NATIONAL QUALITY FORUM

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JOINT MEETING
MAP MEDICAID CHILD AND ADULT TASK FORCES

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WEDNESDAY
JUNE 10, 2015

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The Task Forces 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 and Harold Pincus, Co-Chairs, presiding.

PRESENT:
FOSTER GESTEN, MD, FACP, Co-Chair
HAROLD PINCUS, MD, Co-Chair
TERRY ADIRIM, MD, MPH, FAAP, American Academy of Pediatrics
GEORGE ANDREWS, MD, MBA, CPE, FACP, Humana, Inc.
ANDREA BENIN, MD, Children's Hospital Association
LUTHER CLARK, MD
ANNE COHEN, MPH
JEFF CONVISSAR, MD, Kaiser Permanente
BEVERLY COURT, PhD
DENISE CUNILL, MD, FAAP, America's Essential Hospitals
KIRSTIN DAWSON, America's Health Insurance Plans
DENISE DOUGHERTY, PhD, Agency for Healthcare Research and Quality *
CAROLE FLAMM, MD, MPH, Blue Cross and Blue Shield Association
NANCY HANRAHAN, PhD, RN, FAAN
ASHLEY HIRAI, PhD, Health Resources and Services Administration
SUE KENDIG, American Academy of Nurse Practitioners
SUSAN LACEY, RN, PhD, FAAN, American Nurses

Association
KEVIN LARSEN, MD, FACP Office of the National Coordinator for Health IT
MARC LEIB, MD, JD
DANIEL LESSLER, MD, MHA, FACP, National Association of Medicaid Directors
MARSHA LILLIE-BLANTON, DrPH, Center for Medicaid and CHIP Services
CYNTHIA PELLEGRINI, March of Dimes
CAROL SAKALA, PhD, MSPH, National Partnership for Women and Families
MARISSA SCHLAIFER, Academy of Managed Care Pharmacy
ALVIA SIDDIQI, MD, FAAFP, American Academy of Family Physicians
BROCK SLABACH, MPH, FACHE, National Rural Health Association
MARSHA SMITH, MD, MPH, FAAP, Centers for Medicare & Medicaid Services
ANN MARIE SULLIVAN, MD
SANDRA WHITE, MD, MBA, Aetna

NQF STAFF:
NADINE ALLEN, Project Manager
SEVERA CHAVEZ, Project Analyst
SHACONNA GORHAM, Senior Project Manager
SARAH LASH, MS, CAPM, Senior Director
ZEHRA SHAHAB, Project Manager

ALSO PRESENT:
SEAN CURRIGAN, American College of Obstetricians and Gynecologists
DAVID KELLEY, MD, Pennsylvania Department of Public Welfare *
MEGAN THOMAS, Centers for Medicare & Medicaid Services

* present by teleconference

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9:02 a.m.

CO-CHAIR PINCUS: So, why don't we get started?

Good morning. I'm Harold Pincus from New York Presbyterian Hospital at Columbia University and my partner here is?

CO-CHAIR GESTEN: Foster Gesten from the New York State Department of Health. Welcome everyone.

It's really, you know, we lined you up on teams because there's going to be a baseball game midway. It's not on the agenda, this side against this side.

Actually, we're pleased we have a lot of overlapping members between the adults and the child group. But, to my knowledge, this is the first time we've sort of met all together, at least in person.

So, I'm very much looking forward to today. There is both separate business that each of the groups has conducted and will conduct.

But, today is really focused on overlapping issues and broader issues that affect both groups.

So, really looking forward to today. We had a great day yesterday which we'll recap the highlights of and we'll be doing introductions, I think, in a little bit.

MS. LILLIE-BLANTON: I just want to say welcome to all of you all here. We really, truly want to thank you all for taking your time and, you know, I know that all of you are incredibly busy, but your contributions --

CO-CHAIR PINCUS: Hey, Marsha? Mic? Sorry.

MS. LILLIE-BLANTON: Oh, I'm sorry.

This is what we learned yesterday and I've already forgotten. So, this is a reminder, if you want to be heard, you have to turn on your mic.

So, I just want to thank all of you all for joining us today. I know how hugely busy all of you are, but I want to say that your

contributions to our work in strengthening our child and adult core sets is extremely valuable and important to us.

Having a stakeholder group representing the different sectors that are engaged in this work helps us both to understand the issues, but also to improve on our core set. So, I want to thank you all.

I know this is a grueling process having, you know, three days for those of you who will be here or at least the day and a half for those of you who will be here only for that time.

But, it is highly valued. So, welcome, thank you.

And I'll turn it back over to Dr. Pincus.

CO-CHAIR PINCUS: So, why don't we go to the slide that has the objectives for today?

MS. LASH: Sure.

CO-CHAIR PINCUS: First, the introductions.

CO-CHAIR GESTEN: Yes, how about the

NQF staff first?

CO-CHAIR PINCUS: Yes.

MS. LASH: All right. We'll introduce ourselves as the NQF staff team and then we do have to do just a brief disclosure of interest for two members just joining us that didn't have a chance to complete that at the web meeting.

And then we'll sort of generally go around the room and say hello so that everyone can continue to get acquainted.

I'm Sarah Lash. I'm a Senior Director here at the National Quality Forum. I've been involved in MAPs work since its outset and, specifically, our work on partnering with CMS on offering advice about how they can continue to strengthen the adult and child core sets of measures.

Zehra?

MS. SHAHAB: Good morning. I'm Zehra Shahab and I'm the Project Manager for the Adult Medicaid Task Force and I've been at NQF for about a year and a half now. And I've worked on

a few other projects, re-admissions, care coordination, population health and I'm excited to work on this one as well. And nice to finally meet you all.

MS. GORHAM: Good morning. My name is Shaconna Gorham. I have been with NQF now for five months. Before coming to NQF, I was at Kennedy Krieger Institute.

MS. ALLEN: I am Nadine Allen. I'm the Project Manager for the Child Task Force for Medicaid. I am also working on several other projects, home and community based services, person and family centered care, Surgery Phase II and that's it. Thank you.

MS. LASH: Then on the perimeter of the room is Severa Chavez who's ably assisting us with our web streaming and a number of other really important logistics to keep today running smoothly.

Let's see, and joining us later will be Marcia Wilson who is the Senior Vice President for Quality Measurement here at NQF. She just

had a competing senior staff meeting this morning and she also sends her welcome to everyone.

All right, I will go quickly through the disclosure process, since I know this is everyone's least favorite part of the day. And we'll combine those disclosures with introductions in order to make the best use of our time.

I will first ask for disclosure from organizational subject matter experts, specifically, Cindy was muted on our web meeting and didn't have a chance to do her disclosure in front of the entire group.

So, I'll say that organizational representatives represent the interests of a particular organization and we expect that everyone would come to the table representing those particular interests and that's, in fact, why you are selected to be a part of the MAP.

