum.
14 Then when people see that something's been done,
15 you create a better relationship with your
16 providers, and then they're willing to do
17 something else, so moving the C-sections, for
18 example, from early elective deliveries, I think
19 is something possible now because we have the
20 infrastructure.

21 I think we're still early on in this
22 whole process of national measurement and of

1 integrating it with local stuff. We're a little
2 further along than we were a few years ago, but I
3 think this is all great work. That's where we're
4 at. I greatly appreciate the opportunity to
5 address you guys.

6 MS. LASH: Thank you so much. That
7 does take care of all the questions from the
8 Committee. We want to take a brief moment and
9 pause for any public comments, either in the room
10 or over the web. If anyone is listening remotely
11 and wants to submit a question or comment via
12 chat, Severa will read them over the microphone
13 for the record, so we'll be able to capture that.

14 PUBLIC COMMENTS

15 DR. EISENBERG: I'm Woody Eisenberg.
16 I'm with the Pharmacy Quality Alliance. I'd like
17 to expand a little bit on some of the information
18 that you were provided by Nadine this morning on
19 behavioral health and the use of anti-psychotic
20 drugs. The slides showed us, and Nadine told us
21 that about 1.7 million Medicaid children under
22 the age of -- I'm not sure of the age -- are

1 using psychotropic meds.

2 Most of these are atypical anti-
3 psychotics. That number is from 2005. What's
4 happened since then is every time there's been a
5 study over the last ten years, it's shown that
6 there's been an increased volume in the use of
7 these anti-psychotic drugs, so that in a study by
8 Rubin recently, which also is referenced in the
9 slides, he shows that 13.5 percent of children in
10 what he's calling child welfare -- not sure
11 exactly how he defined that -- use psychotropic
12 drugs.

13 Again, the majority of that is anti-
14 psychotic drugs, mostly these atypical anti-
15 psychotics. Also, I think it's important for you
16 to know that the use of these drugs is
17 disproportionate in Medicaid patients. The
18 commercial population, the use of this is
19 incredibly rare. Within the Medicaid population,
20 there's about a tenfold increase among foster
21 children than the rest of the Medicaid
22 population, so there really are disparities in

1 the use of these drugs amongst children.

2 New information that I'd like to share
3 with you is that none of these drugs -- none of
4 the atypical anti-psychotics, in fact, has any
5 indications for children in this age category,
6 but there are well-documented side effects.
7 Those are cardiometabolic side effects. The
8 studies that have been done now are agreeing that
9 there are important increases in weight pushing
10 more children into overweight and obesity, and
11 then depending upon which age, increases in blood
12 sugar and blood cholesterol.

13 This afternoon you'll have an
14 opportunity to consider one of the measures from
15 PQA, the Pharmacy Quality Alliance, that looks at
16 measuring the use of these drugs amongst Medicaid
17 children that are less than five years old, so I
18 hope that you'll give that measure careful
19 consideration. Thank you.

20 MS. BYRON: Hi, Sepheen Byron from
21 NCQA. I just wanted to address an earlier
22 question that had come up about -- I think you

1 were talking about the HPV vaccination measure
2 and why it was different from some of the
3 information from the National Immunization
4 Service.

5 Just to note, the NIS -- the National
6 Immunization Survey, or NIS, is a group of
7 telephone surveys that is looking across the
8 population. They call parents. They also look
9 at healthcare providers to see what the
10 vaccination coverage is nationally across all
11 teens. The HPV vaccination measure that is
12 stewarded by NCQA actually is a performance
13 measure that is specified to say, did your
14 members -- or for a state, it would be, did the
15 population -- receive a completed series of HPV
16 vaccinations?

17 That would be all three doses of
18 vaccination by the age of 13, which is the
19 Advisory Committee on Immunization Practices'
20 recommendation. Where the NIS is looking at
21 coverage for 13 to 17 years olds, so it actually
22 goes beyond the by age 13 cutoff, and they're

1 looking to understand who initiated the series,
2 who maybe got two doses, and then who got three,
3 our measure looks to see who got all three doses
4 by the age of 13 because that is the
5 recommendation. When we did our analysis of the
6 first and second years of data reporting by
7 health plans, we did look at NIS data to make
8 sure that the coverage looked similar, just to
9 understand whether our specifications were on the
10 right track.

11 When you do cut the data for NIS at
12 the age of 13, the rates were very similar. So
13 we were confident that the measure was looking at
14 what it was supposed to be measuring, and that
15 the feasibility was good.

16 The rates, unfortunately, are very low
17 because very few teens are getting this by the
18 age of 13, but we're hopeful that the measures
19 used in programs such as HEDIS, and also in the
20 child core set, will help to boost the coverage
21 here because it will highlight the importance of
22 this vaccination and how low the rates really

1 are. Then I'll also just tag on to what PQA said
2 about anti-psychotics. We think that's really
3 important. We also had a set of measures that we
4 developed under the Pediatric Quality Measures
5 Program that's looking at anti-psychotics in
6 children. There's a whole series that are
7 looking at additional aspects, beyond the use in
8 very young children. Those should be in your
9 materials, as well. Thank you.

10 MS. LASH: Thank you, both, for those
11 comments. Operator, could you please give the
12 instructions for anyone on the phone that would
13 like to make a public comment at this time?

14 OPERATOR: At this time, if you would
15 like to make a comment, please press star, then
16 the Number 1 on your telephone keypad. Again,
17 that's star one to make a comment.

18 MS. LASH: While you're assembling the
19 queue, I'll ask Severa if there's anyone with a
20 web chat comment? No, it doesn't appear to be
21 so.

22 OPERATOR: And there are no comments

1 at this time.

2 MS. LASH: Wonderful. We've all
3 worked very hard this morning. We've gone
4 through a lot of information, and we've got a
5 busy afternoon ahead. We've earned a lunch
6 break. We'll reconvene at about 35 after.

7 (Whereupon, the above-entitled meeting
8 went off the record at 11:54 a.m. and resumed at
9 12:34 p.m.)

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1 A-F-T-E-R-N-O-O-N S-E-S-S-I-O-N

2 12:34 p.m.

3 MS. LASH: Welcome back, everyone.

4 We're so delighted to welcome Dr. Rebekah Gee and
5 her team from the State of Louisiana to share
6 more about their experience participating in
7 child core set reporting.

8 STATE PERSPECTIVES PANEL -- PART 2

9 DR. GEE: Thanks, Sarah. For those on
10 the phone here, and many of you I know -- I've
11 had the opportunity to meet -- Dr. Rebekah Gee,
12 I'm an obstetrician/gynecologist, with a
13 background in health services research. Started
14 out my work at the state level doing a special
15 project to improve birth outcomes and moved from
16 that into the Medicaid arena, which has been
17 really, really fun.

18 I think there's been no time in
19 American history, other than in 1965, that's been
20 more interesting to be in Medicaid, and
21 particularly to be at the state level and working
22 in a state that is among the neediest. Some of

1 our rates of childhood outcomes, including infant
2 mortality, which in one of our communities is 58,
3 which some of you will know is above the levels
4 you may see in many African countries and Central
5 America. We have tremendous challenges in
6 Louisiana and tremendous health disparities. But
7 if we don't measure them and we don't understand
8 them, we can't begin to improve them, so the work
9 that we've been able to do improving our
10 measurement systems has been extremely key to us,
11 in terms of thinking about where our priorities
12 lie.

13 I'll be talking with you about our
14 measurement, and also about how we're trying to
15 drive some improvement through managed care and
16 some of where we put our money. I'm joined by
17 Sandy Blake and Eddy Myers, who are key partners
18 from Louisiana from the University of Louisiana
19 at Monroe. I wanted them to introduce
20 themselves. They are superstars, and the
21 partnership that we have really allows us to do
22 some great work. So Sandy and Eddy, could you

1 say hello? Could you introduce yourselves?

2 DR. BLAKE: Hi, this is Sandy Blake.
3 I'm with the University of Louisiana and Monroe
4 School of Pharmacy. We have been working with
5 the Medicaid program for a number of years. We
6 have the Office of Outcomes Research and
7 Evaluation, and I'm the director of outcomes
8 research. We provide clinical support for the
9 pharmacy program, and we also provide analytic
10 support for the quality measurement programs in
11 the state. Eddy?

12 MR. MYERS: Hi, I'm Eddy Myers. I'm
13 the assistant director over the analytics group
14 here at the Office of Outcomes Research at
15 University of Louisiana at Monroe. I've worked
16 here in our partnership with Medicaid since 2002.

17 DR. GEE: Thanks, Sandy and Eddy.
18 Sarah asked me if could multitask with two
19 clickers. I said I have five kids and two sets
20 of twins. I can definitely do two things at
21 once. Here's our overview, CHIPRA measures for
22 Louisiana Medicaid, selected results for 2014.

1 We're going to talk about our successes, some of
2 our challenges, things we're doing in quality
3 improvement, recommendations and then we'll have
4 some good discussion.

5 Here is a picture of Louisiana, shaped
6 like a boot. We have statewide mandatory
7 Medicaid managed care as of June 2012 for most
8 children and pregnant women. We had two models
9 that were operating simultaneously until February
10 of this year, a shared risk model and a full risk
11 managed care model. We now, as of February, have
12 all full risk managed care. We have, now, fewer
13 than 10,000 children who remain in fee-for-
14 service Medicaid, so by and large a managed care
15 state, which is why the pay-for-performance
16 measures and our partnerships with the MCOs are
17 so important.

18 Here are listed the 2014 measurement
19 year CHIPRA measures. We were able to report
20 quite a few of them. Eddy, why don't you go into
21 some detail, and then I'll add to it, in terms of
22 these measures and how we did so many. Because I

1 think as a state, we were really able to report
2 probably above average, in terms of these. So
3 can you talk a little bit about our experience?

4 MR. MYERS: Sure. These measures that
5 we were planning to report this year for the 2014
6 measurement year, yes, we have been able to
7 increase the number of measures over the last few
8 years. There have been some synergies with the
9 adult quality grants. Some of the measures
10 overlap the adult core set and the CHIPRA core
11 set, so we're able to do those and report them in
12 both areas, just for the separate age groups. In
13 2013, we reported six measures, and then for
14 2014, we reported 16 measures. There's a big
15 jump there, jumping off from our work with the
16 adult core set. Then this year, we're planning
17 on these 20 of the 24 measures you see here.

18 There are some measures in here that
19 we would not have been able to report in the past
20 because we didn't have the data, so some of these
21 measures, like the Cesarean section or the live
22 birth weight and the frequency of ongoing

1 prenatal care, we've been getting data we need
2 from vital records. Then other measures, we're
3 getting data that we need from chart review. For
4 example, the prenatal care and the frequency of
5 ongoing prenatal care, we're getting necessary
6 data from chart review for the hybrid method
7 there.

8 Then the immunization measures,
9 childhood immunizations and immunizations for
10 adolescents, we get data from the Louisiana
11 immunization system to supplement our claims
12 data. There's been a lot of work in the past few
13 years to increase the number of measures that are
14 reported. So we're excited to continue to be
15 able to report more, so these can be tracked over
16 time, and that the care can be shaped based on
17 them.

18 DR. GEE: Thanks, Eddy. Just to
19 highlight a few key challenges in Louisiana: we
20 are the capitol of many bad health outcomes, but
21 among those include sexually transmitted
22 infections. We have among the highest HIV rates,

1 as well as chlamydia and gonorrhea and syphilis
2 rates in the nation and have had a challenge --
3 chlamydia screening in women was our pay-for-
4 performance measure under our very first round of
5 contracts with MCOs.

6 That's been a real challenge to meet,
7 but I think it's extremely important to measure
8 because I'm a bigger fan of -- I would consider
9 this somewhat of an outcomes measure, not just a
10 process measure. It gets at the fact that there
11 had to be a visit, and then it actually gets at
12 what actually happened during that visit.

13 So whenever there's a measure like
14 that, I prefer that measure, looking at not just
15 that somebody went to a visit. So adolescent
16 well care is obviously important, too. As you
17 know, nationally, teenage pregnancy rates are
18 decreasing, but in Louisiana, they're still high.
19 Cesarean section, we have the highest C-section
20 rate in the nation, other than New Jersey, and
21 have a statewide quality improvement project
22 around reducing C-section rates. In fact the

1 Secretary and I are going to a few hospitals this
2 upcoming week. Postpartum care is a big issue.
3 We've been having a lot of conversations at the
4 national level on this measure.

5 It's inappropriately dated, in terms
6 of 56 days in starting. I think it's 24 to 56
7 days, which is not really accurately the way that
8 these visits happen. Many times these visits an
9 obstetrician will happen two weeks out postpartum
10 and women lose Medicaid majority of the time in
11 states that haven't expanded to 60 days
12 postpartum, so why 56?

13 So there's some movement in these
14 measures. We've been talking at the national
15 level, also learning from them in our state. As
16 Sandy and Eddy said, many of them require chart
17 review. A lot of resources came into our state
18 because of the Adult Quality Measures grant. I
19 cannot say enough positive things about the Adult
20 Quality Measures grant. It was money received
21 from CMS. It allowed us several years of
22 capacity-building, including monies that were

1 used to teach quality improvement science to many
2 of our key staff, as well as giving us the
3 ability to perfect our chart review process and
4 increase the number of measures. As Eddy
5 mentioned, there was a lot of alignment between
6 CHIPRA and the adult set, so we were just able to
7 stratify differently. That was a very positive
8 opportunity for us. Here are reflected some of
9 the 2014 results. Eddy, can you talk a little
10 bit about these?

11 MR. MYERS: Sure. We presented the
12 rates here for just some of the measures. As you
13 can see, there's definitely plenty of room for
14 improvement. Adolescent well care was 35.99
15 percent. Skipping down to the bottom for the
16 other well-child visits for the third, fourth,
17 fifth and sixth years of life is 56.91 percent.

18 But on both of those measures, what
19 I'd like to point out is just how the measurement
20 process can evolve and improve over time because
21 in 2011 when we reported these rates, they were
22 much lower than this because of an issue in the

1 claims data, where many claims were submitted
2 with the clinic or group practice as the provider
3 ID. You couldn't tell that the provider was an
4 actual PCP, so they couldn't be counted as a
5 well-care visit per the HEDIS criteria. In 2011,
6 for adolescent well care, we were at 25.16
7 percent. Then in 2011 -- I'm sorry, it's 2012
8 HEDIS, 2011 measurement year, we were at 35.45
9 percent for well-child visits in the third,
10 fourth, fifth and sixth years of life measure.

11 As of last year, most of the claims
12 are being submitted that have an actual provider
13 that you can tell -- that's an identifiable PCP,
14 so that's an issue there that has been resolved
15 and made the measurement more robust and more
16 accurate. Then also, I'd like to point out in
17 the immunizations for adolescents measures, it
18 said 88.17 percent, but in 2011 measurement year,
19 or 2012 HEDIS, we were at 64.34 percent.

20 The reason for that is not all the
21 immunizations -- there wasn't always a claim
22 submitted from public health offices or

1 immunizations provided for Shots for Tots or
2 things like that. So we were able to get access
3 to Louisiana's LINKS system that is the statewide
4 immunization registry database. By adding that
5 data in, that supplemental data, we were able to
6 get more complete results so, therefore, our rate
7 is able to be calculated much more accurately
8 there. Then the other two measures is Cesarean
9 rates and the live birth weight less than 2,500
10 grams. Those were measures that were newly
11 reported. They were newly reported because we
12 were able to get access to vital records data,
13 and we created a matching process and algorithm
14 to be able to link Medicaid data to vital records
15 data.

16 So those measures were able to be
17 reported for the first time because of that. You
18 see the C-section rate is 29.01 percent, and the
19 live birth weight less than 2,500 grams is 12.14
20 percent. Dr. Gee, is there anything you would
21 like to add?

22 DR. GEE: No, thank you so much, Eddy.

1 I'll just say that when we look at these
2 measures, we also don't look at them individually
3 because what we try to do, in terms of pay for
4 performance, or when we focus on our quality
5 improvement projects, is think about all of the
6 things that would be in a logic model that would
7 lead to desired outcomes. One of our highest
8 priorities -- and we'll be talking about this
9 tomorrow, in terms of how measures align between
10 adult and child -- is prematurity. Obviously,
11 you can't prevent prematurity if you're not
12 dealing with the mom's condition. So we've
13 focused a lot on -- and we'll talk a little bit
14 about this later, too -- our partnership with
15 vital records and using that data.

16 We were also able to modify our vital
17 records, so in 2012, actually, we changed -- for
18 every delivery under 39 weeks, we have additional
19 data field, and we're able to actually pay based
20 on that and report based on that to much greater
21 accuracy. So think as time goes on, we're going
22 to see a lot of states trying to use their vital

1 records capacity to augment measurement because
2 claims data can only get you so far.

3 It's very helpful to have actual
4 clinical numbers. We are actually using our --
5 on one of the few states that have reported out
6 our HIV viral loads, and we're able to do pay-
7 for-performance this year with our health plans,
8 who are actually, for the first time, meeting
9 with our public health partners, looking at the
10 viral loads and doing quality improvement around
11 that. So that's a really great example of where
12 we can use our public health data not just for
13 state reporting, but for actual clinical quality
14 improvement. Many of these go together. We
15 think adolescent well care is a preconception
16 health measure. The postpartum visit, which
17 we've just disallowed in global bundling -- we
18 require them to bill it separately as of last
19 month -- that, in concert with adolescent well
20 check and the STI measures get at what is that
21 preconception health state, which is a big
22 priority for us for our adolescents.

1 Focusing on continuous improvement, as
2 Eddy mentioned, both through our own increasing
3 capacity and interest, as well as the Adult
4 Quality Measures grant, which had a huge impact
5 on us, we were able to move from 6 to 16 to now
6 20 of the 24 measures, so a much better ability
7 to collect and report on measures.

8 Our synergies with the CMS Adult Core
9 grant helped facilitate the programming and
10 development of the new CHIPRA measures. As we
11 mentioned earlier, it's a different
12 stratification, by age, by chlamydia screening,
13 timeliness of prenatal care, follow up after
14 hospitalization for mental illness. These are
15 all adult measures that can be stratified for the
16 children, so that alignment is helpful. We also
17 have worked -- this administration is very intent
18 on working with our public health agency to use
19 the data, don't hide it under a rock. Let's get
20 it out there and start using it. I would say two
21 years ago, and initially with vital records,
22 there was a great resistance to this.

1 There was a lot of mistrust about can
2 we use this data? How would it be used and
3 shared? But we've built trust and capacity, and
4 now alignment with quality improvement. We're
5 going to be applying for a Quality Improvement
6 grant in maternity care that's actually going to
7 be housed in our Title V program and works
8 directly with our Medicaid agency, so really
9 trying to get the public health/Medicaid
10 alignment.

11 As I mentioned earlier, we have the
12 ability to link the HIV viral load data. We
13 might be trying to do this in other areas of
14 infectious disease that are reportable areas, but
15 we also do it in the area of vital records, which
16 has been really valuable. We have two pay-for-
17 performance measures. One that I'm really
18 excited to talk to you we're hoping to take
19 through NQF stewardship, which is we've created
20 the first progesterone measure in the nation.
21 Progesterone is the only medical intervention at
22 the time of pregnancy that's been proven to

1 decrease prematurity at the population level. So
2 we have a measure of initiation of progesterone
3 that requires vital records linkage because it
4 requires one to know when that progesterone was
5 initiated.

6 We are excited to try to take that
7 through NQF stewardship. That was only able to
8 be done because we have a very strong linkage of
9 our data. Then for the CHIPRA measures, the
10 Cesarean section obviously requires the linkage.
11 As Eddy mentioned, the live birth weight less
12 than 2,500 grams, and then the frequency of
13 ongoing prenatal care.

14 We also use these measures to create
15 registries, so our health plans are getting a
16 list when they get the patient enrolled, not just
17 waiting for that patient to come into a
18 provider's office and says, "Hey, this young lady
19 had a prior preterm birth. Maybe you ought to
20 look at getting her progesterone." We're also
21 working with Text4baby at the national level to
22 get some more of this data up front. Because as

1 you know, if you rely on HEDIS, you're looking at
2 year-ago data. It's very hard to act and do
3 quality improvement on HEDIS from what's often
4 two years ago, at that point. So how do we take
5 the same learnings, how do we take the
6 specifications and try to apply them to now, so
7 that we can better understand our population?

8 That's something that we're really
9 focused on and trying to do better with. As I
10 said, claims data can only get you so far. Not
11 only is there claims lag, but claims doesn't give
12 you lab results. Claims doesn't give you a lot
13 of fields. Certainly, ICD-10 might help, but
14 it's not going to be the total solution.

15 We did develop the capacity to do
16 chart reviews through the Adult Quality Measures
17 grant. Initially, we were using our public
18 health nurses. That wasn't such a great
19 approach, so we actually moved that work into
20 Sandy and Eddy's shop. Sandy and Eddy, do you
21 have any thoughts or observations about the chart
22 reviews?

1 MR. MYERS: Yes. We've been doing
2 chart reviews here. This is the second year that
3 we've done them in our office here. We've
4 learned a lot through the process and been able
5 to find ways to streamline the process and make
6 it more efficient and hopefully for more
7 convenient for the providers to be able to submit
8 their charts to us and us review and get the
9 information needed and hopefully be as painless
10 as possible.

11 By doing chart reviews, we have been
12 able to -- there's just some measures that
13 require that right now, so we've been able to
14 develop a process here to be able to do that for
15 the state. Then also, as Dr. Gee mentioned, for
16 the CHIPRA measures, we've been able to use the
17 Louisiana LINKS system with the Office of Public
18 Health and state immunization network for kids to
19 get the data from them because they collect and
20 keep data on all of the immunizations received.

21 So that's how we were able to enhance
22 the completeness and accuracy of our reporting of

1 childhood immunization status and immunizations
2 for adolescent measures. Then of course, the
3 bulk of the other measures are reported through
4 the administrative claims data, where
5 appropriate, because that is a very accessible
6 data source and is very efficient to be able to
7 use that for reporting a number of measures where
8 the data you need is available in claims.

9 DR. GEE: Thanks, Eddy. We also
10 understand part of the challenge here is
11 providers being willing to go through chart
12 reviews. So one of the things we're thinking
13 about a lot is now that we have MCOs, how do we
14 have them align, so that they don't all go into
15 the single provider's office in the same month
16 and say, "Each of you give me 100 charts." How
17 do we do that? We haven't come up with a
18 solution, but that's one thing that we are very
19 aware of.

20 Some initial challenges with the core
21 measure set -- and we understand that the
22 pediatric central line might've been retired, but

1 we have a big challenge getting the feasibility
2 and data availability of that measure. It's time
3 consuming and complex to match Medicaid to vital
4 records and to do it well. It's why not every
5 state does it, so that's been a journey for us.
6 We feel like we're one of the strongest states,
7 at this point, in that arena. Then chart review
8 process and initial learning curve, also
9 providers weren't used to being asked by the
10 Health Department to give them charts, so that
11 relationship is needed to be honed. I'm going to
12 talk a little bit about one of the state
13 challenges that we're trying to address. In
14 2014, Express Scripts published a study that was
15 astounding.

16 As you can see on this map, you can
17 see the states of Louisiana and South Carolina
18 are highlighted as the highest drug utilization
19 for ADHD meds in the nation. In fact, when we
20 dug into it deeper, there's one -- we call them
21 parishes, not counties -- but there's one parish
22 where 61 percent of our white 9-year-old boys

1 have been prescribed an ADHD med.

2 Our overall state rates -- yes, 61.

3 I actually was reviewing our paperwork, going to
4 send it in to hopefully to get published or
5 reviewed, but we have some astounding rates.

6 I'll show you some more of those next. This is
7 the prevalence overall of Louisiana males. In
8 the top graph, you can see the non-Hispanic,
9 white males, at age 10 and 11, upwards of 35
10 percent are prescribed an ADHD med, non-hispanic,
11 black lower rates, but still very high, more than
12 20 percent, and much higher than the national
13 rates, other races. Girls are still higher than
14 the national average, but not as high as boys.
15 Whites prescribed more often than blacks, which
16 is consistent. We also noted that children that
17 enter school younger than their counterparts of
18 children born in the first half of that year, who
19 are in that school year, double the risk of ADHD
20 meds.

21 Tremendous challenges. We have
22 developed a lot of approaches, including claims

1 edits for -- we're particularly concerned about
2 our young kids, our children under 5 being
3 prescribed multiple drugs. One of the
4 individuals in the audience talked about -- there
5 are anti-psychotics and all sorts of other drugs
6 that are prescribed in addition to ADHD.

7 Even, we've seen this year, 2 year
8 olds on anti-psychotics and ADHD meds, so just a
9 lot of work that needs to be done here. So
10 there's a Mandatory Performance Improvement
11 project for our MCOs. We have a performance
12 measure with financial implications, with is the
13 withhold in our MCO contract, which is follow-up
14 care for children prescribed ADHD medication
15 expanded to focus on younger children and
16 adolescents. We have claims that is in place for
17 dispensing for children age 5 and under. In
18 fact, I got a complaining email this morning from
19 a provider who doesn't like our claims edits,
20 which means that, in my opinion, they're working.

21 Provider education, so ADHD treatment
22 guidelines and assessment tools, standard

1 assessment packets and processes for data
2 collection at the practice level, assistance for
3 practices for provision of care coordination.
4 RMCs are learning from each other about what
5 works. Several of them have pediatrician medical
6 directors who are very focused on this. Some of
7 this involves meeting with the schools.

