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

(9:03 a.m.)

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

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

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

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

(No audible response.)

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

additional thoughts from CMS.

WELCOME, INTRODUCTIONS, AND REVIEW OF MEETING OBJECTIVES

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

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

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

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

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

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

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

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

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

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

This is important for two reasons.

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

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

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

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

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

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

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

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

Sandra?

DR. WHITE: I have nothing to disclose.

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

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

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

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

DR. LEIB: I'm Marc Leib --

MS. LASH: Your microphone.

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

anything to do with Medicaid, adult or child measures.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. FLAMM: Hi, my name is Carole

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

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

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

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

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

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

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

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

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

MS. ALLEN: Good morning. I'm Nadine

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

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

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

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

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

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

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

morning.

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

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

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

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

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

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

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

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

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

the committee. Alvia?

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

MS. LASH: I believe it's 24.

DR. SIDDIQI: Okay, thank you.

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

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

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

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

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

OVERVIEW OF MEETING MATERIALS AND KEY POINTS FROM STAFF REVIEW OF CORE SET

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

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

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

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

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

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

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

We would like, here, to see a program

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

born prematurely, defined as birth before 37 weeks gestation.

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

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

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

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

Concerns about access to appropriate behavioral health services and the increased

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

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

Assessment.

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

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

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

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

CHAIR GESTEN: Hi, can you guys hear me?

MS. GORHAM: Yes, we can.

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

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

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

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

MS. COHEN: Okay.

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

MS. COHEN: I won't.

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

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

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

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

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

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

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

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

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

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

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

SPEAKER: Which measure is that?

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

MS. GORHAM: Thank you, Denise.

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

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

states in 2013 reported and decreased to 42 states in 2014, but 46 states reported the measure at least once during the three years. The CHAP measure, states reported the measure increased from 43 states in 2012 to 45 states in FY 2013, and then decreased to 43 states in FY 2014. Forty-six states reported the measure at least once during the three years. The AWC measure, 43 states for 2013. It increased to 44 states for 2014, and then there was a total of 46 states that reported the measure at least once during the three years. The W34 measure, 47 states for 2013. It decreased to 46 states in 2014. Forty-eight states reported the measure at least once during the three years. And so I went through that just to give you an idea how the different states reported over the different years.

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

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

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

(No audible response.)

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

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

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

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

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

MS. GORHAM: Yes, thank you.

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

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

DR. ADIRIM: Even access to primary care --

MS. LILLIE-BLANTON: Yes, actually, it

does.

DR. ADIRIM: Okay.

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

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

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

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

MS. LILLIE-BLANTON: Yes, absolutely.

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

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

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

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

MS. DOUGHERTY: Okay, thanks.

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

DR. CUNILL: Question.

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

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

MS. LASH: There's one annual

submission.

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

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

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

out there.

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

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

so I don't know.

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

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

MS. LASH: That's one factor.

DR. LACEY: Okay.

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

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

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

(Simultaneous speaking.)

CHAIR GESTEN: Can I (telephonic interference.)

MS. LASH: Sure, Foster.

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

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

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

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

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

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

and those are not just limited to the Medicaid population.

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

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

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

report things differently, so maybe ask again later?

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

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

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

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

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

MS. LASH: Anne, go ahead.

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

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

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

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

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

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

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

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

MS. LASH: Alvia?

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

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

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

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

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

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

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

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

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

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

DR. BENIN: Yeah.

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

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

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

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

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

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

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

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

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

DR. LACEY: Okay, I just was --

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

DR. LACEY: All right, thanks.

MS. LASH: Marc?

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

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

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

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

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

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

readmission measure and pediatric lower respiratory infection readmission.

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

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

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

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

(Simultaneous speaking)

MS. LASH: Wonderful, thanks so much.

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

(No audible response.)

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

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

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

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

DR. SCHIFF: Here I am.

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

DR. SCHIFF: Oh, great, thank you.

STATE PERSPECTIVES PANEL -- PART 1

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

One of them that we're working on and

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

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

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

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

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

MS. LASH: Yes, we are, thanks.

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

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

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

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

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

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

You could go on to the next slide. I

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

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

indications we asked in that policy.

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

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

publicity that way, but it worked.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

going. Here's the areas where I know you're considering some measures, or the measures are in development, that are really important. Children's mental health outcomes, I think this is one that we struggled with in 2009 when we did the first core set, and I think we continue to struggle with, is what are relevant outcomes in children's mental health that we can actually report. We have some interest there around trying to reform care.

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

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

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

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

terms of infrastructure process and health outcomes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

So no specific payment for the

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

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

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

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

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

MS. LASH: Thank you. Next question

from Anne.

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

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

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

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

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

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

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

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

together that commonly haven't talked to each other.

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

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

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

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

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

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

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

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

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

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

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

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

for some more process and infrastructure type of sentinel measures.

MS. LASH: Thank you. Terry.

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

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

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

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

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

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

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

squeeze on that, for example.

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

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

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

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

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

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

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

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

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

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

MS. LASH: Thank you. Marsha?

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

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

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

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

MS. LASH: Sandra, you're next.

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

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

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

quality for Aetna.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MS. LASH: Next question from Marc Leib.

DR. LEIB: Sorry. Jeff, this is Marc Leib. Congratulations on finishing your year as president of your medical directors there. Question for you in follow up about the patient-centered medical home. I applaud the efforts that you have to not only just let them designate themselves, but to actually go out and review them, look at their processes, decide if they really meet the criteria.

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

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

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

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

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

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

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

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

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

MS. LASH: Andrea.

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

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

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

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

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

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

MS. LASH: Ashley.

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

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

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

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

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

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

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

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

Then the second thing is if folks are screened, what's the services that are provided for them and whether they're wrap-around. Hennepin County, which is where Minneapolis is, is our shining star. We have a program that does screen and when moms are identified, they get referred to this program. They have wrap-around services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PUBLIC COMMENTS

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

using psychotropic meds.

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

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

the use of these drugs amongst children.

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

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

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

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

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

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

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

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

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

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

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

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

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

OPERATOR: And there are no comments

at this time.

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

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

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

12:34 p.m.

MS. LASH: Welcome back, everyone. We're so delighted to welcome Dr. Rebekah Gee and her team from the State of Louisiana to share more about their experience participating in child core set reporting.

STATE PERSPECTIVES PANEL -- PART 2

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

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

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

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

say hello? Could you introduce yourselves?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

have been prescribed an ADHD med.

Our overall state rates -- yes, 61. I actually was reviewing our paperwork, going to send it in to hopefully to get published or reviewed, but we have some astounding rates. I'll show you some more of those next. This is the prevalence overall of Louisiana males. In the top graph, you can see the non-Hispanic, white males, at age 10 and 11, upwards of 35 percent are prescribed an ADHD med, non-hispanic, black lower rates, but still very high, more than 20 percent, and much higher than the national rates, other races. Girls are still higher than the national average, but not as high as boys. Whites prescribed more often than blacks, which is consistent. We also noted that children that enter school younger than their counterparts of children born in the first half of that year, who are in that school year, double the risk of ADHD meds.

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

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

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

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

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

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

problems like these.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

around five.

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

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

So I would like to see more work at

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

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

because the child has this particular diagnosis?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

dissemination.

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

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

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

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

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

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

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

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

we've looked at and dealt with.

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

MS. LASH: Next question from Terry.

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

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

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

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

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

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

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

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

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

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

MS. LASH: Andrea.

DR. BENIN: Thank you. You had

mentioned that the CLABSI metric was really hard. Can you expand on that a little bit?

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

MR. MYERS: Could you repeat that question?

DR. GEE: The central line infection metric.

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

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

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

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

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

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

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

measure or a proxy measure.

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

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

they're not necessarily set out for, right?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MS. LILLIE-BLANTON: I think so.

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

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

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

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

I'm not sure the extent to which when

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

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

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

get bumped up.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

improvement, it could be bolstered.

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

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

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

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

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

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

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

just too quick.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

work of the afternoon is clearly to --

(Off microphone discussion)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

about some of the ins and outs.

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

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

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

MS. DOUGHERTY: The states.

CHAIR GESTEN: Pay the states?

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

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

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

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

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

(Off microphone discussion)

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

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

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

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

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

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

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

MS. GORHAM: Thanks.

CHAIR GESTEN: Other comments?

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

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

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

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

(Off microphone discussion)

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

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

DR. LACEY: Yes.

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

DR. LACEY: Probably not.

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

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

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

So when I'm an obstetrician doing the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CHAIR GESTEN: Anne.

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

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

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

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

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

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

(Off microphone discussion)

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

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

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

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

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

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

And the data, admittedly, has

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

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

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

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

reporting.

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

(Off microphone discussion)

CHAIR GESTEN: In fact with --

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

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

(Off microphone discussion)

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

MS. LILLIE-BLANTON: Okay.

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

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

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

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

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

CHAIR GESTEN: Andrea.

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

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

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

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

CHAIR GESTEN: Jeff.

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

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

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

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

(Off microphone discussion)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(Off microphone discussion)

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

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

MS. GORHAM: Yes.

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

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

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

(Off microphone discussion)

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

(Off microphone discussion)

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

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

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

(Off microphone discussion)

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

covered in the core set.

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

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

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

And so they're not claims-based measures, but they're eCQMs, so electronic quality measures for the purpose of coming out of an EHR.

A couple of these are already in

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

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

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

(Off microphone discussion)

MS. LASH: It's Row 7.

MS. DOUGHERTY: Oh, before you leave --

MS. LASH: Sure.

MS. DOUGHERTY: --- the psychotropics. So a question. The measure, Use of Anti-Psychotic Medications in Very Young Children, NSIG delivery, how does that differ

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

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

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

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

MS. LASH: Yes.

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

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

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

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

MS. DOUGHERTY: Okay. Thank you.

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

DR. LARSEN: Yes, Kevin Larsen.

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

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

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

the same use.

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

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

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

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

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

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

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

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

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

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

DR. BENIN: So just to clarify, the 90 percent and the 65 percent, are those pediatric facilities?

DR. LARSEN: I can look, I'll jump in line to see if I can pull out PEDS versus adults. I think that they're -- the rate of hospital, pediatric hospitals that have attested Meaningful Use is slightly lower than the rate of general hospitals, which also do a fair bit of pediatric care.

So, I don't know about the -- that we have that data for non-hospital-based care. We know by specialists. And we know that primary care has a very high rate in pediatricians and family doctors that take care of the vast majority children both have a high rate of adoption. So we know by provider type or

hospital type, but we don't know by the Medicaid patients that receive care.

DR. BENIN: I do think that the vendors have been lax in supporting the building of the pediatric measures, perhaps with the same sort of support that the adult measures have gotten. But it's been a real challenge.

CHAIR GESTEN: So Jeff and then Terry.

DR. SCHIFF: Yes. There was a question that started this last binge, was both ADHD and then also access to behavioral health, and so I wanted us to call back that, we didn't talk about that. And it appears, at least, under the mental health tab at Row 11, that basically using caps as a sort of surrogate for access is something for us to at least be aware of and consider.

CHAIR GESTEN: Terry.

DR. ADIRIM: So I have a question. In preparing for this meeting, because I feel very strongly that the core set doesn't reflect, I think, enough of behavioral health, I mean, if

you haven't gotten that, yet.

I did look up on the behavioral health framework that was done with NQF and HHS. Those NQF numbers, 0107, Management of ADHD and Primary Care for School-Aged Children and Adolescents, is that -- it's a provider level measure. I don't know if that --

MS. LASH: That's one of the two measures we mentioned that is lost endorsement, since it was --

DR. ADIRIM: Oh.

MS. LASH: -- initially reviewed, unfortunately.

(Off microphone discussion)

CHAIR GESTEN: Shucks. Denise, do you have your --

MS. DOUGHERTY: Oh, I'm sorry. I --

CHAIR GESTEN: Can you turn your mic off, too?

MS. DOUGHERTY: Yes.

CHAIR GESTEN: Anne.

MS. COHEN: Yes, I just want to

capture from this morning, to sort of add to the gaps list in this behavioral health area and that concept of trauma-driven behavioral health, because I think that's an area that we haven't looked at, and, I believe, through the duals group, the last time we looked at health disparities, one of the areas that came up was trauma-related care in adults and children under the influence of overall health. So it's a new up and coming area and we need to, kind of, highlight that, as an area to look at for future study.

(Off microphone discussion)

CHAIR GESTEN: Go ahead, Andrea.

DR. BENIN: -- we're on this topic of behavioral health gap, I would just add the -- a really large gap around the amount of time children with behavioral health problems spend in the ED, and so sort of ED length of stay, or some type of metric around the burden on the -- of time in the emergency room, which is pretty untenable at this point. And, certainly, in our

environment, it's completely out of control.