So, in light of that status, we ask you just one limited question regarding you as an individual and that is if you have a financial

interest of $10,000.00 or more in an entity that is related to the work before this committee and you can tell us who you represent and if you have anything to disclose.

Cindy?

MS. PELLEGRINI: Good morning everybody. I'm Cindy Pellegrini. I'm Senior Vice President for Public Policy and Government Affairs at the March of Dimes. And I have no conflicts to disclose.

MS. LASH: Thank you so much.

All the other organizational members have already disclosed.

I'll also ask if Ruth Perry is on the phone. And, if so, I will go through the subject matter expert disclosure for Dr. Perry.

Okay. We'll keep an eye out for Dr. Perry on the web platform. If we do have an indication that she's joined the meeting, I will have to stop and, unfortunately, go through that part of the process before we continue the meeting.

We like to be extremely thorough on this front to avoid any potential appearance of conflicts.

I also encourage anyone who believes they might have a conflict or that another member of the group is behaving in a biased manner to approach one of the chairs or one of the NQF staff immediately and we will address the issue.

Do not sit in silence. If there are any irregularities in the process and we'll address it.

Okay, let's do general introductions. Simply, you know, say who you are and who you're working with.

If we could ask Carol to begin?

MS. SAKALA: Good morning. My name is Carol Sakala. I'm representing the National Partnership for Women and Families where I'm Director of Childbirth Connection programs.

DR. CONVISSAR: I am Jeff Convissar from Kaiser Permanente. I'm Medical Director at our Care Management Institute.

DR. CLARK: I'm Luther Clark. I'm in the Office of the Chief Medical Officer at Merck Pharmaceuticals. Prior to joining Merck, I was the Chief of Cardiology and Director of the Health Disparities Research Institute at State University of New York Downstate Medical Center in Brooklyn.

MS. LACEY: Hi, I'm Susan Lacey. I represent the American Nurses Association. My day job is over faculty development and graduate studies at William Carey University in Hattiesburg in Louisiana.

DR. LEIB: I'm Marc Leib. I am here as a subject matter expert. I have spent ten years as the Chief Medical Officer for the State Medicaid Program in Arizona. I retired from that job last July, but continue to do consulting and work in the health care field.

MS. COHEN: Hi, I'm Anne Cohen and am serving as the discipline subject expert and I'm currently serving the Duals MAP also.

I'm a consultant, working with the

California Duals program, working with a number of Medicaid outcomes as well as research as an advocate.

DR. BENIN: Good morning. My name is Andrea Benin. I'm the Senior Vice President for Quality and Patient Safety at Connecticut Children's Medical Center in Hartford. And I am representing the Children's Hospital Association and I am a Pediatric Infectious Disease doctor.

DR. ADIRIM: Hello everyone. My name is Terry Adirim. I am representing the American Academy of Pediatrics. I'm on the Executive Committee of their Counsel on Quality Improvement Patient Safety and I am a pediatrician specializing in emergency medicine.

DR. FLAMM: Hi, I'm Carole Flamm from Blue Coss Blue Shield Association and I am the Executive Medical Director for the Center for Clinical Value in our Office of Clinical Affairs.

MS. HIRAI: Hi, I'm Ashley Hirai. I'm a health scientist at the Maternal and Child Health Bureau. I'm a non-voting Federal Member.

For those of you who don't know, we oversee the Title V Block Grants estates, which is the largest broad based source of funding for maternal and child health including children with special health care needs.

And we, obviously, partner a lot with Medicaid on various initiatives including a quality improvement initiative called the Collaborative Improvement and Innovation Network which Dr. Gee helped to lead a team on pre-interconception health. So, thanks.

DR. SIDDIQI: Good morning everyone. I'm Alvia Siddiqi. I'm representing the American Academy of Family Physicians. I serve on the Commission for Quality and Practice for the AAFP. I'm a family medicine physician, but my day job is actually Medical Director for Illinois Health Connect which is the PCCM program for the State of Illinois. It's a large Medicaid program.

DR. CUNILL: Good morning. I'm Denise Cunill. I'm the Associate Medical Director of Cook County Health and Hospital Systems and M3

Pediatrics. I'm here representing America's Essential Hospitals.

DR. SMITH: Hi, I'm Marsha Smith. I'm with the Centers for Medicare & Medicaid Services and the Center for Clinical Standards and Quality. I am a medical officer in the Division of Program Management and Measure Support and I am the lead for the Quality Improvement Strategies for Marketplace health plans.

DR. GEE: Rebekah Gee, Medicaid Medical Director for the State of Louisiana, Associate Professor at LSU in the School of Public Health where I'm trying to teach the future generations about quality.

I'm an OB/GYN with a particular interest in maternal and child health, particularly prematurity prevention and work with many of you in this room.

It's nice to ACOG and Sean Currigan here representing my peeps today.

Thanks.

MS. DAWSON: Hello, my name is Kirstin

Dawson. I'm with America's Health Insurance Plans in their Clinical Affairs Department leading some quality and accreditation work.

MR. SLABACH: And good morning. I'm Brock Slabach, Senior Vice President for the National Rural Health Association. Previously, I served as a hospital administrator in rural southwest Mississippi and am extremely interested in the topics here and glad to be here.

DR. HANRAHAN: Good morning. My name is Nancy Hanrahan. I'm previously from the University of Pennsylvania School of Nursing. Now, I am the Dean of the School of Nursing of Northeastern University and I'm here as a member of the MAP group.

DR. LESSLER: Good morning. I'm Dan Lessler, I'm the Chief Medical Officer at the Washington State Health Care Authority and here representing the National Association of Medicaid Directors.

DR. SULLIVAN: Good morning, Ann Sullivan. I'm the Commissioner of Mental Health,

New York State and here as a subject matter expert.

DR. ANDREWS: Good morning, I'm George Andrews. I am here representing Humana. I am Humana's corporate Chief of Quality and I have oversight of quality strategy development.

I also serve on the MAP Duals Workgroup.

MS. SCHLAIFER: I'm Marissa Schlaifer. I'm representing the Academy of Managed Care Pharmacy and my day job is with CVS Health as head of policy and I also serve on the MAP Coordinating Council.

MS. COURT: Hi, I'm Beverly Court. I'm a health services researcher. I'm with the State of Washington. I'm the Project Director of the Adult Quality Measures Grant in Washington State as well as responsible for measure reporting for health homes for our managed fee-for-service Duals project and shortly for our State Innovation project.

Thank you.

MS. KENDIG: Hi, I'm Sue Kendig and I'm here representing the American Academy of Nurse Practitioners. I also serve as Director of Policy for the National Association for Nurse Practitioners and Women's Health. I'm a Women's Health Nurse Practitioner.

And my day job is coordinating the Women's Health Nurse Practitioner program at the University of Missouri in St. Louis. I'm also an attorney and provide legal policy consultation around clinical integration and patient safety.