8 We have one band on I-10, which is the
9 lower part of our state, where we've heard from
10 schools and parents -- the parents have been told
11 either you bring your kid back on ADHD meds or
12 he's not coming to school. Things like this are
13 happening. It's going to have to be a multi-
14 disciplinary approach that includes not just the
15 physicians, but parents and teachers, so engaging
16 parents and schools and development of handouts
17 and other educational materials. I think we did
18 not realize this problem until, actually, Express
19 Scripts came out with that study, and then we
20 started digging into the data. I guess we can't
21 stress enough how important it is to understand
22 the data, so that we can start to address

1 problems like these.

2 I think this is pretty astounding. I
3 can share more data if anyone's interested, but
4 it's obviously a problem that needs to be
5 addressed. As I said, understanding the data
6 drives quality improvement. Without
7 understanding the data, without ability to
8 measure it, it doesn't mean it's a panacea, but
9 if you can't recognize a problem, you can't start
10 to solve it.

11 We've had an increased capacity to
12 report quality data across all Medicaid programs
13 in the U.S. recently. I think the Adult Quality
14 Measures grant is something we'd love to see more
15 of, even though we're not going to be able to
16 apply for the next piece of it. We'd like to see
17 CMS do more of that. Results of these analyses
18 are now driving Medicaid policy and interventions
19 to improve health outcomes. Then we have,
20 through these grants and through understanding
21 this work, have developed capacity to report
22 additional measures. The Medicaid and vital

1 records match allows us to do things beyond just
2 reporting a C-section measure. As I said, we're
3 now creating, and hopefully going to take through
4 endorse, and then a quality measure on
5 progesterone that required us to have all of
6 those pieces in place.

7 One of the major challenges in
8 measurement is that -- there's recently a great
9 article by Bob Berenson on this issue -- is that
10 measures work really well for hospitals because
11 hospitals have very narrow margins. Hospitals
12 are really interested, and of course Medicare has
13 driven that conversation.

14 If I have a 2 percent profit margin
15 and I have 1 percent at stake, that is very
16 meaningful to me. The question is how do you
17 move providers when there's a lot more wiggle
18 room in providers' offices? Providers often
19 don't understand what these measures mean.
20 There's a lot of interesting data about practice
21 variation and how much do providers actually have
22 the ability to change certain measures at the

1 individual practice level? How do you risk
2 stratify? I think this is the big question that
3 I'm still grappling with is right now, we have
4 MCOs. They have five different provider portals.
5 No one knows how to log into the portal. When
6 you cut up their data by five, it's not
7 meaningful. If I get reports on my C-sections,
8 I've done two this month. Wow.

9 The outcomes of those is not
10 meaningful to me, so how do you really -- to
11 drive improvement at the individual practice
12 level is important. We can talk about saying we
13 have managed care companies accountable, but if -
14 - how are they really going to be accountable if
15 the provider doesn't feel intrinsically that
16 these things matter?

17 That's, I think, one of our remaining
18 challenges. I think that there are things that
19 we really continue to need to work on. We want
20 to enhance processes for obtaining clarifications
21 about specifications to minimize programming
22 delays. That's a little pitch for my team.

1 Adjust identified quality measure gaps.

2 Potentially avoidable ER visits is a big concern
3 in our state. Of course, as we know, in many
4 states where increased access to care has been
5 granted, ER visits are increasing. Prematurity,
6 huge area. I can't think of any -- I know I'm
7 biased, but there's no more important area in
8 public health than prematurity. I would love to
9 have NQF help us with this measure, little pitch
10 here. We're proud of it, but it needs work, and
11 it needs expansion because prematurity is, I
12 think, the key issue in early childhood.

13 Cross-sector measures, so how, at the
14 NQF level, can we start to develop these measures
15 at the national level that involve the public
16 health data exchange? How do we look at
17 individual physician performance? As I mentioned
18 earlier, this has got to be relevant to
19 practices. It's got to be workable, usable,
20 malleable for them.

21 It's got to be integrated into EMRs.
22 It's just a continued challenge. Then ADHD and

1 behavioral health measures. At the Medicaid
2 Medical Directors Network, we've understood that
3 overuse, especially in foster care populations,
4 other populations, of behavioral health drugs by
5 ADHD is a huge area, and just follow-up visit,
6 it's okay, but I'd like to see something a little
7 sexier than that, so we need to work on it and
8 then strengthen the measure. Sandy and Eddy, do
9 you have any other thoughts? I also have Mary
10 Johnson, who's our Medicaid deputy director for
11 quality, has done wonderful job building our
12 team, and Beverly Hardy-Decuir, formerly from
13 United, is our section chief on quality. We've
14 got a lot of great capacity, and they would also
15 answer questions that you might have. Sandy and
16 Eddy, do you have any thoughts, additional last
17 thoughts?

18 MR. MYERS: Dr. Gee, no, I don't. I
19 think you've covered everything very well, and we
20 look forward to being able to add additional
21 measures and to streamline processes and to be
22 able to report data in a way that's useful and

1 that decisions can be made on to improve
2 healthcare in Louisiana.

3 DR. GEE: Thanks, Eddy. I can't
4 stress -- sorry, Sandy.

5 DR. BLAKE: I was just going to say
6 that I think it's a great opportunity for
7 universities within a state to partner with their
8 state agencies and build the expertise in the
9 state.

10 DR. GEE: Yes, Sandy. Thanks so much.
11 I was just going to say that -- that I think that
12 it's -- I really like the fact that we have a
13 partnership with one of our academic institutions
14 because it allows us to involve students and
15 fellows and others in the learning and build
16 capacity. It's sometimes easier to add capacity
17 to non-state government entities, so we've really
18 enjoyed working with you both. I guess we could
19 -- we have a few minutes for questions.

20 MS. LASH: We do, indeed. Anne is
21 first, then I'm going to go to Sandra, Susan, and
22 then Terry.

1 MS. COHEN: I just wanted to thank you
2 for your presentation, which was really
3 interesting, and you're doing a tremendous amount
4 on difficult budgetary challenges, so we really
5 commend you for that, and the models that you've
6 created seem amusing.

7 I'm curious -- there's a lot of
8 different areas that we focus on for the rest of
9 the day and tomorrow, in terms of looking at
10 expanding financial measures. Given both
11 budgetary challenges for your state, as well as
12 burden to providers, if you were to pick one or
13 two areas, which would be would your focus to
14 look at new measurement adoption?

15 DR. GEE: As I mentioned earlier, I
16 think definitely prematurity because there's just
17 no single issue that has a bigger budgetary
18 impact on our state than a baby born premature,
19 and particularly just to say our rates are
20 horrible. If you look at the eligible number,
21 that percentage of women eligible for
22 progesterone who receive it, in our state, it's

1 around five.

2 That's a public health crisis. That's
3 actually the nice thing about the measuring in
4 that area is you don't have to worry about the
5 tweaks at the -- if you were at 95 percent, you'd
6 really worry about that measure being perfect.
7 When you're that low, you say, gosh, if I triple
8 it, I could still have wiggle room and have,
9 maybe, not the denominator not perfectly set and
10 do well.

11 I think that's really -- that would be
12 on a scale of 100, that would be 100, and then
13 I'd say ADHD and behavioral health would be
14 second in line just because I think a follow-up
15 visit is okay, but not great. I think we need to
16 have cross-sector measures. Three, I didn't
17 mention this earlier, but Louisiana -- and a lot
18 of our young kids, unfortunately, are passing
19 through prison system, particularly our most
20 high-risk kids, and particularly our kids with
21 behavioral health issues.

22 So I would like to see more work at

1 the national level on cross-sector re-admissions
2 measures that affect the prisons, how well are
3 they doing at getting kids healthy, and looking
4 at cross-state agency measures and moving beyond
5 claims data. I know ACOG has had to revitalize.
6 We've done a lot of work in terms of trying to
7 create measures that are more EMR-friendly. I
8 know it's not going to happen today, but just
9 anything that we can do to move beyond claims
10 data alone is really helpful, too.

11 DR. WHITE: Dr. Gee, thank you so much
12 for you and your university partners providing us
13 with such comprehensive information, and also for
14 demonstrating the significant work that can be
15 done with a private/public partnership. I was
16 particularly struck by the information that you
17 provided on the children that are on ADHD drugs,
18 very high percentage of them that are on these
19 medications. I'm wondering whether or not there
20 is a socioeconomic component that we may not be
21 aware of, and that is does the diagnosis of ADHD
22 provide the parent with a disability check

1 because the child has this particular diagnosis?

2 DR. GEE: I'm just quickly going to
3 answer that question. One of the problems is
4 schools -- not the parent, but schools get more
5 money when they have a higher number of
6 disability students, so that's one issue that's
7 been brought up as potentially why schools ----
8 then if you look at income, lower income kids are
9 more likely to be prescribed an ADHD med, kids
10 under 200 percent of the poverty level. Let me
11 see if I can get you that number, actually.

12 Children who live at 200 percent or
13 greater than poverty level nationally have a 7.9
14 percent rate, but children who are between --
15 less than 100, and 100 to 199, which seems to be
16 the magic -- under 200 seems to be the magic
17 number -- are at ten -- a little bit above ten.
18 Economics plays a critical part. I think
19 parenting -- I can't stress enough that single-
20 parent households are tough. You have a parent
21 dealing with kids on her own or his own. Kids
22 also -- the issue of obesity and lack of physical

1 activity. There are many neighborhoods in New
2 Orleans and other parts of the state that are not
3 safe for kids to play, so they're hyper because
4 they can't run, and they can't play outside.
5 These are extremely complex issues that are
6 multi-factorial, but I think poverty has a big
7 component, but also poverty more greatly affects
8 African-Americans in our state.

9 I think it's very interesting that you
10 have this -- it's really a greater problem among
11 Caucasian boys, so why is that? Is that because
12 -- we don't know the answer to that. I think
13 more research is needed. My guess would be
14 because parents are maybe pushing for it more,
15 but I don't know. I'd be interested to other
16 folks' thoughts on that.

17 It's largely pediatricians. If you
18 look at behavioral health providers -- yes. I
19 think that AAP, in my opinion, should -- I have a
20 behavioral health medical director, he and I both
21 feel strongly that you need to start looking at
22 nutrition and physical activity as first line,

1 not drugs as first line. I think AAP should
2 change their guidelines because I think they're
3 too friendly towards go straight to medication.
4 I think that hasn't helped the AAP's stance on
5 this issue, but I think that -- because it's so
6 many, right? It's so many prescriptions going
7 out that it's really the primary care
8 pediatricians who are mostly responsible.

9 Of course, your behavioral health --
10 we lack behavioral health providers, as well, so
11 some of the things we've thought about is
12 requiring second opinions, et cetera, but then we
13 don't have capacity, so it's -- yes. This is a
14 problem in every state, but --

15 DR. LACEY: Thank you so much. I just
16 moved back to Mississippi, so we have lots of
17 challenges, so we go back and forth for who's the
18 last and who's the next to the last, so I'll be
19 calling you. My question is you seem to have
20 done a remarkable job with moving things to be
21 extracted and linked with the vital health data.
22 Do you have a paper published about that? Is it

1 something that other states could replicate?
2 Because we've heard, in the last meeting and this
3 meeting, that is a difficult issue. So, it seems
4 to me you guys have moved past that and have a
5 good methodology that's working. Is that --

6 DR. GEE: I'll have Sandy and Eddy
7 speak to this, but I will say -- and I'll brag on
8 us and the CDC -- we're the first state to have a
9 CDC assignee specifically to Medicaid. I think
10 having increased public health capacity within
11 Medicaid agencies is an important part of
12 building this.

13 We had had a very strong MCH
14 epidemiologist and a relationship for some time.
15 I'll have Eddy and Sandy talk about it. I know
16 it's complex. We have not published a paper.
17 Maybe we should. What do you think, Eddy? One
18 of the challenges, I'll say quickly, is sometimes
19 we assume things are easier than they are.

20 For our prematurity measure this year,
21 it's going to just be a reporting year. It's not
22 going to be a pay-for-performance year because it

1 has been a challenge making sure that the health
2 plans get that data in time. It hasn't been
3 easy, but I do feel that we've come very far.
4 Eddy and Sandy, do you have thoughts there?

5 DR. LACEY: Can I ask a couple more
6 that they can kind of link on to this? You seem
7 to have also overcome, to a great extent, the
8 issue around provider wariness about what you're
9 doing with the data, and you've gotten them to be
10 part of this process and not put barriers in
11 place. Somehow or another, it would be nice to
12 see that, in terms of the path that you chose and
13 the work that you did and how did you have that
14 engagement to happen?

15 Because I think that trust is
16 critical, and I think some states have good
17 mechanisms for that. You seem to have done a
18 terrific job with your team, so that would be
19 great. Then the other piece is your process
20 improvement. I know you're really letting the
21 data drive where you spend your resources, so
22 even kind of talking about that, in terms of your

1 dissemination.

2 I hate that we're the only people
3 getting to hear what you have to say because I
4 think states really struggle with all three
5 pieces of this. I believe what you're saying,
6 that you've done some pretty miraculous things in
7 a very complicated state. It'd be great if you
8 were able to share that with a larger audience to
9 really build some champions. Thanks.

10 DR. GEE: Sandy, Eddy, why don't you
11 start?

12 MR. MYERS: Okay. As Dr. Gee
13 mentioned, no, we have not published a paper yet
14 on our vital records matching process, but that
15 is something that could be considered. What we
16 did is we -- the matching process, it's fairly
17 complex and time consuming.

18 We spent a lot of time programming,
19 and then just looking at results all along the
20 way, comparing to see what were good matches and
21 what weren't matches because obviously, it would
22 be easy if vital records had everyone's Medicaid

1 ID, but they do not. Some of the new
2 enhancements to the LEERS, the enhanced vital
3 records system Dr. Gee mentioned, there is a
4 place to capture Medicaid ID.

5 In situations where it is captured in
6 newer data, that certainly helps. That provides
7 a primary key for matching, but then a lot of the
8 matching is done based on Social Security number,
9 but even that, for children, is often not
10 populated in a timely manner in Medicaid because
11 the children have to get their Social Security
12 number, then it has to be reported back to
13 Medicaid. That's there in some cases, in others
14 it's not. So then you have to get into matching
15 of -- looking at names and addresses and how
16 close a match you have between the child's name
17 and the mother's name. Because in Medicaid, in
18 our eligibility system for most of the births, we
19 are able to link the child to the mother through
20 our eligibility system, so we can also look at
21 those, how they match up on the vital records
22 side.

1 We had to look through and determine
2 all the ways that you could look link, and then
3 look and see which ones gave you the highest
4 level of confidence and accuracy, so those are
5 prioritized and linked first. Then as you get
6 into more fuzzy linkages are where you may be
7 looking at Social Security number, like a couple
8 numbers in it transposed or something, but
9 everything else matches, date of birth and name.

10 You can link things that way. It just
11 took time to go through and see, in our data,
12 what works and what didn't. Some of that
13 knowledge could help other states because I'm
14 sure there would be similarities between the data
15 in our vital records system, and then our
16 Medicaid data. Then, of course, I'm sure there's
17 some state-specific differences because if the
18 state vital records aren't collecting as much
19 information as we have in ours, then some of the
20 information we're gaining from vital records to
21 be able to use in some of these measures may not
22 be there yet. That's just some of the things

1 we've looked at and dealt with.

2 DR. BLAKE: And I would like to just
3 add one thing about the chart reviews. We try to
4 make it as easy and painless on the provider as
5 possible. We can take paper. We can take
6 electronic. We take fax, and it faxes into an
7 electronic file. We've done several, so many
8 providers' offices know who we are now, so
9 they're used to dealing -- we have ULM, so
10 there's, I think, a level of trust that makes
11 them a little bit more willing, possibly, to go
12 ahead and deliver what we're asking.

13 MS. LASH: Next question from Terry.

14 DR. ADIRIM: Thank you. Thank you so
15 much. That was really informative, a great
16 discussion. I just have a couple of things. I
17 wasn't going to bring it up, but I just can't get
18 past this ADHD. I'm sorry. I'm representing the
19 AAP. That is an astounding figure, anti-
20 stimulants in Louisiana. I do need to defend the
21 practice guideline from the AAP, which has very
22 strong evidence for its recommendations, which

1 includes how it's diagnosed, assessment, when to
2 use stimulants, looking for other physical issues
3 that can account for the behavior.

4 What I would say is that practitioners
5 in your state are not following evidence-based
6 guidelines. I felt like I need to defend it.
7 Anyway --

8 DR. GEE: Maybe you could be stronger
9 in your suggestions about alternatives to
10 medication --

11 DR. ADIRIM: Right, and it does. It
12 brings up assessing for sleep apnea, looking for
13 learning disabilities and other things like that.

14 DR. GEE: The message has not gotten
15 out there to Louisianians. Anyway, let's -- I'd
16 love to talk to you about what we could do with
17 Louisiana AAP.

18 DR. ADIRIM: Right. I'm not the AAP.
19 I'm actually a pediatrician with somewhere else.
20 But anyway, so I just needed to mention that.
21 The other thing I wanted to mention is that I
22 really appreciated your discussion about multi-

1 sector look. I think there's a tension between
2 whether or not this core set is a population
3 health, reflecting health, versus being a quality
4 improvement tool on the individual practitioner
5 level.

6 Today's discussion all day has kind of
7 been that tension, so I think it's worth
8 discussing the goals of the particular core set,
9 so I appreciated some of the discussion around
10 how do you gather information and data from other
11 sectors? I know parts of the federal government
12 has tried to do this, the Administration for
13 Children and Families.

14 When I ran the home visiting program
15 that was something that we tried to do, too, but
16 it's really tough because in a lot of states,
17 they may not have as great relationship -- the
18 health agencies, with the Medicaid agencies, with
19 the education agencies, but that is something to
20 look in the future. That was all I had to say.

21 MS. LASH: Andrea.

22 DR. BENIN: Thank you. You had

1 mentioned that the CLABSI metric was really hard.

2 Can you expand on that a little bit?

3 DR. GEE: Eddy, can you expand on the
4 CLABSI metric for kids?

5 MR. MYERS: Could you repeat that
6 question?

7 DR. GEE: The central line infection
8 metric.

9 MR. MYERS: The issue there was that
10 we didn't have access to the data that was
11 required. I can't remember exactly now, from
12 when we looked at that, what the data was. It
13 was requiring data from the -- I believe from the
14 hospital. It wasn't easily accessible. I cannot
15 remember, off the top of my head, exactly what
16 the challenge was right now.

17 DR. BLAKE: When our claims data --
18 our hospital claims don't have ---

19 DR. BENIN: Is that a claims metric?
20 I don't think that's a claims metric.

21 DR. BLAKE: It's not, so we can't get
22 it from claims. It would take a chart review.

1 It seemed like to me the Louisiana Hospital
2 Association was looking at that measure.

3 MS. LILLIE-BLANTON: I wanted to
4 clarify a little bit about that measure. A
5 couple of years ago we held a workgroup of state
6 agencies, hospitals and CDC. The measure, as it
7 is in the core set, is pediatric and neonatal.
8 The data are collected at the hospital level, but
9 you don't have data stratified by pair. The pair
10 is the problem to get the information from the
11 hospitals.

12 We actually talked with CDC, at one
13 point, to see if they would be willing to help us
14 encourage the hospitals to stratify by pair, but
15 in the course of our workgroup, as we reviewed
16 the evidence, given that there was already
17 information available on NICU CLABSI rates -- and
18 that so many of those children were actually
19 Medicaid -- and that we don't have any evidence
20 that Medicaid differs from privately insured, we
21 decided to use the CDC reported data, or the data
22 that the hospitals report to CDC, as a surrogate

1 measure or a proxy measure.

2 Because we had heard what Louisiana
3 said, as well, that it was just hard to get that
4 data from hospitals. So that's a roundabout way
5 of saying we understand the challenges, and we
6 have -- we actually think it becomes -- when we
7 can be more efficient in collecting data from a
8 direct source, like a hospital going to CDC, it
9 helps the state. What we are doing now is not
10 the perfect measure because it is not Medicaid
11 specific, and it is not the measure as specified.
12 I just want, in full disclosure -- so it's really
13 just NICU central line rates that we're
14 reporting.

15 DR. BENIN: I have another question.
16 Sorry, that just gave me a lot to think about, so
17 I'm -- because I do think that most children's
18 hospitals, which is where probably a number of
19 your NICUs are, are working hard on this. One of
20 the things I'm always interested in is how these
21 measures get used in ways that maybe we're not
22 thinking of, or that we are thinking of, but

1 they're not necessarily set out for, right?

2 The measures, as we're looking at
3 them, are to be the Medicaid program metrics for
4 the state's apropos, what they report to the
5 feds. You mentioned a couple of ways that you
6 use these, also, for pay-for-performance. Can
7 you expand a little bit on how you think about
8 that and how that plays out? One of the things
9 that is striking to me is the measures that does
10 sort of take on a life of their own. It becomes
11 a whole other thing. It would be helpful for me
12 to understand a little bit how you think about --
13 how do you decide if a metric then should become
14 part of your pay-for-performance or not? Because
15 I think as we think about what metrics we put in
16 here, are we labeling them as okay for whatever
17 your other purposes are or not? How do you think
18 about those things?

19 DR. GEE: Measurement is a delicate
20 balance. My favorite story about measurement is
21 that a gal who worked with me got a CDC grant for
22 \$1 million to improve 54 measures. It's just

1 absurd. It can't be done. You have to think
2 about what can you actually improve, and what do
3 you have a bandwidth for? We have eight. My
4 director wanted five. I wanted ten. We
5 compromised. We have eight.

6 I hope that's enough -- it's enough
7 that we'll get some movement on a population
8 level, but not too many that we can't focus on
9 it. It's hard. We just joined the MED Project,
10 which is out of Oregon. We have 17 states now
11 that share evidence-based reviews and such. One
12 of the things I asked for from that group was we
13 really need data at the national level or
14 suggestions at the national level about how we
15 benchmark in pay-for-performance. Because one of
16 the challenges -- and we've just started doing
17 pay-for-performance, but how did we set the
18 metrics? So for the HIV viral load, actually, we
19 set them too low, so all of our health plans have
20 already met the viral load.

21 With certain things like progesterone,
22 we had a national call with the MFMs who were the

1 leaders in their field, Elliot Main, Kate Menard
2 and such, and said, what do you think is a
3 reasonable improvement? Or you can take one
4 state's story and say, here's what's happened in
5 one state. You can take the Quality Compass and
6 look at it and say, we're in the 50th percentile
7 for the cell for managed care. I think we can
8 meet the 75th percentile.

9 But it's often arbitrary and
10 capricious, so I think we need a lot of national
11 work on as we think about setting standards and
12 improving, what is an actual improvement goal
13 that's reachable, but achievable, but also
14 aspirational, and how does that differ based on
15 patient characteristics? I think that there's a
16 lot of need for that. I'm not sure that these
17 are good enough for pay-for-performance, but what
18 is our other alternative I guess I would ask?
19 Our managed care plans understand HEDIS
20 specifications. It's something that I'm actually
21 -- I think Sandy and Eddy can agree, when we did
22 the HIV measure and the progesterone measure,

1 there's a huge amount of discomfort, even if it's
2 doable.

3 Folks are not used to dealing with
4 public health data in a pay-for-performance
5 arena, feel uncomfortable about it. It's always
6 the Kubler-Ross cycle with data, where the first
7 is shock and disbelief, and then it's anger,
8 bargaining, and then acceptance. People will
9 always disbelieve data that they're not familiar
10 with or comfortable with.

11 I would also say that I think if you
12 really want to do performance improvement, my
13 belief is -- I think it's important to do pay-
14 for-performance in certain areas, and I'll also
15 say we chose areas where our MCOs were not going
16 to necessarily lose a substantial amount of money
17 if they didn't do them. So for example, HIV is
18 not an area that is of a great focus to our MCOs
19 because it's a relatively small percentage of our
20 population, so we chose that because we wanted
21 them to focus on it. We chose the areas we knew
22 they wouldn't already be focused on. We also

1 chose areas like progesterone, as an example,
2 where we knew we were doing very badly. ADHD we
3 chose because you saw the data, but also because
4 our MCOs might not -- our ADHD kids aren't high
5 cost, necessarily.

6 They're not ending up in our high-cost
7 population, so it might not be something that
8 they're keyed into, so that's another strategy
9 we've used that my director really always
10 encourages is how do you focus on something
11 they're not already going to do? I'd also say
12 that there's an important aspect of using -- so
13 we're doing a statewide NICU collaborative with
14 Vermont Oxford data that's solely going to be
15 used among our NICU directors, not shared with
16 the public.

17 So there's a very important piece of
18 quality improvement that involves not using this
19 kind of data and using something that can be
20 agreed to. When you're a state agency or a
21 health department, there's a lot of mistrust of
22 why are we in this space. Do we really care

1 about it? It's all about money. We had done
2 several years of work with our birth outcomes
3 initiative and actually reduced our NICU rates by
4 10 percent statewide, which we were really proud
5 of. Our hospitals saw that and that we were in
6 there for hopefully the right reasons, so a lot
7 of it's trust building.