CHAIR GESTEN: So before I get to Rebekah, Jeff, I want to make sure I understood your -- what you were suggesting. Were you suggesting, in terms of the access, that within CAHPS, there's a potential inability to generate a measure related to access to behavioral health or that that might be a vehicle to do that? I just want to circle back to it.

DR. SCHIFF: I was just using the resources you all had, and I hadn't heard it called out or show up on that list as a measure to consider that was in the space of behavioral health access. I wasn't, necessarily, commenting on -- it was -- if I was endorsing it, or not, but just that it is there, available with these list of other things to consider.

CHAIR GESTEN: Rebekah.

MR. BERTRAND: Just wanted to add, and I know I've already said this, but the prematurity measure, progesterone, and we could use any help that could be offered to us, in

terms of getting it endorsed and helping us with that process.

And number 2, cross-sector measures. So, you know, my opinion is schools have as much, or more, responsibility for pediatric obesity, as do pediatricians, so can we do cross-sector measures?

Particularly relevant in states where state agencies are often funded by a super budget, how do we have cross sector measures, whether it's prison health, or health in education? And how do we start to work to develop those types of things? I think it would require a conversation. They're not just going to happen spontaneously in my opinion.

CHAIR GESTEN: So I think we're starting to have -- we're having a conversation about general gaps, which is -- which is fine. I think we want to -- we had some of it -- you all had some of it this morning, and we're going to, I think, circle back to it, as well.

But, I think, for right now, it would

be helpful to know whether the three measures that are being teed up, or their measures that accompany them, excite interest, deal with concerns or questions that were raised about gaps and gaps related to behavioral health.

Clearly, two of them relate to behavioral health. One of them is an inpatient measure about readmission and that gets to issues around care coordination, and so I think that they are aimed in the direction of gaps that have been identified.

The question is, do they hit the target for this group or not, and are there any questions about those three? Because, I think, we're going to want to probably take a vote about whether they these are ones that we want to put on the list for potential endorsement to go forward. Marc.

MS. GORHAM: Before --

DR. LEIB: Oh.

MS. GORHAM: Before we do that, can I actually go through more detail about the three

measures? And then we can take comments. And so --

DR. LEIB: Sure. I just had a general questions --

CHAIR GESTEN: Oh, okay.

DR. LEIB: -- not about these three but about behavioral health. Given that we're talking strictly behavioral health, and we're talking children are on anti-psychotics, why -- I was just wondering why there was no consideration, or at least there wasn't an acceptance of like the metabolic monitoring of children who are on anti-psychotics, which seems like it would be a relatively easy measure to see if there is the lab tests that are done once a year, or once -- whatever the proper measure would be? I just wondered why those weren't part of it.

MS. LASH: We can definitely talk more about the pros and cons of these measures. It was a tough call. On this particular page, they all seem to be a little narrow for our liking.

They're sort of sounding a lot like that ADH measure -- ADHD measure that we don't particularly love today about follow-up visits. They seem to be a little in that vein, so I will suggest that we come back to that.

CHAIR GESTEN: So if it's okay with the folks who have cards, unless you have something urgent on this point, I'm going to turn it over to Shaconna to go through the detail of these three measures.

MS. DOUGHERTY: Well, I'm wondering whether people have had a chance to look at the other tabs on this -- other measures to --

CHAIR GESTEN: Would you like to take a vote to see if they've looked at them, or would -- I mean, I think, why -- Denise, why don't we do this, why don't we go through these, and then it'll be an open conversation about the ones that the staff did not pick as well as the other ones that are in the document that was sent to you all?

MS. DOUGHERTY: Okay.

CHAIR GESTEN: Is that fair?

(No Response.)

CHAIR GESTEN: Okay?

MS. DOUGHERTY: Yes.

CHAIR GESTEN: We're not voting right now. We're not voting. We'll have a thorough conversation before we do any voting.

MS. GORHAM: Okay. So the available measures in the care coordination gap area are -- well, they're not on the slide, yet. Hold on. Okay. So those are the available measures in the care coordination gap area. We did not have any staff picks in that particular gap area.

The next slide, the inpatient gap area, I just want to bring your attention to the measure next to the last. While it was not a staff pick, we alluded to it earlier about the behavioral therapy at the first-line treatment for preschool-aged children with ADHD.

Sir, I kind of mentioned that earlier, so I just wanted to kind of highlight that it is in the inpatient gap area, and we can discuss it

more, if you would like.

(Off microphone discussion)

MS. GORHAM: So one of the --

(Off microphone discussion)

CHAIR GESTEN: I think folks are bubbling over.

MS. GORHAM: Right.

CHAIR GESTEN: So Denise. I don't want to stop the boil. Go ahead.

MS. DOUGHERTY: So on care coordination, I'm wondering why, unless I'm not looking at this correctly, why the new family experience of care coordination measures -- it's a survey, but it's a set of 20 measures, is not listed at all? I understand it's not endorsed, yet, but --

MS. GORHAM: It sounds familiar, so we think that it is --

MS. DOUGHERTY: Care coordination.

MS. GORHAM: -- yes, it's on the, it should --

MS. DOUGHERTY: Oh it is. I'm sorry.

MS. GORHAM: -- under behavioral --

MS. DOUGHERTY: I'm sorry. I'm sorry.

MS. GORHAM: -- under behavioral health.

MS. DOUGHERTY: It is there.

(Off microphone discussion)

MS. DOUGHERTY: It's --

(Off microphone discussion)

MS. DOUGHERTY: Yes. Okay. Apologies.

CHAIR GESTEN: It's okay. As Emily Litella said "never mind". Kevin, did you want something, or no?

DR. LARSEN: I'll save it.

CHAIR GESTEN: Okay.

DR. LARSEN: Just until we get to the overall conversation.

MS. LILLIE-BLANTON: Okay. Question around the 1360, audiological evaluation, no later than three months of age. I just want to make sure there's discussion, or at least we're making a conscience decision, because the issue

with both hearing and vision screening continues to get raised of CMS, and we have trusted this body to say to us, there is no measure that could help us grasp well whether or not children enrolled in Medicaid are getting the screenings they need for hearing and vision. But I just wanted to make sure that we're --- I mean, I'm hearing from NQF they feel like this is a measure that has value.

DR. SIDDIQI: It's --

MS. LILLIE-BLANTON: That's fine.

DR. SIDDIQI: And then to that measure, is that an inpatient measure because the newborn, as part of the newborn screening, and during the hospital, of course, is when that hearing screening takes place?

(No Response.)

DR. SIDDIQI: That's what I -- that's what I thought, okay.

CHAIR GESTEN: It looks to me like inpatient is an unfortunate word to put on the slide for these measures. I'm not quite sure how

it happened, is that all right. It's just, maybe some of them do, some of them don't?

MS. LASH: I even asked that we double check that one, because it seems like, of course, you're not in the hospital for the entire first three months of your life, you can have the screening at a later date. That is what the measure submission form said. We could --

CHAIR GESTEN: And let me --

MS. LASH: There might be opportunities in multiple settings of care.

CHAIR GESTEN: Let me speak for the staff that because they chose some things, which we're going to talk about, it doesn't mean the other ones aren't worthy, or that they're not -- and they clearly are on the list, and they are available for our conversation and consideration.

But how about if we just get the through the slides I've just offered. Get through the slides, their decision making, and then we can revisit that.

I think, you know, Sarah mentioned up

front that this is where they landed, not because it was the sum total of the universe of measures that might be adequate or fill gaps, and so on. So, Shaconna.

MS. GORHAM: And we'll discuss these three measures that staff quote unquote picked, and Nadine and I are taking notes. So the measures that you have brought up, such as the 1360, we'll make sure we go back to the Excel sheet and look at those as well.

Okay. So the first measure that we highlighted is the pediatric all conditions readmissions measure. It is a new measure from the Centers of Excellence, endorsed by NQF. This measure includes all conditions and covers patients discharged from general acute care hospitals, including children's hospitals.

It is an outcome facilities level measure. The data source is administrative claims. There are quite a bit of exclusions to this particular measure and a detailed list of those exclusions are in your Excel spreadsheet.

And so if we want to go there now, and I don't know if it's better to go to the Excel spreadsheet or go through the other two measures? Just --

CHAIR GESTEN: Let's do that. The measures.

MS. GORHAM: -- just go through the other two measures, okay.

CHAIR GESTEN: Yes.

MS. GORHAM: Okay, and then we have the antipsychotic use in children under 5 years of age. That is the NQF-endorsed 2337 measure. So this gives emphasis, giving emphasis placed on the antipsychotic use.

We highlighted two measures in the mental health gap area. Again, it is NQF-endorsed, and it is stewarded by the Pharmacy Quality Allowance. It measures antipsychotic use in very young children. It's a process measure, a health plan level measure with no exclusions.

The last measure, the use of multiple concurrent antipsychotics, is not NQF-endorsed.

It is stewarded by NCINQ. It is a process measure and it would be used in ambulatory settings using administrative claims data. Okay?

So we can actually look at the other measures. I'm pulling my Excel spreadsheet up, as well. So do you want to start? I don't --

CHAIR GESTEN: Well, can I just take a wild guess at the things -- these three things, why staff might have found these attractive and why they're worthy of our consideration, maybe, as the first things to consider.

One, it seems to me, is obviously the NQF endorsement. Two, the readmission measure has analogies and for adults and for other populations and has some alignment with other measures for other purposes, and while imperfect, like all measures, it tries to get at this issue about integration of care and care coordination and follow-up of care and so on, as well as, potentially, resource use.

And the other two are aimed in the direction of behavioral health and filling gaps,

concerns about safety, and again, the fact that these are administrative measures make them, probably, attractive, God bless you, as a -- so I'm just guessing, because you guys are --

MS. GORHAM: Very good guess.

CHAIR GESTEN: Does that --

MS. GORHAM: It does.

CHAIR GESTEN: We were just reflecting what some of the advantages are. Not that they're not, they're not issues; they're not things that we should talk about for the other measures, as well.

So anyhow, I think what we want to do is invite some specific conversation about these three measures and then -- why don't we do that first, and then take up the issue of, is there a better measure getting the same concept? Is this the wrong concept to be getting at and invite other, sort of, nominations, if you will? So, Kevin.

DR. LARSEN: Just to speak a little bit to that multiple concurrent antipsychotics in

children. I'm developing one analog to that for use in electronic health records.

As we went to our expert panels that was viewed as a really important topic in children, especially in children on Medicaid, and it's also something that was measurable.

One of the challenges in measuring behavioral health in general and, especially, behavioral health in children is, there are not very many things that we could find that we could build a measure that we could implement very straightforwardly, and this was, certainly, one of those places.

And as we have talked to various stakeholders about as we've been developing this for the last few years, they've been very interested and engaged in the measure.

It may seem narrow. I'll tell you, it's complex to implement because the way to -- you have to be able to mathematically account for when there's appropriate switching from one medication to another versus when there's

inappropriate doubling up and overlap of medications, and so it becomes a combinatorial challenge. It's not an undoable one. But, before you want something more complicated than this, you might try one of these first.

CHAIR GESTEN: Could I just ask a question that I think people asked before, wanted to know the details about the non-endorsed, and I'm assuming, at this point, it's not endorsed, not because it was rejected, but it has not been --

(Off microphone discussion)

CHAIR GESTEN: It's not been submitted. Do you we know if it will be, or if it might be, or it's about to be, or never will be?

MS. LASH: There's a few moving pieces. We would hope that there would be an opportunity to look at a number of measures, or child health in the coming year.

CHAIR GESTEN: Marsha, did you have -- your card is up, did you have something?

MS. LILLIE-BLANTON: Oh no, I'm sorry.

CHAIR GESTEN: Okay. Jeff and then Terry.

DR. SCHIFF: So I don't -- I'm looking into subject matter experts now, and that could be anybody else in the room, other than me. Is there a relatively short list of the diagnoses that are really driving the antipsychotic use? Like --

(Off microphone discussion)

DR. SCHIFF: What -- I'm sorry. I mean, so like what's, what are people really prescribing these for, is this --

(Off microphone discussion)

DR. SCHIFF: Well that's what I thought, okay. So --

(Off microphone discussion)

DR. SCHIFF: -- so okay. So great.

(Off microphone discussion)

DR. SCHIFF: Well that's what my unsubject matter expert brain was suggesting to me, but I wasn't sure if that was right. And so,

I wonder if we also, maybe not instead of, but also want to be considering if really the problem that we're trying to get at is how we're managing children with ADHD, this feels a little bit, I mean, maybe, relevant, but roundabout, and for, maybe, us to be thinking about that.

DR. LARSEN: If I can make a quick comment? We're also building an outcomes measure for ADHD, based on an AAP guideline that --- where you do a behavioral assessment by parents and teachers on a standardized scale at the diagnosis, and you do the same behavioral assessment after a few months, and it's agnostic to treatment, so whatever treatment parents and doctor would choose, you just see if you achieve that outcome.