MS. LILLIE-BLANTON: I'll just reintroduce myself very quickly. I'm Marsha Lillie-Blanton. I'm the Chief Quality Officer for Medicaid and CHIP and I also direct the Division of Quality, Evaluations and Health Outcome. And I'm pleased to be here and pleased that you all are here.

MS. LASH: Thank you, everyone.

Just a few housekeeping notes before we move on to reviewing today's meeting objectives.

Most of you seem to have mastered the microphone, but I will say that only three of them can be broadcasting at a time. So, if you get a flashing green light, you'll have to wave at a fellow committee member to turn their microphone off before you're able to speak.

And it is very important that you do use your microphone consistently throughout the meeting so that our remote participants can hear everything that you're saying and also so we can capture it for the transcript of today's meeting.

When we get to points for questions and comments throughout today's discussion, we have a very large group, so we'll ask that people sort of signal to put themselves in the queue by taking their tent card and standing it on its end. If you could try to aim your name towards our chairs, that will also help them.

And also remind everyone about who is a voting and a non-voting member of this panel. Our organizational members, our subject matter experts and our chairs are able to participate in

voting.

Our state panelists like Rebekah and Beverly and our Federal liaisons will not be voting but are absolutely invited to share their opinions freely during discussion at any time.

Okay, let's talk about meeting objectives.

CO-CHAIR PINCUS: This is really a unique meeting because it actually combines both groups, both the child and adult.

And part of it's to help to align what we're doing in similar ways, but also there's a set of measures that actually overlap between the two groups and that's one of the things we're going to be talking about today.

In particular, we want to go over the experiences that states have had in implementing both the child and adult core sets. I think that's very important in terms of alerting us to issues that have come up, what's important, gaps, problems.

We're going to need to also come up

with some specific recommendations for how we might strengthen the core sets by identifying the most important measure gaps and potential measures that might exist to address them.

And also to think about measures that don't work, to figure out which ones might be eliminated. And, overall, our goal is to provide strategic guidance to CMS about how we can strengthen the measure set over time to achieve the goals of improving quality for both adults and children under Medicaid.

So, the adult charge, yesterday, I guess, Foster went over the child charge, is, number one, we want to review the states' experiences and reporting measures today, then we're going to hear from several states about that.

We want to refine the gap areas that we had previously identified and see if there are ways which we might change some of those recommendations for gaps, add or be more specific about some of those gaps and try to recommend

potential measures that might be an addition to the set that would help fill those gaps.

And, secondly, to, as I said before, to think about measures that aren't working that may be misleading or that are simply too difficult to implement and consider removing those.

The task force, I guess, consists of members from the MAP coordinating committee, the various MAP workgroups and other groups with relative interest and expertise.

I guess this is the -- for the adult group, this is the second time we're meeting and I guess the report that we're going to have to prepare is going to be due by August. So, it's going to be coming back to us for suggestions and revision after this meeting. It's got to go up through various levels and, ultimately, it goes to CMS as a formal report in August.

So, today, during our joint discussion is to think about alignment, as I said before. You know, and this is particularly relevant when

we get into some of the potentially arbitrary issues about what are the age ranges of different measures and it's something we're going to be talking about.

In particular, there's clearly overlap about some of these issues. One is the perinatal and maternity care measures. And that's going to be a big focus of our discussion today and, actually, because of that, the child group I guess moved over the actual voting on those for today so we would actually -- both groups would be voting on those measures.

Number two, to have some discussion about the whole sort of movement in the quality measurement effort of how do we get from process to outcome measurement? Under what circumstances are process measures more appropriate versus outcome measures? What's realistic in terms of the expectations for moving ahead in that area?

The third thing to talk about is, you know, we're not measuring for measurement sake. We're actually measuring to actually change

things and improve things. And how do we actually motivate actual quality improvement that goes beyond simply measurement activities?

And finally, while we're pleased that the -- about the number of states that actually are participating, how can we actually get greater participation among all the states as well as having states really work towards reporting in all of the measures. And because if the measures aren't important, then we need to know about it if they're not reporting on it.

And so, presumably, we would like all the states to report on all the measures ideally.

And so, those are the kinds of things that we're going to be discussing today.

Now, Foster's going to talk to us about what we learned from yesterday and the experiences of yesterday's meeting of the child group.

CO-CHAIR GESTEN: We learned not to take a plane early in the morning but to arrive the day before, especially if you're the chair.

Actually, Sarah's going to do some of the recap of relevant points and then we'll invite folks, if we missed any important points to jump in.

So, Sarah?

MS. LASH: Thank you.

Can I have the next slide?

We want to emphasize as part of the reorientation CMS's goals for the child and adult core sets because this is the frame for everything we're trying to accomplish within this meeting.

First, to increase the number of states reporting core set measures, to increase the number of measures reported by each state and to increase the number of states using measures to drive quality improvement.

So, we heard two fabulous presentations from state partners yesterday.

First, from Jeff Schiff from Minnesota. He, throughout his presentation, emphasized the need to have vertical integration

of measures. I've also heard this described as a cascade of related measure concepts.

And talked about the role of the state acting as a convener to achieve consensus internal to the state on which measures are important to establish a process for change and to support individual practices and facilities with data and financial resources.

He advised the MAP that the choice of measures to put in these core sets and to report, they really must be meaningful to providers because many are not going to be interested in reporting on processes and outcomes they don't find relevant or they don't believe that they can influence.

He also observed, you know, there is a tension between the joint purposes of measuring at the level of care delivery and improving those processes and the overarching public health goals of the Medicaid program. So, we have to hold those two joint purposes of measurement in our heads at the same time as we deliberate about the

choice of measures.

He also described the success his state has had in reducing early elective deliveries which the Minnesota stakeholders regarded as a sentinel measure that there was a lot of quality improvement that could be catalyzed by focusing on a big dot measure such as that.

He also shared an important observation that they have the capacity as a Medicaid agency to really do a full court press on quality improvement for just three or four measures at a time.

They can certainly be reporting more data but when it comes to this convening function and really throwing a lot of problem solving effort that's essentially the state of affairs in Minnesota.

And Louisiana, and Rebekah can supplement any of these comments, described very openly and honestly with us that their state is usually at the bottom of a lot of health rankings

and they have undertaken a large series of activities to try to change some of those health outcomes for their state.

There's been a movement to enroll beneficiaries in Louisiana Medicaid in five managed care organizations. And so, this has created opportunities to partner with those plans around measurement, quality improvement projects and pay for performance.

They have made very significant strides with matching vital records to their Medicaid data and also incorporating information from the state immunization registry to be able to enable the reporting of more measures.

So, they are pretty well above the median, I think, in terms of the number that their state is able to submit on an annual basis.

Rebekah also described the extent to which public health partnerships had benefitted their state and quality improvement efforts there.

There was a strong case made for

premature birth being one of the top public health issues, especially when we consider the Medicaid population, hugely influential on a lifetime of health outcomes, very costly and they have numerous strategies in place to look at those outcomes and one around increasing access to progesterone in particular.