8 I think that we need a lot more
9 clarity at the national level about how to set
10 standards and how to set improvement goals and
11 how to pay based on them because it's also
12 unclear if pay-for-performance really works,
13 right Marsha?

14 MS. LILLIE-BLANTON: I think so.

15 DR. GEE: Even though we want to do
16 it, we know it focuses the lens on certain areas.
17 But as I said, I think it does work if you look
18 at a hospital. It does work if you look at
19 larger provider groups. I'm not convinced it
20 works when you're talking about an individual
21 practice. There's too many things that primary
22 care docs do. In the case of a lot of these

1 things, they can't improve 54 or 80 things at
2 once. That's just my little diatribe on --

3 DR. BENIN: I have one more question,
4 sorry. So this question --- I'm not sure I
5 totally understood, but you had said that some of
6 the data that you get comes from your epi or your
7 public health side. One of the things that I
8 know about working with the Department of Public
9 Health is that we have an enormous amount of
10 trust in our epi and public health side.

11 If I have a case of TB, a case of
12 syphilis, anything reportable, I call them, we
13 email back -- it's a very close relationship
14 that's really focused on doing the right thing at
15 that moment for the patient and that kind of
16 thing. But the other arms of the Health
17 Department, there's varying types of trust.
18 There's kind of the regulatory arm of the Health
19 Department. Then I guess there's this Medicaid
20 arm of the Health Department, amongst other
21 things.

22 I'm not sure the extent to which when

1 you start mixing those data -- and I think this
2 is a little bit what Susan was getting at maybe -
3 - is there a piece, part and parcel, to making
4 sure that the trusted pieces can remain trusted?
5 I'm just not sure if you've run across any issues
6 like that.

7 DR. GEE: One of the things we did
8 this year -- because I actually think that the
9 Texas and South Carolina policy on this is bogus.
10 Texas and South Carolina said, hey, we're going
11 to stop paying you for 39-week deliveries, but
12 providers, you say when you did one of these that
13 didn't have any reason, and we won't pay you.
14 Guess how many claims there were of that?
15 Probably zero.

16 In our state there were zero, so we
17 had to use our -- what I had wanted to do -- we
18 ended up doing a hybrid, but my initial idea was
19 we're going to use vital records, and all the
20 claims will pass through vital records. The
21 provider's going to have to put down the actual
22 reason why that delivery occurred, and then it'll

1 get bumped up.

2 So the bottom line is we're going to
3 do a hybrid where the claim processes, and then
4 it's going to be retrospectively authorized. The
5 funny thing was that the hospitals were really
6 against using it because it was public health
7 data. The great news about the vital records
8 data was we said, actually, wow, it's your data.
9 You're putting this data in. So they were
10 questioning it, and then we said, talk to your
11 own birth clerks, then. I think it depends on
12 where the public health data comes from. People
13 don't like having it be pay-for-performance.
14 HIV, I think the provider community is not
15 resistant because a lot of our HIV providers have
16 been dying to have more care coordination for
17 those patients, and they're happy to see more
18 resources put towards that.

19 I don't know about the trust there.
20 I don't know how much people actually trust
21 public health data more than they trust -- I
22 don't know that most people are even aware of the

1 difference. The birth certificate data's very
2 sensitive. As I said, we work very, very closely
3 with our folks there. It took a long time to
4 build that trust. Mostly what was Medicaid -- it
5 was mostly between agencies, not among the
6 public.

7 I'm not sure the public understands
8 the distinctions. But it's always nice if you
9 can use data where there's -- it would be hard to
10 have pay-for-performance using vital records data
11 if the hospital or provider had no say in how
12 that data looked. It was nice that they both had
13 to sign off on it when we decided to use that.

14 MS. LASH: We are a little behind, so
15 if we could take these last two questions
16 quickly, Alvia, then Kevin.

17 DR. SIDDIQI: Sure. I was just going
18 to say that I think alignment between the P for
19 P, and then the quality measures that are being
20 reported, is really helpful. I think from the
21 provider's standpoint, especially putting on my
22 hat with AAFP, I think providers are looking for

1 that alignment across the board. If we're asking
2 states to measure this, what's the usefulness of
3 that if, then, it doesn't downstream, have a
4 trickle effect into an incentive program to you,
5 as a provider.

6 So I like the mixed blend that we have
7 for some measures that are more directed towards
8 plans and some that can be passed on to the
9 individual provider as part of an incentive P for
10 P-type program. But I was going to say that -- I
11 know Susan, even Andrea, sort of touched on some
12 of this, which is what is the meaningfulness of
13 this work and sort of the information sharing and
14 that importance of best practice sharing across
15 the board to other states? I think, offline I
16 was telling Marsha -- I was only picking on you,
17 Marsha, because you're on behalf of CMS, but that
18 this I would love to see published. I do think
19 that there's a lot of value for states seeing
20 each other's data, for our state to see it.
21 Denise comes from our state. We were talking
22 about all of our issues in our state right now,

1 saying it would be great to be able to have that
2 sort of competition going on and that competitive
3 spirit that can drive some quality reform.

4 I think housing some of those best
5 practices, sharing the presentation that we just
6 had, and also from earlier today with other
7 states, is going to make really a huge difference
8 when we talk about integrating public health and
9 the medical world and healthcare delivery.
10 Things are changing so rapidly in this world.

11 The AAFP and the AEP and a lot of
12 provider associations are interested in how do we
13 improve this, but our state agencies don't always
14 talk together, talk to each other, so they don't
15 always play in the same sandbox. But I do want
16 to also add that for NQF, the progesterone
17 measure sounds fascinating. It sounds like
18 definitely a measure we would add. So as that
19 progresses along, we'd strongly hope that you
20 could include us in that discussion, or maybe if
21 even by tomorrow, if we could hear a little
22 update on where that's at by staff, that would be

1 useful for us, I think. Then the last point I
2 was just going to make, Rebekah, I was going to
3 ask you a question, really.

4 Seeing all these issues you've had
5 with ADHD -- and it was so interesting how
6 Express Scripts sort of published its data, and
7 then it had you get the conversation started --
8 we've had discussions about this follow-up ADD
9 and ADHD measure not being useful, but yet it is
10 the measure that sort of is out there right now
11 that we have available, and certainly looking to
12 staff if there's more that are geared towards
13 behavioral health that we could look at that may
14 be more helpful.

15 I'm just curious with that specific
16 measure, did it help that you had been looking at
17 and reporting on that measure, now looking at
18 that Express Scripts data were you able to get
19 all the MCOs on board to try and look at that
20 measure even more closely because of the data, or
21 did it really -- was it not related to that at
22 all, really?

1 DR. GEE: It wasn't -- the Express
2 Scripts study came out, then we got cued in to
3 it, then it became a P for P measure, then it
4 became a -- so I'm not sure -- yes, but I think
5 the MCOs -- I think that data really helped
6 highlight it, and I think that study was
7 fantastic.

8 As you said, more sharing, I think
9 this is okay, but I think what would be better,
10 as I mentioned earlier, is okay, here are these
11 measures, and here are key examples of where a
12 state has chosen one and they improved it, and
13 they improved it by X. That is what's needed. I
14 can see what's being reported. I can look at a
15 Quality Compass, but I can't see, other than from
16 anecdotal reports -- often things don't get
17 published, so how am I going to know a) how to
18 improve something, and b) by how much?

19 Those are really important questions
20 that need more sharing. Of course, we have
21 medical directors sharing. We have other ways,
22 but I think that in the area of quality

1 improvement, it could be bolstered.

2 DR. LARSEN: Rebekah, good to see you.
3 Thank you so much for presenting this. It's
4 Kevin Larsen. Two quick things. The first, I'm
5 curious how you're balancing your Medicaid
6 accountability with a public health goal? It
7 sounds like you're doing a kind of nice job of
8 it, and you actually have a strategy around it,
9 but I'm wondering how you conceptualized that?

10 Because there's a tension, right, in
11 measures that an individual provider can actually
12 take action on and things that have an overall
13 public health impact. Public health impact tends
14 to be over years, over large populations, and a
15 lot of it, 75 percent or more, happens outside of
16 a provider/officer control. I wonder if you
17 could talk through what your strategy is there?
18 Then just a really quick tactical question after
19 that.

20 DR. GEE: I guess I would focus
21 clearly -- we're over time, though, so we can
22 talk later -- on prematurity. I would say first

1 of all that I really don't think these measures
2 are relevant to the providers. I don't think
3 they know what they are. I don't think they have
4 a clue how they perform. I don't think they have
5 a clue what our MCOs are accountable for. These
6 are accountable in terms of care coordination,
7 MCO resources, but at the provider level, I would
8 argue a lot more needs to be done, so I'm not sure
9 what's relevant to them. But in terms of
10 population health, prematurity's our big thing,
11 three-legged stool, decreasing STIs, improving
12 women's health prior to pregnancy. So we got a
13 SPA for that, and we're really pushing that.

14 That's done not by quality measures,
15 but with our providers, but chlamydia's a part of
16 that, so we're trying to have a measure that gets
17 at that. Long-acting reversible contraceptives
18 and pregnancy spacing, so we've done a ton of
19 things around that goal at the population level,
20 increasing prices, paying for postpartum
21 delivery. We've put in contracts that MCOs can't
22 prior authorize them.

1 We threw the kitchen sink at it. Then
2 three, progesterone, we don't allow any prior
3 authorization. We cover all forms. We cover
4 home administration. We've taken the prematurity
5 at a population health level. This is all of the
6 things that are preventable -- and smoking
7 cessation's another focus -- everything we could
8 throw at it and say, we have to do all these at
9 once, because you can't just do one thing and
10 shift population health in a significant way. It
11 requires measurement along with individual visits
12 to providers, along with changing the way people
13 access their healthcare, so it's not an easy
14 thing. The only thing I think, at a population
15 level, we're really going to drive -- it's our
16 major focus.

17 We also have a three-year learning
18 collaborative with our MCOs instead of -- I think
19 we have learning performance improvement ADHD,
20 where we were individually going to do one every
21 year. This year we're going to improve
22 chlamydia, next year we're going to do -- it's

1 just too quick.

2 You can't get anything done in just
3 one year, so we're now having them do it over the
4 entire course of their contract, so they can
5 really get the measurement down, get a data grid,
6 start to look at what's happening, learn from
7 each other, take a good long time to do it.
8 Because if you're really looking at population
9 health improvement, it doesn't happen overnight.

10 DR. LARSEN: That's fantastic and very
11 thoughtful. The quick tactical question is I
12 love your use of the birth records. We just had
13 a hearing last week of advanced mental health
14 models, so we heard the same call for use of
15 death records for outcomes. At a state level, if
16 you're using your state-reported death
17 certificates and can map that back to measure
18 outcomes of large plans or other kinds of
19 programs, it seems like there's another appealing
20 opportunity. Wondering have you looked at other
21 of these vital records, like death records, for
22 the purposes of your outcomes?

1 DR. GEE: We haven't looked in death
2 just because once a death has happened, it's hard
3 to prevent anything, so we're more -- but yes, I
4 think that's -- certainly in terms of outcomes,
5 that would be interesting, and we've thought
6 about it, but haven't used it.

7 Do you know what other states -- I
8 mean, what would you improve once you've already
9 -- of course with maternity, we're interested in
10 maternal morbidity and mortality, so we have
11 chart reviews, and we're hoping to start a
12 collaborative on hemorrhage once a death has --
13 we hope once a death has happened, it's very
14 rare, and we learn from it, though.

15 DR. LARSEN: I could imagine -- and
16 this is just a guess -- you could do things like
17 100 percent review of all deaths. So if you're a
18 hospital, you already do that for in-hospital
19 deaths, but you actually don't know about deaths
20 that happen quickly after hospitalization because
21 you don't have a signal. So you could use the
22 same strategy of 100 percent review of post-

1 hospital death of some time period to understand
2 what you can learn from that process. Anyway,
3 just an idea.

4 DR. GEE: We have a FIMR, fetal infant
5 mortality review, where we review all deaths in
6 our public health agency. We also have a
7 maternal death review. I think it's very useful,
8 but not necessarily for pay-for-performance or
9 that type of thing. Sandy and Eddy, any
10 responses to the last questions?

11 MR. MYERS: No, Dr. Gee. We don't.
12 There is a possibility that death records could
13 be utilized in some of the measures to make sure
14 that -- as a way of double-checking to make sure
15 that your population is correct if you remove
16 members who you have a death record for. Of
17 course, those shouldn't be there because they
18 shouldn't be eligible for Medicaid.

19 MS. LASH: Okay, well thank you all,
20 to the entire Louisiana team, for the
21 presentation. I think we got a lot out of it,
22 and great discussion. I'll suggest that we move

1 up the break that we were scheduled to take later
2 this afternoon now and pause for ten minutes so
3 that we can welcome our chair, get him up to
4 speed on some of the conversations we've been
5 having, and we'll regroup at that time.

6 We were scheduled to, I guess, take
7 public comment at the start of that break. Is
8 there anyone in the room that would like to
9 comment at this time? Operator, if you could
10 give the instructions for the phone, as well?

11 OPERATOR: Again, if you'd like to ask
12 a question or make a comment, please press star
13 one. There are no public comments on the phone
14 line.

15 MS. LASH: All right, thank you.
16 We'll start promptly again in ten minutes.

17 (Whereupon, the above-entitled meeting
18 went off the record at 1:47 p.m. and resumed at
19 1:59 p.m.)

20 MS. LASH: All right, we're going to
21 go ahead and get started, restarted, if everyone
22 could take their seat.

1 CHAIR GESTEN: So what a long, strange
2 trip it's been, but I'm really thrilled to be
3 here, and apologize to you all for not making it
4 earlier. But I was listening in for most of it.
5 And my big fear is actually that I'm going to
6 screw it up, because it was going so well before
7 I got here. And I've been known to do that.

8 So I'm Foster Gesten, from New York.
9 And I have a little bit of a travel issue, but I
10 hope what I did not -- was not able to do on
11 timeliness and made up for in terms of just raw
12 effort to get here. So it was, you know, planes,
13 trains, and automobiles.

14 So the morning conversation and the
15 input from the states and the questions have been
16 just fantastic, and it's just been a great
17 discussion.

18 And Sarah and Shaconna and Nadine have
19 just done a fabulous job without me. As I was
20 saying on the break, I think I'm really just the
21 figurehead and the pretty face here, they're the
22 real engine of the work. So the challenge, the

1 work of the afternoon is clearly to --

2 (Off microphone discussion)

3 CHAIR GESTEN: Taking into
4 consideration all the conversations coming up
5 with a prioritized list of measures to fill gap
6 areas, including the gap areas that have been
7 mentioned previously, and that this group has
8 commented on from the last time we did this back,
9 feels like yesterday, but I guess it was in the
10 fall of last year, and some of the gap areas that
11 were mentioned by the speakers today.

12 So Shaconna will be presenting some
13 more data on some of the measures that we have
14 currently, some proposals from the staff, which I
15 think you've had a chance to look at, for
16 measures taken from the Arc measures and then,
17 obviously, that we welcome comments and
18 suggestions from you, from the group, around
19 measures to address gap areas. So, Shaconna,
20 I'll turn it over to you.

21 MS. GORHAM: Sure. So the presenters
22 gave us some really good food for thought, and we

1 thank you for your discussion. This chart is
2 just a recap from earlier, and if there's no
3 objections, I'm going to, kind of move through
4 this portion of the presentation pretty quickly.

5 This, again, is a recap without the
6 2013 data, so this just shows the 2014 data. The
7 bold blue lines separate the lowest reporting
8 through the middle reporting and then the highest
9 reporting. So if we can move to the next slide?

10 So I don't want to take too much time
11 discussing the measures reported in 2015, as we
12 definitely want to spend most of the remaining
13 day reviewing the potential gap filling measures.

14 We are going to look really briefly at
15 the measures reported by 20 or fewer states. And
16 then, of course, we heard some concerns from our
17 presenters, just about some other measures,
18 earlier. So just as a recap, this is the lowest,
19 the three lowest reported measures.

20 If we move to the next slide, we have
21 the 1448, the Developmental Screening for the
22 First Three Years of Life. This is a NQF

1 endorsed process measure. We pulled the
2 information from the measure properties from QPS.

3 We can move to the next slide, please.
4 So again, based on the CMS one pagers, we know
5 that 20 states reported this measure in 2013 and
6 2014, which is an increase from the 12 states in
7 2012. Eighteen states reported the measure used
8 in the Child Core Set Specifications.

9 So we didn't have a lot of TA
10 requests, however, we did -- 31 states reported -
11 - 31 states did not report this measure, the most
12 common reason being that data was not available.

13 CMS TA, team provided additional
14 support to the states with this particular
15 measure. One of the support mechanisms they used
16 was through a webinar on collecting and using the
17 measure. We can move to the next slide.

18 So Measure 0471, again, you see the
19 measure properties that we pulled from QPS. This
20 particular measure, if we can move to the next
21 slide, the reporting increased from 12 states in
22 2012 to 17 states in 2013 and 16 states in 2014.

1 Ten states reported the measure using the Child
2 Core Specifications. Thirty-five states reported
3 reasons for not reporting this measure. Again,
4 the most common reason was data not available, so
5 you'll see that as a, pretty much, as a theme
6 throughout the measures.

7 So the very last measure, behavioral
8 health risk assessments for pregnant women.
9 Again, this was added in 2013. We pulled the
10 measure properties from QPS.

11 And, if we go to the next slide, 47
12 states did not report this measure, the most
13 common reason, again, is that the data were not
14 available.

15 There were no TA requests submitted
16 and CMS did provide additional support for this
17 measure. So that was real quick. But, if we
18 could continue on to discussion, Foster?

19 CHAIR GESTEN: So are there any
20 questions, first about what Shaconna just
21 presented? I think some of this was presented
22 this morning, as well, but a little more detail

1 about some of the ins and outs.

2 Some of these measures are actually
3 fairly new, I think, in terms of their addition
4 to the measure set. And I think we -- there was
5 a conversation earlier about challenges related
6 to VS data, but any questions, or comments about
7 what was presented? Denise.

8 MS. DOUGHERTY: I'm still channeling
9 Carolyn Clancy, even though she's been gone for a
10 while. But, way back when in 2009, she made the
11 suggestion, in order to get the states to report
12 more measures, to pay them for reporting, just
13 like the way Medicare started out, I think with
14 the physician quality reporting. So that's one
15 idea.

16 CHAIR GESTEN: Paying providers or
17 paying states? Or both?

18 MS. DOUGHERTY: The states.

19 CHAIR GESTEN: Pay the states?

20 MS. DOUGHERTY: I guess, pay -- yes.
21 Yes. I hadn't thought that far down the train.
22 I was thinking states.

1 CHAIR GESTEN: Other comments on these
2 measures? And, I didn't hear this morning any,
3 despite the lower number states that were able to
4 report, anybody saying that these measures should
5 be thrown off the island. In fact, I think I
6 heard a lot of conversation about the importance
7 of some of these measures, despite their
8 difficulty. Yes.

9 MS. DOUGHERTY: Just, on the
10 developmental screening, I understand from
11 Oregon, from Colleen Reuland, that she's not
12 going to be a waitress, who is not going to be
13 able to afford to be a measure steward anymore,
14 without some support. And there are measures
15 submitted under the COEs that are developmental
16 screening follow-up that were developed with the
17 help of the AAP, and it's at the provider level,
18 as well. So just comment on that.

19 CHAIR GESTEN: Other comments or
20 suggestions about ways to increase some
21 participation reporting the measures? Yes,
22 Susan.

1 DR. LACEY: So if you could just
2 clarify for me, Shaconna, the issue around the
3 measure of the maternal mental health screening,
4 et cetera. There were a list, a laundry list of
5 things that how many states -- that was the
6 highest state, highest number of states not
7 reporting?

8 (Off microphone discussion)

9 DR. LACEY: Forty-seven? And it was
10 associated with -- at least, the feedback you're
11 getting is associated with the data were not
12 available?

13 MS. GORHAM: So the most common reason
14 reported was data not available. They had other
15 reasons, as well as listed on the slide.
16 Information was not collected because of budget
17 constraints, staff constraints, data source not
18 easy assessable.

19 DR. LACEY: Yes. So I'm just curious,
20 because it seems like there's another one that I
21 can't put my finger on or put my head on, right
22 now, in terms of -- maybe there's lack of clarity

1 around how -- or consistency about how to put
2 that on the billing statement, how to do that.

3 Because, I think, when you have
4 something that -- it seems like somewhat of a
5 catchall. I mean, you're talking about
6 individual partner abuse.

7 There's about six things in there that
8 would require different types of screening that
9 could take an hour for each screening. And I
10 worry that it's a kitchen sink kind of measure.

11 And I think people are never -- it
12 would be highly unlikely that people can
13 disentangle all of that and appropriately deal
14 with all of that. So I would ask you guys to
15 think about, think about that.

16 MS. GORHAM: Thanks.

17 CHAIR GESTEN: Other comments?

18 DR. SIDDIQI: Oh, I had just said,
19 sort of, earlier, too, that I don't think there
20 is one simple code or claim that, you'd have to
21 specify a completely different coding system for
22 that measure. Whereas the prenatal care, there is

1 like a prenatal screening one that I think
2 captures the PPC measure.

3 So that's why I kind of was -- felt
4 challenged by this one, in terms of states'
5 ability to report on this one, because it's just
6 not really easy to capture the data. You'd have
7 to do medical record reviews, which in our state
8 we don't do anything like that.

9 DR. ADIRIM: Yes, and I thought where
10 you were going with this was that the
11 practitioner may not do this, because there may
12 not be the resources, the time, or any place to
13 refer the patient, so it just may not be done,
14 right?

15 (Off microphone discussion)

16 DR. LACEY: And the fact that it's all
17 lumped into this one piece, but they're very
18 discrete issues at stake under that measure. So
19 yes, I don't know what --

20 CHAIR GESTEN: Right. There's also
21 potentially global billing issues --

22 DR. LACEY: Yes.

1 CHAIR GESTEN: -- for prenatal care
2 that challenges this. And I'm guessing that
3 ICD-10 is probably not going to have --

4 DR. LACEY: Probably not.

5 CHAIR GESTEN: -- although it's got
6 lots of new codes, I'd have to defer to my
7 specialist here, probably isn't going to set us
8 free, relative to coding on this. Rebekah.

9 MR. BERTRAND: Well, there are expert
10 codes that do describe this. There are Medicare
11 codes and we activated them in our state, and we
12 paid additional for them. But I'll say, even
13 though you have a way to measure it, there are
14 codes. It was not successful.

15 I was part of our birth outcomes
16 effort a few years ago, and the reason is
17 two-fold. One is that we really weren't paying
18 enough to providers to do this, and the second is
19 that ACOG or professional organizations that
20 counsel providers on how to do screening don't
21 put it in a bundle like this.

22 So when I'm an obstetrician doing the

1 postpartum visit, or I'm doing an assessment of
2 violence in a patient, I don't think of it as I'm
3 doing my behavioral health bundle now and
4 therefore -- and so that's the big problem.

5 And so I think you can do one of two
6 things. The low-hanging fruit, and we tried it
7 and it didn't work in our state, was tell them
8 about the expert code and say we're already doing
9 it, just bill it this way. But for \$35 it just
10 wasn't -- people weren't going to bother.

11 But I think we need to work with
12 professional organizations. And in pregnancy,
13 there's a big problem. I think -- we've been
14 working with Jeanne Conry and ACOG about the
15 postpartum visit and some of the things that need
16 to be done at that visit, including screening for
17 depression, what tools are used, making sure
18 that, that not just the visit happens, but what
19 is the content of that.

20 So I think we need to move beyond an
21 NQF in some of our measurement strategy, not
22 just, did prenatal care occur, did that the

1 postpartum visit occur, but what actually
2 occurred during that visit?

3 And I think that we need to work more
4 closely with the professional societies, so that
5 there are meaningful recommendations around these
6 bundled care episodes that we expect to happen.

7 CHAIR GESTEN: But just so I
8 understand that, even if Esper was recorded,
9 specifically, it only accounts for a part of this
10 measure, it doesn't account for the other
11 screening aspects to it, right?

12 MR. BERTRAND: But my point was, even
13 when we acted in the Esper codes --

14 CHAIR GESTEN: Have a specific code,
15 you don't see it.

16 MR. BERTRAND: -- yes, and I'm not
17 familiar with all of the pieces of this measure.
18 I'm just saying, if you're looking at behavioral
19 risk assessment in pregnancy that was our focus.

20 We had this whole Esper. We did this
21 thing called the Heart. We created a website tool
22 for providers, we went out and spoke to the

1 practices, it still didn't work. Because the
2 other issue is, until you have resources for
3 pregnant women to refer them to, people also
4 don't want to do this.

5 So -- and I, personally, had an
6 experience where I had a heroin-addicted woman on
7 a labor floor, needed a bed for her and I called
8 -- anyway, I called and they basically said you
9 find a bed yourself and tell us how it went.

10 So, you know, and providers are
11 experiencing that, and I told them I was the
12 Medical Director for Medicaid. That still didn't
13 help. So anyway, so I think that there are
14 multiple issues here, but it's a really important
15 area of focus.

16 CHAIR GESTEN: Anne.

17 MS. COHEN: So I have a couple of
18 things. I would agree with Rebekah, Dr. Gee, in
19 the fact there's only two hospitals in the
20 country that serve postpartum depression, so
21 that's a huge issue and outpatient services are
22 highly lacking.