People are very excited about it. It's going to be a while before we have enough offices that implemented routine collection of that kind of patient reported outcome instrument for us to be able to rely on that routinely.

We're using the Vanderbilt, as part of

this measure, but there are a number of these around, and it's essentially an objective, well-studied, well-validated scale. And that patient reported outcome model is something we really believe in in overall measure development, but it's going to be a while before those are implemented in a way that we're ready to use them routinely in care, I think.

CHAIR GESTEN: Terry.

DR. ADIRIM: Yes, I just kind of wanted to ask the staff who chose these two, you know, I understand antipsychotic use for children under 5 years old. I mean that's a huge issue. There's no indication, really, for children under 5 to be on antipsychotics.

But, is the reason why you chose the multiple current antipsychotics because it's easy to measure and that's all we have? I mean, I'm not --

MS. LASH: It seemed like a huge red flag, but this is kind of a borderline never event to be on multiple concurrent antipsychotic

medication at a young age. It was just one of those multiple lenses, at which the ADHD care was being examined.

So if there is a measure you feel would be a superior choice to be the complement to the use in children under 5 --

DR. ADIRIM: No, I mean, I think it --

MS. LASH: -- then, yes.

DR. ADIRIM: I think it's a good measure. I think, though -- I can't help but think that there's a limit through how many measures that we can recommend. And so I know last year we prioritized the measures, so -- and it's tough.

But I just have to echo what my colleagues have been saying about really searching for more appropriate behavioral health measures that kind of get at what we're looking at in ADHD, you know. Show our thoughts.

CHAIR GESTEN: So let me just comment on that. So I think we're at a phase now where we don't necessarily have to worry about

prioritizing. I think you're right, Terry, that there's going to come a point where in which we're going to be asking you all to do that.

Recognizing that, it's likely that it will be a limited number that would be introduced to the set. But for right now, I would encourage folks to think about the merit of the measure itself.

And I would just comment that the multiple concurrent is one that we use both for kids and for adults. It does -- the numbers are a little eye-popping, shocking, and so it has some synergy there, in terms of looking at kids and adolescents, as well as adults.

And had some success, in terms of actually making a dent in this, as well, in an improvement program. But, again, that doesn't mean that it's the best of all measures related to the concept.

I would say, in terms of the diagnoses, when we looked for kids, we oftentimes, and adults, frankly, we often don't

see specific behavioral health diagnoses. So, one of the most common diagnoses is none, for seeing this, or nothing clearly that you can associate with this.

And when you talk to a child psychiatrist, or folks, they, you know, may be prescribing it for ADHD, or off-label, or related to symptoms, both for adults and for kids. So I think there was a -- I don't know who's first. Susan.

DR. LACEY: Sarah, can you -- I'm going to go back to after you asked the question, Foster, so how are these being queued up to be -- get on the table at NQF, et cetera? And you said there was some pieces and some parts, but you're not really -- I just want to get a little clarity, because it sounded like things weren't going to move forward on the ones that we were going to propose, in a long period of time, or did I misunderstand?

MS. LASH: No, there are -- there's a lot of variety in the readiness of some of these

non-endorsed measures for implementation. So my recommendation to the Task Force would be that you might -- this is really up to you not me, suggest that a measure like the multiple concurrent antipsychotics is conditionally supported for CMS to use in the program after it has successfully cleared an NQF endorsement review.

It would be my prediction that that wouldn't be complete for the annual update that would take place at the end of 2015, we're already halfway through the year, but that, next year that recommendation would still be in play, and it could give CMS the freedom that they would need to act on adding the measure at that time.

Or, if CMS is comfortable with it at its current stage of development, they could kind of overrule the MAP and throw it in. So there's a few pathways that all of these recommendations can take.

CHAIR GESTEN: Sarah, I may be overstepping here, but I -- my interpretation of

what Sarah just said, based on history with NQF and with measure developers is that having conditional endorsement kind of waves out, yes, we'll use this measure if, and sometimes can be helpful in getting the measure developers to the table of going through the process of getting the endorsement. At least that's my interpretation.

MS. LASH: Sure.

CHAIR GESTEN: So some of the value of the conditional endorsement process, if the group feels it's promising but wants that NQF process to review it may be helpful in getting it to that last stage. Not always, but I think that's part of it. So Anne, Andrea and then, Alvia, all the A's.

MS. COHEN: So this is an area I feel pretty strongly about, and I was going to address Jeff's question about the use of antipsychotics and, kind of, why? I know in the disability field I've seen them used in a number of ways. All five ways. One is, because it's not entirely enlisted development disability or autism, and so

that's, sort of, the first line of trying, because there's a behavioral mental health condition. There's actually a really amazing --- and I'll send this study that I just found about pediatric psychosis out of NYU. It's a child study center. And they look at the actual weight of psychosis in children in use of antipsychotics and how you tease that out. So that will give you valuable background. So that's one thing.

And then, even the seizure disorders have been used to --- looking at antipsychotics, and so that's, kind of, another thing to look at.

In my mind, where I was seeing at the Medicaid level working for a plan, where we had the biggest problems -- and oftentimes and this was true in adults and true in kids, although it looks like increasingly true for children, issues of multiple psychotropic drugs. So I really strongly --- the multiple concurring antipsychotics is really critical for us to look at, because it covers a broader area than just mental health, and I really feel like when we

need the institutional data about what's happening to kids on these meds and we don't have that. And I think that this measure could go a long way to, sort of, promoting the need to study that more on an individual basis.

CHAIR GESTEN: Thanks, Anne. Andrea.

DR. BENIN: Sarah, were there particular criteria that staff used to pull out measures that might help us, if we understood those a little bit, how to think about these?

MS. LASH: Sure. We favored claims-based, or other administratively derived measures, over patient surveys and registry-based measures, and even some that can only be extracted from an electronic health record, because of what we've heard from states and partners, about large scale statewide feasibility when things are derived from those data sources.

We looked at measures that would capture the broad slice of the Medicaid population, so that's why we favored the all condition readmission over the respiratory

conditions.

I'd say, those were the primary drivers. And in some cases, we were looking for measures that were dissimilar from metrics already collected in the core set, so they were, sort of, taking on a real gap area in our new aspect of care that isn't being examined.

DR. BENIN: Okay. That's helpful, thank you. I just, one other framework thing. As I look at these and I tried to think about how to place them in my mind, one of the things that might help me would be thinking about the framework of this list a little bit differently, not super differently, but there are a couple of these metrics that are, where we don't really know what the right answer is metric.

So they're, sort of, a little bit more population healthy in some -- I don't know what the right word is, exactly, but where we don't know if what, it's not -- let me try to be more clear.

With immunizations, we want it to be

100 percent. We're clear what the target is. We may or not ever get there, but we're pretty clear what the target is.

With some of these measures, we're not totally clear what the target is and those are kind of a different type of metric to me, and they're a little bit more epidemiological in some ways and -- or population healthier. I'm not sure what that is.

I think, you know, the live births weighing less than 2,500 grams. That's another example of that. I don't know what the right number is. I'm not even 100 percent sure what we do to prevent it all, but, you know, it's like really multifactorial.

So I guess, I just wonder if there's another access that some of these things should go under that might help us, as we're thinking about the framework, because what bucket am I putting this in?

Like, am I, as a provider -- I mean, I know we're trying to hold the states

accountable for this, conceptually, but like, as a provider, I'm thinking, what am I doing to move this, right?

And so if I think about these a little bit differently ---- and along with that, I guess, I'm wondering if there's a category that, you know, that Medicaid would want to consider that would be almost like a pilot category?

And maybe that's not necessary, because this idea that these are optional anyway, but if we're trying to -- we almost need like a run-in section, right? Like, we need to be able to say, you know what? We're not really going to tell everybody that you should be doing XYZ metric yet because there's not a lot of background data on it yet, but there is all these new measures and we kind of need to start getting people measuring things.

So if there is a -- it would almost be like a run-in section where we could start to get some experience and encouraging people, you know, states to look at those metrics. I think that

will help us in the long run, and it might impact how I think about some of these metrics.

So for example, the readmission metric, that's, you know, it's a pretty good metric. It's a Centers of Excellence metric, but the first thing I think of when I look at that metric is you're going to have it at the state level.

So that's great in a big state, like Texas, or California, but in a small state, you know, you don't know where those patients are being readmitted. So if you're only looking at state level data, you know, I don't know exactly what that means. I don't think we know how that'll play out on a big level, right?

So I look at that from New England and I'm like, I don't know where they're going to be readmitted. And so that's the thing that's always bothered me about that metric. Having said that, it's the closest thing we're going to get to, you know, one of these big player kinds of metrics for children's hospitals.

So I think about these measures in a couple of different ways, and I'm just wondering if there's a little bit of, you know, frameworking that would help us, as we move this forward? I don't know.

CHAIR GESTEN: Great points. Alvia.

DR. SIDDIQI: So looking at the two antipsychotic use measures, I ---- it sounds like, just from hearing experiences from yourself and others that the use of multiple concurrent antipsychotics in children and adolescents makes sense. It's one that we should be looking at.

The second one with antipsychotic use in children under 5, I kind of agree that I'm not really seeing, hopefully, that that's really prevalent in our Medicaid populations.

Whereas, there is a measure that's in the Excel under mental health, measure four, which says follow-up for patients that are on antipsychotics. And I know we're already doing follow-up for ADHD and ADD patients, but I would suggest that we look at that measure in

particular, number four.

Like you said, you know, this one doesn't even have exclusions for seizure disorder patients, for example, where it's rarely going to be actually prescribed by pediatricians and family physicians that are seeing pediatric patients. So I would recommend looking at that, measure number four, in the mental health section.

And the second was the pediatric all-condition readmission measure. I was curious if there's one for ambulatory-sensitive conditions, and I don't think there is one, but that's hopefully where NQF and other stewards are hopefully going towards.

And then looking at the adult set, we know that there's a couple -- one for heart failure, one for diabetes, so it's helpful to know what the top five or ten, readmission diagnoses are for pediatric hospitalized patients and then try and maybe pick out one of those, perhaps? Just to be able to give a little bit

more focus to that specific measure.

MS. LASH: On the readmission measure, I do believe the measure steward was planning to join us to sort of help clarify some of these. Is that line open?

DR. SCHUSTER: Mark Schuster is here, can you hear me?

MS. LASH: Yes we can, please go ahead.

DR. SCHUSTER: So we did look at specific conditions the way the adults did.

So first of all, our measure is very much harmonized with the adult measure, intentionally, because this was all funded by CMS and AHRQ, and the idea was that we wanted hospitals and states that insures everybody to be able to have a common approach to measuring readmissions.

And in terms of the disease-specific -- or condition-specific measures, we did create the lower respiratory infection measure, as a parallel to the congestive heart failure,

myocardial infarction, pneumonia measures for adults.

The one we reviewed ---- quite a long list of candidate measures for condition-specific measures, and the one that panned out was lower respiratory infection, in terms of enough variability and enough prevalence across a wide array of institutions to be able to feel like one that we felt could work at a national level. And clearly, the all-condition measure, also was able to work at a national level. So that is how we came up with LRI.

CHAIR GESTEN: Very helpful, thank you. Susan.

DR. LACEY: In response to that comment, the pediatric all-condition readmission measure, as we know, it's caused a great deal of consternation in the adult population. People really, really, really struggle with it for a variety of reasons.

And so I understand the mindset of marrying pediatric indicators that are aligned

with adult indicators. And I'm not saying that this body, or the Center of Excellence, is saying that that is the majority of reason of why we should have this, but the pediatric all-condition readmission measure seems like almost a fishing expedition in my mind.

And it's like, what are we trying to do here? Because I'm not sure where we're going in the adult land. I think most people aren't, and they certainly are struggling with what to do about it and who's responsible, like the multi-state -- if you live on the state line. So it just feels like the level of specificity and knowledge we have about that, to me, it's premature.

CHAIR GESTEN: Jeff, and then, Terry.

DR. CONVISSAR: I'm just going to speak for my own experience in our organization. The adult readmission measure ---- not obviously just solely in the Medicaid population, but for all of our membership have driven an enormous amount of quality improvement. From things like

palliative care, end-of-life care, to transitions in care and the coordination across settings.

So I don't -- again, I'll defer to pediatric specialists, because again, I mean I don't know that we've been doing that. But in the adult side, I mean, it's driven incredible amount of improvement.

DR. SCHUSTER: So can I jump in here? It's Mark, again. Would it be reasonable for me to respond to the last two comments?

CHAIR GESTEN: Sure, Mark, go ahead.

DR. SCHUSTER: Thanks. So the last speaker really captured what we were trying to do and what we've been observing, which is readmissions, as a possibility, has been ---- and this is all anecdotal, but we've been observing across the country substantial efforts to improve the discharge planning, the discharge instructions, the coordination with the primary care providers, making sure patients are going to actually fill a prescription know how to do it.