They're also looking closely at prescriptions for ADHD drugs. There were some really eye-popping data that 30-some percent of young white males had a prescription for psychostimulants in the state. And they're doing a lot of root cause analysis to understand what's driving some potentially inappropriate overuse.

And then taking a multi-sector approach to that problem because there is going to be a strong influence of the education system and other societal factors on that particular condition.

We also heard from other MAP members about crosscutting implementation issues that we might revisit later this afternoon in our joint

discussion.

Suggestions that states could use more support from CMS and other partners in measurement in setting appropriate benchmarks for when they are using these core set measures in value-based purchasing with health plans and P for P.

Louisiana, specifically, is tying results on eight measures to help plan payment at this time.

There was also a request for exploration of stratification of some measures where we know there are potential disparities in care. Specifically, segmenting out the results for children with special health care needs in areas like oral health that are important quality improvement opportunities.

Next slide, please?

I also want to be really clear about the purpose of these measurement programs more broadly and how CMS uses the data it receives from states.

There are annual reports of health quality in adult and child enrollee populations. They've recently started publishing, I think, more analyses, things like chart packs and calling out high performance states for their ability to participate and use the measures. And then, generally, informing policy and program decisions.

I think I've heard Karen Llanos and Marsha both describe the core set as a snapshot of Medicaid quality, really is one of the only things giving us the ability to understand the quality of Medicaid care on a national level.

Next, I want to quickly review the MAP measure selection criteria as our rubric for decision making and highlight some of the ways in which the child task force applied these criteria to measure discussions yesterday.

These have been developed several years ago now to assist MAP with identifying the characteristics of an ideal measure set, either for public reporting or payment programs and the

like. And these are consistently applied across all of MAP's different groups.

I will advise that they are not absolute rules. They are meant to provide general guidance and sometimes it's necessary to balance one against the other. They are not ranked in order of importance.

And essentially, they help to evaluate the relative strengths and weaknesses of a particular program measure set. And to help you think through how the addition of a particular measure would change the composition of the overall program.

So, some of the factors that influenced the choice of measures yesterday, the child task force did favor endorsed measures when possible because of the confidence that the group was able to have in their scientific properties.

The reference to the measure selection criteria about data source, we looked at measures that are able to use administrative data of some kind, measures that also capture reasonably broad

segment of the Medicaid population, measures that could catalyze quality improvement action in an area with low performance or a recognized health disparity, measures that were designed for use at the health plan or population level and measures that are aligned with other programs like HEDIS, Joint Commission accreditation, meaningful use, so on and so forth.

Some of the factors that are a little bit the flip of the measure selection criteria and tended to cause the group to shy away from recommending particular measures were that it would potentially require data from a source that isn't universal like administration of a survey directly to patient and family or participation in a clinical data registry.

Measures that were pretty closely related to a measure already in the program and, therefore, are not really addressing a gap area or measures that were too narrow to be meaningful to the state to say the juice is worth the squeeze.

So, in summary, the group selected from among many available measures that they looked at three measures that they would like CMS to consider adding to the child core set.

The pediatric all-condition readmission measure, which is NQF endorsed, audiological evaluation no later than three months of age, also endorsed and then not endorsed, so with conditional support, use of multiple concurrent antipsychotics in children and adolescents.

Next slide, please?

The group also looked at current measures in the core set to discuss those with relatively fewer states reporting, hypothesizing about some of the barriers as to what might be going on there and what could be taken to address those barriers.

There was not a decision to remove any of the current measures from the core set, but that was on the table for discussion. So, some of the reasons why the group might have chosen to

remove a measure are on this slide.

Sometimes there's a change in evidence that makes a measure obsolete. Sometimes a superior measure on the same topic has become available. And sometimes, there are consistently high levels of performance or we call the measure tapped out if it's consistently above 95 percent performance in multiple years.

Specific to the measures in the child core set, the group observed that the measures that have been added recently need at least two years to really catch on for state reporting and decided that it would be premature to discard them after just a year or two of experience. That the states need time to respond and adjust.

That's apparent at the measure level, but I think also in the fact that the child core set, which has been around a few years more has a significantly higher number of states participating.

Also, that the most common reason for not reporting any given measure was simply data

not available.

First, the task force suggested CMS might try to gather more granular information on understanding what that category was meaning to the state staff.

But, also, a MAP member made the observation that states who are able to be creative with their partnerships have gained access to additional data like the vital records and charts and they're actually able to make great strides in quality improvement as a result. So, that's a little bit of a tension there as well.

There might be a role for CMS's technical assistance team and the CMS staff and other communication platforms like professional societies to help the states share best practices about how to overcome some of those data collection obstacles in particular.

There was also some discussion of low feasibility of measure collection when a single measure is trying to capture quite a few

components of care. I think Alvia called them a kitchen sink measure, that there would be so many components that it would maybe be unlikely a provider would do all of them in a single visit and also the coding gets much more complex as a result.

I think the last sort of background slide here is about the decision categories that MAP uses.

We can think of these as a green light supporting a measure for immediate use, that MAP has no reservations about CMS putting it in one of the measurement programs right away.

MAP might also like a measure but want to see some type of modification or additional action taken on that measure, in which case you could recommend it with conditional support and specify any condition you wish.

For example, I think the most common one is that they would like to see endorsement review completed by NQF or sometimes a measure is not designed to be used at a large enough level

of analysis and it would need to undergo a little bit of respecification and additional testing.

I don't think we're going to be using the do not support category too much in this meeting, we'll essentially just not take a vote on a measure that doesn't seem to have the interest of the group.

Okay, one last thing, I guess, to talk about is the measure gaps that the child task force discussed.

They were certainly very eager for today's discussion on maternity care. They talked a lot about trauma informed care as a way to acknowledge and deal with the social complexities underlying many of the preventable poor health outcomes in the Medicaid enrollee population.

We talked quite a bit about opioid use and a gap actually relevant to the adult group, possibly more so than the child is intervening with people who have a prescription about 45-day range to ensure that they don't go on to become

addicted and using illegal drugs.

There was a citation that affects about 35,000 people a year in Minnesota and was a very important disparity in the Native American population in particular.

We also discussed measures of injuries like TBI as an important gap area for children. Patient reported outcomes given some of the statutory emphasis on those types of measures and recent legislation.

And then there's actually quite a laundry list on the flip chart behind me that we'll make available in the meeting summary as well.

I'll quickly pause here for any additional comments from the child task force members or questions from the adult group to clarify.

Sure, Andrea?

DR. BENIN: Sarah, I'll just briefly comment.

The summary of the commentary about

the categories of why states don't report, when I had said that I had intended to mean that there were two categories that were mostly used, one was not unable to collect the data and the other was other and that there may be -- it wasn't intention with this idea that states could potentially get data from other places, but those concepts weren't intention. Those are different concepts to my mind.