1 One idea that I've heard talked about
2 a number of years ago is the Behavioral Risk
3 Factor Surveillance System, the BRFSS Survey is
4 done very broadly by states.

5 And while modules can be expensive to
6 add, I know in the past they've looked at
7 maternal health measurement in that area and that
8 would be something that's already collected by
9 states, it's already on a public health level,
10 more than two questions can be added and filled
11 in very quickly, and you could get a large amount
12 of data to the -- down in a more concrete way to
13 look at what additional surveys could be done and
14 that provide -- so.

15 CHAIR GESTEN: Carol. Is that -- I
16 called on you, even as you were putting your card
17 up?

18 MS. SAKALA: Thank you. So it looks
19 like we have very important testing data from
20 Louisiana. I know that the PCPI process for the
21 perinatal care measure set, kind of, stalled on
22 resources for testing, and that's an issue here,

1 I think, that we don't really -- it's not really
2 piloted to my understanding. Does anyone know
3 whether they have testing data that are available
4 for this measure?

5 (Off microphone discussion)

6 CHAIR GESTEN: So we are actually one
7 of the states that is making a crack at trying to
8 report this. It's not, what I would say, testing
9 data on the measure but an approach to doing it
10 jumping onto a separate quality measurement, an
11 improvement project we're doing that's provider
12 and practice driven, in which we're asking
13 practices to review a random sample of 20 cases
14 that we select.

15 And it's a self-assessment, so at this
16 point, there's no external audit, and asking
17 practices to look at a number of different areas,
18 including risk screening on those patients, those
19 members, and reporting it.

20 And that's the vehicle that we're
21 getting at to use to be able to evaluate this.
22 And we see that, again, despite the fact that

1 self-assessment, the rates are -- they're not in
2 the 80s and 90s and so on, so if people are not
3 being honest, they're really doing a lousy job at
4 cheating at this test.

5 So clearly it's a challenge, I think,
6 meeting all those different things. But that's
7 been one way of doing it. I know the
8 specifications for this measure, electronic
9 health records, and it turns out that a lot of
10 the providers actually use electronic health
11 records and they may be getting some of this
12 through electronic health records, and many are
13 trying to build it into the electronic health
14 records, so that they can actually capture it on
15 a more ongoing basis.

16 But that's not what I would describe
17 as through testing data for the measure, but, you
18 know, our attempt to try to create -- be able to
19 report on a measure that we think is really
20 fundamentally very important but very challenging
21 to collect the data on.

22 And the data, admittedly, has

1 limitations, given that so far we've only been
2 able to look at about half of the practices and
3 maybe in two years we'd have a complete
4 state-wide look and it's self-assessment data.
5 Go ahead.

6 DR. SIDDIQI: I was just going to add,
7 and I'm trying to look for it, but I can't really
8 find it, but I believe there's a measure for just
9 looking at prenatal depression screening, and
10 that is a measure I do think states would feel
11 that they could be able to report on, because
12 that is something that providers do, typically,
13 code for and bill for and states actually capture
14 that data.

15 I think this one is always
16 challenging, because there's four components in
17 this depression, tobacco, alcohol, and there's
18 one other one, IPV, yes, domestic violence, or
19 intimate partner violence.

20 So I think if you teased out the one
21 just for the depression, I think, you would
22 actually have a lot better results, in terms of

1 reporting.

2 CHAIR GESTEN: Andrew? Okay. And I
3 suppose the really sneaky thing we could do is we
4 give this to the adult group.

5 (Off microphone discussion)

6 CHAIR GESTEN: In fact with --

7 MS. LILLIE-BLANTON: Right, we could
8 --

9 CHAIR GESTEN: I think we're going to
10 talk about --

11 (Off microphone discussion)

12 CHAIR GESTEN: -- tomorrow, about some
13 of the measures --

14 MS. LILLIE-BLANTON: Okay.

15 CHAIR GESTEN: -- that really cross
16 the child and the adult group on what these
17 measures --

18 MS. LILLIE-BLANTON: And also, it
19 would be helpful to go back to look at the
20 records when this measure was added, because this
21 was not -- this measure was not in the initial
22 core set. We added it in, I think, 2013. So I

1 want to revisit some of the history to understand
2 what the discussion was then.

3 I also know that whenever there's a
4 new measure added, uptake is generally slow.
5 Maybe because states are focused on what they've
6 been focused on.

7 And, unless there's a really big push
8 or a problem in the state, it's hard to -- you
9 don't usually see a big jump. So while I am
10 concerned about this measure, I'm sensitive to
11 the fact that it's only been in the core set for
12 the last two years.

13 CHAIR GESTEN: Andrea.

14 DR. BENIN: Well, just a generic
15 comment. When I was looking through those sheets
16 where this -- however that data was aggregated
17 about why things were not -- so why states didn't
18 submit the -- there was a lot -- everybody,
19 pretty much, looks like they responded, did not
20 have data, or other.

21 There was a lot of other, and I don't
22 know if there's a way to get a little bit more of

1 a deep dive into some of that. It may be worth
2 revamping how those questions are asked, so that
3 it's a little more informative as to what the
4 problems are.

5 And I don't know where that all comes
6 from, or what that thing is, but it may be worth
7 reaching out and getting some different options
8 to check off, because it seems like the options
9 are -- were localized in those two categories.

10 CHAIR GESTEN: Jeff.

11 DR. SCHIFF: I was just going to add
12 on that we heard from our friends from Louisiana
13 that there was a lot of data that wasn't
14 available, until they actually did a pile of
15 really great work, to make the data available.
16 All right? So I think you have to totally keep
17 that in consideration, as well.

18 CHAIR GESTEN: So I'm wondering
19 whether we should move on to start talking about
20 some of the new suggested measures and, well, I
21 think, pick up some of these, at least two, of
22 these measures, probably, tomorrow when we talk

1 to the adult group about overlap areas. So we
2 did public comment, previously. Okay. So the
3 next slides are about new measures, new proposed
4 measures.

5 MS. GORHAM: So may I suggest that you
6 open the Excel file that we sent to you, if you
7 could, pull that up on your laptop? It was
8 included in your big bundle of materials.

9 (Off microphone discussion)

10 MS. GORHAM: Okay, so during the 2014
11 expedited review by this Task Force, MAP
12 identified gaps in the measure and measures in
13 the core set, so all of the core set includes
14 some of these measures.

15 MAP did not perceive them as
16 comprehensive. So for example, we have two
17 measures in the child core set related to mental
18 health, but others are available and in
19 development that we can consider today.

20 So in preparation for this year's
21 review, staff conducted an analysis of available
22 measures. We compiled a list of NQF-endorsed

1 measures, and then, also, some from PQNP
2 measures, based on the MAP's recommendations to
3 review PQNP measures under development. And
4 then, also, other available measures, and so that
5 is what you have in your Excel sheet.

6 You have different tabs, according to
7 the measure gaps, and so I just kind of want to
8 steer you away from the maternal and perinatal
9 tab, because we will discuss that tomorrow when
10 the Adult Task Force joins us.

11 Okay. So the list on the slide before
12 you summarizes the potential gap-filling measures
13 that staff identify that you talked about last
14 year. We found measures in cost -- we found, I'm
15 sorry, cost measures, mental and behavioral
16 health measures, care coordination measures, as
17 well as inpatient measures.

18 We found "strong" --- what we
19 consider, and I'm using air quotes, "strong"
20 measures in these gap areas. And so as we
21 reviewed available measures to consider for
22 potential addition, we stayed mindful that

1 additional resources are required for each new
2 measure that we will consider.

3 And, as we heard earlier, states are
4 challenged through resources, so they don't have
5 a bunch of unused resources kind of tucked away
6 in a corner to add a bunch of measures.

7 And so with that in mind, the staff
8 chose three measures that we consider as staff
9 picks. We are not wed to these measures, but
10 they are just a starting point for your -- just
11 to start the conversation. So we can move on.

12 I just want to just reiterate the
13 decision categories discussed earlier, by Nadine,
14 and so this task force will focus mostly on
15 support and conditional support.

16 Okay. So the list you have in front
17 of you are all the available measures and cost
18 and readmissions gap area, and the one that is
19 highlighted, the 2393, will be our quote unquote
20 staff pick.

21 And we'll go, I'll go into that a
22 little bit more in detail, but we wanted to, kind

1 of, give you that list. And we favored the old
2 conditions, rather than condition-specific
3 measure for readmission.

4 Okay, so the mental and behavioral
5 health gap area, we have ten available measures
6 in this gap area and we identified two that we
7 thought were rather strong. So we can move to
8 the next slide.

9 One pick is the antipsychotic use for
10 children under age of 5 years old. That is 2337
11 and that is an NQF-endorsed measure.

12 (Off microphone discussion)

13 MS. GORHAM: No, I'm sorry. This on
14 the first slide. Exactly. The 2337 is
15 NQF-endorsed. And then we have the other staff
16 pick that is not endorsed, and that is a
17 compliment, the use of multiple concurrent
18 antipsychotics in children and adolescents. So
19 those are the two staff picks in that particular
20 gap area.

21 DR. LACEY: Shaconna, can I ask a
22 question?

1 MS. GORHAM: Yes.

2 DR. LACEY: So I know that Sarah told
3 us this morning that there are different reasons
4 why NQF has not endorsed a particular measure,
5 it's not necessarily linked to it being rejected.
6 There are a lot of reasons why it's not there.

7 So do you have any more detail around
8 the use of multiple concurrent antipsychotics in
9 children and adolescents? Because that's pretty
10 -- it seems pretty serious.

11 MS. GORHAM: Yes. So as I present all
12 the available measures, then we'll go back and
13 give a little bit more detail about the
14 individual measures the staff picked, as well as,
15 a lot of the information is on your Excel sheet,
16 and so we'll kind of go back and forth.

17 (Off microphone discussion)

18 DR. ADIRIM: Can I ask a question
19 about the behavioral health measures?

20 (Off microphone discussion)

21 DR. ADIRIM: In light of the
22 discussion that we've had this morning, it seemed

1 like a lot of people centered around a couple of
2 issues, one around ADHD and treatment of ADHD,
3 and two, with access to behavioral health
4 services. Were there any measures that in your
5 research that address those two issues?

6 MS. GORHAM: So in light of the
7 conversation, we did of course, some background
8 work. And in light of the conversation, we
9 researched, while sitting here and over the
10 break, two ADH measures, measures in primary care
11 in school-aged kids that was, at one time,
12 endorsed by NQF, but the steward opted to retire
13 the measure, due to lack of testing data. So
14 those were two measures. And in your spreadsheet
15 and, Sarah, help me to remember, we do have a
16 list of other measures.

17 (Off microphone discussion)

18 MS. LASH: Everything in the
19 spreadsheet would match the table you're seeing
20 on the screen. Although, mea culpa, I removed
21 one other measure from the PQNP, related to ADHD
22 care, because I thought we already had that

1 covered in the core set.

2 So we have, for your consideration,
3 and this was not in your meeting materials, it's
4 sort of a just in time opportunity to look at
5 another measure called behavioral therapy, as
6 first-line treatment for preschool-aged children
7 with ADHD.

8 And so we would have to, I think, take
9 some time to understand more of the properties of
10 this measure and determine if it's a good fit for
11 the program. Kevin seems to be familiar with it.

12 DR. LARSEN: Yes, just another couple
13 of comments. So we've been building a number of
14 -- and what I mean by we, ONC, under, under, kind
15 of, leadership and stewardship from Marsha's
16 team, have been building some of these measures
17 for EHRs and for the Meaningful Use Program.

18 And so they're not claims-based
19 measures, but they're eQMs, so electronic
20 quality measures for the purpose of coming out of
21 an EHR.

22 A couple of these are already in

1 Meaningful Use Stage II, and we are building, for
2 example, the multiple concurrent antipsychotics
3 in children for EHRs and have that nearly
4 completed now.

5 And so, happy to, at whatever point,
6 to talk about these non-claims-based measures, as
7 well, that to this, kind of, alignment question I
8 read earlier.

9 MS. LASH: Foster, I also noticed that
10 we did find it, after all, and it's in the sheet
11 just on the inpatient tab. So if you can look at
12 the high-level measure description there in your
13 information. It's the purple tab.

14 (Off microphone discussion)

15 MS. LASH: It's Row 7.

16 MS. DOUGHERTY: Oh, before you leave

17 --

18 MS. LASH: Sure.

19 MS. DOUGHERTY: --- the psychotropics.

20 So a question. The measure, Use of
21 Anti-Psychotic Medications in Very Young
22 Children, NSIG delivery, how does that differ

1 from the pharmacy -- pharmaceutical measure that
2 was in the page before -- the slide before, that
3 you're -- that the staff is picking, to
4 recommend?

5 MS. LASH: Shaconna's going to go over
6 each one in a little bit more detail. So
7 essentially, Number 2337 looks at prescription of
8 an anti-psychotic to a child less than five years
9 of age.

10 The denominator population for this
11 non-endorsed measure for the use of multiple
12 anti-psychotics is broader.

13 MS. DOUGHERTY: No, I'm talking about
14 the last one on this chart, use of very young
15 children --

16 MS. LASH: Yes.

17 MS. DOUGHERTY: -- which I assume
18 would be under five, but I'm kind --

19 MS. LASH: It is likely very similar.
20 We picked the one that had gone through the
21 endorsement process, as the staff pick, for that
22 reason.

1 MS. DOUGHERTY: Because it had gone
2 through the staff?

3 MS. LASH: Because it has, yes,
4 completed the scientific review.

5 MS. DOUGHERTY: Okay. Thank you.

6 DR. WHITE: All right, I have a
7 question for one of our colleagues. I wonder if
8 the -- the gentleman from the ONC?

9 DR. LARSEN: Yes, Kevin Larsen.

10 DR. WHITE: Kevin? Can you comment a
11 bit about the penetration of EHR and then a
12 little bit of the EHR owners that have the
13 measures turned and was reportable that, that we
14 have an interest in?

15 DR. LARSEN: Certainly. So on the
16 hospital side -- so the EHR Incentive Program is
17 for both hospitals and what are called eligible
18 providers.

19 On the hospital side, the EHR adoption
20 rates and the Meaningful Use Attestation Rates
21 are over 90 percent U.S. wide. And the rural and
22 urban mix is the same. They both have obtained

1 the same use.

2 The only hospitals that seem to be
3 lagging, and they're at 70 percent, are what are
4 called the small urban hospitals, which are small
5 suburban hospitals, which we think are largely
6 specialty hospitals, like orthopedics and
7 cardiology hospitals that are kind of private
8 practice groups.

9 On the physician side, eligible
10 providers, about 65 percent of providers in the
11 U.S. have attested to Meaningful Use, either
12 through the Medicare or the Medicaid program, so
13 the penetration on the provider side is also
14 quite high. Some states are -- over 90 percent
15 of their providers have attested to Meaningful
16 Use.

17 A number of these measures, we put
18 into the Meaningful Use Stage II Rule, as what
19 was called a recommended pediatric core set, so
20 we didn't require that the vendors use them.

21 But we did call out what -- we worked
22 with, again, Marsha's group on what would be the

1 most closely aligned to the Medicaid core set and
2 those that we thought would be most important or
3 kind of address some of the big priority areas
4 for children.

5 And so there are --- there is a
6 recommended core set in children, and what we
7 know, from what the vendors have done, is they
8 went to the core sets. They went to the adult
9 core set, and they went to pediatrics core set,
10 and there's a really high penetration of the
11 measures that we put into that core set in
12 Meaningful Use Stage II.

13 So the penetration there is nearly
14 completely for their availability in the
15 providers that have adopted EHRs under, either
16 Medicaid, or Medicare.

17 DR. LARSEN: There's a little bit of
18 nuance in that, so for example, some of the oral
19 health measures were targeted at dental
20 practices.

21 And so we know that under the dental
22 practices, they're going to be much more likely

1 to have put in the oral health measures than some
2 of the traditional EMR practices aimed at
3 permanent care didn't prioritize some of the oral
4 health measures in the same way that a dental
5 practice would.

6 DR. BENIN: So just to clarify, the 90
7 percent and the 65 percent, are those pediatric
8 facilities?

9 DR. LARSEN: I can look, I'll jump in
10 line to see if I can pull out PEDS versus adults.
11 I think that they're -- the rate of hospital,
12 pediatric hospitals that have attested Meaningful
13 Use is slightly lower than the rate of general
14 hospitals, which also do a fair bit of pediatric
15 care.

16 So, I don't know about the -- that we
17 have that data for non-hospital-based care. We
18 know by specialists. And we know that primary
19 care has a very high rate in pediatricians and
20 family doctors that take care of the vast
21 majority children both have a high rate of
22 adoption. So we know by provider type or

1 hospital type, but we don't know by the Medicaid
2 patients that receive care.

3 DR. BENIN: I do think that the
4 vendors have been lax in supporting the building
5 of the pediatric measures, perhaps with the same
6 sort of support that the adult measures have
7 gotten. But it's been a real challenge.

8 CHAIR GESTEN: So Jeff and then Terry.

9 DR. SCHIFF: Yes. There was a
10 question that started this last binge, was both
11 ADHD and then also access to behavioral health,
12 and so I wanted us to call back that, we didn't
13 talk about that. And it appears, at least, under
14 the mental health tab at Row 11, that basically
15 using caps as a sort of surrogate for access is
16 something for us to at least be aware of and
17 consider.

18 CHAIR GESTEN: Terry.

19 DR. ADIRIM: So I have a question. In
20 preparing for this meeting, because I feel very
21 strongly that the core set doesn't reflect, I
22 think, enough of behavioral health, I mean, if

1 you haven't gotten that, yet.

2 I did look up on the behavioral health
3 framework that was done with NQF and HHS. Those
4 NQF numbers, 0107, Management of ADHD and Primary
5 Care for School-Aged Children and Adolescents, is
6 that -- it's a provider level measure. I don't
7 know if that --

8 MS. LASH: That's one of the two
9 measures we mentioned that is lost endorsement,
10 since it was --

11 DR. ADIRIM: Oh.

12 MS. LASH: -- initially reviewed,
13 unfortunately.

14 (Off microphone discussion)

15 CHAIR GESTEN: Shucks. Denise, do you
16 have your --

17 MS. DOUGHERTY: Oh, I'm sorry. I --

18 CHAIR GESTEN: Can you turn your mic
19 off, too?

20 MS. DOUGHERTY: Yes.

21 CHAIR GESTEN: Anne.

22 MS. COHEN: Yes, I just want to

1 capture from this morning, to sort of add to the
2 gaps list in this behavioral health area and that
3 concept of trauma-driven behavioral health,
4 because I think that's an area that we haven't
5 looked at, and, I believe, through the duals
6 group, the last time we looked at health
7 disparities, one of the areas that came up was
8 trauma-related care in adults and children under
9 the influence of overall health. So it's a new
10 up and coming area and we need to, kind of,
11 highlight that, as an area to look at for future
12 study.

13 (Off microphone discussion)

14 CHAIR GESTEN: Go ahead, Andrea.

15 DR. BENIN: -- we're on this topic of
16 behavioral health gap, I would just add the -- a
17 really large gap around the amount of time
18 children with behavioral health problems spend in
19 the ED, and so sort of ED length of stay, or some
20 type of metric around the burden on the -- of
21 time in the emergency room, which is pretty
22 untenable at this point. And, certainly, in our

1 environment, it's completely out of control.

2 CHAIR GESTEN: So before I get to
3 Rebekah, Jeff, I want to make sure I understood
4 your -- what you were suggesting. Were you
5 suggesting, in terms of the access, that within
6 CAHPS, there's a potential inability to generate
7 a measure related to access to behavioral health
8 or that that might be a vehicle to do that? I
9 just want to circle back to it.

10 DR. SCHIFF: I was just using the
11 resources you all had, and I hadn't heard it
12 called out or show up on that list as a measure
13 to consider that was in the space of behavioral
14 health access. I wasn't, necessarily, commenting
15 on -- it was -- if I was endorsing it, or not,
16 but just that it is there, available with these
17 list of other things to consider.

18 CHAIR GESTEN: Rebekah.

19 MR. BERTRAND: Just wanted to add, and
20 I know I've already said this, but the
21 prematurity measure, progesterone, and we could
22 use any help that could be offered to us, in

1 terms of getting it endorsed and helping us with
2 that process.

3 And number 2, cross-sector measures.
4 So, you know, my opinion is schools have as much,
5 or more, responsibility for pediatric obesity, as
6 do pediatricians, so can we do cross-sector
7 measures?

8 Particularly relevant in states where
9 state agencies are often funded by a super
10 budget, how do we have cross sector measures,
11 whether it's prison health, or health in
12 education? And how do we start to work to develop
13 those types of things? I think it would require
14 a conversation. They're not just going to happen
15 spontaneously in my opinion.

16 CHAIR GESTEN: So I think we're
17 starting to have -- we're having a conversation
18 about general gaps, which is -- which is fine. I
19 think we want to -- we had some of it -- you all
20 had some of it this morning, and we're going to,
21 I think, circle back to it, as well.

22 But, I think, for right now, it would

1 be helpful to know whether the three measures
2 that are being teed up, or their measures that
3 accompany them, excite interest, deal with
4 concerns or questions that were raised about gaps
5 and gaps related to behavioral health.

6 Clearly, two of them relate to
7 behavioral health. One of them is an inpatient
8 measure about readmission and that gets to issues
9 around care coordination, and so I think that
10 they are aimed in the direction of gaps that have
11 been identified.

12 The question is, do they hit the
13 target for this group or not, and are there any
14 questions about those three? Because, I think,
15 we're going to want to probably take a vote about
16 whether they these are ones that we want to put
17 on the list for potential endorsement to go
18 forward. Marc.

19 MS. GORHAM: Before --

20 DR. LEIB: Oh.

21 MS. GORHAM: Before we do that, can I
22 actually go through more detail about the three

1 measures? And then we can take comments. And so

2 --

3 DR. LEIB: Sure. I just had a general
4 questions --

5 CHAIR GESTEN: Oh, okay.

6 DR. LEIB: -- not about these three
7 but about behavioral health. Given that we're
8 talking strictly behavioral health, and we're
9 talking children are on anti-psychotics, why -- I
10 was just wondering why there was no
11 consideration, or at least there wasn't an
12 acceptance of like the metabolic monitoring of
13 children who are on anti-psychotics, which seems
14 like it would be a relatively easy measure to see
15 if there is the lab tests that are done once a
16 year, or once -- whatever the proper measure
17 would be? I just wondered why those weren't part
18 of it.

19 MS. LASH: We can definitely talk more
20 about the pros and cons of these measures. It
21 was a tough call. On this particular page, they
22 all seem to be a little narrow for our liking.

1 They're sort of sounding a lot like
2 that ADH measure -- ADHD measure that we don't
3 particularly love today about follow-up visits.
4 They seem to be a little in that vein, so I will
5 suggest that we come back to that.

6 CHAIR GESTEN: So if it's okay with
7 the folks who have cards, unless you have
8 something urgent on this point, I'm going to turn
9 it over to Shaconna to go through the detail of
10 these three measures.

11 MS. DOUGHERTY: Well, I'm wondering
12 whether people have had a chance to look at the
13 other tabs on this -- other measures to --

14 CHAIR GESTEN: Would you like to take
15 a vote to see if they've looked at them, or would
16 -- I mean, I think, why -- Denise, why don't we
17 do this, why don't we go through these, and then
18 it'll be an open conversation about the ones that
19 the staff did not pick as well as the other ones
20 that are in the document that was sent to you
21 all?

22 MS. DOUGHERTY: Okay.

1 CHAIR GESTEN: Is that fair?

2 (No Response.)

3 CHAIR GESTEN: Okay?

4 MS. DOUGHERTY: Yes.

5 CHAIR GESTEN: We're not voting right
6 now. We're not voting. We'll have a thorough
7 conversation before we do any voting.

8 MS. GORHAM: Okay. So the available
9 measures in the care coordination gap area are --
10 well, they're not on the slide, yet. Hold on.
11 Okay. So those are the available measures in the
12 care coordination gap area. We did not have any
13 staff picks in that particular gap area.

14 The next slide, the inpatient gap
15 area, I just want to bring your attention to the
16 measure next to the last. While it was not a
17 staff pick, we alluded to it earlier about the
18 behavioral therapy at the first-line treatment
19 for preschool-aged children with ADHD.

20 Sir, I kind of mentioned that earlier,
21 so I just wanted to kind of highlight that it is
22 in the inpatient gap area, and we can discuss it

1 more, if you would like.

2 (Off microphone discussion)

3 MS. GORHAM: So one of the --

4 (Off microphone discussion)

5 CHAIR GESTEN: I think folks are
6 bubbling over.

7 MS. GORHAM: Right.

8 CHAIR GESTEN: So Denise. I don't
9 want to stop the boil. Go ahead.

10 MS. DOUGHERTY: So on care
11 coordination, I'm wondering why, unless I'm not
12 looking at this correctly, why the new family
13 experience of care coordination measures -- it's
14 a survey, but it's a set of 20 measures, is not
15 listed at all? I understand it's not endorsed,
16 yet, but --

17 MS. GORHAM: It sounds familiar, so we
18 think that it is --

19 MS. DOUGHERTY: Care coordination.

20 MS. GORHAM: -- yes, it's on the, it
21 should --

22 MS. DOUGHERTY: Oh it is. I'm sorry.

1 MS. GORHAM: -- under behavioral --

2 MS. DOUGHERTY: I'm sorry. I'm sorry.

3 MS. GORHAM: -- under behavioral

4 health.