It fills like it's driving a lot of

quality improvement and that is, I believe, CMS's -- part of CMS's motivation for having the adult measure and for selecting the pediatric measure to be one of the ones assigned to the PQMP. And I think that we want pediatrics to benefit from all these efforts the same way that the adults are, and that's a big part of this.

CHAIR GESTEN: Great. Thank you, Mark. Terry.

DR. ADIRIM: Mark, can I ask, because my gestalt is, as a pediatrician working in the pediatric emergency department that we in pediatrics do this better than adults.

So I can see, you know, having this kind of measure for adults because they don't -- and this is, again, anecdotal perform as well --- - I mean, not that we're better, but just saying that closing the loop and, you know, discharge instructions, medical homes started in pediatrics and so on and so forth. So do you have data that demonstrates that there's a lot of preventable, you know, hospital 30-day readmissions, that's

number one.

And Number 2, when I first looked at these two measures, I mean, I thought that the pediatric lower respiratory infection readmission measure was probably better, for two reasons.

Number one, you know, there are a lot of asthma, preventable asthma admissions and readmissions, and number two, we now have new guidelines with regard to bronchiolitis where, you know, you can see excess readmissions for bronchiolitis based on those particular guidelines. So I thought maybe you could comment on those.

DR. SCHUSTER: Well, I don't want to seem too biased by my own discipline, but I am thrilled that you think that pediatrics is doing a better job, but I also think there's a lot of room to move.

And so yes, there are traditions of trying to give instructions of patient-centered medical home, but I'm not sure we always do as well as we would like in even informing the

primary care provider that the patient was admitted, let alone that they're now going home and need to be seen the next day.

And I know we often give instructions -- well we do give instructions, but we don't always make sure that the family actually understands them. We don't always have them repeat them back to us. We don't always give them the support that they're going to need once they go home, and so I do think that we have a fair amount of room to move.

We've also got a study that's not yet published because we're still writing it, where we've looked at all of the readmissions at one large children's hospital during a several-month period, and interviewed the parent, the child, if the child's an adolescent, the primary care provider, the attending physician, the primary nurse, the caseworkers, et cetera, et cetera, and it was over 1,400 interviews and found that about a third of them appear to be preventable.

So I do think preventable -- we also

do chart review, so -- but that's, this is not a public forum, so I hope it can still be published by an academic journal.

And so I do think there's plenty of room to move in pediatrics. And so I do think that -- I don't think we're in a position where we can say the adults need this measure and the children don't. If the adults need the measure, I think the children do.

In terms of lower respiratory infections, I think it's -- I think it's a great measure too, you know, we're very proud of what we developed, so I'm not sure what to say there.

Asthma is a condition, which, you know, has higher prevalence, but lower readmission rates -- you know, it's a higher prevalence pediatric condition, but it has lower readmission rates than a number of other pediatric conditions.

So the overall number of readmissions can be high in asthma just because the base rate is so high. I don't know if I said that clearly,

I hope I did, but there are other conditions in pediatrics that have much higher readmission rates, which are captured by the all-condition measure.

CHAIR GESTEN: Thanks, Mark. So I'm -- they pay me the big bucks to keep track of time and to make sure that we get our job done. So I'm looking at the clock and thinking about the fact that we have to lay it -- have a full discussion of the measures on the tables, invite you to put measures on the table, vote on them in some way, and prioritize them before like, 4:15 p.m.

So we have a lot to get to. So the conversation's great, but I just encourage people to be as concise, as possible. Kevin.

DR. LARSEN: Yes, I just wanted a quick support for the pediatric all-cause readmission. We have seen it's really measurable at the national level impact of the adult readmission, it was not without pain, on behalf of, I think, many people involved.

But it -- to the last speaker's point, these are some of the few measures that actually encompass a whole range of people with various needs. And so as we talk to outside stakeholders that continue to tell us, don't pick narrow measures that only measure against a really specific set of people, where is this relevance for me?

And these readmission measures have a high amount of relevance, are often used to drive, not only things like care coordination, but also, integration with community services and supports, and we've seen amazing improvements.

CHAIR GESTEN: Alvia, your card is up, did you -- oh.

DR. SIDDIQI: Oh, so I just had a comment and then a proposal to add a couple of measures to this list.

So the first comment I was going to say is it sounds like the pediatric all-condition readmission rate measure, it does align well with the adult, it is important across the board, but

I do think that pediatric LRI one is also very important.

So I would propose the addition of that measure on the list of us at least discussing, or voting on, again, as an additional measure to propose, recognizing that there are limited resources, but also recognizing that amongst the pediatric population, when you're talking about the top ten hospitalization diagnoses, LRI, you know, is probably number one or one of the number ones, so asthma, bronchiolitis, for this population, so I think it is important to focus on that one in addition to the all-cause.

And then the second was going back to that number four, use of follow-up visit for children and adolescents on antipsychotics. I know it's not an endorsed measure, we are looking at another non-endorsed measure from NQF, but I didn't hear any feedback, in terms of where that's on the pipeline, in terms of through NQF. Are we close, or is it going to be endorsed, and

I would propose, at least, for all of us to vote on those additional two measures, in addition to these three measures.

MS. GORHAM: So just a bit of clarification. There is -- there are two measures in your spreadsheet on mental health. You referred to measure number four, but that is actually not the measure that I think you're talking about.

DR. SIDDIQI: I'm sorry, number five, follow-up visits for children --

MS. GORHAM: So line number five.

DR. SIDDIQI: -- and adolescents on antipsychotics.

MS. GORHAM: Right.

DR. SIDDIQI: Yes.

MS. GORHAM: Okay.

DR. SIDDIQI: Is that close to NQF endorsement, or is it in the pipeline?

MS. LASH: It hasn't been submitted, but we do -- it's our best information that development is complete. So we'll be waiting for

the child health project to open. I think they're all in relatively the same place. There's a group of measures from the same steward.

CHAIR GESTEN: Marc.

DR. LEIB: I can tell you that by focusing on readmissions, you can really drive, as Jeff said, a lot of improvement and lower cost. You get both. You decrease your cost and you get better care all combined, what more could you want? That's ultimate value.

I am not sure if you do the all-cause readmission that would include the admissions for LRIs, why would you then want to segregate those out, as a separate measure, it seems like duplicative work.

DR. SIDDIQI: So I'll just follow-up that I ---- my concern is when we're asking states to report on this -- and again, just looking at all conditions, whether there's meaningful work being done in a specific condition.

When you look at LRI as separate from all conditions, you could have states that would actually focus, possibly, quality improvement when they recognize maybe their all-condition rate doesn't look too bad, but their LRI one looks pretty high. Again, recognizing that the conditions that would be most at top, in terms of diagnoses for pediatric Medicaid populations for hospital readmissions would be around asthma, bronchiolitis readmissions.

CHAIR GESTEN: Andrea.

DR. BENIN: Process question, are we going to be block voting or individually voting on these?

CHAIR GESTEN: I would propose that we individually vote on these when we get to voting.

DR. BENIN: All right.

CHAIR GESTEN: I think right now we're still kind of --

DR. BENIN: Oh, I'm just --

CHAIR GESTEN: -- trying to get a sense of whether these --

DR. BENIN: I just wanted to make sure --

CHAIR GESTEN: -- should stay on the table, what other things do we want to put on the table.

My suggestion would be, we did have -- unless there's any other burning comments that you want to make about these three, there were other measures that were not prioritized in the last round that we had that we might want to go back to briefly.

Two of the three are the ones, I think, we're going to take up tomorrow when we talk to adults because they relate, as well, to pregnancy, exclusive breast milk feeding, and delivery of under 1,500 gram infants at the appropriate level of care.

But we might want to just have a brief conversation, or refresher course, in the dental sealant measure, which was one that, again, was put on the table last time, didn't make the -- you know, the MAP top three or four list, but we

might want to take it up again right now and just have a discussion.

And then my suggestion is that people, you know, put things on the table that we'll ---- I hope we're keeping track of over here, and then at some point there will be some voting, we can get a chance to prioritize. Does that sound okay, could we do that?

So dental sealants, do you want to say something about the measure, introducing --

MS. LASH: I can do that. If you look at your tab above the current child core set -- pardon me. You can see the measure of sealants for children at the lower age range.

Essentially they are two separate measures because they're designed to capture the first and second set of molars, and CMS chose to add one, but not the other.

They had, I think, a combination of drivers for that decision, including there was a sort of statutory requirement that they specifically look at that first set of sealant

application.

And there was some discussion within the MAP that, if you are doing quality improvement around sealants, we would be hoping that behavior change would affect the second application as well.

So when we ranked last year's priorities for addition, the younger age group came out ahead of the 10 to 14, but it would still be in play for this year, if the group thinks that we need to have more oral health measurement. Anne?

MS. COHEN: So I have an oral health measurement area, and then, I also have an additional one to add that we had on the list, but has seemed to be falling off in the conversation, so which would you like me to address first?

MS. LASH: Why don't you start with the oral health?

MS. COHEN: Okay, so oral health among kids with disabilities, in particular,

developmental disabilities, is a huge challenge, and they frequently don't get it. And I don't know whether this measure, exactly gets at their needs, or not. If it does, it needs to be stratified for this population at minimum.

A big issue is the need for general anesthesia in some kids with disabilities who need specialized equipment and chairs and, it just ---- it just falls off the list. And so I don't think there's a specific measure, but there really needs to be a focus within CMS to look at this because it's one of the number one preventative health issues with the population.

So that's one, and then there is an ADHD measure that was behavioral health intervention before medication, I thought?

MS. LASH: Yes, it's our --

MS. COHEN: Okay.

MS. LASH: -- frontline behavioral therapy.

MS. COHEN: Yes, and I think that I am, sort of, advocating for considering that to

replace the ADHD measure that has been problematic.

MS. LASH: The follow-up --

MS. COHEN: Yes.

MS. LASH: -- care measure. Okay. I think that's noted. Okay.

DR. LARSEN: Just to ---- again, quick alignment. The breast milk feeding is in the Meaningful Use hospital measure set, and the dental sealant is in the Meaningful Use pediatric set for data collection under the EHRs.

I can look quickly -- I think we didn't split it by age group the way you did here, I think we might have done the whole thing, but I'll take a quick look.

Another measure that we might consider -- again, it's only been specified to date for EHRs, is cavities in children. And so it's an outcome ---- an oral health outcome measure that just asks to count cavities. And then, you count cavities every year and you determine what range of follow-up and services have lead those

outcomes, or not lead to those outcomes.

Whoever we ask to count the cavities. So it could be the dentist, it could be the primary care doctors, the measure is agnostic to the cavity counter.

It can be used with dental claims, and so every time a claim for a cavity comes through, it can work that way, but kids have to have access to a dentist in order for you to actually be able to count the cavities. So it's also specified for pediatricians to be able to count cavities and use that as an outcome.

Now again, it requires a new data source, because if kids aren't getting any oral health care, you're not actually going to know which of them had cavities, but it's an outcomes measure.

DR. WHITE: I do have a question, or maybe a clarification, from Anne -- from Anne Cohen, on the recommendation for the frontline behavioral therapy prior to antipsychotics for children with ADHD ---- it's for children with

ADHD.

So are we proposing that we will be able to find the treatments within our claims coded data, so that there will not be a need for medical record review?

MS. COHEN: You know, I don't know if I had gone that in detail. I wanted to just discuss it, because I know that the existing measure wasn't something that seemed to be responsive.

And I know from Dr. Gee, one of the things she suggested is looking at intervention before medication, so that's more what I was looking at. I think that it's worth further debate whether that's an inappropriate measure, but I wanted to highlight it as a need.

DR. WHITE: You know, I think that we should also understand that there are some other pressures around the use of antipsychotics, or the diagnosis of ADHD in children. I mean, there are socioeconomic, or certainly potential for secondary gain, with this diagnosis.

It is a diagnosis where there could be an application for social security disability, or SSI, so I think that we really must keep this in mind, as we think about this measure, and the number of children that has this diagnosis and that is receiving treatment.

CHAIR GESTEN: So the Chair needs a little orientation, sorry. Are we at the point of folks suggesting specific new measures, in addition to the three, in addition to, potentially, dental sealants?

MS. LASH: Yes. So the flip chart behind me was my running log of measures people wanted to revisit over the course of this prior discussion.

So I think that we would want to individually take up the three staff picks, the sealants measure, and everything behind me.

CHAIR GESTEN: Okay.

MS. LASH: So it's gotten to be quite a long list.

CHAIR GESTEN: So some of the things

behind you, so again, I would encourage us, for right now, we'll have a conversation, I think, about gap areas, about what the measures don't do.

Right now, I think, our challenge is to say what other measures that we have had a chance to look at the specifications, again, not in development, although, certainly, measures that haven't been NQF endorsed, are on the table, but what other measures, particularly, measures that relate to identified gap areas, should this group put on that table for eventual voting, along with those other ones?