The issue was that because of the dichotomy of, you know, the splitting of the answers into those two questions, you may or may not have the granularity of information in order to just kind of solve the problem.

And so, in order to understand that better, whoever collects that data may or may not want to either qualitatively or in some other way dig into that so that in the future those categories can be more meaningful so we can understand what the real challenges are.

Because, right now, the data is not -- it's not particularly meaningful to see it

presented that way. So, I had meant it slightly differently than I think I heard you reflect it.

MS. LASH: Thanks for that clarification.

CO-CHAIR GESTEN: Andrea, you're talking about the other trying to expand out and amplify what's in the other category. And as you're describing it, it's not clear to me whether other is up there as a convenient way of lumping miscellaneous responses or whether, in fact, other is a choice point for states.

So, I don't know if you know, Marsha, and it's the --

MS. LILLIE-BLANTON: Both.

CO-CHAIR GESTEN: Okay, so to the degree that it's a lumping miscellaneous, there's an easy way to deal with that which is to list out the 27 reasons why idiosyncratic reasons that states put that don't categorize neatly into those if, in fact, states said to you other, then they're, you know, I think what you're saying is it would be nice to be able to know what that

other is. Is that right?

So, some of the --

DR. BENIN: And even if somebody knows the answer to this.

CO-CHAIR GESTEN: Some of them may be able to de done with current data is what I'm suggesting because other is often a cover for miscellaneous.

CO-CHAIR PINCUS: Also, just simply saying data not available is not necessarily a single reason why the data is not available to get a better sense about what are some of the barriers in the data availability.

CO-CHAIR GESTEN: I mean I'm speaking as a state, data not available can mean it really doesn't exist or it could mean the cost of trying to mine it is not feasible. And it's often it, you know, it can be one or the other or both.

MS. COURT: This is Bev Court from Washington State, and having filled out that ungodly manual input, the other is broken down into, for example, if too costly to get or

medical record base. So, the other category is broken down.

But, to be frank, if you're filling out one of those in that excruciating detail with all the breakdowns, sometimes it's just easier to hit that button.

DR. BENIN: That's what it looks like when you look at the information. It looks like those were convenient categories. I mean when you look at the data.

So, if you want that to be meaningful, then it may deserve more work. It may not need to be more meaningful. I don't know the answer.

CO-CHAIR PINCUS: So, this is I guess more or less feedback to CMS in terms of, you know, giving us back in the future sort of the information in a more, I guess, qualitative way, as you said, that may break it down.

And, obviously, you know, hearing from state Medicaid officials who are presenting whether it's Louisiana or Minnesota or Washington is critical in this as well to, you know, hear

back from them in terms of their direct experience.

MS. LILLIE-BLANTON: So, let me just give you an example of one measure, the developmental screening measure which we have been very proactive in getting qualitative information from states to better understand why they are unable to collect the data and what we can do to better support them.

And so, there are efforts, but, as she says, on the form itself, there's a little more information but it's just, you know, when you've got 22 to 26 measures and two or three people trying to go to each measure, the time to be detailed isn't always available to the state staff.

But, we recognize and value that input and will work to bring to this body in the future more granular information.

CO-CHAIR GESTEN: I mean, New York's other for the developmental screening is about 30 pages. We could have a meeting on that. I think

we will.

MS. LASH: Great. Let's quickly move to this issue of measure alignment.

And to preview for everyone or just explain rather the degree to which the adult and child core sets are already aligned, this has been a focus, I think, of CMS and MAP over the past few years.

So, there are, in some cases, the same identical measure with different age groups reported across the child and adult core sets. So, this is the case for a measure of chlamydia screening followed back for hospitalization for mental illness.

In another case, there is one measure with one NQF measure number that has two rates within it.

One, about prenatal care is in the child core set. The logic there being that it is most reflective of the birth outcomes of the infant. That's why you need prenatal care.

And the postpartum care rate is in the

adult core set because, by this time, the child and the mother are separate and it's the mother that needs to go in for that visit.

And then, finally, there are cases where there are similar measures on essentially the same topic but they are specified and measured separately. So, there are not endorsed measures of BMI screening and counseling in those measure sets.

Next slide?

So, we wanted to pose to this body the broad question of, is further alignment of measures needed between the adult and child core sets given their different purposes? But they're joint operation by state agencies.

And also, to think about alignment with other programs that are out there in the measurement space and there are many.

So, to simply ask the question, does it help states if the measure is selected for the adult and child core sets are used for other reporting requirements, are they going to be

similar enough that we can actually achieve alignment or do we have look alike measures potentially?

But, if we do want to align with other programs, which do you think are most important? Recognizing you can't run in every direction.

There was a recent IOM report called Vital Signs that keyed up a number of big dot health issues that they would like to see more measure alignment around.

If anyone has had the chance to look at that and extract any relevant guidance for this question, we'll actually open the floor now here for questions and comments on this.

CO-CHAIR GESTEN: Before we get into this, let me just frame that we're going to get into specific measures and specific alignment issues after this, but this is sort of a higher level Capital A alignment set of questions to entertain for the next 10, 15 minutes or so before we break.

CO-CHAIR PINCUS: And I think people

can all -- I mean, certainly, feel free to bring up specific issues that have come up that they've experienced at their state or in terms of some of the issues that they've dealt with in other ways.

Susan?

MS. LACEY: Yes, thanks for that recap and what you were talking about in this alignment issue.

I think, for me, it might be helpful, a lot of times yesterday, somebody said, well, so and so collects that and CDC does this and I'm kind of in the know but I can't know all of it. So, I think maybe it would be helpful to add a column on the Excel spreadsheet that actually talks about that.

And I know you have the steward there and but that's for these measures. So, it'd be really helpful if we could know what other entity actually collects it.

Because I do think the issue of burden is really critical in terms of compliance. And we see some states, you know, only report three.

So, I think that would be helpful because we can't keep all of that in our head.

DR. LARSEN: I'm Kevin Larsen from the ONC. Sorry, for I came on late. For those of you who don't know me, happy to answer questions about the IOM report. I was lucky enough to get to serve on that committee. So, if you want questions there, I can help.

I serve on the HHS Measurement Policy Council whose main goal for the last three years has been alignment across HHS.

And one of the things that we've been working on is kind of what are the goals of alignment and what would be some rules about how and why we would align. So, that we kind of bring it to a higher level and say, you know, here's the rationale and here's the place we think that makes sense and then here are places that we don't think it makes sense.

And I would think that a discussion like that might be helpful here that first starts with these first principles and then moves from

the first principles into the particular opportunities and strategies.

CO-CHAIR PINCUS: Kevin, actually, could you maybe give a brief summary of your view of the particular perspective of the IOM Committee on alignment issues?

DR. LARSEN: Yes, so the, you know, the IOM Committee, it's called -- the report's called Vital Signs: Core Measures for the Nation.