5 MS. DOUGHERTY: It is there.

6 (Off microphone discussion)

7 MS. DOUGHERTY: It's --

8 (Off microphone discussion)

9 MS. DOUGHERTY: Yes. Okay.

10 Apologies.

11 CHAIR GESTEN: It's okay. As Emily

12 Litella said "never mind". Kevin, did you want

13 something, or no?

14 DR. LARSEN: I'll save it.

15 CHAIR GESTEN: Okay.

16 DR. LARSEN: Just until we get to the

17 overall conversation.

18 MS. LILLIE-BLANTON: Okay. Question

19 around the 1360, audiological evaluation, no

20 later than three months of age. I just want to

21 make sure there's discussion, or at least we're

22 making a conscience decision, because the issue

1 with both hearing and vision screening continues
2 to get raised of CMS, and we have trusted this
3 body to say to us, there is no measure that could
4 help us grasp well whether or not children
5 enrolled in Medicaid are getting the screenings
6 they need for hearing and vision. But I just
7 wanted to make sure that we're --- I mean, I'm
8 hearing from NQF they feel like this is a measure
9 that has value.

10 DR. SIDDIQI: It's --

11 MS. LILLIE-BLANTON: That's fine.

12 DR. SIDDIQI: And then to that
13 measure, is that an inpatient measure because the
14 newborn, as part of the newborn screening, and
15 during the hospital, of course, is when that
16 hearing screening takes place?

17 (No Response.)

18 DR. SIDDIQI: That's what I -- that's
19 what I thought, okay.

20 CHAIR GESTEN: It looks to me like
21 inpatient is an unfortunate word to put on the
22 slide for these measures. I'm not quite sure how

1 it happened, is that all right. It's just, maybe
2 some of them do, some of them don't?

3 MS. LASH: I even asked that we double
4 check that one, because it seems like, of course,
5 you're not in the hospital for the entire first
6 three months of your life, you can have the
7 screening at a later date. That is what the
8 measure submission form said. We could --

9 CHAIR GESTEN: And let me --

10 MS. LASH: There might be
11 opportunities in multiple settings of care.

12 CHAIR GESTEN: Let me speak for the
13 staff that because they chose some things, which
14 we're going to talk about, it doesn't mean the
15 other ones aren't worthy, or that they're not --
16 and they clearly are on the list, and they are
17 available for our conversation and consideration.

18 But how about if we just get the
19 through the slides I've just offered. Get through
20 the slides, their decision making, and then we
21 can revisit that.

22 I think, you know, Sarah mentioned up

1 front that this is where they landed, not because
2 it was the sum total of the universe of measures
3 that might be adequate or fill gaps, and so on.
4 So, Shaconna.

5 MS. GORHAM: And we'll discuss these
6 three measures that staff quote unquote picked,
7 and Nadine and I are taking notes. So the
8 measures that you have brought up, such as the
9 1360, we'll make sure we go back to the Excel
10 sheet and look at those as well.

11 Okay. So the first measure that we
12 highlighted is the pediatric all conditions
13 readmissions measure. It is a new measure from
14 the Centers of Excellence, endorsed by NQF. This
15 measure includes all conditions and covers
16 patients discharged from general acute care
17 hospitals, including children's hospitals.

18 It is an outcome facilities level
19 measure. The data source is administrative
20 claims. There are quite a bit of exclusions to
21 this particular measure and a detailed list of
22 those exclusions are in your Excel spreadsheet.

1 And so if we want to go there now, and
2 I don't know if it's better to go to the Excel
3 spreadsheet or go through the other two measures?
4 Just --

5 CHAIR GESTEN: Let's do that. The
6 measures.

7 MS. GORHAM: -- just go through the
8 other two measures, okay.

9 CHAIR GESTEN: Yes.

10 MS. GORHAM: Okay, and then we have
11 the antipsychotic use in children under 5 years
12 of age. That is the NQF-endorsed 2337 measure.
13 So this gives emphasis, giving emphasis placed on
14 the antipsychotic use.

15 We highlighted two measures in the
16 mental health gap area. Again, it is
17 NQF-endorsed, and it is stewarded by the Pharmacy
18 Quality Allowance. It measures antipsychotic use
19 in very young children. It's a process measure,
20 a health plan level measure with no exclusions.

21 The last measure, the use of multiple
22 concurrent antipsychotics, is not NQF-endorsed.

1 It is stewarded by NCINQ. It is a process
2 measure and it would be used in ambulatory
3 settings using administrative claims data. Okay?

4 So we can actually look at the other
5 measures. I'm pulling my Excel spreadsheet up,
6 as well. So do you want to start? I don't --

7 CHAIR GESTEN: Well, can I just take
8 a wild guess at the things -- these three things,
9 why staff might have found these attractive and
10 why they're worthy of our consideration, maybe,
11 as the first things to consider.

12 One, it seems to me, is obviously the
13 NQF endorsement. Two, the readmission measure
14 has analogies and for adults and for other
15 populations and has some alignment with other
16 measures for other purposes, and while imperfect,
17 like all measures, it tries to get at this issue
18 about integration of care and care coordination
19 and follow-up of care and so on, as well as,
20 potentially, resource use.

21 And the other two are aimed in the
22 direction of behavioral health and filling gaps,

1 concerns about safety, and again, the fact that
2 these are administrative measures make them,
3 probably, attractive, God bless you, as a -- so
4 I'm just guessing, because you guys are --

5 MS. GORHAM: Very good guess.

6 CHAIR GESTEN: Does that --

7 MS. GORHAM: It does.

8 CHAIR GESTEN: We were just reflecting
9 what some of the advantages are. Not that they're
10 not, they're not issues; they're not things that
11 we should talk about for the other measures, as
12 well.

13 So anyhow, I think what we want to do
14 is invite some specific conversation about these
15 three measures and then -- why don't we do that
16 first, and then take up the issue of, is there a
17 better measure getting the same concept? Is this
18 the wrong concept to be getting at and invite
19 other, sort of, nominations, if you will? So,
20 Kevin.

21 DR. LARSEN: Just to speak a little
22 bit to that multiple concurrent antipsychotics in

1 children. I'm developing one analog to that for
2 use in electronic health records.

3 As we went to our expert panels that
4 was viewed as a really important topic in
5 children, especially in children on Medicaid, and
6 it's also something that was measurable.

7 One of the challenges in measuring
8 behavioral health in general and, especially,
9 behavioral health in children is, there are not
10 very many things that we could find that we could
11 build a measure that we could implement very
12 straightforwardly, and this was, certainly, one
13 of those places.

14 And as we have talked to various
15 stakeholders about as we've been developing this
16 for the last few years, they've been very
17 interested and engaged in the measure.

18 It may seem narrow. I'll tell you,
19 it's complex to implement because the way to --
20 you have to be able to mathematically account for
21 when there's appropriate switching from one
22 medication to another versus when there's

1 inappropriate doubling up and overlap of
2 medications, and so it becomes a combinatorial
3 challenge. It's not an undoable one. But,
4 before you want something more complicated than
5 this, you might try one of these first.

6 CHAIR GESTEN: Could I just ask a
7 question that I think people asked before, wanted
8 to know the details about the non-endorsed, and
9 I'm assuming, at this point, it's not endorsed,
10 not because it was rejected, but it has not been
11 --

12 (Off microphone discussion)

13 CHAIR GESTEN: It's not been
14 submitted. Do you we know if it will be, or if
15 it might be, or it's about to be, or never will
16 be?

17 MS. LASH: There's a few moving
18 pieces. We would hope that there would be an
19 opportunity to look at a number of measures, or
20 child health in the coming year.

21 CHAIR GESTEN: Marsha, did you have --
22 your card is up, did you have something?

1 MS. LILLIE-BLANTON: Oh no, I'm sorry.

2 CHAIR GESTEN: Okay. Jeff and then

3 Terry.

4 DR. SCHIFF: So I don't -- I'm looking
5 into subject matter experts now, and that could
6 be anybody else in the room, other than me. Is
7 there a relatively short list of the diagnoses
8 that are really driving the antipsychotic use?
9 Like --

10 (Off microphone discussion)

11 DR. SCHIFF: What -- I'm sorry. I
12 mean, so like what's, what are people really
13 prescribing these for, is this --

14 (Off microphone discussion)

15 DR. SCHIFF: Well that's what I
16 thought, okay. So --

17 (Off microphone discussion)

18 DR. SCHIFF: -- so okay. So great.

19 (Off microphone discussion)

20 DR. SCHIFF: Well that's what my
21 unsubject matter expert brain was suggesting to
22 me, but I wasn't sure if that was right. And so,

1 I wonder if we also, maybe not instead of, but
2 also want to be considering if really the problem
3 that we're trying to get at is how we're managing
4 children with ADHD, this feels a little bit, I
5 mean, maybe, relevant, but roundabout, and for,
6 maybe, us to be thinking about that.

7 DR. LARSEN: If I can make a quick
8 comment? We're also building an outcomes measure
9 for ADHD, based on an AAP guideline that ---
10 where you do a behavioral assessment by parents
11 and teachers on a standardized scale at the
12 diagnosis, and you do the same behavioral
13 assessment after a few months, and it's agnostic
14 to treatment, so whatever treatment parents and
15 doctor would choose, you just see if you achieve
16 that outcome.

17 People are very excited about it.
18 It's going to be a while before we have enough
19 offices that implemented routine collection of
20 that kind of patient reported outcome instrument
21 for us to be able to rely on that routinely.

22 We're using the Vanderbilt, as part of

1 this measure, but there are a number of these
2 around, and it's essentially an objective,
3 well-studied, well-validated scale. And that
4 patient reported outcome model is something we
5 really believe in in overall measure development,
6 but it's going to be a while before those are
7 implemented in a way that we're ready to use them
8 routinely in care, I think.

9 CHAIR GESTEN: Terry.

10 DR. ADIRIM: Yes, I just kind of
11 wanted to ask the staff who chose these two, you
12 know, I understand antipsychotic use for children
13 under 5 years old. I mean that's a huge issue.
14 There's no indication, really, for children under
15 5 to be on antipsychotics.

16 But, is the reason why you chose the
17 multiple current antipsychotics because it's easy
18 to measure and that's all we have? I mean, I'm
19 not --

20 MS. LASH: It seemed like a huge red
21 flag, but this is kind of a borderline never
22 event to be on multiple concurrent antipsychotic

1 medication at a young age. It was just one of
2 those multiple lenses, at which the ADHD care was
3 being examined.

4 So if there is a measure you feel
5 would be a superior choice to be the complement
6 to the use in children under 5 --

7 DR. ADIRIM: No, I mean, I think it --

8 MS. LASH: -- then, yes.

9 DR. ADIRIM: I think it's a good
10 measure. I think, though -- I can't help but
11 think that there's a limit through how many
12 measures that we can recommend. And so I know
13 last year we prioritized the measures, so -- and
14 it's tough.

15 But I just have to echo what my
16 colleagues have been saying about really
17 searching for more appropriate behavioral health
18 measures that kind of get at what we're looking
19 at in ADHD, you know. Show our thoughts.

20 CHAIR GESTEN: So let me just comment
21 on that. So I think we're at a phase now where
22 we don't necessarily have to worry about

1 prioritizing. I think you're right, Terry, that
2 there's going to come a point where in which
3 we're going to be asking you all to do that.

4 Recognizing that, it's likely that it
5 will be a limited number that would be introduced
6 to the set. But for right now, I would encourage
7 folks to think about the merit of the measure
8 itself.

9 And I would just comment that the
10 multiple concurrent is one that we use both for
11 kids and for adults. It does -- the numbers are
12 a little eye-popping, shocking, and so it has
13 some synergy there, in terms of looking at kids
14 and adolescents, as well as adults.

15 And had some success, in terms of
16 actually making a dent in this, as well, in an
17 improvement program. But, again, that doesn't
18 mean that it's the best of all measures related
19 to the concept.

20 I would say, in terms of the
21 diagnoses, when we looked for kids, we
22 oftentimes, and adults, frankly, we often don't

1 see specific behavioral health diagnoses. So,
2 one of the most common diagnoses is none, for
3 seeing this, or nothing clearly that you can
4 associate with this.

5 And when you talk to a child
6 psychiatrist, or folks, they, you know, may be
7 prescribing it for ADHD, or off-label, or related
8 to symptoms, both for adults and for kids. So I
9 think there was a -- I don't know who's first.
10 Susan.

11 DR. LACEY: Sarah, can you -- I'm
12 going to go back to after you asked the question,
13 Foster, so how are these being queued up to be --
14 get on the table at NQF, et cetera? And you said
15 there was some pieces and some parts, but you're
16 not really -- I just want to get a little
17 clarity, because it sounded like things weren't
18 going to move forward on the ones that we were
19 going to propose, in a long period of time, or
20 did I misunderstand?

21 MS. LASH: No, there are -- there's a
22 lot of variety in the readiness of some of these

1 non-endorsed measures for implementation. So my
2 recommendation to the Task Force would be that
3 you might -- this is really up to you not me,
4 suggest that a measure like the multiple
5 concurrent antipsychotics is conditionally
6 supported for CMS to use in the program after it
7 has successfully cleared an NQF endorsement
8 review.

9 It would be my prediction that that
10 wouldn't be complete for the annual update that
11 would take place at the end of 2015, we're
12 already halfway through the year, but that, next
13 year that recommendation would still be in play,
14 and it could give CMS the freedom that they would
15 need to act on adding the measure at that time.

16 Or, if CMS is comfortable with it at
17 its current stage of development, they could kind
18 of overrule the MAP and throw it in. So there's
19 a few pathways that all of these recommendations
20 can take.

21 CHAIR GESTEN: Sarah, I may be
22 overstepping here, but I -- my interpretation of

1 what Sarah just said, based on history with NQF
2 and with measure developers is that having
3 conditional endorsement kind of waves out, yes,
4 we'll use this measure if, and sometimes can be
5 helpful in getting the measure developers to the
6 table of going through the process of getting the
7 endorsement. At least that's my interpretation.

8 MS. LASH: Sure.

9 CHAIR GESTEN: So some of the value of
10 the conditional endorsement process, if the group
11 feels it's promising but wants that NQF process
12 to review it may be helpful in getting it to that
13 last stage. Not always, but I think that's part
14 of it. So Anne, Andrea and then, Alvia, all the
15 A's.

16 MS. COHEN: So this is an area I feel
17 pretty strongly about, and I was going to address
18 Jeff's question about the use of antipsychotics
19 and, kind of, why? I know in the disability
20 field I've seen them used in a number of ways.
21 All five ways. One is, because it's not entirely
22 enlisted development disability or autism, and so

1 that's, sort of, the first line of trying,
2 because there's a behavioral mental health
3 condition. There's actually a really amazing ---
4 and I'll send this study that I just found about
5 pediatric psychosis out of NYU. It's a child
6 study center. And they look at the actual weight
7 of psychosis in children in use of antipsychotics
8 and how you tease that out. So that will give you
9 valuable background. So that's one thing.

10 And then, even the seizure disorders
11 have been used to --- looking at antipsychotics,
12 and so that's, kind of, another thing to look at.

13 In my mind, where I was seeing at the
14 Medicaid level working for a plan, where we had
15 the biggest problems -- and oftentimes and this
16 was true in adults and true in kids, although it
17 looks like increasingly true for children, issues
18 of multiple psychotropic drugs. So I really
19 strongly --- the multiple concurring
20 antipsychotics is really critical for us to look
21 at, because it covers a broader area than just
22 mental health, and I really feel like when we

1 need the institutional data about what's
2 happening to kids on these meds and we don't have
3 that. And I think that this measure could go a
4 long way to, sort of, promoting the need to study
5 that more on an individual basis.

6 CHAIR GESTEN: Thanks, Anne. Andrea.

7 DR. BENIN: Sarah, were there
8 particular criteria that staff used to pull out
9 measures that might help us, if we understood
10 those a little bit, how to think about these?

11 MS. LASH: Sure. We favored
12 claims-based, or other administratively derived
13 measures, over patient surveys and registry-based
14 measures, and even some that can only be
15 extracted from an electronic health record,
16 because of what we've heard from states and
17 partners, about large scale statewide feasibility
18 when things are derived from those data sources.

19 We looked at measures that would
20 capture the broad slice of the Medicaid
21 population, so that's why we favored the all
22 condition readmission over the respiratory

1 conditions.

2 I'd say, those were the primary
3 drivers. And in some cases, we were looking for
4 measures that were dissimilar from metrics
5 already collected in the core set, so they were,
6 sort of, taking on a real gap area in our new
7 aspect of care that isn't being examined.

8 DR. BENIN: Okay. That's helpful,
9 thank you. I just, one other framework thing.
10 As I look at these and I tried to think about how
11 to place them in my mind, one of the things that
12 might help me would be thinking about the
13 framework of this list a little bit differently,
14 not super differently, but there are a couple of
15 these metrics that are, where we don't really
16 know what the right answer is metric.

17 So they're, sort of, a little bit more
18 population healthy in some -- I don't know what
19 the right word is, exactly, but where we don't
20 know if what, it's not -- let me try to be more
21 clear.

22 With immunizations, we want it to be

1 100 percent. We're clear what the target is. We
2 may or not ever get there, but we're pretty clear
3 what the target is.

4 With some of these measures, we're
5 not totally clear what the target is and those
6 are kind of a different type of metric to me, and
7 they're a little bit more epidemiological in some
8 ways and -- or population healthier. I'm not
9 sure what that is.

10 I think, you know, the live births
11 weighing less than 2,500 grams. That's another
12 example of that. I don't know what the right
13 number is. I'm not even 100 percent sure what we
14 do to prevent it all, but, you know, it's like
15 really multifactorial.

16 So I guess, I just wonder if there's
17 another access that some of these things should
18 go under that might help us, as we're thinking
19 about the framework, because what bucket am I
20 putting this in?

21 Like, am I, as a provider -- I mean,
22 I know we're trying to hold the states

1 accountable for this, conceptually, but like, as
2 a provider, I'm thinking, what am I doing to move
3 this, right?

4 And so if I think about these a little
5 bit differently ---- and along with that, I
6 guess, I'm wondering if there's a category that,
7 you know, that Medicaid would want to consider
8 that would be almost like a pilot category?

9 And maybe that's not necessary,
10 because this idea that these are optional anyway,
11 but if we're trying to -- we almost need like a
12 run-in section, right? Like, we need to be able
13 to say, you know what? We're not really going to
14 tell everybody that you should be doing XYZ
15 metric yet because there's not a lot of
16 background data on it yet, but there is all these
17 new measures and we kind of need to start getting
18 people measuring things.

19 So if there is a -- it would almost be
20 like a run-in section where we could start to get
21 some experience and encouraging people, you know,
22 states to look at those metrics. I think that

1 will help us in the long run, and it might impact
2 how I think about some of these metrics.

3 So for example, the readmission
4 metric, that's, you know, it's a pretty good
5 metric. It's a Centers of Excellence metric, but
6 the first thing I think of when I look at that
7 metric is you're going to have it at the state
8 level.

9 So that's great in a big state, like
10 Texas, or California, but in a small state, you
11 know, you don't know where those patients are
12 being readmitted. So if you're only looking at
13 state level data, you know, I don't know exactly
14 what that means. I don't think we know how
15 that'll play out on a big level, right?

16 So I look at that from New England and
17 I'm like, I don't know where they're going to be
18 readmitted. And so that's the thing that's
19 always bothered me about that metric. Having
20 said that, it's the closest thing we're going to
21 get to, you know, one of these big player kinds
22 of metrics for children's hospitals.

1 So I think about these measures in a
2 couple of different ways, and I'm just wondering
3 if there's a little bit of, you know,
4 frameworking that would help us, as we move this
5 forward? I don't know.

6 CHAIR GESTEN: Great points. Alvia.

7 DR. SIDDIQI: So looking at the two
8 antipsychotic use measures, I ---- it sounds
9 like, just from hearing experiences from yourself
10 and others that the use of multiple concurrent
11 antipsychotics in children and adolescents makes
12 sense. It's one that we should be looking at.

13 The second one with antipsychotic use
14 in children under 5, I kind of agree that I'm not
15 really seeing, hopefully, that that's really
16 prevalent in our Medicaid populations.

17 Whereas, there is a measure that's in
18 the Excel under mental health, measure four,
19 which says follow-up for patients that are on
20 antipsychotics. And I know we're already doing
21 follow-up for ADHD and ADD patients, but I would
22 suggest that we look at that measure in

1 particular, number four.

2 Like you said, you know, this one
3 doesn't even have exclusions for seizure disorder
4 patients, for example, where it's rarely going to
5 be actually prescribed by pediatricians and
6 family physicians that are seeing pediatric
7 patients. So I would recommend looking at that,
8 measure number four, in the mental health
9 section.

10 And the second was the pediatric
11 all-condition readmission measure. I was curious
12 if there's one for ambulatory-sensitive
13 conditions, and I don't think there is one, but
14 that's hopefully where NQF and other stewards are
15 hopefully going towards.

16 And then looking at the adult set, we
17 know that there's a couple -- one for heart
18 failure, one for diabetes, so it's helpful to
19 know what the top five or ten, readmission
20 diagnoses are for pediatric hospitalized patients
21 and then try and maybe pick out one of those,
22 perhaps? Just to be able to give a little bit

1 more focus to that specific measure.

2 MS. LASH: On the readmission measure,
3 I do believe the measure steward was planning to
4 join us to sort of help clarify some of these.
5 Is that line open?

6 DR. SCHUSTER: Mark Schuster is here,
7 can you hear me?

8 MS. LASH: Yes we can, please go
9 ahead.

10 DR. SCHUSTER: So we did look at
11 specific conditions the way the adults did.

12 So first of all, our measure is very
13 much harmonized with the adult measure,
14 intentionally, because this was all funded by CMS
15 and AHRQ, and the idea was that we wanted
16 hospitals and states that insures everybody to be
17 able to have a common approach to measuring
18 readmissions.

19 And in terms of the disease-specific
20 -- or condition-specific measures, we did create
21 the lower respiratory infection measure, as a
22 parallel to the congestive heart failure,

1 myocardial infarction, pneumonia measures for
2 adults.

3 The one we reviewed ---- quite a long
4 list of candidate measures for condition-specific
5 measures, and the one that panned out was lower
6 respiratory infection, in terms of enough
7 variability and enough prevalence across a wide
8 array of institutions to be able to feel like one
9 that we felt could work at a national level. And
10 clearly, the all-condition measure, also was able
11 to work at a national level. So that is how we
12 came up with LRI.

13 CHAIR GESTEN: Very helpful, thank
14 you. Susan.

15 DR. LACEY: In response to that
16 comment, the pediatric all-condition readmission
17 measure, as we know, it's caused a great deal of
18 consternation in the adult population. People
19 really, really, really struggle with it for a
20 variety of reasons.

21 And so I understand the mindset of
22 marrying pediatric indicators that are aligned

1 with adult indicators. And I'm not saying that
2 this body, or the Center of Excellence, is saying
3 that that is the majority of reason of why we
4 should have this, but the pediatric all-condition
5 readmission measure seems like almost a fishing
6 expedition in my mind.

7 And it's like, what are we trying to
8 do here? Because I'm not sure where we're going
9 in the adult land. I think most people aren't,
10 and they certainly are struggling with what to do
11 about it and who's responsible, like the
12 multi-state -- if you live on the state line. So
13 it just feels like the level of specificity and
14 knowledge we have about that, to me, it's
15 premature.

16 CHAIR GESTEN: Jeff, and then, Terry.

17 DR. CONVISSAR: I'm just going to
18 speak for my own experience in our organization.
19 The adult readmission measure ---- not obviously
20 just solely in the Medicaid population, but for
21 all of our membership have driven an enormous
22 amount of quality improvement. From things like

1 palliative care, end-of-life care, to transitions
2 in care and the coordination across settings.

3 So I don't -- again, I'll defer to
4 pediatric specialists, because again, I mean I
5 don't know that we've been doing that. But in
6 the adult side, I mean, it's driven incredible
7 amount of improvement.

8 DR. SCHUSTER: So can I jump in here?
9 It's Mark, again. Would it be reasonable for me
10 to respond to the last two comments?

11 CHAIR GESTEN: Sure, Mark, go ahead.

12 DR. SCHUSTER: Thanks. So the last
13 speaker really captured what we were trying to do
14 and what we've been observing, which is
15 readmissions, as a possibility, has been ---- and
16 this is all anecdotal, but we've been observing
17 across the country substantial efforts to improve
18 the discharge planning, the discharge
19 instructions, the coordination with the primary
20 care providers, making sure patients are going to
21 actually fill a prescription know how to do it.

22 It fills like it's driving a lot of

1 quality improvement and that is, I believe, CMS's
2 -- part of CMS's motivation for having the adult
3 measure and for selecting the pediatric measure
4 to be one of the ones assigned to the PQMP. And
5 I think that we want pediatrics to benefit from
6 all these efforts the same way that the adults
7 are, and that's a big part of this.

8 CHAIR GESTEN: Great. Thank you,
9 Mark. Terry.

10 DR. ADIRIM: Mark, can I ask, because
11 my gestalt is, as a pediatrician working in the
12 pediatric emergency department that we in
13 pediatrics do this better than adults.