MS. LASH: And I can review it --- if you can't read it.

CHAIR GESTEN: Okay. Terry.

DR. ADIRIM: Can I just ask a question? Can you just review, very briefly, the exclusive breast milk feeding measure?

MS. LASH: We're planning to discuss that tomorrow morning. That is a Joint Commission measure that goes in a bundle with a

C-section and a few other birth outcome oriented measures.

We are revisiting it tomorrow with the whole perinatal discussion, because the Joint Commission has recently made a pretty significant change to remove the subset measure you see described in the measure title. So we'll have to put a pin in that one.

CHAIR GESTEN: Jeff.

DR. SCHIFF: I think if you're asking, are there other things we want on the list to discuss, it's that CAHPS one about availability of behavioral health services. Is that there? Oh, there you go. Sorry. Thank you.

(Off microphone discussion)

DR. SCHIFF: Yes.

CHAIR GESTEN: Other suggestions of specific measures that folks want to be sure is on that list, because I think what we're going to do after we exhaust the list, is potentially take some votes, get a sense of the support for each of the measures, assuming they even may get lots

of votes, then we'll think about whether we need to, or want to prioritize, depending on how many, what kind of support there is, the measures.

Is the hearing, hearing's on there?

(Off microphone discussion)

CHAIR GESTEN: Yes, okay. Susan.

DR. LACEY: So that newborn hearing screening, is that what you're talking about?

(Off microphone discussion)

DR. LACEY: Is that a --

(Off microphone discussion)

DR. LACEY: -- before three months.

(Off microphone discussion)

DR. LACEY: Would a follow-up --

(Off microphone discussion)

DR. LACEY: Yes, I didn't hear follow-up at the beginning, it's just a screening. So is that a state-by-state mandate? I thought that was --

(Off microphone discussion)

DR. LACEY: I thought that happened. I'm, so maybe I was --

DR. ADIRIM: Right. So that was my point, Marsha. I think when you --

(Off microphone discussion)

DR. ADIRIM: -- when you're talking about hearing --

(Off microphone discussion)

DR. ADIRIM: -- screening, and the pediatrics population's different from the inpatient side of things, in terms of newborn care level, I think, it's pretty much universal. But I think what you were getting at was hearing screening for older children, so --

(Off microphone discussion)

MS. LILLIE-BLANTON: But it said inpatient, so I mean, I think it is inpatient, so I'm comfortable with it, if it really is inpatient and only inpatient.

DR. LACEY: Okay, wait. So, Foster, could you --

CHAIR GESTEN: What, go over the measure?

DR. LACEY: Yes, can you just --

CHAIR GESTEN: What it is?

DR. LACEY: -- synthesize what was said here, so we know what we're doing?

CHAIR GESTEN: So do you have the measure in front?

MS. LASH: I do.

(Off microphone discussion)

MS. LASH: We're on the inpatient tab, Row Number 4, audiological evaluation no later than three months of age. Assesses the percentage of newborns, who did not pass hearing screening, and have an audiological evaluation no later than three months of age.

CHAIR GESTEN: So it's actually more, it's both. It's both screening, not passing the screening, and then having a follow-up within three months. So it's not just the screening, as was mentioned, which is, I think, currently -- well, in many states, maybe all states, requirement for newborns. But it's the next step. If you failed the hearing test, did you have an evaluation within a certain time frame?

Does that help, Susan?

DR. LACEY: Yes.

MS. LASH: It's the CDC's measure. They have noted multiple care settings, so the hospital, as well as ambulatory care, and a multiple levels of analysis that which this could be applied, including individual and group practice clinicians, facilities, and national and state populations.

DR. LACEY: So then, can I ask Kevin, where we are on, on this measure, in your --

DR. LARSEN: So in Meaningful Use we have the hearing screening, prior to hospital discharge. I don't know about this follow-up, we have not done an eMeasure for this additional follow-up after hospital screening.

We've been building a related measure around visual screening in the outpatient office and had a number of discussions about whether or not to include the follow-up responsibility in that.

And most of our expert panels say that

that's a much bigger leap to track all of the appropriate follow-up than to just assure that the screening and treatment has happened, so most of the expert panels have told us to put those into two measures and not try to lump them all into one.

CHAIR GESTEN: Any other questions about that measure?

(No Response.)

CHAIR GESTEN: Thank you. Again, any -- go ahead.

MS. GORHAM: Oh, I'm sorry. I wish I had my notes with me. We actually, another project that I am involved in, we actually had CDC here last week, and so that measure was one measure that we reviewed and that is on our CDP side.

So they were actually up for maintenance, and the Committee, after hearing the scientific evidence and reliability and all of that, went through the measure and we are actually continuing endorsement.

And we brought up some really good points about the measure, so as you all talk, I'll kind of see if I can find my notes on the computer and see if I can add anything additional.

CHAIR GESTEN: So I don't, when we start voting everyone gets nervous, I get nervous, so before we start making people nervous about voting, I want to make sure that the plate that we set, in terms of things we're going to vote on, looks right. That the folks aren't holding back recommendations for discussion.

Although, again, after we vote we can also put something else on the table. I think it doesn't -- things don't conclude until we've done some prioritization and we go home and that is not, we're not there, yet, and so --

DR. ADIRIM: SO what specifically are we voting for?

CHAIR GESTEN: My suggestion would be that we look at each of the ones, individually, the ones that were teed up by NQF staff, the

ones, if there's a specific measure up there that relates to the -- either the issue, or specific measure.

And my suggestion to the group would be that we have, by show of hands, see how much support there is for each measure. And then, once we see how the measures play out, then we can talk about prioritization process, if necessary, right, assuming that there's lots of measures that gets lots of support that, which may, or may not happen.

DR. ADIRIM: Can I add to that?

CHAIR GESTEN: Yes.

DR. ADIRIM: Going into the vote, I actually want to be pretty crystal clear about whether we're voting for immediate use by CMS, as full support, or whether there would have to be some type of condition placed on the measure before it would be ready for use?

(Off microphone discussion)

DR. WHITE: -- and how many total measures are we voting for?

CHAIR GESTEN: As many as we want, right now. So as many as are teed up, so we have the three, we have sealants, we have hearing, we have CAHPS, we have a follow-up on the antipsychotics, we have the lower respiratory, and cavities.

DR. LACEY: Last time --

CHAIR GESTEN: Go ahead.

DR. LACEY: Last time, we did this differently. We, can somebody remember we got three votes, it seems like we were able to vote for three and then we had, and we were able to get the top three. I mean, it worked out really well, so could we, maybe, either do that again, or -- because it sounds like we're doing it differently this time.

CHAIR GESTEN: We are, we talked about that, and we can do it that way, as well, where you get three votes and put stickers up, I think is how we did it last time.

I guess, I was thinking that if there were measures that, I was thinking that we might

want to vote on these individually, and then, do prioritization next, and do this in two steps. I can't recall, exactly, why we did it the way we did it, previously, but I'm open to an alternative suggestion about how to do this.

DR. LACEY: I don't care, but I don't understand how many that I get to vote for, one of all of these long lists, I can vote for all of them?

CHAIR GESTEN: I am proposing that you can vote for any of them. Not voting, voting for it, obviously, says that you're supportive of it, not voting for it says you're not.

DR. LACEY: Correct.

CHAIR GESTEN: And that, by virtue of counting up the votes, we would get some sense of how the group feels about the prioritization, or which ones have more votes. Depending how that turns out, we might then want to do a prioritization process, as a secondary step. Again, just a proposal, it's not, I'm --- In terms of Sarah's, your comment, what we can do is

we can vote each one as unconditional support, conditional support, or no support, I guess, in order to tease out that issue, unless you have another idea?

MS. LASH: Can we tell you that, I really suggest we take one vote per measures, but that there's a motion from the Task Force to say I propose measure X, Y, Z, to be added with full support. Or, conditional support, pending endorsement.

CHAIR GESTEN: Okay. So you want a specific nomination for each measure?

MS. LASH: I would like someone to try to put a stick in the stand --

CHAIR GESTEN: Okay.

MS. LASH: -- on each one, and we can react to that --

CHAIR GESTEN: Okay.

MS. LASH: -- and see how close we are.

CHAIR GESTEN: Lots of cards up, so let's, we're talking about process, I don't know

whose was up first?

DR. LEIB: I'll let Jeff go first.

CHAIR GESTEN: Jeff, we'll do Jeff, Marc, and then, Alvia.

DR. SCHIFF: So the ones that are on that list, the staff didn't pick. You guys are really smart. I know this stuff. I'm wondering, if before we vote, because some of those things are things I'm, like, you know, drawn to. If, perhaps, you all could, sort of, share with us what the challenges were with those, I didn't get them, sort of, to meet your guys, sort of, picks. So that's -- informative type thing.

MS. LASH: Sure, let me try to do that quickly. The first measure on that list, surveying the family about their experience of care coordination.

I haven't seen a lot of states with a lot of extra capacity to do survey-based measures. That does not tend to be like a nice plug and play. But, if you're interested as care coordination, as a gap, feel free to vote for it.

This front line behavioral therapy for ADHD was not a staff pick, because we thought we already had a measure of ADHD, it's only today's conversation that really brought to light some flaws with people's perception of how narrow that measure is.

Hearing screening was not on MAP's list of gaps that we were aware that you were interested in, but we've heard a lot of good justification for why that might be a priority.

Whether states are publically reporting on CAHPS results related to behavioral health access. Again, relies on the administration of the survey, so potentially less feasible.

Follow-up appointments for antipsychotics. I already described that we looked at the polypharmacy measure, as a different lens on that, and we didn't want to overload the list with antipsychotic measures, although, there were many that were potential.

Lower respiratory readmissions. We

went for the broader and, kind of, cavities, we were not aware of. Do you want --

DR. LARSEN: Let me just, I'll give you the details. There aren't very many, but it's Measure CMS 75. That's how it's counted in the Meaningful Use Program.

Its name is children who had cavities, or decayed teeth. It's children ages 0 to 20 years, with a visit during the measurement period, who had cavities, or decayed teeth, with no exclusions, or exceptions. It's part of the Meaningful Use Core Set of measures for children.

CHAIR GESTEN: Marc.

DR. LEIB: Just a question, in order to move a measure along, is it a simple majority, or is there a simple majority required?

CHAIR GESTEN: So great question. So my notion was that we're just counting votes, as a measure of the degree of support, not necessarily a pass, fail, or do we want to move it forward?

And it's, certainly, conceivable that

if everybody voted for something that we would say, we don't want to recommend it. But I would think, unlikely, if half, or less, then we might need to have a discussion about whether it goes forward, or not.

But, I wasn't thinking, at least, in this first round that it was anything more than just, kind of, gauging the amount of support for each measure.

MS. LASH: Or taking the stronghold and maybe we shouldn't do the support, conditional support nuance. That would give it a little bit different tone of a more formal recommendation where we --

CHAIR GESTEN: Okay.

MS. LASH: -- would need greater than 60 percent. That's eight of you.

CHAIR GESTEN: Okay. Alvia.

DR. SIDDIQI: I just wanted to, I felt the need to, to clarify my comments about the hearing screen one, in particular, but also, again, looking at all these measures, one of the

key areas of gaps for our pediatric core set has been care coordination and measures that really talk about the outcomes of care coordination and whether that's occurring.

Looking at the fact that CMS is now proposing Medicaid managed care rules, network adequacy, all of that does come to play in that Hearing Screening I, if you're looking at follow-up for an abnormal screen within three months. So I do support that one.

And, again, follow-up for antipsychotics I think, again, speaks to care coordination. So I just wanted to make those comments on that.

CHAIR GESTEN: Susan.

DR. LACEY: I'm back to the hearing one. I just want to be sure. That seems like a pretty busy measure, if we're going to do initial recommendation for intervention, or what have you, and then a follow-up, all captured in one thing. So to meet the mark, you have to hit all three of those subsumed within the one, right?

CHAIR GESTEN: Correct. That would be my understanding of the measure.

DR. LACEY: So that's what we're voting on?

(Off microphone discussion)

CHAIR GESTEN: That's what that measure is.

DR. LEIB: I don't read the measure that way. I read the measure as of all the newborns, who failed the screening. What percentage of those who failed went and had a follow-up evaluation within three months.

DR. LACEY: That makes sense.

CHAIR GESTEN: So that --

DR. LEIB: That is what I, that's my reasoning I make, right --

MS. LASH: That makes sense.

DR. LEIB: I could be wrong.

CHAIR GESTEN: But does that mean if you don't screen you're, you're not in the measure?

(Off microphone discussion)

CHAIR GESTEN: Is that the way that --

DR. LACEY: It's a universal --

CHAIR GESTEN: Is --

(Off microphone discussion)

DR. LEIB: Yes.