We were charged with coming up with a draft set of core measures and a goal around how core measures could really help the country move forward.

I think like many of these kinds of conversations have been part of the -- we get in the -- it's easy to get bogged down in the weeds of how do you have full alignment all the way to an individual provider up to what you needed at public health level nationally?

And that is, I think, a goal to keep in our heads. But, in the current state of

measures that were all built on top of the data set with program requirements around them, that's a goal that we have to aspire to, not one that we can just do right now today.

And so, what we attempted to do as a group was to say here's why we thought it was important to have core measures for the country and how we can assure that we're really achieving health as a country, both nationally but also in geographies and areas and regions that want to do that.

And how do we be sure that that's balanced across a number of attributes that we think are important to health and that health isn't the only goal?

Health is so that you can live happily and you can work effectively and you can have good relationships. So, some of it is also measuring the actual reasons why we aspire to health and that the key inputs, things like graduation attainment is one of the core measures that we articulated because we know there's a

really strong relationship between high quality education and graduation attainment and people that go on to lead healthy lives.

So, that's kind of a basic general discussion of what that looks like.

We did propose essentially in addition to the three part aim, which is a very similar addition that the military has used which is resilience in readiness. So, that it's not just about health care, it's about you as a person and as a community engaged, resilient, ready, able to do the work that you're able to do and how are we measuring and focusing on those areas.

So, that was one of the things that I think we had the most discussion about but, in the end, we were most proud of out of the report.

DR. HANRAHAN: I think it would help to have a brief summary of the conceptual models that we're using to develop these measures.

I think Kevin said it and the Institute of Medicine developed the living well with chronic illness model that they published a

few years ago that I found to be really helpful and what happens in the discussion of these -- of measures, in my experience, is that we move from a disease management model, so managing a particular disease to a population model, managing population health, and many things in between.

So, I think the assumptions or the conceptual from which we evaluate what measures are here, especially where the gaps are would be extremely helpful.

CO-CHAIR PINCUS: Foster?

CO-CHAIR GESTEN: So, taking off my chair hat and speaking as a state answering the question about which measurement programs are the most important for alignment, I'd say, for the Medicaid program, for us, in no particular order, alignment with HEDIS is critical as we see that a measure that plans are -- particularly plans that have a large managed care approach to the delivery of services and insurance, those measures are sort of on the table and available

for collection.

I think meaningful use is increasingly important in terms of alignment.

Many states have waivers. We have a waiver that has a set of measures associated with it. They don't necessarily jive with HEDIS or meaningful use or PQRS or anything.

So, one of our biggest challenges, frankly, is jiving waiver-related measures with core measures. They don't necessarily jive with core measures.

Many states have health home programs. Those health home programs also have a set of measures associated with them. Beverly, you're nodding your head. You know that they don't necessarily align with any of these other programs.

And then last, I would submit that the exchange measures are important given that there was a population that, on one day, may be in Medicaid and another day may be in the exchange. There may not be for subsets of the exchange

population very much difference in terms of the epidemiology, the demographics and so on.

So, that's a lot of alignment. And, you know, there's probably six or seven other things in the atmosphere really to measures including private commercial measures and other kinds of things.

But, I would say for Medicaid, those are the things that we struggle with and try to figure out how we can overlay measures and get multiple bangs for the buck.

CO-CHAIR PINCUS: So, not to put our Federal partners on the spot, but I get a sense of as -- is there a forum in which you get together to look at these different measures like, for example, that are being applied for achieving a particular goal and then, related to that goal are potentially a set of measurement concepts. And then, for each of those measurement concepts, there are potentially alternative measures that could be operationalized.

Is there a place where you guys get together a forum to actually go through and look at options about how to achieve that and try to narrow or reduce some of the misalignments?

DR. LARSEN: Yes, I can take that.

So, again, there are two things I think were key for the group. One is called the CMS Measurement Council and the other is the HHS Measurement Policy Council.

So, first CMS looks internally across their programs. They have over 30 quality reporting programs now and has a very focused intentional set of work and activity with leadership to really look at how they can align across their whole suite of quality reporting programs.

Some of it is fairly straightforward. Some of it's quite difficult how you align hospice measurement with, you know, newborn measurement. It's not an easy slam dunk thing that you do with those two very different kinds of measurement programs.

At the HHS Measurement Policy Council, we then do that same thing, but we include CDC, HRSA, Indian Health Service, the VA actually attends the Office of Personnel Management who manages all of the Federal employee benefits and the measure sets that the Federal Government offers on all the exchanges.

So, we work together and we'll often go domain by domain. We'll say, okay, let's look at diabetes. And when we started with diabetes, we had 60-some measures and various programs and we found that we had many of what we called look-alike, sound-alike measures.

They weren't -- they said something about A1c attainment, but they had all sorts of slight differences, different age ranges, different inclusions and exclusions, a little different thing here and there.

And we were able to come down to a set of four out of 60 that are our core measures for diabetes that we then ask each agency or department or program to tell us how they're

going to use those four. And, if they're not going to use those four, why are they not going to use them?

And there's a process that we would review with them and say, well, you know, this isn't appropriate for managing childhood diabetes. Okay, we get it. That makes sense. You know, there's an exception for that.

But, it becomes a kind of group consensus process within the Government.

MS. LILLIE-BLANTON: Add to one more layer of that, we also have what's called the CMS Quality Improvement Council, one of the first things that Patrick Conway who's our new Acting Administrator set up.

And in that Quality Improvement Council, we broaden it beyond the people who focus on measurement to the people who are the policy and programmatic people to understand how the measures are being used in the different programs.

And within that council, you have from

the Center for Medicaid and CHIP Services, people who work on the disabled and elderly group, people who work from the children and adults group, people, of course, from the Duals Office, the coordinating office now for individuals with Medicaid and Medicare.

So, that group, I think, is an extra layer of, you know, are we making the best choices and decisions for the programs that we're operating in for the people we are serving?

CO-CHAIR PINCUS: Is there a way that some of this -- I mean it sounds like a lot of thought goes into this -- is there a way that information, in terms of when a choice is made that there's some intentionality in misalignment that that can be conveyed so that it's clear to us, for example, as we go through these and have these discussions about why that decision was made so that we can understand that?

Because I think that's an important piece of this.

DR. LARSEN: Yes, I can say that we're

learning as we go. So, we thought we could tackle this condition by condition and make our way all the way through the measure set. And we spent about 18 months doing that and got through six or ten conditions and realized we had a kind of really long tail of how to do it after that.

So, we are also thinking what's the best way for us to do this en masse.

So, when it come to one of the high impact conditions that we'd worked on, we absolutely make that clear in our policy and you start to see everyone using the same measures in the policy.

And we have and are happy to present about the specifics of what we've come up with and how we've come up with it.

But, this is not to say we've gotten to most of the measures in our Federal programs. This a long, big job that we all have to do together.

CO-CHAIR PINCUS: And is there a way that the MAP can help with that in a more

effective way?