14 So I can see, you know, having this
15 kind of measure for adults because they don't --
16 and this is, again, anecdotal perform as well ---
17 - I mean, not that we're better, but just saying
18 that closing the loop and, you know, discharge
19 instructions, medical homes started in pediatrics
20 and so on and so forth. So do you have data that
21 demonstrates that there's a lot of preventable,
22 you know, hospital 30-day readmissions, that's

1 number one.

2 And Number 2, when I first looked at
3 these two measures, I mean, I thought that the
4 pediatric lower respiratory infection readmission
5 measure was probably better, for two reasons.

6 Number one, you know, there are a lot
7 of asthma, preventable asthma admissions and
8 readmissions, and number two, we now have new
9 guidelines with regard to bronchiolitis where,
10 you know, you can see excess readmissions for
11 bronchiolitis based on those particular
12 guidelines. So I thought maybe you could comment
13 on those.

14 DR. SCHUSTER: Well, I don't want to
15 seem too biased by my own discipline, but I am
16 thrilled that you think that pediatrics is doing
17 a better job, but I also think there's a lot of
18 room to move.

19 And so yes, there are traditions of
20 trying to give instructions of patient-centered
21 medical home, but I'm not sure we always do as
22 well as we would like in even informing the

1 primary care provider that the patient was
2 admitted, let alone that they're now going home
3 and need to be seen the next day.

4 And I know we often give instructions
5 -- well we do give instructions, but we don't
6 always make sure that the family actually
7 understands them. We don't always have them
8 repeat them back to us. We don't always give
9 them the support that they're going to need once
10 they go home, and so I do think that we have a
11 fair amount of room to move.

12 We've also got a study that's not yet
13 published because we're still writing it, where
14 we've looked at all of the readmissions at one
15 large children's hospital during a several-month
16 period, and interviewed the parent, the child, if
17 the child's an adolescent, the primary care
18 provider, the attending physician, the primary
19 nurse, the caseworkers, et cetera, et cetera, and
20 it was over 1,400 interviews and found that about
21 a third of them appear to be preventable.

22 So I do think preventable -- we also

1 do chart review, so -- but that's, this is not a
2 public forum, so I hope it can still be published
3 by an academic journal.

4 And so I do think there's plenty of
5 room to move in pediatrics. And so I do think
6 that -- I don't think we're in a position where
7 we can say the adults need this measure and the
8 children don't. If the adults need the measure,
9 I think the children do.

10 In terms of lower respiratory
11 infections, I think it's -- I think it's a great
12 measure too, you know, we're very proud of what
13 we developed, so I'm not sure what to say there.

14 Asthma is a condition, which, you
15 know, has higher prevalence, but lower
16 readmission rates -- you know, it's a higher
17 prevalence pediatric condition, but it has lower
18 readmission rates than a number of other
19 pediatric conditions.

20 So the overall number of readmissions
21 can be high in asthma just because the base rate
22 is so high. I don't know if I said that clearly,

1 I hope I did, but there are other conditions in
2 pediatrics that have much higher readmission
3 rates, which are captured by the all-condition
4 measure.

5 CHAIR GESTEN: Thanks, Mark. So I'm
6 -- they pay me the big bucks to keep track of
7 time and to make sure that we get our job done.
8 So I'm looking at the clock and thinking about
9 the fact that we have to lay it -- have a full
10 discussion of the measures on the tables, invite
11 you to put measures on the table, vote on them in
12 some way, and prioritize them before like, 4:15
13 p.m.

14 So we have a lot to get to. So the
15 conversation's great, but I just encourage people
16 to be as concise, as possible. Kevin.

17 DR. LARSEN: Yes, I just wanted a
18 quick support for the pediatric all-cause
19 readmission. We have seen it's really measurable
20 at the national level impact of the adult
21 readmission, it was not without pain, on behalf
22 of, I think, many people involved.

1 But it -- to the last speaker's point,
2 these are some of the few measures that actually
3 encompass a whole range of people with various
4 needs. And so as we talk to outside stakeholders
5 that continue to tell us, don't pick narrow
6 measures that only measure against a really
7 specific set of people, where is this relevance
8 for me?

9 And these readmission measures have a
10 high amount of relevance, are often used to
11 drive, not only things like care coordination,
12 but also, integration with community services and
13 supports, and we've seen amazing improvements.

14 CHAIR GESTEN: Alvia, your card is up,
15 did you -- oh.

16 DR. SIDDIQI: Oh, so I just had a
17 comment and then a proposal to add a couple of
18 measures to this list.

19 So the first comment I was going to
20 say is it sounds like the pediatric all-condition
21 readmission rate measure, it does align well with
22 the adult, it is important across the board, but

1 I do think that pediatric LRI one is also very
2 important.

3 So I would propose the addition of
4 that measure on the list of us at least
5 discussing, or voting on, again, as an additional
6 measure to propose, recognizing that there are
7 limited resources, but also recognizing that
8 amongst the pediatric population, when you're
9 talking about the top ten hospitalization
10 diagnoses, LRI, you know, is probably number one
11 or one of the number ones, so asthma,
12 bronchiolitis, for this population, so I think it
13 is important to focus on that one in addition to
14 the all-cause.

15 And then the second was going back to
16 that number four, use of follow-up visit for
17 children and adolescents on antipsychotics. I
18 know it's not an endorsed measure, we are looking
19 at another non-endorsed measure from NQF, but I
20 didn't hear any feedback, in terms of where
21 that's on the pipeline, in terms of through NQF.
22 Are we close, or is it going to be endorsed, and

1 I would propose, at least, for all of us to vote
2 on those additional two measures, in addition to
3 these three measures.

4 MS. GORHAM: So just a bit of
5 clarification. There is -- there are two
6 measures in your spreadsheet on mental health.
7 You referred to measure number four, but that is
8 actually not the measure that I think you're
9 talking about.

10 DR. SIDDIQI: I'm sorry, number five,
11 follow-up visits for children --

12 MS. GORHAM: So line number five.

13 DR. SIDDIQI: -- and adolescents on
14 antipsychotics.

15 MS. GORHAM: Right.

16 DR. SIDDIQI: Yes.

17 MS. GORHAM: Okay.

18 DR. SIDDIQI: Is that close to NQF
19 endorsement, or is it in the pipeline?

20 MS. LASH: It hasn't been submitted,
21 but we do -- it's our best information that
22 development is complete. So we'll be waiting for

1 the child health project to open. I think
2 they're all in relatively the same place.
3 There's a group of measures from the same
4 steward.

5 CHAIR GESTEN: Marc.

6 DR. LEIB: I can tell you that by
7 focusing on readmissions, you can really drive,
8 as Jeff said, a lot of improvement and lower
9 cost. You get both. You decrease your cost and
10 you get better care all combined, what more could
11 you want? That's ultimate value.

12 I am not sure if you do the all-cause
13 readmission that would include the admissions for
14 LRIs, why would you then want to segregate those
15 out, as a separate measure, it seems like
16 duplicative work.

17 DR. SIDDIQI: So I'll just follow-up
18 that I ---- my concern is when we're asking
19 states to report on this -- and again, just
20 looking at all conditions, whether there's
21 meaningful work being done in a specific
22 condition.

1 When you look at LRI as separate from
2 all conditions, you could have states that would
3 actually focus, possibly, quality improvement
4 when they recognize maybe their all-condition
5 rate doesn't look too bad, but their LRI one
6 looks pretty high. Again, recognizing that the
7 conditions that would be most at top, in terms of
8 diagnoses for pediatric Medicaid populations for
9 hospital readmissions would be around asthma,
10 bronchiolitis readmissions.

11 CHAIR GESTEN: Andrea.

12 DR. BENIN: Process question, are we
13 going to be block voting or individually voting
14 on these?

15 CHAIR GESTEN: I would propose that we
16 individually vote on these when we get to voting.

17 DR. BENIN: All right.

18 CHAIR GESTEN: I think right now we're
19 still kind of --

20 DR. BENIN: Oh, I'm just --

21 CHAIR GESTEN: -- trying to get a
22 sense of whether these --

1 DR. BENIN: I just wanted to make sure

2 --

3 CHAIR GESTEN: -- should stay on the
4 table, what other things do we want to put on the
5 table.

6 My suggestion would be, we did have --
7 unless there's any other burning comments that
8 you want to make about these three, there were
9 other measures that were not prioritized in the
10 last round that we had that we might want to go
11 back to briefly.

12 Two of the three are the ones, I
13 think, we're going to take up tomorrow when we
14 talk to adults because they relate, as well, to
15 pregnancy, exclusive breast milk feeding, and
16 delivery of under 1,500 gram infants at the
17 appropriate level of care.

18 But we might want to just have a brief
19 conversation, or refresher course, in the dental
20 sealant measure, which was one that, again, was
21 put on the table last time, didn't make the --
22 you know, the MAP top three or four list, but we

1 might want to take it up again right now and just
2 have a discussion.

3 And then my suggestion is that people,
4 you know, put things on the table that we'll ----
5 I hope we're keeping track of over here, and then
6 at some point there will be some voting, we can
7 get a chance to prioritize. Does that sound
8 okay, could we do that?

9 So dental sealants, do you want to say
10 something about the measure, introducing --

11 MS. LASH: I can do that. If you look
12 at your tab above the current child core set --
13 pardon me. You can see the measure of sealants
14 for children at the lower age range.

15 Essentially they are two separate
16 measures because they're designed to capture the
17 first and second set of molars, and CMS chose to
18 add one, but not the other.

19 They had, I think, a combination of
20 drivers for that decision, including there was a
21 sort of statutory requirement that they
22 specifically look at that first set of sealant

1 application.

2 And there was some discussion within
3 the MAP that, if you are doing quality
4 improvement around sealants, we would be hoping
5 that behavior change would affect the second
6 application as well.

7 So when we ranked last year's
8 priorities for addition, the younger age group
9 came out ahead of the 10 to 14, but it would
10 still be in play for this year, if the group
11 thinks that we need to have more oral health
12 measurement. Anne?

13 MS. COHEN: So I have an oral health
14 measurement area, and then, I also have an
15 additional one to add that we had on the list,
16 but has seemed to be falling off in the
17 conversation, so which would you like me to
18 address first?

19 MS. LASH: Why don't you start with
20 the oral health?

21 MS. COHEN: Okay, so oral health among
22 kids with disabilities, in particular,

1 developmental disabilities, is a huge challenge,
2 and they frequently don't get it. And I don't
3 know whether this measure, exactly gets at their
4 needs, or not. If it does, it needs to be
5 stratified for this population at minimum.

6 A big issue is the need for general
7 anesthesia in some kids with disabilities who
8 need specialized equipment and chairs and, it
9 just ---- it just falls off the list. And so I
10 don't think there's a specific measure, but there
11 really needs to be a focus within CMS to look at
12 this because it's one of the number one
13 preventative health issues with the population.

14 So that's one, and then there is an
15 ADHD measure that was behavioral health
16 intervention before medication, I thought?

17 MS. LASH: Yes, it's our --

18 MS. COHEN: Okay.

19 MS. LASH: -- frontline behavioral
20 therapy.

21 MS. COHEN: Yes, and I think that I
22 am, sort of, advocating for considering that to

1 replace the ADHD measure that has been
2 problematic.

3 MS. LASH: The follow-up --

4 MS. COHEN: Yes.

5 MS. LASH: -- care measure. Okay. I
6 think that's noted. Okay.

7 DR. LARSEN: Just to ---- again, quick
8 alignment. The breast milk feeding is in the
9 Meaningful Use hospital measure set, and the
10 dental sealant is in the Meaningful Use pediatric
11 set for data collection under the EHRs.

12 I can look quickly -- I think we
13 didn't split it by age group the way you did
14 here, I think we might have done the whole thing,
15 but I'll take a quick look.

16 Another measure that we might consider
17 -- again, it's only been specified to date for
18 EHRs, is cavities in children. And so it's an
19 outcome ---- an oral health outcome measure that
20 just asks to count cavities. And then, you count
21 cavities every year and you determine what range
22 of follow-up and services have lead those

1 outcomes, or not lead to those outcomes.

2 Whoever we ask to count the cavities.
3 So it could be the dentist, it could be the
4 primary care doctors, the measure is agnostic to
5 the cavity counter.

6 It can be used with dental claims, and
7 so every time a claim for a cavity comes through,
8 it can work that way, but kids have to have
9 access to a dentist in order for you to actually
10 be able to count the cavities. So it's also
11 specified for pediatricians to be able to count
12 cavities and use that as an outcome.

13 Now again, it requires a new data
14 source, because if kids aren't getting any oral
15 health care, you're not actually going to know
16 which of them had cavities, but it's an outcomes
17 measure.

18 DR. WHITE: I do have a question, or
19 maybe a clarification, from Anne -- from Anne
20 Cohen, on the recommendation for the frontline
21 behavioral therapy prior to antipsychotics for
22 children with ADHD ---- it's for children with

1 ADHD.

2 So are we proposing that we will be
3 able to find the treatments within our claims
4 coded data, so that there will not be a need for
5 medical record review?

6 MS. COHEN: You know, I don't know if
7 I had gone that in detail. I wanted to just
8 discuss it, because I know that the existing
9 measure wasn't something that seemed to be
10 responsive.

11 And I know from Dr. Gee, one of the
12 things she suggested is looking at intervention
13 before medication, so that's more what I was
14 looking at. I think that it's worth further
15 debate whether that's an inappropriate measure,
16 but I wanted to highlight it as a need.

17 DR. WHITE: You know, I think that we
18 should also understand that there are some other
19 pressures around the use of antipsychotics, or
20 the diagnosis of ADHD in children. I mean, there
21 are socioeconomic, or certainly potential for
22 secondary gain, with this diagnosis.

1 It is a diagnosis where there could be
2 an application for social security disability, or
3 SSI, so I think that we really must keep this in
4 mind, as we think about this measure, and the
5 number of children that has this diagnosis and
6 that is receiving treatment.

7 CHAIR GESTEN: So the Chair needs a
8 little orientation, sorry. Are we at the point
9 of folks suggesting specific new measures, in
10 addition to the three, in addition to,
11 potentially, dental sealants?

12 MS. LASH: Yes. So the flip chart
13 behind me was my running log of measures people
14 wanted to revisit over the course of this prior
15 discussion.

16 So I think that we would want to
17 individually take up the three staff picks, the
18 sealants measure, and everything behind me.

19 CHAIR GESTEN: Okay.

20 MS. LASH: So it's gotten to be quite
21 a long list.

22 CHAIR GESTEN: So some of the things

1 behind you, so again, I would encourage us, for
2 right now, we'll have a conversation, I think,
3 about gap areas, about what the measures don't
4 do.

5 Right now, I think, our challenge is
6 to say what other measures that we have had a
7 chance to look at the specifications, again, not
8 in development, although, certainly, measures
9 that haven't been NQF endorsed, are on the table,
10 but what other measures, particularly, measures
11 that relate to identified gap areas, should this
12 group put on that table for eventual voting,
13 along with those other ones?

14 MS. LASH: And I can review it --- if
15 you can't read it.

16 CHAIR GESTEN: Okay. Terry.

17 DR. ADIRIM: Can I just ask a
18 question? Can you just review, very briefly, the
19 exclusive breast milk feeding measure?

20 MS. LASH: We're planning to discuss
21 that tomorrow morning. That is a Joint
22 Commission measure that goes in a bundle with a

1 C-section and a few other birth outcome oriented
2 measures.

3 We are revisiting it tomorrow with the
4 whole perinatal discussion, because the Joint
5 Commission has recently made a pretty significant
6 change to remove the subset measure you see
7 described in the measure title. So we'll have to
8 put a pin in that one.

9 CHAIR GESTEN: Jeff.

10 DR. SCHIFF: I think if you're asking,
11 are there other things we want on the list to
12 discuss, it's that CAHPS one about availability
13 of behavioral health services. Is that there?
14 Oh, there you go. Sorry. Thank you.

15 (Off microphone discussion)

16 DR. SCHIFF: Yes.

17 CHAIR GESTEN: Other suggestions of
18 specific measures that folks want to be sure is
19 on that list, because I think what we're going to
20 do after we exhaust the list, is potentially take
21 some votes, get a sense of the support for each
22 of the measures, assuming they even may get lots

1 of votes, then we'll think about whether we need
2 to, or want to prioritize, depending on how many,
3 what kind of support there is, the measures.

4 Is the hearing, hearing's on there?

5 (Off microphone discussion)

6 CHAIR GESTEN: Yes, okay. Susan.

7 DR. LACEY: So that newborn hearing
8 screening, is that what you're talking about?

9 (Off microphone discussion)

10 DR. LACEY: Is that a --

11 (Off microphone discussion)

12 DR. LACEY: -- before three months.

13 (Off microphone discussion)

14 DR. LACEY: Would a follow-up --

15 (Off microphone discussion)

16 DR. LACEY: Yes, I didn't hear
17 follow-up at the beginning, it's just a
18 screening. So is that a state-by-state mandate?
19 I thought that was --

20 (Off microphone discussion)

21 DR. LACEY: I thought that happened.
22 I'm, so maybe I was --

1 DR. ADIRIM: Right. So that was my
2 point, Marsha. I think when you --

3 (Off microphone discussion)

4 DR. ADIRIM: -- when you're talking
5 about hearing --

6 (Off microphone discussion)

7 DR. ADIRIM: -- screening, and the
8 pediatrics population's different from the
9 inpatient side of things, in terms of newborn
10 care level, I think, it's pretty much universal.
11 But I think what you were getting at was hearing
12 screening for older children, so --

13 (Off microphone discussion)

14 MS. LILLIE-BLANTON: But it said
15 inpatient, so I mean, I think it is inpatient, so
16 I'm comfortable with it, if it really is
17 inpatient and only inpatient.

18 DR. LACEY: Okay, wait. So, Foster,
19 could you --

20 CHAIR GESTEN: What, go over the
21 measure?

22 DR. LACEY: Yes, can you just --

1 CHAIR GESTEN: What it is?

2 DR. LACEY: -- synthesize what was
3 said here, so we know what we're doing?

4 CHAIR GESTEN: So do you have the
5 measure in front?

6 MS. LASH: I do.

7 (Off microphone discussion)

8 MS. LASH: We're on the inpatient tab,
9 Row Number 4, audiological evaluation no later
10 than three months of age. Assesses the
11 percentage of newborns, who did not pass hearing
12 screening, and have an audiological evaluation no
13 later than three months of age.

14 CHAIR GESTEN: So it's actually more,
15 it's both. It's both screening, not passing the
16 screening, and then having a follow-up within
17 three months. So it's not just the screening, as
18 was mentioned, which is, I think, currently --
19 well, in many states, maybe all states,
20 requirement for newborns. But it's the next
21 step. If you failed the hearing test, did you
22 have an evaluation within a certain time frame?

1 Does that help, Susan?

2 DR. LACEY: Yes.

3 MS. LASH: It's the CDC's measure.

4 They have noted multiple care settings, so the
5 hospital, as well as ambulatory care, and a
6 multiple levels of analysis that which this could
7 be applied, including individual and group
8 practice clinicians, facilities, and national and
9 state populations.

10 DR. LACEY: So then, can I ask Kevin,
11 where we are on, on this measure, in your --

12 DR. LARSEN: So in Meaningful Use we
13 have the hearing screening, prior to hospital
14 discharge. I don't know about this follow-up, we
15 have not done an eMeasure for this additional
16 follow-up after hospital screening.

17 We've been building a related measure
18 around visual screening in the outpatient office
19 and had a number of discussions about whether or
20 not to include the follow-up responsibility in
21 that.

22 And most of our expert panels say that

1 that's a much bigger leap to track all of the
2 appropriate follow-up than to just assure that
3 the screening and treatment has happened, so most
4 of the expert panels have told us to put those
5 into two measures and not try to lump them all
6 into one.

7 CHAIR GESTEN: Any other questions
8 about that measure?

9 (No Response.)

10 CHAIR GESTEN: Thank you. Again, any
11 -- go ahead.

12 MS. GORHAM: Oh, I'm sorry. I wish I
13 had my notes with me. We actually, another
14 project that I am involved in, we actually had
15 CDC here last week, and so that measure was one
16 measure that we reviewed and that is on our CDP
17 side.

18 So they were actually up for
19 maintenance, and the Committee, after hearing the
20 scientific evidence and reliability and all of
21 that, went through the measure and we are
22 actually continuing endorsement.

1 And we brought up some really good
2 points about the measure, so as you all talk,
3 I'll kind of see if I can find my notes on the
4 computer and see if I can add anything
5 additional.

6 CHAIR GESTEN: So I don't, when we
7 start voting everyone gets nervous, I get
8 nervous, so before we start making people nervous
9 about voting, I want to make sure that the plate
10 that we set, in terms of things we're going to
11 vote on, looks right. That the folks aren't
12 holding back recommendations for discussion.

13 Although, again, after we vote we can
14 also put something else on the table. I think it
15 doesn't -- things don't conclude until we've done
16 some prioritization and we go home and that is
17 not, we're not there, yet, and so --

18 DR. ADIRIM: SO what specifically are
19 we voting for?

20 CHAIR GESTEN: My suggestion would be
21 that we look at each of the ones, individually,
22 the ones that were teed up by NQF staff, the

1 ones, if there's a specific measure up there that
2 relates to the -- either the issue, or specific
3 measure.

4 And my suggestion to the group would
5 be that we have, by show of hands, see how much
6 support there is for each measure. And then,
7 once we see how the measures play out, then we
8 can talk about prioritization process, if
9 necessary, right, assuming that there's lots of
10 measures that gets lots of support that, which
11 may, or may not happen.

12 DR. ADIRIM: Can I add to that?

13 CHAIR GESTEN: Yes.

14 DR. ADIRIM: Going into the vote, I
15 actually want to be pretty crystal clear about
16 whether we're voting for immediate use by CMS, as
17 full support, or whether there would have to be
18 some type of condition placed on the measure
19 before it would be ready for use?

20 (Off microphone discussion)

21 DR. WHITE: -- and how many total
22 measures are we voting for?

1 CHAIR GESTEN: As many as we want,
2 right now. So as many as are teed up, so we have
3 the three, we have sealants, we have hearing, we
4 have CAHPS, we have a follow-up on the
5 antipsychotics, we have the lower respiratory,
6 and cavities.

7 DR. LACEY: Last time --

8 CHAIR GESTEN: Go ahead.

9 DR. LACEY: Last time, we did this
10 differently. We, can somebody remember we got
11 three votes, it seems like we were able to vote
12 for three and then we had, and we were able to
13 get the top three. I mean, it worked out really
14 well, so could we, maybe, either do that again,
15 or -- because it sounds like we're doing it
16 differently this time.

17 CHAIR GESTEN: We are, we talked about
18 that, and we can do it that way, as well, where
19 you get three votes and put stickers up, I think
20 is how we did it last time.

21 I guess, I was thinking that if there
22 were measures that, I was thinking that we might

1 want to vote on these individually, and then, do
2 prioritization next, and do this in two steps. I
3 can't recall, exactly, why we did it the way we
4 did it, previously, but I'm open to an
5 alternative suggestion about how to do this.

6 DR. LACEY: I don't care, but I don't
7 understand how many that I get to vote for, one
8 of all of these long lists, I can vote for all of
9 them?

10 CHAIR GESTEN: I am proposing that you
11 can vote for any of them. Not voting, voting for
12 it, obviously, says that you're supportive of it,
13 not voting for it says you're not.

14 DR. LACEY: Correct.

15 CHAIR GESTEN: And that, by virtue of
16 counting up the votes, we would get some sense of
17 how the group feels about the prioritization, or
18 which ones have more votes. Depending how that
19 turns out, we might then want to do a
20 prioritization process, as a secondary step.
21 Again, just a proposal, it's not, I'm --- In
22 terms of Sarah's, your comment, what we can do is

1 we can vote each one as unconditional support,
2 conditional support, or no support, I guess, in
3 order to tease out that issue, unless you have
4 another idea?

5 MS. LASH: Can we tell you that, I
6 really suggest we take one vote per measures, but
7 that there's a motion from the Task Force to say
8 I propose measure X, Y, Z, to be added with full
9 support. Or, conditional support, pending
10 endorsement.

11 CHAIR GESTEN: Okay. So you want a
12 specific nomination for each measure?

13 MS. LASH: I would like someone to try
14 to put a stick in the stand --

15 CHAIR GESTEN: Okay.

16 MS. LASH: -- on each one, and we can
17 react to that --

18 CHAIR GESTEN: Okay.

19 MS. LASH: -- and see how close we
20 are.

21 CHAIR GESTEN: Lots of cards up, so
22 let's, we're talking about process, I don't know

1 whose was up first?

2 DR. LEIB: I'll let Jeff go first.

3 CHAIR GESTEN: Jeff, we'll do Jeff,
4 Marc, and then, Alvia.

5 DR. SCHIFF: So the ones that are on
6 that list, the staff didn't pick. You guys are
7 really smart. I know this stuff. I'm wondering,
8 if before we vote, because some of those things
9 are things I'm, like, you know, drawn to. If,
10 perhaps, you all could, sort of, share with us
11 what the challenges were with those, I didn't get
12 them, sort of, to meet your guys, sort of, picks.
13 So that's -- informative type thing.