(Off microphone discussion)

DR. LEIB: Yes, screening is fair. I mean, it's required by state law on --

CHAIR GESTEN: So it's screen, you have to get the result.

DR. LEIB: It fails.

CHAIR GESTEN: You have to get the results and then you have to get information that says whether a follow-up happens.

(Off microphone discussion)

CHAIR GESTEN: That's -- right?

FEMALE PARTICIPANT: There are two parts to it.

CHAIR GESTEN: Okay.

(Off microphone discussion)

CHAIR GESTEN: There are two out of three. You're saying the third, the screening is

presumed?

(Off microphone discussion)

CHAIR GESTEN: That's what's called a gameable aspect to a measure. So --

(Off microphone discussion)

CHAIR GESTEN: -- Carol, then Sandra.

MS. SAKALA: Could you, please, asterisk the measures on that list that are NQF endorsed?

CHAIR GESTEN: Sandra.

DR. WHITE: Since we are adding measures for the child core measures, I wanted to be sure that I didn't miss my opportunity to talk about a population, children are considered under the age of 18, or 21, is that correct?

(Off microphone discussion)

DR. WHITE: Under the age of 21, okay. Well, if we're adding measures, I know that this particular measure falls under the maternal and perinatal health. Or, the population that I have the most interest in is children, or teens.

So I want to open the conversation

today, even if we must put it until tomorrow, peer literature review support that it is important for women to have access to LARCs immediately after delivery.

And when I read the measures that is in the perinatal tab, it is measuring the access to LARCs within 99 days. That does not get at the issue of having access to access to LARCs, immediately postpartum.

So what I'd like to -- well, first of all, I believe, that the literature supports that LARCs, immediately after delivery, is of value, it's valuable. The greatest barrier to initiating this is because of reimbursement. And that is because the state pays for pregnancy, as a global fee, and for all of its related care.

So what would need to occur is for the state to be the convener, the catalyst, as well as the change agent and reimbursement for postpartum contraceptive services in the in-patient setting, so that the physician is reimbursed for the education and the procedure,

and the facility has the device stocked within the pharmacy.

This is important because teens, or adolescent pregnancy -- that's ages 13 to 21, 12 to 49 percent of them are pregnant again within one year.

And if we are looking at reducing NICU stays, we are looking at increasing interpregnancy intervals, we are looking at decreasing the risk of pre-term birth and low birth weight and the indirect cost of teen pregnancy, then we must seriously consider having LARCs available to women, particularly teenage and adolescent women, immediately postpartum, and that is within three days of birth.

CHAIR GESTEN: So, Sandra, are you proposing a specific measure?

DR. WHITE: Yes I am.

CHAIR GESTEN: Is it in --

DR. WHITE: I'm proposing a modification to the measure that is already on the maternal and perinatal tab. I'm proposing

that we have three submeasures, a submeasure A, submeasure B, and a submeasure C.

Submeasure A would the three-day post-delivery of being able to receive a LARC, with these changes by the state for reimbursement. And then, the other measures, as stated within the measure that's already there.

CHAIR GESTEN: Okay, just a process question, we'll be taking up this measure tomorrow?

MS. LASH: Tomorrow, mm-hmm.

CHAIR GESTEN: Okay. So we'll, as you say, put a pin in it for tomorrow, or whatever --

MS. LASH: Yes.

CHAIR GESTEN: -- whatever that terminology is.

MS. LASH: We certainly want to have the conversation with both groups about, I think you were making a very strong case, this needs to be in the child core set, in addition to the adult core, and so we want to, specifically, take this up with the group present.

DR. WHITE: Thank you so very much.

CHAIR GESTEN: Anne.

MS. COHEN: So I know there's a lot of confusion about the -- screening one and I wanted to add on, and I'm sure people have thought about this, but I think that we're all clear that kids are screened at birth.

The issue is the follow-up. And I think this one gets the fact, as to whether states are utilizing EPSDT services for the hearing screening component.

And there was a study done in 2010, there's been involved studies that most states are not fully utilizing all the EPSDT screens, and one of them that was highlighted was hearing. And that's what that gets at.

And there's a whole article about the National Health Law Program that comes in, Sarah that backs up why the rationale for doing that measure actually, kind of, makes sense.

CHAIR GESTEN: Great. I don't know who was next, Andrea.

DR. BENIN: Oh, just for clarification. It looks to me as though the behavioral therapy for ADHD metric is depending on the paper medical record, electronic medical record, so it looks like it's based on medical record review. I'm wondering, if that's why you had taken it off the list --- originally? So now I'm a little bit more confused as to what I, my opinion, about that metric. Are we, are we shying away from metrics that rely on record review, or we, like, do we have a global opinion on that, are we --

(Off microphone discussion)

CHAIR GESTEN: Well, Susan's not there. Marc, do you have your --

DR. LEIB: I just have a follow-up question for Anne. When you said not utilizing EPSDT services for hearing screenings, do you mean not paying for it separately, or not doing it at all?

MS. COHEN: There's a lack of awareness, in relation of that category, of that

-- category. So for instance, the state level might be aware of it, but at the provider level it's not happening, or they're not aware that there's an opportunity to bill for it, under that specific program, or there's just not utilization of the services.

DR. LEIB: Oh, you're not talking about the newborn screening, because that's required --

MS. COHEN: No, not talking about that, so --- So the concern, initially, from Susan, was that the measure was really too complicated, right? And so the idea is you have to figure out, who wasn't screened, and if they weren't screened, did they get the follow-up in all of the events?

And to me, what I read about that measure is, ideally, under the EPSDT Program, you're going to know, these are the kids that did not, that failed the reviewing test.

So if they failed the hearing test, did they actually get the follow-up screening and

treatment? And that's what I mean about that not utilizing the EPSDT category, is that second part.

CHAIR GESTEN: So before we get to other questions, Shaconna, you have something you want to add to this measure, this hearing measure, itself?

MS. GORHAM: So specifically for the 1360, as I said, we reviewed it last week in our ENT review, so this measure is a follow-up to the newborn hearing screening measure, an evaluation by audiologists, to determine whether there is a hearing problem, or not, so it is the screening and actual evaluation. Excuse me.

There are variations in the state requirements for audiologists to report this data. There's definitely opportunity for improvement, as the 2012 results were 69 percent.

(Off microphone discussion)

MS. GORHAM: Sixty-nine percent and, yes, as the measure is written now. And there are disparities and follow-up after initial

screenings, and we talked about that, as well.

The Committee voted 100 percent to continue endorsement for this particular measure, because they thought it was really important, with no conditions, so --

(Off microphone discussion)

MS. GORHAM: Per Committee conversation, the measure is really important.

CHAIR GESTEN: Alvia.

DR. SIDDIQI: So two quick things, one just going along the lines, again, about the hearing screening measure. If you have an abnormal hearing screening in the hospital, after the newborn screen, that is a code. That is something that can be easily captured.

I think the challenge will be getting that audiologic evaluation follow-up code, but again, it's something that I think, 69 percent is really sad. I think, us, a lot of the pediatric providers around this corner are frustrated by that one, so I strongly recommend that.

Now the second thing. Sarah, I know

you had said, even if it's not NQF endorsed, there's some that are on the pipeline, they're complete, they're, sort of, pending NQF, could you put like a P next to those, for another symbol?

MS. LASH: I don't think any of the measures we've discussed are --

(Off microphone discussion)

MS. LASH: -- still in an early stage of development. Maybe Kevin can --

DR. LARSEN: Yes the --

(Off microphone discussion)

FEMALE PARTICIPANT: -- you said it contains the follow-up antipsychotic one.

CHAIR GESTEN: Actually, while we're giving you work to do, these three, it would be helpful if we could --- to refer to, because we are going to vote very soon. So but they're not up on the board, and maybe that's a good place to put the votes.

MS. LASH: Okay.

CHAIR GESTEN: So those three, maybe

should go on there, along with sealants. Kevin.

DR. LARSEN: Yes, I'll just say the children who have dental decay, or cavities, there is an NQF endorsed measure in that space that measure that is in the EHR incentive program is a modification of the endorsed measure, and the modification is to expand the age range, it only went up to 17, we went up to 20, and to change the data source to the EHR from what was a population health survey measure, phone calls to the parents.

So it's structurally nearly identical to the endorsed measure, other than those two minor modifications and, it's again, been in the program for three years now.

CHAIR GESTEN: Marc, did you -- your card's up.

DR. LEIB: Okay.

CHAIR GESTEN: Jeff.

DR. SCHIFF: I have a question about, just the experience of care coordination if it, whenever that's the right time, is it now? Okay.

Is there someone who could explain what that -- I mean, it looks like there's 19 domains, and we were having trouble with the assessment of behavioral health, with five, like, really obviously important things. So could someone just could --

CHAIR GESTEN: Make whoever nominated it to explain it to us?

DR. SCHIFF: No, I'm not looking to call anybody out, I'm just wanting to understand, so I can know how to vote.

CHAIR GESTEN: Okay. Denise, experience of care.

MS. LASH: Yes, you were speaking in favor of the experience of care survey earlier.

MS. DOUGHERTY: Yes.

MS. LASH: Any further rationale, as to why you'd like to see it added?

CHAIR GESTEN: Or, Jeff, did you have a specific questions about its components, or testing, or validation, or limitation issues, I'm not sure, all the above, none of the above?

DR. SCHIFF: Yes, I mean, and maybe I'm just against, and I'm not sure if it's for Denise, or, like, that measure, you know, sort of, through the rubric, if you will, of decision making that has gone on, and I understand, you know, claims data versus medical record review, that's simple for me to understand, you know, how does this one, with all of those dimensions, you know, the point of views.

MS. DOUGHERTY: Well this is -- there's a lot of concern about children with medical complexity and this is built on top of a pediatric medical complexity algorithm that has been published.

And this has been very widely tested and it's being used in a couple of CMMI projects, to measure outcomes for kids, who are medically complex. So it's already being used. It's very well tested. The publications aren't out, yet, but it's -- so we had a webinar on it and there were lots of interested people.

CHAIR GESTEN: Sepheen, antipsychotics

seem to clarify the pipeline issue?

MS. BYRON: Hi. So there has been some questions around antipsychotic measures, whether they're done being developed and whether they're endorsed, and that sort of thing, so I just wanted to speak to that.

I'm with NCQA, but NCQA is the lead of the -- what you see as NCINQ, the Center of Excellence, under PQNP. So the antipsychotic measures are complete. They have been developed. They've been specified at a state level.

They've also been specified at the health plan level, in terms of alignment, and as Kevin was noting, one of them is also specified for EHRs, and that's the multiple concurrent measure that you see here, the NQF staff had highlighted.

They were just finished completion of developments, so they haven't been submitted for endorsement, and there hasn't been an opportunity, yet. So it's not that they've been submitted and rejected, or anything like that.

It's actually a suite of measures and, maybe, NQF can speak to why they chose one over the others, but what I will explain, because I think there were some questions among the Committee, is that we developed them, really, with sort of a logic in mind.

So really we have some that look at appropriateness and overuse of antipsychotics in kids, so multiple concurrent use, which is in there now, it's a lowest better measure. That's one where we, we will aim to, you know, avoid use, when possible.

We also have a measure that's on the list that looks at the use of psycho social care as first line treatment. And so that measure says, if you don't have a primary indication for antipsychotics, then did you try psycho social care, as a first line, before putting kids on medications? So that's another, kind of, appropriateness measure.

And then, the follow-up care measure, which you guys highlighted, says that you have a

follow-up visit, if you're on an antipsychotic. Another measure that was brought up was the metabolic screening and the metabolic monitoring measures.

So this is because metabolic effects are really pronounced in children and adolescents. And because that can have such an impact on their development, we develop the measures that say, did you get baseline screening, if you were put on antipsychotics within a defined period of time.

And then, also, if you continue to be on antipsychotics, did you have follow-up visits. And then, there is one about the very young and then there's one more that looks at higher than recommended dosages, if you're on antipsychotics.

And I know I went through those really quickly and I apologize, because I have to leave in a few minutes. But, I just wanted to lay that out, so you understood that these were all developed and complete.

CHAIR GESTEN: You got a question for

Sepheen?

MS. COHEN: Yes. Given how you highlighted that, and that makes it much more clear, as to the intention of NCQA in developing them.

MS. BYRON: Yes.

MS. COHEN: Given the fact that they're looked at, as a suite, breaking them up, is that possible? And if it is possible, which one would make the most sense to get at that, sort of, category of mental health drugs?

MS. BYRON: That's a good question. So they are a suite. It is possible to break them up, because I understand that, you know, burden's an issue.

I will note that they're all developed for administrative claims. So they're all administrative measures, so feasibility around these measures is really good. Having to choose among them is very difficult, because they are like my children.

But, I will note a couple of things

for consideration. NCQA looked at these measures for the HEDIS Health Plan Measure Set and considered them for HEDIS and chose three of them across, sort of, those different topic areas.