DR. LARSEN: You do. You have been and you continue to and groups like this that help us with priorities, that's absolutely input we take into those decisions at the Measurement Policy Council.

We really appreciate and are grateful for the kind of thoughtfulness that's here.

I, again, would sort of call out this first principle idea. Those are a little bit easier to take in, as you can imagine, than a spreadsheet where 60 people have ranked 500 measures and we somehow try to make sense of that.

It's a little bit easier to be sure that we all are aligned on the right first principles and the same first principles and then do our work out from those first principles.

CO-CHAIR PINCUS: Other comments, questions on alignment?

Andrea?

DR. BENIN: You know, I think there's

a principle here that I'm not sure exactly how to put into words and whether it plays into what we did today, but I do think there's a principle around alignment that there's sort of like countermeasure to alignment is what I would call double dipping.

And so, you know, the Federal programs often do double dipping, right, so the HAC measures get into multiple programs. Right?

And, you know, and so there's some compromise between alignment and double dipping. And I know that double dipping often happens because you really want to make it important that CLABSI are like the worst possible thing that could happen and so, it's going to be in every program and you're going to be penalized eight ways to Sunday for having one.

But I think there's some, you know, continuum along how you think about that. And I'm just not sure what that is. And so, I think that it's not entirely --

Because the things that we measure and

can measure and can measure well are kind of narrow, that when you really double dip or triple dip because then once the Feds are dipping in one thing, then, you know, Anthem or Aetna or whoever, you know, everybody kind of piles in and takes that one measure, then the providers are left really focusing on that.

And that's great if it is the single most important think that we want to drive. But there's so many other things out there that need to be driven that we get this un-weighted or over-weighted emphasis on things that are really important but it's not clear that the degree of emphasis is really in direct relationship to the degree of importance.

And so, I think that there's this competing value that goes in the category of alignment for me that is what I would call double dipping, I don't know what like less jargony word for that is.

But, so, I think that's something to sort of keep in mind. And so, is it good or bad

to have more or less HEDIS measures? Is it good or bad to have things aligned more or less with meaningful use? I don't know the answer to that. But I do always think about that.

CO-CHAIR PINCUS: Other comments? Questions?

This will have -- oh.

DR. ANDREWS: Yes, I'd like to add to what Andrea just said.

You know, from the plan perspective, and if we look at what we have to do, what is the must have?

And what is the must have is we need to ensure that we meet certain expectations of compliance when it comes to the regulatory accreditation or state mandated specific compliance.

And so, when you look at that and you look at it from the provider perspective, there is a constellation of measures that you have to push under.

And so, you know, for me, we need to

look at those three categories and kind of hone in and maybe push back a little bit in terms of what should be included or not included in those categories.

CO-CHAIR PINCUS: Anne?

MS. COHEN: So, you know, my experience in the Duals group is that there's a lot of measures that can fit into that category for the senior the same hole group and we really struggle with parsimoniousness, not just across, you know, Duals programs and Medicare and Medicaid but also with the MAP itself.

And one of the things we've looked really hard at is trying to look at, okay, how are measures aligned with the other various MAP groups to make sure that at least from the MAPs perspective they are parsimonious?

And so, one thing that's been helpful to us is that, because, you know, we'll go on a diabetes strain for instance and say, oh, it's these six diabetes measures. And then we sort of step back and say, okay, well, what have the

other MAP groups or what have the other NQF groups done in terms of certification and like and alignment and start there and then we'll work backwards.

So, that at least within NQF, things are aligned because at least can control that space.

So, I think as we look at the measures today and tomorrow, I think it -- and it's really hard for staff if you have done that already, but I think it's really helpful to say, okay, the hospital group agree on this, the Duals group agree on this, so-and-so agrees with this, particularly for adult Medicaid which encompasses so much of the other MAP groups, I think, and the NQF groups, I think that would really at least get us one step in the right direction.

CO-CHAIR PINCUS: Any other comments? We'll other opportunities to comment on specific measures and with regard to alignment as we go through other discussion during the day. But, I think we'll take a break now, is that --

MS. LASH: Yes, we have a pretty intense session coming up right next so we wanted to give everyone ten minutes to stretch their legs, get another cup of coffee if you need to.

So, we will come back at 20 after by the clock to my left.

(Whereupon, the above-entitled matter went off the record at 10:07 a.m. and resumed at 10:20 a.m.)

CO-CHAIR GESTEN: So, we're really committed to getting you guys out of here at the times that we said, so we're going to move on to the next topic which is we've talked to you generally about alignment and shared interests, so we want to get into the weeds now and a conversation about specific maternity care measures.

So, again, this is -- it's time to get into the weeds and we're going to present some of the specific measures. Some of them are new measures being proposed, some of them area measures that were discussed by the child

committee last go round in the fall of last year in that accelerated process but did not make it on the priority list.

So, between now and lunch, is a discussion about what those measures are, talk a little bit about some alignment issues between adult and child. And then, just as we did yesterday, we're going to ask the groups to vote on these measures and see whether we have a majority vote which -- Sarah, do we know what the majority vote means for the groups today?

MS. LASH: I will take a head count and let you know what the actual number we need to get to. But, percentage-wise, we need greater than 60 percent of voting members to say that we have MAP consensus on a particular decision.

CO-CHAIR GESTEN: I think our process is going to be as we did yesterday, full discussion of the measures so that people understand what they are, some of the changes that were made to the measure and then votes and there'll be votes on for both separate votes for

the Child Task Force and for the Adult Task Force on these measures. Is that right?

MS. LASH: That's right. It'll be necessary, yes, to define at the start of each vote whether the measure is being supported, conditionally supported and for use in which program.

So, we would take sequential votes of the child core set and the adult core set.

CO-CHAIR PINCUS: Talk about alignment.

CO-CHAIR GESTEN: And then, in terms of the prioritization, there'll be, we think likely you need to do prioritization. For those of you that remember that sticky notes and you get three votes that we did last time on the Child Task Force, we will likely be doing that at lunch time in which we'll be posting both the measures from yesterday as well as today's measures -- any measures that get voted in, again, assuming that we're going to vote some of these in and it'll be more than a few measures to

contend with.

So, that's the process from here until noontime. And I think -- I believe it's only the child group that will do the prioritization today. Is that right?

MS. LASH: The adult group will be considering other measures tomorrow and, therefore, we'll do a prioritization if needed at the end of tomorrow's deliberations.

CO-CHAIR GESTEN: So, let me just see, do we have Ruth Perry on the phone? Any task force members on the phone? I think Ruth is the only person, right? Is that right? Denise Dougherty, are you on the phone, Denise? Would she be muted? She should be open line. Okay.

Any questions about the process from here until lunch that folks have? Okay.

Shaconna, are you up?

MS. GORHAM: I'm up. If we can have the next slide, we'll start our discussion on the measurement of maternity care.