14 MS. LASH: Sure, let me try to do that
15 quickly. The first measure on that list,
16 surveying the family about their experience of
17 care coordination.

18 I haven't seen a lot of states with a
19 lot of extra capacity to do survey-based
20 measures. That does not tend to be like a nice
21 plug and play. But, if you're interested as care
22 coordination, as a gap, feel free to vote for it.

1 This front line behavioral therapy for
2 ADHD was not a staff pick, because we thought we
3 already had a measure of ADHD, it's only today's
4 conversation that really brought to light some
5 flaws with people's perception of how narrow that
6 measure is.

7 Hearing screening was not on MAP's
8 list of gaps that we were aware that you were
9 interested in, but we've heard a lot of good
10 justification for why that might be a priority.

11 Whether states are publically
12 reporting on CAHPS results related to behavioral
13 health access. Again, relies on the
14 administration of the survey, so potentially less
15 feasible.

16 Follow-up appointments for
17 antipsychotics. I already described that we
18 looked at the polypharmacy measure, as a
19 different lens on that, and we didn't want to
20 overload the list with antipsychotic measures,
21 although, there were many that were potential.

22 Lower respiratory readmissions. We

1 went for the broader and, kind of, cavities, we
2 were not aware of. Do you want --

3 DR. LARSEN: Let me just, I'll give
4 you the details. There aren't very many, but
5 it's Measure CMS 75. That's how it's counted in
6 the Meaningful Use Program.

7 Its name is children who had cavities,
8 or decayed teeth. It's children ages 0 to 20
9 years, with a visit during the measurement
10 period, who had cavities, or decayed teeth, with
11 no exclusions, or exceptions. It's part of the
12 Meaningful Use Core Set of measures for children.

13 CHAIR GESTEN: Marc.

14 DR. LEIB: Just a question, in order
15 to move a measure along, is it a simple majority,
16 or is there a simple majority required?

17 CHAIR GESTEN: So great question. So
18 my notion was that we're just counting votes, as
19 a measure of the degree of support, not
20 necessarily a pass, fail, or do we want to move
21 it forward?

22 And it's, certainly, conceivable that

1 if everybody voted for something that we would
2 say, we don't want to recommend it. But I would
3 think, unlikely, if half, or less, then we might
4 need to have a discussion about whether it goes
5 forward, or not.

6 But, I wasn't thinking, at least, in
7 this first round that it was anything more than
8 just, kind of, gauging the amount of support for
9 each measure.

10 MS. LASH: Or taking the stronghold
11 and maybe we shouldn't do the support,
12 conditional support nuance. That would give it a
13 little bit different tone of a more formal
14 recommendation where we --

15 CHAIR GESTEN: Okay.

16 MS. LASH: -- would need greater than
17 60 percent. That's eight of you.

18 CHAIR GESTEN: Okay. Alvia.

19 DR. SIDDIQI: I just wanted to, I felt
20 the need to, to clarify my comments about the
21 hearing screen one, in particular, but also,
22 again, looking at all these measures, one of the

1 key areas of gaps for our pediatric core set has
2 been care coordination and measures that really
3 talk about the outcomes of care coordination and
4 whether that's occurring.

5 Looking at the fact that CMS is now
6 proposing Medicaid managed care rules, network
7 adequacy, all of that does come to play in that
8 Hearing Screening I, if you're looking at
9 follow-up for an abnormal screen within three
10 months. So I do support that one.

11 And, again, follow-up for
12 antipsychotics I think, again, speaks to care
13 coordination. So I just wanted to make those
14 comments on that.

15 CHAIR GESTEN: Susan.

16 DR. LACEY: I'm back to the hearing
17 one. I just want to be sure. That seems like a
18 pretty busy measure, if we're going to do initial
19 recommendation for intervention, or what have
20 you, and then a follow-up, all captured in one
21 thing. So to meet the mark, you have to hit all
22 three of those subsumed within the one, right?

1 CHAIR GESTEN: Correct. That would be
2 my understanding of the measure.

3 DR. LACEY: So that's what we're
4 voting on?

5 (Off microphone discussion)

6 CHAIR GESTEN: That's what that
7 measure is.

8 DR. LEIB: I don't read the measure
9 that way. I read the measure as of all the
10 newborns, who failed the screening. What
11 percentage of those who failed went and had a
12 follow-up evaluation within three months.

13 DR. LACEY: That makes sense.

14 CHAIR GESTEN: So that --

15 DR. LEIB: That is what I, that's my
16 reasoning I make, right --

17 MS. LASH: That makes sense.

18 DR. LEIB: I could be wrong.

19 CHAIR GESTEN: But does that mean if
20 you don't screen you're, you're not in the
21 measure?

22 (Off microphone discussion)

1 CHAIR GESTEN: Is that the way that --

2 DR. LACEY: It's a universal --

3 CHAIR GESTEN: Is --

4 (Off microphone discussion)

5 DR. LEIB: Yes.

6 (Off microphone discussion)

7 DR. LEIB: Yes, screening is fair. I
8 mean, it's required by state law on --

9 CHAIR GESTEN: So it's screen, you
10 have to get the result.

11 DR. LEIB: It fails.

12 CHAIR GESTEN: You have to get the
13 results and then you have to get information that
14 says whether a follow-up happens.

15 (Off microphone discussion)

16 CHAIR GESTEN: That's -- right?

17 FEMALE PARTICIPANT: There are two
18 parts to it.

19 CHAIR GESTEN: Okay.

20 (Off microphone discussion)

21 CHAIR GESTEN: There are two out of
22 three. You're saying the third, the screening is

1 presumed?

2 (Off microphone discussion)

3 CHAIR GESTEN: That's what's called a
4 gameable aspect to a measure. So --

5 (Off microphone discussion)

6 CHAIR GESTEN: -- Carol, then Sandra.

7 MS. SAKALA: Could you, please,
8 asterisk the measures on that list that are NQF
9 endorsed?

10 CHAIR GESTEN: Sandra.

11 DR. WHITE: Since we are adding
12 measures for the child core measures, I wanted to
13 be sure that I didn't miss my opportunity to talk
14 about a population, children are considered under
15 the age of 18, or 21, is that correct?

16 (Off microphone discussion)

17 DR. WHITE: Under the age of 21, okay.
18 Well, if we're adding measures, I know that this
19 particular measure falls under the maternal and
20 perinatal health. Or, the population that I have
21 the most interest in is children, or teens.

22 So I want to open the conversation

1 today, even if we must put it until tomorrow,
2 peer literature review support that it is
3 important for women to have access to LARCs
4 immediately after delivery.

5 And when I read the measures that is
6 in the perinatal tab, it is measuring the access
7 to LARCs within 99 days. That does not get at
8 the issue of having access to access to LARCs,
9 immediately postpartum.

10 So what I'd like to -- well, first of
11 all, I believe, that the literature supports that
12 LARCs, immediately after delivery, is of value,
13 it's valuable. The greatest barrier to
14 initiating this is because of reimbursement. And
15 that is because the state pays for pregnancy, as
16 a global fee, and for all of its related care.

17 So what would need to occur is for the
18 state to be the convener, the catalyst, as well
19 as the change agent and reimbursement for
20 postpartum contraceptive services in the
21 in-patient setting, so that the physician is
22 reimbursed for the education and the procedure,

1 and the facility has the device stocked within
2 the pharmacy.

3 This is important because teens, or
4 adolescent pregnancy -- that's ages 13 to 21, 12
5 to 49 percent of them are pregnant again within
6 one year.

7 And if we are looking at reducing NICU
8 stays, we are looking at increasing
9 interpregnancy intervals, we are looking at
10 decreasing the risk of pre-term birth and low
11 birth weight and the indirect cost of teen
12 pregnancy, then we must seriously consider having
13 LARCs available to women, particularly teenage
14 and adolescent women, immediately postpartum, and
15 that is within three days of birth.

16 CHAIR GESTEN: So, Sandra, are you
17 proposing a specific measure?

18 DR. WHITE: Yes I am.

19 CHAIR GESTEN: Is it in --

20 DR. WHITE: I'm proposing a
21 modification to the measure that is already on
22 the maternal and perinatal tab. I'm proposing

1 that we have three submeasures, a submeasure A,
2 submeasure B, and a submeasure C.

3 Submeasure A would the three-day
4 post-delivery of being able to receive a LARC,
5 with these changes by the state for
6 reimbursement. And then, the other measures, as
7 stated within the measure that's already there.

8 CHAIR GESTEN: Okay, just a process
9 question, we'll be taking up this measure
10 tomorrow?

11 MS. LASH: Tomorrow, mm-hmm.

12 CHAIR GESTEN: Okay. So we'll, as you
13 say, put a pin in it for tomorrow, or whatever --

14 MS. LASH: Yes.

15 CHAIR GESTEN: -- whatever that
16 terminology is.

17 MS. LASH: We certainly want to have
18 the conversation with both groups about, I think
19 you were making a very strong case, this needs to
20 be in the child core set, in addition to the
21 adult core, and so we want to, specifically, take
22 this up with the group present.

1 DR. WHITE: Thank you so very much.

2 CHAIR GESTEN: Anne.

3 MS. COHEN: So I know there's a lot of
4 confusion about the -- screening one and I wanted
5 to add on, and I'm sure people have thought about
6 this, but I think that we're all clear that kids
7 are screened at birth.

8 The issue is the follow-up. And I
9 think this one gets the fact, as to whether
10 states are utilizing EPSDT services for the
11 hearing screening component.

12 And there was a study done in 2010,
13 there's been involved studies that most states
14 are not fully utilizing all the EPSDT screens,
15 and one of them that was highlighted was hearing.
16 And that's what that gets at.

17 And there's a whole article about the
18 National Health Law Program that comes in, Sarah
19 that backs up why the rationale for doing that
20 measure actually, kind of, makes sense.

21 CHAIR GESTEN: Great. I don't know
22 who was next, Andrea.

1 DR. BENIN: Oh, just for
2 clarification. It looks to me as though the
3 behavioral therapy for ADHD metric is depending
4 on the paper medical record, electronic medical
5 record, so it looks like it's based on medical
6 record review. I'm wondering, if that's why you
7 had taken it off the list --- originally? So now
8 I'm a little bit more confused as to what I, my
9 opinion, about that metric. Are we, are we
10 shying away from metrics that rely on record
11 review, or we, like, do we have a global opinion
12 on that, are we --

13 (Off microphone discussion)

14 CHAIR GESTEN: Well, Susan's not
15 there. Marc, do you have your --

16 DR. LEIB: I just have a follow-up
17 question for Anne. When you said not utilizing
18 EPSDT services for hearing screenings, do you
19 mean not paying for it separately, or not doing
20 it at all?

21 MS. COHEN: There's a lack of
22 awareness, in relation of that category, of that

1 -- category. So for instance, the state level
2 might be aware of it, but at the provider level
3 it's not happening, or they're not aware that
4 there's an opportunity to bill for it, under that
5 specific program, or there's just not utilization
6 of the services.

7 DR. LEIB: Oh, you're not talking
8 about the newborn screening, because that's
9 required --

10 MS. COHEN: No, not talking about
11 that, so --- So the concern, initially, from
12 Susan, was that the measure was really too
13 complicated, right? And so the idea is you have
14 to figure out, who wasn't screened, and if they
15 weren't screened, did they get the follow-up in
16 all of the events?

17 And to me, what I read about that
18 measure is, ideally, under the EPSDT Program,
19 you're going to know, these are the kids that did
20 not, that failed the reviewing test.

21 So if they failed the hearing test,
22 did they actually get the follow-up screening and

1 treatment? And that's what I mean about that not
2 utilizing the EPSDT category, is that second
3 part.

4 CHAIR GESTEN: So before we get to
5 other questions, Shaconna, you have something you
6 want to add to this measure, this hearing
7 measure, itself?

8 MS. GORHAM: So specifically for the
9 1360, as I said, we reviewed it last week in our
10 ENT review, so this measure is a follow-up to the
11 newborn hearing screening measure, an evaluation
12 by audiologists, to determine whether there is a
13 hearing problem, or not, so it is the screening
14 and actual evaluation. Excuse me.

15 There are variations in the state
16 requirements for audiologists to report this
17 data. There's definitely opportunity for
18 improvement, as the 2012 results were 69 percent.

19 (Off microphone discussion)

20 MS. GORHAM: Sixty-nine percent and,
21 yes, as the measure is written now. And there
22 are disparities and follow-up after initial

1 screenings, and we talked about that, as well.

2 The Committee voted 100 percent to
3 continue endorsement for this particular measure,
4 because they thought it was really important,
5 with no conditions, so --

6 (Off microphone discussion)

7 MS. GORHAM: Per Committee
8 conversation, the measure is really important.

9 CHAIR GESTEN: Alvia.

10 DR. SIDDIQI: So two quick things, one
11 just going along the lines, again, about the
12 hearing screening measure. If you have an
13 abnormal hearing screening in the hospital, after
14 the newborn screen, that is a code. That is
15 something that can be easily captured.

16 I think the challenge will be getting
17 that audiologic evaluation follow-up code, but
18 again, it's something that I think, 69 percent is
19 really sad. I think, us, a lot of the pediatric
20 providers around this corner are frustrated by
21 that one, so I strongly recommend that.

22 Now the second thing. Sarah, I know

1 you had said, even if it's not NQF endorsed,
2 there's some that are on the pipeline, they're
3 complete, they're, sort of, pending NQF, could
4 you put like a P next to those, for another
5 symbol?

6 MS. LASH: I don't think any of the
7 measures we've discussed are --

8 (Off microphone discussion)

9 MS. LASH: -- still in an early stage
10 of development. Maybe Kevin can --

11 DR. LARSEN: Yes the --

12 (Off microphone discussion)

13 FEMALE PARTICIPANT: -- you said it
14 contains the follow-up antipsychotic one.

15 CHAIR GESTEN: Actually, while we're
16 giving you work to do, these three, it would be
17 helpful if we could --- to refer to, because we
18 are going to vote very soon. So but they're not
19 up on the board, and maybe that's a good place to
20 put the votes.

21 MS. LASH: Okay.

22 CHAIR GESTEN: So those three, maybe

1 should go on there, along with sealants. Kevin.

2 DR. LARSEN: Yes, I'll just say the
3 children who have dental decay, or cavities,
4 there is an NQF endorsed measure in that space
5 that measure that is in the EHR incentive program
6 is a modification of the endorsed measure, and
7 the modification is to expand the age range, it
8 only went up to 17, we went up to 20, and to
9 change the data source to the EHR from what was a
10 population health survey measure, phone calls to
11 the parents.

12 So it's structurally nearly identical
13 to the endorsed measure, other than those two
14 minor modifications and, it's again, been in the
15 program for three years now.

16 CHAIR GESTEN: Marc, did you -- your
17 card's up.

18 DR. LEIB: Okay.

19 CHAIR GESTEN: Jeff.

20 DR. SCHIFF: I have a question about,
21 just the experience of care coordination if it,
22 whenever that's the right time, is it now? Okay.

1 Is there someone who could explain what that -- I
2 mean, it looks like there's 19 domains, and we
3 were having trouble with the assessment of
4 behavioral health, with five, like, really
5 obviously important things. So could someone
6 just could --

7 CHAIR GESTEN: Make whoever nominated
8 it to explain it to us?

9 DR. SCHIFF: No, I'm not looking to
10 call anybody out, I'm just wanting to understand,
11 so I can know how to vote.

12 CHAIR GESTEN: Okay. Denise,
13 experience of care.

14 MS. LASH: Yes, you were speaking in
15 favor of the experience of care survey earlier.

16 MS. DOUGHERTY: Yes.

17 MS. LASH: Any further rationale, as
18 to why you'd like to see it added?

19 CHAIR GESTEN: Or, Jeff, did you have
20 a specific questions about its components, or
21 testing, or validation, or limitation issues, I'm
22 not sure, all the above, none of the above?

1 DR. SCHIFF: Yes, I mean, and maybe
2 I'm just against, and I'm not sure if it's for
3 Denise, or, like, that measure, you know, sort
4 of, through the rubric, if you will, of decision
5 making that has gone on, and I understand, you
6 know, claims data versus medical record review,
7 that's simple for me to understand, you know, how
8 does this one, with all of those dimensions, you
9 know, the point of views.

10 MS. DOUGHERTY: Well this is --
11 there's a lot of concern about children with
12 medical complexity and this is built on top of a
13 pediatric medical complexity algorithm that has
14 been published.

15 And this has been very widely tested
16 and it's being used in a couple of CMMI projects,
17 to measure outcomes for kids, who are medically
18 complex. So it's already being used. It's very
19 well tested. The publications aren't out, yet,
20 but it's -- so we had a webinar on it and there
21 were lots of interested people.

22 CHAIR GESTEN: Sepheen, antipsychotics

1 seem to clarify the pipeline issue?

2 MS. BYRON: Hi. So there has been
3 some questions around antipsychotic measures,
4 whether they're done being developed and whether
5 they're endorsed, and that sort of thing, so I
6 just wanted to speak to that.

7 I'm with NCQA, but NCQA is the lead of
8 the -- what you see as NCINQ, the Center of
9 Excellence, under PQNP. So the antipsychotic
10 measures are complete. They have been developed.
11 They've been specified at a state level.

12 They've also been specified at the
13 health plan level, in terms of alignment, and as
14 Kevin was noting, one of them is also specified
15 for EHRs, and that's the multiple concurrent
16 measure that you see here, the NQF staff had
17 highlighted.

18 They were just finished completion of
19 developments, so they haven't been submitted for
20 endorsement, and there hasn't been an
21 opportunity, yet. So it's not that they've been
22 submitted and rejected, or anything like that.

1 It's actually a suite of measures and,
2 maybe, NQF can speak to why they chose one over
3 the others, but what I will explain, because I
4 think there were some questions among the
5 Committee, is that we developed them, really,
6 with sort of a logic in mind.

7 So really we have some that look at
8 appropriateness and overuse of antipsychotics in
9 kids, so multiple concurrent use, which is in
10 there now, it's a lowest better measure. That's
11 one where we, we will aim to, you know, avoid
12 use, when possible.

13 We also have a measure that's on the
14 list that looks at the use of psycho social care
15 as first line treatment. And so that measure
16 says, if you don't have a primary indication for
17 antipsychotics, then did you try psycho social
18 care, as a first line, before putting kids on
19 medications? So that's another, kind of,
20 appropriateness measure.

21 And then, the follow-up care measure,
22 which you guys highlighted, says that you have a

1 follow-up visit, if you're on an antipsychotic.
2 Another measure that was brought up was the
3 metabolic screening and the metabolic monitoring
4 measures.

5 So this is because metabolic effects
6 are really pronounced in children and
7 adolescents. And because that can have such an
8 impact on their development, we develop the
9 measures that say, did you get baseline
10 screening, if you were put on antipsychotics
11 within a defined period of time.

12 And then, also, if you continue to be
13 on antipsychotics, did you have follow-up visits.
14 And then, there is one about the very young and
15 then there's one more that looks at higher than
16 recommended dosages, if you're on antipsychotics.

17 And I know I went through those really
18 quickly and I apologize, because I have to leave
19 in a few minutes. But, I just wanted to lay that
20 out, so you understood that these were all
21 developed and complete.

22 CHAIR GESTEN: You got a question for

1 Sepheen?

2 MS. COHEN: Yes. Given how you
3 highlighted that, and that makes it much more
4 clear, as to the intention of NCQA in developing
5 them.

6 MS. BYRON: Yes.

7 MS. COHEN: Given the fact that
8 they're looked at, as a suite, breaking them up,
9 is that possible? And if it is possible, which
10 one would make the most sense to get at that,
11 sort of, category of mental health drugs?

12 MS. BYRON: That's a good question.
13 So they are a suite. It is possible to break
14 them up, because I understand that, you know,
15 burden's an issue.

16 I will note that they're all developed
17 for administrative claims. So they're all
18 administrative measures, so feasibility around
19 these measures is really good. Having to choose
20 among them is very difficult, because they are
21 like my children.

22 But, I will note a couple of things

1 for consideration. NCQA looked at these measures
2 for the HEDIS Health Plan Measure Set and
3 considered them for HEDIS and chose three of them
4 across, sort of, those different topic areas.

5 So multiple concurrent is in HEDIS,
6 because that one looks at a very important topic
7 area of whether kids are on, you know, more than
8 one for a sustained period of time.

9 They also chose the metabolic testing
10 measure, although, I would advocate for both the
11 screening and the testing, because I think that
12 baseline screening establishes the relationship
13 with the provider, and then the testing says that
14 you have an ongoing relationship there.

15 And then the access to psycho social
16 care as a first line treatment was also added to
17 HEDIS. And so if you're thinking about
18 alignment, you know, these measures that health
19 plans are going to be reporting on, and then, one
20 of them is also being e-specified, and so that
21 would be first states. So.

22 Which one's what, I'm sorry?

1 HEDIS passed --

2 CHAIR GESTEN: Which was e-specified.

3 MS. BYRON: Oh, e-specified, the
4 multiple concurrent. Oh, so --

5 CHAIR GESTEN: So thank you, Sepheen.
6 So this is difficult. This is our children and
7 grandchildren, in Denise's case, that we have to
8 vote on, so again, it creates some of the
9 challenge, but that's what we have to do. It's
10 that time of the day where we have to do this.

11 So one of the things, looking at your
12 note that says eight votes get us consensus on a
13 measure, right? So one of the things we might
14 want to do, we've got 20 minutes, or so to do
15 this, maybe we should vote on each measure and
16 see if we reach consensus. And then, among the
17 measures we get consensus on, then do a
18 prioritization process, does that make sense?

19 Which means that we have to address
20 this issue of, for each measure, are we posing it
21 as a as is versus conditional? And I'm not quite
22 sure how to handle that, except, unless we want

1 to do a default, being -- well, do you have an
2 idea?

3 MS. LASH: I would propose a default
4 as full support, if it's NQF endorsed, and
5 conditional support, pending endorsement, if it
6 isn't. Other conditions, we sort of asked, you
7 suggest those, before we would vote on each one.
8 Nominate them, you want a nomination?

9 CHAIR GESTEN: Before we, we'll take
10 it from the top. We'll take it from, I don't
11 know what the top is --

12 I'll start with these, but before we
13 start the voting, I want to make sure people
14 understand a) what it is that we're voting on,
15 what their vote means.

16 So eight votes means the Committee
17 hasn't endorsed it, suggested it, it doesn't mean
18 that it would then, after we gather all the
19 votes, we may then do a prioritization process.
20 But that's what you're voting on to do.

21 We're going to go down the list and
22 see how many of the measures pass the eight. And

1 if anybody has a burning question about what the
2 measures are, what it means, now is the time to,
3 now is a good time to ask your last question
4 about it.

5 DR. LACEY: And we can vote as many
6 times as we like.

7 CHAIR GESTEN: You can vote as many
8 times as you like.

9 DR. LACEY: Or not at all.

10 CHAIR GESTEN: Or not at all. Okay.
11 All right, so somebody want to, for pediatric
12 all-condition readmission measures, somebody want
13 to nominate it?

14 Okay, and do we have any seconds?

15 Second, okay. So by a show of hands,
16 folks raise their hand, if they're in favor of
17 this measure. I vote? I can't remember. Yes?

18 MS. LASH: Yes, I thought --

19 CHAIR GESTEN: Full endorsement is
20 what we're voting on.

21 MS. LASH: I thought we were voting
22 yay, or nay, on full support. One, two, three,

1 four, five, six, seven, I count nine votes for
2 full support.

3 CHAIR GESTEN: Okay. And we don't
4 have to take any votes of no's, but we might want
5 to, out of interest, ask Andrea, what was your
6 condition?

7 DR. BENIN: I would conditionally
8 support this, the condition being that there is
9 attention paid to the ability to look at data
10 across states and to further understand what that
11 really means, because I actually don't, I think
12 that it's really problematic to look at it just
13 state by state --

14 CHAIR GESTEN: Okay.

15 DR. BENIN: -- but that we need to be
16 able to, moving forward, be able to develop an
17 understanding of what the real implications are
18 for the metrics.

19 CHAIR GESTEN: Okay. I'm going to
20 take and suggest that we note conditions that
21 folks want to make after we have a vote. Sarah.
22 And if a measure does not pass then somebody, as

1 full endorsement, then somebody could propose a
2 conditional endorsement and describe what those
3 conditions are, does that sound right?

4 DR. WHITE: I'd like to make a
5 comment. Yes, I think that if this measure's
6 going to follow the adult measure that is the
7 all-conditions readmission, the adult measure
8 also has conditions on it. For example,
9 readmission for chemotherapy. I mean, there are
10 exceptions.

11 CHAIR GESTEN: There are --

12 DR. WHITE: -- there are already
13 exceptions to the --

14 CHAIR GESTEN: They're in there.

15 DR. WHITE: Yes.

16 CHAIR GESTEN: Yes.

17 DR. WHITE: Yes, it's there.

18 CHAIR GESTEN: Yes.

19 DR. BENIN: I mean that's pretty,
20 that's distinct from what I'm talking about.

21 DR. WHITE: Okay.

22 CHAIR GESTEN: Somebody want to, for

1 2337, antipsychotic use in children under 5
2 years, does somebody want to nominate this
3 measure?

4 (No Response.)

5 CHAIR GESTEN: See, see what we
6 learned. Okay. Of interest. For the use of
7 multiple concurrent antipsychotic in children
8 adolescents, is there a nomination for full
9 endorsement? Anne. Is there a second? Second?
10 And vote, all those in favor, raise your hand.