So multiple concurrent is in HEDIS, because that one looks at a very important topic area of whether kids are on, you know, more than one for a sustained period of time.

They also chose the metabolic testing measure, although, I would advocate for both the screening and the testing, because I think that baseline screening establishes the relationship with the provider, and then the testing says that you have an ongoing relationship there.

And then the access to psycho social care as a first line treatment was also added to HEDIS. And so if you're thinking about alignment, you know, these measures that health plans are going to be reporting on, and then, one of them is also being e-specified, and so that would be first states. So.

Which one's what, I'm sorry?

HEDIS passed --

CHAIR GESTEN: Which was e-specified.

MS. BYRON: Oh, e-specified, the multiple concurrent. Oh, so --

CHAIR GESTEN: So thank you, Sepheen. So this is difficult. This is our children and grandchildren, in Denise's case, that we have to vote on, so again, it creates some of the challenge, but that's what we have to do. It's that time of the day where we have to do this.

So one of the things, looking at your note that says eight votes get us consensus on a measure, right? So one of the things we might want to do, we've got 20 minutes, or so to do this, maybe we should vote on each measure and see if we reach consensus. And then, among the measures we get consensus on, then do a prioritization process, does that make sense?

Which means that we have to address this issue of, for each measure, are we posing it as a as is versus conditional? And I'm not quite sure how to handle that, except, unless we want

to do a default, being -- well, do you have an idea?

MS. LASH: I would propose a default as full support, if it's NQF endorsed, and conditional support, pending endorsement, if it isn't. Other conditions, we sort of asked, you suggest those, before we would vote on each one. Nominate them, you want a nomination?

CHAIR GESTEN: Before we, we'll take it from the top. We'll take it from, I don't know what the top is --

I'll start with these, but before we start the voting, I want to make sure people understand a) what it is that we're voting on, what their vote means.

So eight votes means the Committee hasn't endorsed it, suggested it, it doesn't mean that it would then, after we gather all the votes, we may then do a prioritization process. But that's what you're voting on to do.

We're going to go down the list and see how many of the measures pass the eight. And

if anybody has a burning question about what the measures are, what it means, now is the time to, now is a good time to ask your last question about it.

DR. LACEY: And we can vote as many times as we like.

CHAIR GESTEN: You can vote as many times as you like.

DR. LACEY: Or not at all.

CHAIR GESTEN: Or not at all. Okay. All right, so somebody want to, for pediatric all-condition readmission measures, somebody want to nominate it?

Okay, and do we have any seconds?

Second, okay. So by a show of hands, folks raise their hand, if they're in favor of this measure. I vote? I can't remember. Yes?

MS. LASH: Yes, I thought --

CHAIR GESTEN: Full endorsement is what we're voting on.

MS. LASH: I thought we were voting yay, or nay, on full support. One, two, three,

four, five, six, seven, I count nine votes for full support.

CHAIR GESTEN: Okay. And we don't have to take any votes of no's, but we might want to, out of interest, ask Andrea, what was your condition?

DR. BENIN: I would conditionally support this, the condition being that there is attention paid to the ability to look at data across states and to further understand what that really means, because I actually don't, I think that it's really problematic to look at it just state by state --

CHAIR GESTEN: Okay.

DR. BENIN: -- but that we need to be able to, moving forward, be able to develop an understanding of what the real implications are for the metrics.

CHAIR GESTEN: Okay. I'm going to take and suggest that we note conditions that folks want to make after we have a vote. Sarah. And if a measure does not pass then somebody, as

full endorsement, then somebody could propose a conditional endorsement and describe what those conditions are, does that sound right?

DR. WHITE: I'd like to make a comment. Yes, I think that if this measure's going to follow the adult measure that is the all-conditions readmission, the adult measure also has conditions on it. For example, readmission for chemotherapy. I mean, there are exceptions.

CHAIR GESTEN: There are --

DR. WHITE: -- there are already exceptions to the --

CHAIR GESTEN: They're in there.

DR. WHITE: Yes.

CHAIR GESTEN: Yes.

DR. WHITE: Yes, it's there.

CHAIR GESTEN: Yes.

DR. BENIN: I mean that's pretty, that's distinct from what I'm talking about.

DR. WHITE: Okay.

CHAIR GESTEN: Somebody want to, for

2337, antipsychotic use in children under 5 years, does somebody want to nominate this measure?

(No Response.)

CHAIR GESTEN: See, see what we learned. Okay. Of interest. For the use of multiple concurrent antipsychotic in children adolescents, is there a nomination for full endorsement? Anne. Is there a second? Second? And vote, all those in favor, raise your hand.

MS. LASH: Eleven.

CHAIR GESTEN: Okay, where are we, experience of care?

MS. LASH: Experience of care coordination.

CHAIR GESTEN: Somebody want to nominate experience of care coordination? Okay. Front line behavioral therapy? Nominate. Second? Second. Will --

MS. COHEN: With a caveat for moving, oh, I've lost track, removing the other ADHD measure, all right?

MS. LASH: That would be a separate vote.

MS. COHEN: Oh, okay.

CHAIR GESTEN: Do you still stand by your nomination?

Okay, we had a second.

Yes?

There was a second, okay. All those in favor of that measure, raise your hand. Three?

MS. LASH: Just three.

CHAIR GESTEN: Okay.

MS. LASH: Yes, hearing screening, Measure 1360?

CHAIR GESTEN: Yes. Do I have a second?

Second. All those in favor of the hearing screen measure, raise your hand.

MS. LASH: Nine.

CHAIR GESTEN: One more time, hands up.

MS. LASH: Put them up.

CHAIR GESTEN: Ten.

MS. LASH: That is ten.

CHAIR GESTEN: Ten. And reporting on behavioral health access through CAHPS? Okay, second?

Oh, you're so nice.

All those in favor of reporting the reporting on behavioral health access through CAHPS, raise your hand.

DR. WHITE: Just one quick question, please?

CHAIR GESTEN: There's a, hang on, put your hands down.

DR. WHITE: One quick question.

CHAIR GESTEN: Okay.

DR. WHITE: Is this in lieu of doing a separate behavioral health survey, which is what is required now?

CHAIR GESTEN: Right now there's a CAHPS, right now in the set there is a, I believe, it's a health plan CAHPS 5.0, it is currently in the measure set, so this would be an

additional module, I believe, is that right?

DR. WHITE: Okay, great.

CHAIR GESTEN: Okay, so we had a nomination and a second, all those in favor of this, raise your hand. Okay. Okay, we have a follow-up on the antipsychotics, does that have a number?

MS. LASH: No, it's not endorsed.

CHAIR GESTEN: It's not endorsed?

MS. LASH: No.

CHAIR GESTEN: Before we vote, any questions on this measure, before we vote on it? Yes, question?

MS. COHEN: Is it part of the NCQA list that we went over, is it, which one is it now? I'm confused.

MS. LASH: In your measures spreadsheet --
Row Number 5, follow-up visit for children and adolescents on antipsychotics.

CHAIR GESTEN: Susan.

DR. LACEY: So is there, I can't read

very well on mine. So does it have anything about a time, a window of time, in terms of the follow-up?

What is it? It's 30 days?

MS. GORHAM: Thirty days, yes.

DR. LACEY: Okay. Thank you.

CHAIR GESTEN: So do we have a nominate --

So you'd like to not add it with the conditional support? Is there a second for that?

Second. All those in favor of conditional support for this measure of follow-up for antipsychotics, raise your hand.

Four?

MS. LASH: Four.

CHAIR GESTEN: The next measure is the low respiratory readmission rates. So we already voted on the pediatric all-condition, we had a conversation about this one, as a subset of that. There were some support and back and forth about that. Somebody want to nominate this to add? Yes, nominated, and a second?

Okay. All those in favor of adding this favor, raise your hand.

MS. LASH: It's just four.

CHAIR GESTEN: Four. You guys all right? Is everybody okay? I told you, this is the hard part. This is why, this is, you know, this is why you got fed lunch and coffee. Counting cavities, this is a measure, Kevin that you described, it's not in the grid where I think folks got, but you went through some of the specifications, e-specifications for it.

DR. LARSEN: It's, sort of, NQF endorsed.

CHAIR GESTEN: You'll have to --

DR. LARSEN: So this is consistent with a lot of electronic medical record measures. The initial thought was that we could take claims measure and just make it an e-measure. And as we have lived that out, we've realized that even as close to what we stick to what the claims measure is, the electronic measure is different.

And so we're still working through

with NQF exactly how they inherit the research and endorsement, because they're designed and intended to do exactly the same thing. But, because the data source is different it -- so there is an NQF endorsed measure, NQF 1335 that is dental decay, or cavities, in children, and this is built on that architecture.

CHAIR GESTEN: Susan.

DR. LACEY: So count of cavities by a provider neutral, I understood that. So by which, by what age, like, anytime?

DR. LARSEN: Zero to 20.

DR. LACEY: Zero to 20, only one time it has to be counted?

DR. LARSEN: Yes. It, how many cavities, you know, overall in Health Plan A, when they have, you know, 20 percent of their kids have cavities and Health Plan B has zero percent of their kids with cavities.

The design, the idea was this was an outcome measure doesn't tell you what preventative services are being done, or not

done, it tells you whether or not important oral health outcome is, has been achieved.

CHAIR GESTEN: All right, thanks. Is there a nomination for this measure? Are you allowed to nominate your own measure? Well, if this --

DR. LARSEN: I'm not a boarding member, we're feds, so we can't vote.

CHAIR GESTEN: Oh that's right, yes.

Okay. Is there a second? All right.

Sealants. Sealants 6 to 10, this is a measure held over from the last expedited review that we had that just didn't make the cut last time. I think we had sealants for a different age group, a younger age group, is that right? And --

So this age is sealants for 10 to 14. Any nominations for this measure? You guys are just tired, right, is that what's going on?

MS. LASH: Okay.

CHAIR GESTEN: Okay. Okay that, that is it. So we have, so how many measures do we

have --

MS. LASH: Nadine, could you review the list of measures that gained the consensus threshold?

MS. ALLEN: So first measure with the highest support would be use of multiple concurring antipsychotics in children and adolescent with 11 votes for full support.

Next measure is NQF Measure Number 1360, audiological evaluation, no later than three months of age that got ten votes. The third measure is Measure 2393, pediatric all-condition readmissions measure that received nine votes, full support.

CHAIR GESTEN: The others didn't make it? Wow. So we have three.

I'm kind of thinking we don't need to do more, in terms of prioritizing. But --

DR. LEIB: I'll just throw it out there. I'm going to reopen 2337, an antipsychotic use in children under 5, and throw it open for a vote, because we never took a vote,

because no one nominated it. But I'll nominate it and go from there.

CHAIR GESTEN: Group okay with this slightly unorthodox suggestion? I mean, I'm terrible at Robert's rules, I'm sure it violates ten of them, but again, I think we have time and --

DR. LEIB: Motion to reconsider.

CHAIR GESTEN: The Chair has inclination.

DR. LEIB: Motion to reconsider, so.

CHAIR GESTEN: Anyone object to --

So we have one, we have a nomination of 2337, is there a second?

DR. LEIB: It officially dies, for lack of seconding.

CHAIR GESTEN: Oh, wait.

DR. LEIB: Oh.

CHAIR GESTEN: We have one. All those in favor of 2337, antipsychotic use in children under 5 years, raise your hand. Three.

MS. LASH: That's three.

CHAIR GESTEN: Okay.

So thank you, everybody. I know it's a little, little tedious, but we actually, I think, got through it. In terms of the next phase of this, I guess, there are two things, there are a number of things we probably need to go through, one is what tomorrow is going to be.

And, again, sort of, a little bit of refresh that we're going to tee up measures that really are somewhat arbitrary across the adult and child measure sets, essentially, the perinatal measures for discussion tomorrow, particularly, thinking about both choice, but also, alignment of the two groups.

I think there's a general conversation we're going to have about, kind of, next steps, in terms of measure direction, how to deal with gap areas, how to decrease the burden and the challenge of reporting measures, particularly, ones that have high priority, and some thoughts and conversations between the two groups about that. Is there anything else on the agenda for

tomorrow that folks need to think about?

MS. LASH: I think one of the major points of discussion, we have two hours and, possibly, even more time set aside, is the maternity and perinatal care issues.

There are a number of very specific measures we would like the group to think about whether they would support for addition to the child and/or adult core sets.

And that'll be challenging with such a large group of people together, so if you need to spend any further mental energy on this tonight, that would be the best point to prepare.

The balance of the afternoon we want to talk a lot about building infrastructure within states to bolster their participation and their ability to take on quality improvement projects, in response to things that they are collecting.

So you can take a look at the agenda, or we can, sort of, preview for you now the slide that we're going to show you tomorrow morning

about what is ahead for the day, if you think that would be helpful?