11 MS. LASH: Eleven.

12 CHAIR GESTEN: Okay, where are we,
13 experience of care?

14 MS. LASH: Experience of care
15 coordination.

16 CHAIR GESTEN: Somebody want to
17 nominate experience of care coordination? Okay.
18 Front line behavioral therapy? Nominate.
19 Second? Second. Will --

20 MS. COHEN: With a caveat for moving,
21 oh, I've lost track, removing the other ADHD
22 measure, all right?

1 MS. LASH: That would be a separate
2 vote.

3 MS. COHEN: Oh, okay.

4 CHAIR GESTEN: Do you still stand by
5 your nomination?

6 Okay, we had a second.

7 Yes?

8 There was a second, okay. All those
9 in favor of that measure, raise your hand.
10 Three?

11 MS. LASH: Just three.

12 CHAIR GESTEN: Okay.

13 MS. LASH: Yes, hearing screening,
14 Measure 1360?

15 CHAIR GESTEN: Yes. Do I have a
16 second?

17 Second. All those in favor of the
18 hearing screen measure, raise your hand.

19 MS. LASH: Nine.

20 CHAIR GESTEN: One more time, hands
21 up.

22 MS. LASH: Put them up.

1 CHAIR GESTEN: Ten.

2 MS. LASH: That is ten.

3 CHAIR GESTEN: Ten. And reporting on
4 behavioral health access through CAHPS? Okay,
5 second?

6 Oh, you're so nice.

7 All those in favor of reporting the
8 reporting on behavioral health access through
9 CAHPS, raise your hand.

10 DR. WHITE: Just one quick question,
11 please?

12 CHAIR GESTEN: There's a, hang on, put
13 your hands down.

14 DR. WHITE: One quick question.

15 CHAIR GESTEN: Okay.

16 DR. WHITE: Is this in lieu of doing
17 a separate behavioral health survey, which is
18 what is required now?

19 CHAIR GESTEN: Right now there's a
20 CAHPS, right now in the set there is a, I
21 believe, it's a health plan CAHPS 5.0, it is
22 currently in the measure set, so this would be an

1 additional module, I believe, is that right?

2 DR. WHITE: Okay, great.

3 CHAIR GESTEN: Okay, so we had a
4 nomination and a second, all those in favor of
5 this, raise your hand. Okay. Okay, we have a
6 follow-up on the antipsychotics, does that have a
7 number?

8 MS. LASH: No, it's not endorsed.

9 CHAIR GESTEN: It's not endorsed?

10 MS. LASH: No.

11 CHAIR GESTEN: Before we vote, any
12 questions on this measure, before we vote on it?
13 Yes, question?

14 MS. COHEN: Is it part of the NCQA
15 list that we went over, is it, which one is it
16 now? I'm confused.

17 MS. LASH: In your measures
18 spreadsheet --
19 Row Number 5, follow-up visit for children and
20 adolescents on antipsychotics.

21 CHAIR GESTEN: Susan.

22 DR. LACEY: So is there, I can't read

1 very well on mine. So does it have anything
2 about a time, a window of time, in terms of the
3 follow-up?

4 What is it? It's 30 days?

5 MS. GORHAM: Thirty days, yes.

6 DR. LACEY: Okay. Thank you.

7 CHAIR GESTEN: So do we have a
8 nominate --

9 So you'd like to not add it with the conditional
10 support? Is there a second for that?

11 Second. All those in favor of
12 conditional support for this measure of follow-up
13 for antipsychotics, raise your hand.

14 Four?

15 MS. LASH: Four.

16 CHAIR GESTEN: The next measure is the
17 low respiratory readmission rates. So we already
18 voted on the pediatric all-condition, we had a
19 conversation about this one, as a subset of that.
20 There were some support and back and forth about
21 that. Somebody want to nominate this to add?
22 Yes, nominated, and a second?

1 Okay. All those in favor of adding
2 this favor, raise your hand.

3 MS. LASH: It's just four.

4 CHAIR GESTEN: Four. You guys all
5 right? Is everybody okay? I told you, this is
6 the hard part. This is why, this is, you know,
7 this is why you got fed lunch and coffee.
8 Counting cavities, this is a measure, Kevin that
9 you described, it's not in the grid where I think
10 folks got, but you went through some of the
11 specifications, e-specifications for it.

12 DR. LARSEN: It's, sort of, NQF
13 endorsed.

14 CHAIR GESTEN: You'll have to --

15 DR. LARSEN: So this is consistent
16 with a lot of electronic medical record measures.
17 The initial thought was that we could take claims
18 measure and just make it an e-measure. And as we
19 have lived that out, we've realized that even as
20 close to what we stick to what the claims measure
21 is, the electronic measure is different.

22 And so we're still working through

1 with NQF exactly how they inherit the research
2 and endorsement, because they're designed and
3 intended to do exactly the same thing. But,
4 because the data source is different it -- so
5 there is an NQF endorsed measure, NQF 1335 that
6 is dental decay, or cavities, in children, and
7 this is built on that architecture.

8 CHAIR GESTEN: Susan.

9 DR. LACEY: So count of cavities by a
10 provider neutral, I understood that. So by
11 which, by what age, like, anytime?

12 DR. LARSEN: Zero to 20.

13 DR. LACEY: Zero to 20, only one time
14 it has to be counted?

15 DR. LARSEN: Yes. It, how many
16 cavities, you know, overall in Health Plan A,
17 when they have, you know, 20 percent of their
18 kids have cavities and Health Plan B has zero
19 percent of their kids with cavities.

20 The design, the idea was this was an
21 outcome measure doesn't tell you what
22 preventative services are being done, or not

1 done, it tells you whether or not important oral
2 health outcome is, has been achieved.

3 CHAIR GESTEN: All right, thanks. Is
4 there a nomination for this measure? Are you
5 allowed to nominate your own measure? Well, if
6 this --

7 DR. LARSEN: I'm not a boarding
8 member, we're feds, so we can't vote.

9 CHAIR GESTEN: Oh that's right, yes.

10 Okay. Is there a second? All right.

11 Sealants. Sealants 6 to 10, this is
12 a measure held over from the last expedited
13 review that we had that just didn't make the cut
14 last time. I think we had sealants for a
15 different age group, a younger age group, is that
16 right? And --

17 So this age is sealants for 10 to 14.
18 Any nominations for this measure? You guys are
19 just tired, right, is that what's going on?

20 MS. LASH: Okay.

21 CHAIR GESTEN: Okay. Okay that, that
22 is it. So we have, so how many measures do we

1 have --

2 MS. LASH: Nadine, could you review
3 the list of measures that gained the consensus
4 threshold?

5 MS. ALLEN: So first measure with the
6 highest support would be use of multiple
7 concurring antipsychotics in children and
8 adolescent with 11 votes for full support.

9 Next measure is NQF Measure Number
10 1360, audiological evaluation, no later than
11 three months of age that got ten votes. The
12 third measure is Measure 2393, pediatric
13 all-condition readmissions measure that received
14 nine votes, full support.

15 CHAIR GESTEN: The others didn't make
16 it? Wow. So we have three.

17 I'm kind of thinking we don't need to
18 do more, in terms of prioritizing. But --

19 DR. LEIB: I'll just throw it out
20 there. I'm going to reopen 2337, an
21 antipsychotic use in children under 5, and throw
22 it open for a vote, because we never took a vote,

1 because no one nominated it. But I'll nominate
2 it and go from there.

3 CHAIR GESTEN: Group okay with this
4 slightly unorthodox suggestion? I mean, I'm
5 terrible at Robert's rules, I'm sure it violates
6 ten of them, but again, I think we have time and
7 --

8 DR. LEIB: Motion to reconsider.

9 CHAIR GESTEN: The Chair has
10 inclination.

11 DR. LEIB: Motion to reconsider, so.

12 CHAIR GESTEN: Anyone object to --

13 So we have one, we have a nomination
14 of 2337, is there a second?

15 DR. LEIB: It officially dies, for
16 lack of seconding.

17 CHAIR GESTEN: Oh, wait.

18 DR. LEIB: Oh.

19 CHAIR GESTEN: We have one. All those
20 in favor of 2337, antipsychotic use in children
21 under 5 years, raise your hand. Three.

22 MS. LASH: That's three.

1 CHAIR GESTEN: Okay.

2 So thank you, everybody. I know it's
3 a little, little tedious, but we actually, I
4 think, got through it. In terms of the next
5 phase of this, I guess, there are two things,
6 there are a number of things we probably need to
7 go through, one is what tomorrow is going to be.

8 And, again, sort of, a little bit of
9 refresh that we're going to tee up measures that
10 really are somewhat arbitrary across the adult
11 and child measure sets, essentially, the
12 perinatal measures for discussion tomorrow,
13 particularly, thinking about both choice, but
14 also, alignment of the two groups.

15 I think there's a general conversation
16 we're going to have about, kind of, next steps,
17 in terms of measure direction, how to deal with
18 gap areas, how to decrease the burden and the
19 challenge of reporting measures, particularly,
20 ones that have high priority, and some thoughts
21 and conversations between the two groups about
22 that. Is there anything else on the agenda for

1 tomorrow that folks need to think about?

2 MS. LASH: I think one of the major
3 points of discussion, we have two hours and,
4 possibly, even more time set aside, is the
5 maternity and perinatal care issues.

6 There are a number of very specific
7 measures we would like the group to think about
8 whether they would support for addition to the
9 child and/or adult core sets.

10 And that'll be challenging with such
11 a large group of people together, so if you need
12 to spend any further mental energy on this
13 tonight, that would be the best point to prepare.

14 The balance of the afternoon we want
15 to talk a lot about building infrastructure
16 within states to bolster their participation and
17 their ability to take on quality improvement
18 projects, in response to things that they are
19 collecting.

20 So you can take a look at the agenda,
21 or we can, sort of, preview for you now the slide
22 that we're going to show you tomorrow morning

1 about what is ahead for the day, if you think
2 that would be helpful?

3 CHAIR GESTEN: If we can do, just hold
4 that, just for a second --

5 MS. LASH: Okay.

6 CHAIR GESTEN: -- because I do want to
7 get to the topic of, have a little bit more of a
8 conversation around gap areas, before we go to
9 public comments.

10 MS. LASH: Yes.

11 CHAIR GESTEN: And then, maybe, we can
12 do that remaining, but there is some cards up,
13 before we do that. Andrea, do you have something
14 for --

15 DR. BENIN: Yes, I was wanting to just
16 refer to the gaps, so --

17 CHAIR GESTEN: Okay.

18 DR. BENIN: Oh.

19 DR. LEIB: I got a question for Sarah,
20 since she mentioned we're going to talk about
21 pregnancy tomorrow, what would be the reasons,
22 since pregnancy spans late childhood into

1 adulthood, what would be the reasons for
2 approving it, a measure for one and not the
3 other, either way, why would, what would be the
4 rationale for not being aligned?

5 MS. LASH: Great point. Some
6 measures, historically, around postpartum care
7 had been in the adult core set, but not the
8 child, and if that is a situation you would like
9 to rectify, so that the whole age range of a
10 hurdle of women --

11 DR. LEIB: So 18-year-old pregnant
12 women gets the same series of things, as a
13 21-year-old pregnant women?

14
15 MS. LASH: Absolutely.

16 DR. LEIB: Okay.

17 MS. LASH: Yes.

18 CHAIR GESTEN: There may not be much,
19 except for historic, or --

20 MS. LASH: Yes. I believe there is.

21 CHAIR GESTEN: -- different group
22 reasons, or if, you know, different folks who

1 prioritize and they have a certain amount of
2 space. But I think it's a great question. I
3 think it's part of the reason why we wanted to
4 have the two -- two groups to talk to each other.
5 Terry.

6 It's about CAHPS?

7 DR. ADIRIM: Yes, gaps.

8 CHAIR GESTEN: Oh, gaps, good. Okay.

9 So --

10 MS. DOUGHERTY: My question, I just --

11 CHAIR GESTEN: Go ahead.

12 MS. DOUGHERTY: Just let me clarify,
13 the reason that perinatal measures are in the
14 child core set at all, is not because of teenage
15 pregnant women, it's because the legislation said
16 services to promote healthy birth. So it's
17 looking at the outcome for the child and not the
18 woman, unless she's a pregnant woman. So does
19 that help?

20 CHAIR GESTEN: So I think, in terms of
21 the gaps, folks can consider anything they want
22 about the gaps, but I would just suggest that one

1 of the things you might want to do is revisiting
2 these, this list of gap areas that this group, or
3 at least its previous incarnation, has identified
4 as gap areas.

5 And, I think, part of what we're
6 looking to do is, sort of, future, looking to the
7 future both, in terms of, you know, the next
8 year, as well as years.

9 Remember, that this exercise is an
10 annual event, right, so every year we get a
11 chance to take a look at the measures and to,
12 hopefully, in each of that year, as it has been
13 in this year, it's been a, this is a banner year
14 for new measures to consider for gap areas.

15 But I don't presume that that's going
16 to stop, so I'm wondering, at looking at some of
17 the questions, they might be helpful both to NQF
18 and to CMS and to measure developers, are there,
19 do we want to have some conversation about
20 whether these are still the right gap areas.

21 Does anyone want to put a final point
22 on any of these areas, or prioritize them, or say

1 something that might be useful, in terms of
2 thinking about this next year and thinking about
3 measure development, or thinking about choosing
4 from another list of measures going forward? So,
5 Terry, I know you, go ahead.

6 DR. ADIRIM: Chomping at the bit. One
7 gap area, which I have not, nobody has brought up
8 at all this year, has to do with injuries and
9 trauma.

10 That it's a high cost, affects the
11 Medicaid population in a lot of ways and, you
12 know, now we have, in some areas, for example, in
13 head injuries we have evidence-based pathways.

14 So I want to make a pitch for more
15 measures in this particular area, if we already
16 have measures then I think we need to consider
17 those measures.

18 MS. GORHAM: And so that was a -- I'm
19 sorry.

20 CHAIR GESTEN: Go ahead.

21 MS. GORHAM: I need to use my tent,
22 too. That was a area identified last year, as

1 you can see on your slide. When we did a search
2 for measures in that gap area, we couldn't find
3 any. So we're definitely open if someone wants
4 to point us in the right direction, but we did
5 look.

6 DR. ADIRIM: And the other category
7 that wasn't available is screening for abuse and
8 neglect and DME.

9 CHAIR GESTEN: Alvia.

10 DR. SIDDIQI: I was just going to say
11 that, in looking at the measures that we've
12 selected, it seems like we have, somewhat,
13 tackled the care coordination mental health
14 inpatient measures categories, at least, by the
15 measures that we selected.

16 But I do think trauma informed care is
17 a big topic right now, I know for the AAP and a
18 lot of things that are going on in different
19 states, it's looking at how we best, again,
20 integrate mental health and primary care and
21 trying to find measures that deal with care
22 coordination, is still really challenging.

1 CAHPS surveys, they're great, but
2 they're really hard to, sort of, implement for
3 states to go ahead and do and then report on. So
4 I do think, you know, any new measures that are
5 coming out about care coordination will be
6 helpful.

7 I also wanted to suggest, maybe, for
8 a future meeting, maybe next year, that we do
9 hear some highlights about the CMS proposed rules
10 about Medicaid and Medicaid managed care and
11 trying to see if there's any alignment with
12 measures, based on what these plans are being
13 held accountable for, so again, the provider and
14 the plans could all be aligned with the same
15 measures that we're proposing in our core sets.

16 CHAIR GESTEN: Okay. Ashley.

17 MS. HIRAI: I just wanted to mention,
18 on injury that, Title 5, we have more
19 population-based measures for injury, and so what
20 we're using as a performance measure is non-fatal
21 injury hospitalization, which can be stratified
22 by payer.

1 And we, actually, are providing that
2 data to states to inform their needs assessment
3 and selection of eight of 15 National Performance
4 Measures, and then that rolls up into actual
5 fatalities, due to injury.

6 DR. ADIRIM: Right, and there's new
7 databases, too, like data sources, state data
8 sources. NEMSIS is one of them, it's a
9 pre-hospital. I don't know how good it is, but
10 it's a pre-hospital data and there's other
11 sources, data sources, as well.

12 CHAIR GESTEN: Sorry, Anne.

13 MS. COHEN: So I wanted to add the
14 trauma piece, so that's right on and, obviously,
15 I agree with that. There was two areas we
16 haven't looked at, they're pretty complicated
17 that I don't quite know how to deal with.

18 The most complicated is stratification
19 of the areas for trauma special healthcare needs,
20 to look at health disparities. That's,
21 obviously, the challenge, but I think it's really
22 critical to look at that.

1 The second is dental care access for
2 trauma special healthcare needs, particularly,
3 looking at those developmental disabilities. The
4 University Centers of Excellence on developmental
5 disabilities may have done some work in that
6 area, and I know there's a lot of DD relevant
7 research on dental care access, so.

8 CHAIR GESTEN: Andrea. Thank you.

9 DR. BENIN: I think that the, for next
10 year, we should really be able to take a, somehow
11 take a good look at the PQMP, Centers of
12 Excellence areas in a really comprehensive way,
13 and that over the course of this next year.

14 It would be good to have an
15 environment where we can get as many of those
16 measures, either through NQF and/or through
17 whatever other piloting and, you know, field use
18 that they need, so that if we were to have a
19 meeting like this next year that it would
20 actually be able to pretty cogently go through
21 those areas, which I think were identified to be
22 gap areas to start with, and then metrics were

1 built to fill them.

2 And we should be able to have a pretty
3 cogent analysis of that situation, so that those
4 could be put into play. And I would say, you
5 know, the sickle cell metrics, the complex, you
6 know, children with complex medical health needs,
7 I mean, there's a whole, there's a number of
8 those things, all of which we should have in
9 front of us to review on putative sets.

10 CHAIR GESTEN: Great. Kevin.

11 DR. LARSEN: Another priority area
12 that I would call out in the new law around the
13 SGR fix called HR 2, or also known as MACRA, the
14 Medicare Authorization and CHIP Reauthorization
15 Act.

16 Congress called out outcome measures
17 for providers, and so those providers will be, we
18 have -- that's a priority for CMS, and if we're
19 thinking about alignment, they'll be looking for
20 outcomes, especially, patient reported outcome
21 measures.

22 And so I don't think we've really

1 discussed, or looked at, any patient reported
2 outcomes here, but that has been something that
3 Congress has asked us at HHS to prioritize, at
4 least, under that particular measures suite for,
5 I presume, it will be both Medicaid and CHIP, at
6 least, as the fee for service providers.

7 CHAIR GESTEN: All right, tremendously
8 helpful. So let's go to public comment and then,
9 before we have you leave we'll just review a
10 little bit of that tomorrow, go over the agenda
11 with a little bit more detail. But, let's start
12 with the phone. We've got an operator who can
13 open up the line, if there's public comment, or
14 invite public comment through the phone and then
15 we'll do the room.

16 OPERATOR: At this time, if you would
17 like to make a public comment, please press star,
18 then the Number One on your telephone keypad.
19 And you do have a public comment, one of Lawrence
20 Kleinman.

21 MR. KLEINMAN: Well, I'd just want to
22 say how, as one of the Centers of Excellence

1 Directors, how pleased I am that this process is
2 open and available to listen to, I've learned a
3 lot. And, I would like to plant one seed and,
4 hopefully, we'll have lots of measures for you
5 next year, some of which will, at least, have
6 come through the NQF process.

7 But it seems to me that one of the
8 things the Centers were set up to do was to
9 identify, at least, or develop at least some
10 measures in areas where it might not, by design,
11 meet the standards of NQF.

12 So because of the fact that it's a
13 real practice need and there may be insufficient
14 evidence, or the cost for developing that
15 evidence may be too expensive, et cetera.

16 So I would love to see next year, and
17 I'm thrilled, I'm not sure who made that comment
18 about looking at the PQM fee measures, but when
19 they looked at it, that could be a part of what's
20 thrown in the hopper when considering them, that
21 sometimes there's a reason they may not fit for
22 NQF endorsement, because pediatrics doesn't have

1 the investment and doesn't have the data
2 infrastructure. And I'll leave it at that.
3 Thank you very much.

4 CHAIR GESTEN: Thank you, Larry. Any
5 other comments on the phone?

6 OPERATOR: And there are no further
7 public comments.

8 CHAIR GESTEN: Okay, and to the room.

9 MS. TURBYVILLE: Thank you. Good
10 afternoon. I'm Sally Turbyville with the
11 Children's Hospital Association. First, I do
12 want to thank the Committee, for all your hard
13 work, both today, and I know there's a lot of
14 preparation coming in and NQF --

15 So my name is Sally Turbyville. I'm
16 with the Children's Hospital Association. I do
17 want to thank the Committee for all your hard
18 work, as well as NQF staff. So thank you, it
19 really allowed for fantastic conversations today.

20 I just have three comments that I
21 would like you to consider. A, one, and you can
22 think for lens, Children's Hospital Association,

1 that looking at the measures that were slotted
2 into the inpatient measures gaps. Some of them,
3 in my view, don't really fit there. And the
4 reason that's important to me, because it's
5 really critical that we can articulate back out
6 to the quality measurement enterprise, if there
7 are still gaps in that area.

8 I think there were cross settings, so
9 probably clunky and difficult to fit, but I don't
10 think they reside in that domain alone. I also
11 want to echo a comment that Andrea made earlier
12 about rethinking how we even call out some of
13 these gap areas.

14 I'm sure the Committee will be working
15 on that for your next report, but that, perhaps,
16 there are others, some axes, to consider that
17 would, maybe, allow us to better understand what
18 the measures are really looking at, for example,
19 you know, these cross-cutting measures, not
20 saying, necessarily, we want to call one
21 cross-cutting, but as an example.

22 I also really want to encourage and I

1 think NQF is for this, but I don't want to speak
2 for NQF, encourage and support that NQF has the
3 opportunity to have a broad-based child health
4 call for measures that would really allow a lot
5 of the PQMP measures that are ready to be put
6 forth, it would allow this Committee, for
7 example, as well as others, to understand which
8 ones are suitable for NQF endorsement and which
9 ones may not and then to Larry Kleinman's point,
10 then allow for additional conversation, as well.

11 So hopefully we can see that happen
12 where they can call for measures, not just by
13 clinical topic area, but a broad-based child
14 measure. If we just do clinic topic-by-topic,
15 it's going to take years to get all the PQMP
16 measures in, so big supporter of that.

17 And I also, just sitting back and
18 observing today, would encourage and, again, I
19 know how much work goes into these meetings, that
20 when measure developers are provided an
21 opportunity to comment that we try to do it a
22 little bit consistently, both in terms of timing,

1 as well as, all of those that might have the
2 opportunity for their measure to be discussed.
3 So just an observation. Again, I know that these
4 things are challenging logistically. And those
5 are my few comments. Thank you.

6 CHAIR GESTEN: Thank you very much,
7 Sally, great comments. So how about we find out
8 what fun is in store for tomorrow? Wait,
9 anything else in the room?

10 No? Okay. Let's find out, you were
11 going to tee up, we'll tee up the agenda, we'll
12 have more detail about tomorrow and then --

13 MS. LASH: Yes, sure. So we'll do
14 some level setting first thing in the morning to
15 recap our discussion for the benefit of those
16 people who will be new to the meeting.

17 We will be talking a lot of about
18 measure alignment and the cross-cutting issue of
19 maternal perinatal care. And then, we have a
20 series of what I have termed, issues of shared
21 importance, so moving from process to outcome
22 measurement and all that would be entailed in

1 that, motivating quality improvement action
2 within the states, and then, any action CMS could
3 take to support states' ability to participate in
4 reporting, how can we remove some of the barriers
5 that they have shared with us, and that will be
6 the subject of the day.

7 CHAIR GESTEN: Great. Thank you. Any
8 questions about tomorrow?

9 (No Response.)

10 CHAIR GESTEN: So I just want to
11 extend my thanks and appreciation to all the
12 folks who made it here, actually on time, unlike
13 moi.

14 And the hard work of not only being
15 here, but also reviewing the materials and
16 participating. Tomorrow should be a fun day.
17 Thanks again to Sarah and Shaconna and Sarah and
18 Nadine, they just, you know, NQF staff just
19 makes, makes it all happen.

20 But some great suggestions about how
21 we can improve the process, I thank the, I
22 appreciate folks who made those suggestions to

1 us. And, Marsha, anything?

2 MS. LILLIE-BLANTON: No, no, not
3 today. I gave welcoming remarks.

4 CHAIR GESTEN: You're waiting for the
5 big bang at the end, okay. All right, well have
6 a great evening, everyone, look forward to seeing
7 you tomorrow. Thank you, again. Thanks --

8 MS. GORHAM: Just as a reminder, we
9 convene tomorrow at 8:30 a.m. for a continental
10 breakfast.

11 CHAIR GESTEN: 8:30 a.m.?

12 MS. GORHAM: 8:30 a.m.

13 CHAIR GESTEN: Okay.

14 MS. GORHAM: Right.

15 CHAIR GESTEN: I'll be there.

16 (Whereupon, the above-entitled matter
17 was concluded at 4:35 p.m.)
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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: In-Person Meeting Map Medicaid Child
Task Force

Before: NQF

Date: 06-09-2015

Place: Washington, D.C.

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