CHAIR GESTEN: If we can do, just hold that, just for a second --

MS. LASH: Okay.

CHAIR GESTEN: -- because I do want to get to the topic of, have a little bit more of a conversation around gap areas, before we go to public comments.

MS. LASH: Yes.

CHAIR GESTEN: And then, maybe, we can do that remaining, but there is some cards up, before we do that. Andrea, do you have something for --

DR. BENIN: Yes, I was wanting to just refer to the gaps, so --

CHAIR GESTEN: Okay.

DR. BENIN: Oh.

DR. LEIB: I got a question for Sarah, since she mentioned we're going to talk about pregnancy tomorrow, what would be the reasons, since pregnancy spans late childhood into

adulthood, what would be the reasons for approving it, a measure for one and not the other, either way, why would, what would be the rationale for not being aligned?

MS. LASH: Great point. Some measures, historically, around postpartum care had been in the adult core set, but not the child, and if that is a situation you would like to rectify, so that the whole age range of a hurdle of women --

DR. LEIB: So 18-year-old pregnant women gets the same series of things, as a 21-year-old pregnant women?

MS. LASH: Absolutely.

DR. LEIB: Okay.

MS. LASH: Yes.

CHAIR GESTEN: There may not be much, except for historic, or --

MS. LASH: Yes. I believe there is.

CHAIR GESTEN: -- different group reasons, or if, you know, different folks who

prioritize and they have a certain amount of space. But I think it's a great question. I think it's part of the reason why we wanted to have the two -- two groups to talk to each other. Terry.

It's about CAHPS?

DR. ADIRIM: Yes, gaps.

CHAIR GESTEN: Oh, gaps, good. Okay. So --

MS. DOUGHERTY: My question, I just --

CHAIR GESTEN: Go ahead.

MS. DOUGHERTY: Just let me clarify, the reason that perinatal measures are in the child core set at all, is not because of teenage pregnant women, it's because the legislation said services to promote healthy birth. So it's looking at the outcome for the child and not the woman, unless she's a pregnant woman. So does that help?

CHAIR GESTEN: So I think, in terms of the gaps, folks can consider anything they want about the gaps, but I would just suggest that one

of the things you might want to do is revisiting these, this list of gap areas that this group, or at least its previous incarnation, has identified as gap areas.

And, I think, part of what we're looking to do is, sort of, future, looking to the future both, in terms of, you know, the next year, as well as years.

Remember, that this exercise is an annual event, right, so every year we get a chance to take a look at the measures and to, hopefully, in each of that year, as it has been in this year, it's been a, this is a banner year for new measures to consider for gap areas.

But I don't presume that that's going to stop, so I'm wondering, at looking at some of the questions, they might be helpful both to NQF and to CMS and to measure developers, are there, do we want to have some conversation about whether these are still the right gap areas.

Does anyone want to put a final point on any of these areas, or prioritize them, or say

something that might be useful, in terms of thinking about this next year and thinking about measure development, or thinking about choosing from another list of measures going forward? So, Terry, I know you, go ahead.

DR. ADIRIM: Chomping at the bit. One gap area, which I have not, nobody has brought up at all this year, has to do with injuries and trauma.

That it's a high cost, affects the Medicaid population in a lot of ways and, you know, now we have, in some areas, for example, in head injuries we have evidence-based pathways.

So I want to make a pitch for more measures in this particular area, if we already have measures then I think we need to consider those measures.

MS. GORHAM: And so that was a -- I'm sorry.

CHAIR GESTEN: Go ahead.

MS. GORHAM: I need to use my tent, too. That was a area identified last year, as

you can see on your slide. When we did a search for measures in that gap area, we couldn't find any. So we're definitely open if someone wants to point us in the right direction, but we did look.

DR. ADIRIM: And the other category that wasn't available is screening for abuse and neglect and DME.

CHAIR GESTEN: Alvia.

DR. SIDDIQI: I was just going to say that, in looking at the measures that we've selected, it seems like we have, somewhat, tackled the care coordination mental health inpatient measures categories, at least, by the measures that we selected.

But I do think trauma informed care is a big topic right now, I know for the AAP and a lot of things that are going on in different states, it's looking at how we best, again, integrate mental health and primary care and trying to find measures that deal with care coordination, is still really challenging.

CAHPS surveys, they're great, but they're really hard to, sort of, implement for states to go ahead and do and then report on. So I do think, you know, any new measures that are coming out about care coordination will be helpful.

I also wanted to suggest, maybe, for a future meeting, maybe next year, that we do hear some highlights about the CMS proposed rules about Medicaid and Medicaid managed care and trying to see if there's any alignment with measures, based on what these plans are being held accountable for, so again, the provider and the plans could all be aligned with the same measures that we're proposing in our core sets.

CHAIR GESTEN: Okay. Ashley.

MS. HIRAI: I just wanted to mention, on injury that, Title 5, we have more population-based measures for injury, and so what we're using as a performance measure is non-fatal injury hospitalization, which can be stratified by payer.

And we, actually, are providing that data to states to inform their needs assessment and selection of eight of 15 National Performance Measures, and then that rolls up into actual fatalities, due to injury.

DR. ADIRIM: Right, and there's new databases, too, like data sources, state data sources. NEMSIS is one of them, it's a pre-hospital. I don't know how good it is, but it's a pre-hospital data and there's other sources, data sources, as well.

CHAIR GESTEN: Sorry, Anne.

MS. COHEN: So I wanted to add the trauma piece, so that's right on and, obviously, I agree with that. There was two areas we haven't looked at, they're pretty complicated that I don't quite know how to deal with.

The most complicated is stratification of the areas for trauma special healthcare needs, to look at health disparities. That's, obviously, the challenge, but I think it's really critical to look at that.

The second is dental care access for trauma special healthcare needs, particularly, looking at those developmental disabilities. The University Centers of Excellence on developmental disabilities may have done some work in that area, and I know there's a lot of DD relevant research on dental care access, so.

CHAIR GESTEN: Andrea. Thank you.

DR. BENIN: I think that the, for next year, we should really be able to take a, somehow take a good look at the PQMP, Centers of Excellence areas in a really comprehensive way, and that over the course of this next year.

It would be good to have an environment where we can get as many of those measures, either through NQF and/or through whatever other piloting and, you know, field use that they need, so that if we were to have a meeting like this next year that it would actually be able to pretty cogently go through those areas, which I think were identified to be gap areas to start with, and then metrics were

built to fill them.

And we should be able to have a pretty cogent analysis of that situation, so that those could be put into play. And I would say, you know, the sickle cell metrics, the complex, you know, children with complex medical health needs, I mean, there's a whole, there's a number of those things, all of which we should have in front of us to review on putative sets.

CHAIR GESTEN: Great. Kevin.

DR. LARSEN: Another priority area that I would call out in the new law around the SGR fix called HR 2, or also known as MACRA, the Medicare Authorization and CHIP Reauthorization Act.

Congress called out outcome measures for providers, and so those providers will be, we have -- that's a priority for CMS, and if we're thinking about alignment, they'll be looking for outcomes, especially, patient reported outcome measures.

And so I don't think we've really

discussed, or looked at, any patient reported outcomes here, but that has been something that Congress has asked us at HHS to prioritize, at least, under that particular measures suite for, I presume, it will be both Medicaid and CHIP, at least, as the fee for service providers.

CHAIR GESTEN: All right, tremendously helpful. So let's go to public comment and then, before we have you leave we'll just review a little bit of that tomorrow, go over the agenda with a little bit more detail. But, let's start with the phone. We've got an operator who can open up the line, if there's public comment, or invite public comment through the phone and then we'll do the room.

OPERATOR: At this time, if you would like to make a public comment, please press star, then the Number One on your telephone keypad. And you do have a public comment, one of Lawrence Kleinman.

MR. KLEINMAN: Well, I'd just want to say how, as one of the Centers of Excellence

Directors, how pleased I am that this process is open and available to listen to, I've learned a lot. And, I would like to plant one seed and, hopefully, we'll have lots of measures for you next year, some of which will, at least, have come through the NQF process.

But it seems to me that one of the things the Centers were set up to do was to identify, at least, or develop at least some measures in areas where it might not, by design, meet the standards of NQF.

So because of the fact that it's a real practice need and there may be insufficient evidence, or the cost for developing that evidence may be too expensive, et cetera.

So I would love to see next year, and I'm thrilled, I'm not sure who made that comment about looking at the PQM fee measures, but when they looked at it, that could be a part of what's thrown in the hopper when considering them, that sometimes there's a reason they may not fit for NQF endorsement, because pediatrics doesn't have

the investment and doesn't have the data infrastructure. And I'll leave it at that. Thank you very much.

CHAIR GESTEN: Thank you, Larry. Any other comments on the phone?

OPERATOR: And there are no further public comments.

CHAIR GESTEN: Okay, and to the room.

MS. TURBYVILLE: Thank you. Good afternoon. I'm Sally Turbyville with the Children's Hospital Association. First, I do want to thank the Committee, for all your hard work, both today, and I know there's a lot of preparation coming in and NQF --

So my name is Sally Turbyville. I'm with the Children's Hospital Association. I do want to thank the Committee for all your hard work, as well as NQF staff. So thank you, it really allowed for fantastic conversations today.

I just have three comments that I would like you to consider. A, one, and you can think for lens, Children's Hospital Association,

that looking at the measures that were slotted into the inpatient measures gaps. Some of them, in my view, don't really fit there. And the reason that's important to me, because it's really critical that we can articulate back out to the quality measurement enterprise, if there are still gaps in that area.

I think there were cross settings, so probably clunky and difficult to fit, but I don't think they reside in that domain alone. I also want to echo a comment that Andrea made earlier about rethinking how we even call out some of these gap areas.

I'm sure the Committee will be working on that for your next report, but that, perhaps, there are others, some axes, to consider that would, maybe, allow us to better understand what the measures are really looking at, for example, you know, these cross-cutting measures, not saying, necessarily, we want to call one cross-cutting, but as an example.

I also really want to encourage and I

think NQF is for this, but I don't want to speak for NQF, encourage and support that NQF has the opportunity to have a broad-based child health call for measures that would really allow a lot of the PQMP measures that are ready to be put forth, it would allow this Committee, for example, as well as others, to understand which ones are suitable for NQF endorsement and which ones may not and then to Larry Kleinman's point, then allow for additional conversation, as well.

So hopefully we can see that happen where they can call for measures, not just by clinical topic area, but a broad-based child measure. If we just do clinic topic-by-topic, it's going to take years to get all the PQMP measures in, so big supporter of that.

And I also, just sitting back and observing today, would encourage and, again, I know how much work goes into these meetings, that when measure developers are provided an opportunity to comment that we try to do it a little bit consistently, both in terms of timing,

as well as, all of those that might have the opportunity for their measure to be discussed. So just an observation. Again, I know that these things are challenging logistically. And those are my few comments. Thank you.

CHAIR GESTEN: Thank you very much, Sally, great comments. So how about we find out what fun is in store for tomorrow? Wait, anything else in the room?

No? Okay. Let's find out, you were going to tee up, we'll tee up the agenda, we'll have more detail about tomorrow and then --

MS. LASH: Yes, sure. So we'll do some level setting first thing in the morning to recap our discussion for the benefit of those people who will be new to the meeting.

We will be talking a lot of about measure alignment and the cross-cutting issue of maternal perinatal care. And then, we have a series of what I have termed, issues of shared importance, so moving from process to outcome measurement and all that would be entailed in

that, motivating quality improvement action within the states, and then, any action CMS could take to support states' ability to participate in reporting, how can we remove some of the barriers that they have shared with us, and that will be the subject of the day.

CHAIR GESTEN: Great. Thank you. Any questions about tomorrow?

(No Response.)

CHAIR GESTEN: So I just want to extend my thanks and appreciation to all the folks who made it here, actually on time, unlike moi.

And the hard work of not only being here, but also reviewing the materials and participating. Tomorrow should be a fun day. Thanks again to Sarah and Shaconna and Sarah and Nadine, they just, you know, NQF staff just makes, makes it all happen.

But some great suggestions about how we can improve the process, I thank the, I appreciate folks who made those suggestions to

us. And, Marsha, anything?

MS. LILLIE-BLANTON: No, no, not today. I gave welcoming remarks.

CHAIR GESTEN: You're waiting for the big bang at the end, okay. All right, well have a great evening, everyone, look forward to seeing you tomorrow. Thank you, again. Thanks --

MS. GORHAM: Just as a reminder, we convene tomorrow at 8:30 a.m. for a continental breakfast.

CHAIR GESTEN: 8:30 a.m.?

MS. GORHAM: 8:30 a.m.

CHAIR GESTEN: Okay.

MS. GORHAM: Right.

CHAIR GESTEN: I'll be there.

(Whereupon, the above-entitled matter 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.

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R Gross

Court Reporter