And there are 11 measures in the area

of perinatal and maternity care across the child and adult sets highlighting the fact that the mother's health and health care is extremely important to that of her child or her children.

Perinatal measures have a large presence in the child core set and few are contained in the adult core set. This reflects the longstanding importance of Medicaid in providing health coverage to low income women and babies.

We know that nearly three-quarters of women enrolled in Medicaid are in their reproductive years between the ages of 18 and 44.

During the discussion, the task forces will review relevant perinatal and maternity measures in both sets to see a full picture of quality.

Acknowledging the 11 measures across the sets may seem like a large number of measures, but, of course, this is still viewed as a gap area by many.

This group will need to discuss how

many more measures are needed in the topic area and, if any, how many we want to add.

Next slide, please?

So, the picture illustrates measures specific to the child core set, the adult core set and then those shared. In the middle, you'll see the prenatal and postpartum care, again, that is one measure before NQF number, but the rates are split across the core sets.

In the child core set, measures are relevant to the health of the infant and pregnant woman in order to encompass both the prenatal and postpartum quality care issues. So, we have seven measures that are currently in the child core set.

In the adult core set, the measures are focused on the mother. We have four maternity related measures currently in the adult core set.

So, yesterday, we had really good discussion and the question was raised, should all the measures on the mother's health be

present in both the adult and the child core set?

Many women giving birth are not old enough to be included in the adult core set, so there's some concerns that we're missing some information on some of the younger women, if you will, 15 to 17 and then just their postpartum care, for example.

So, another way to potentially address this is to suggest that CMS expand the denominator populations of the measures in the adult core set related to the mother's health to include all pregnancies regardless of whether she's enrolled as an adult to capture that age population.

So, I just want to pause for a minute to see if we have discussions on that alignment issue. No? Okay.

Marsha?

MS. LILLIE-BLANTON: I just want to clarify the suggestion that was made that the measure be considered regardless of whether the mother was enrolled as an adult. Is that what

you said?

MS. GORHAM: Technical difficulties.

So, the concern was that we were not capturing maybe the 15 to 17 year olds and so, we wanted to make sure we incorporated that population as well.

And so, while the child core set does not include some of the like, for example, the postpartum measure, we wanted to make sure that they're also included in the count.

CO-CHAIR GESTEN: Which gets to a question which I'll ask in a second.

Sue?

MS. KENDIG: Yes, as a woman's health provider, I'm a little confused about how these measures are aligned, particularly those that do reflect women's health.

And as I look at the way they are divided, maybe somebody who's worked on this could provide some clarification.

The one that is really drawing my attention is the behavioral health risk

assessment for pregnant women because that risk assessment is going to be equally important in the postpartum period.

And when we're considering behavioral health and mental health issues, suicide risk, all of those things that are occurring in the postpartum period, it just seems that that would be something that would be extremely important for us to be thinking about from a women's health perspective because that interconception period is also going to point to child outcomes and subsequent pregnancies.

CO-CHAIR GESTEN: So, I think you're making a comment about wanting to change or adjust or add another measure, which I think we'll have a time to do it.

I thought initially, you were asking about why it's in one bucket versus another, which, you know, I'm not even sure I can explain how it is some of this is historic or to some degree arbitrary. Right?

But there will be a time, I think, for

folks to comment on whether they like these measures that are in there or whether they want to modify them. I think we are going to have some comments about that in a second.

Marc?

DR. LEIB: Just a question I guess about process.

Is it possible that when a measure is in either the child core or the adult core that applies to the pregnant woman, not to the child, either pre or post birth, the proposal that we move all those across both cores or across both core sets so there's consistency and a 17-year-old pregnant woman gets treated or gets measured the same as a 21-year-old pregnant woman or is that not because of the rules of the MAPs, we can't just automatically move those across and make them consistent?

MS. LASH: It's really not a MAP rule, but potentially the disruption to states or the program operations to suddenly shuffle the measures to a great degree, I think we would want

to be purposeful.

DR. LEIB: Oh, yes.

MS. LASH: But the -- but it is possible, yes.

DR. LEIB: Okay.

CO-CHAIR PINCUS: I was going to ask the same question but in a slightly different way.

Is there anything negative about having something being put in a shared box so that behavioral health risk assessment for pregnant women be in the shared box or Cesarean section might be in the shared box?

CO-CHAIR GESTEN: I think the only issue would be measured once but I mean I haven't actually -- I have a rule question for you, Marsha.

Is there anything congressional that says that an adult measure cannot include somebody, a pregnant woman who is 15 in the measure?

MS. LILLIE-BLANTON: Well, the way we

worked it is that, thus far, and, you know, we can change this, is that if a measure is in both the child and adult core set, we just defined the age specifications for those two measures.

So, chlamydia screening, for example, in the child core set is for women up to age 21 and in the adult core set it's for 21 and older.

CO-CHAIR GESTEN: So, it's just stratified. So, we have currently -- let me make sure I understand that current conundrum, if there is one.

Postpartum care starts at, what, 18 or 19? The measure?

MS. LILLIE-BLANTON: No, that's a little different measure. And Megan might be -- Megan Thomas is here and might be able to help me if I'm going to say something that's not correct.

The prenatal measure and the postpartum care measure really are two different definitions of the measure itself. So, well, that's obvious, prenatal is what happens before and postnatal is what happens -- postpartum is

what happens after.

So, it is not divided up just by age. So, but, it is the same denominator and that is something that we have tried to stress to the states that the women who are counted for prenatal care, in theory, should be the same in the postpartum care bucket.

Now, because of some transitions that occur in states for women who come in for prenatal and may not deliver or vice versa, they are in the postpartum but they're not in the prenatal, we know that there could be some differences in the denominator.

But, basically, that measure's a little different because it's not the same measure. It's the same measure name but it's measuring content that's different.

CO-CHAIR GESTEN: Alvia?

Dr. SIDDIQI: So, I was just going to add that a couple of challenges that I think we have here is one sort of when is the impact being made? Who is it being made to? And who is the

benefit for?

So, the way I see it is, a lot of the child care work and the measures that are for child care do impact the delivery and then the newborns health rather than the woman's health.

But, another part of this, a couple of things I'm thinking about, one is all the work that CHIPRA does and a lot of the demonstration projects, does revolve around prenatal all the way through postpartum care and the child, leaving a lot of those in the child set helps strengthen, I think, the ability of the states to report it because you have the same people working on these measures and reporting them that work on the CHIPRA work.

Now, the second point I was just going to make is that I think also another challenge is when a woman delivers now as an adult, she is accessing care for some of the work that maybe, for example, the postpartum visit that may now be a different insurance carrier for Medicaid.

Again, you're talking about maybe a

managed care plan that's now for a woman and an adult possibly different from the child, usually, it's the same, but it's a possibility that now you're asking the plans to be accountable for the adult postpartum care visit, in which case, maybe the postpartum care visit should also be in the adult core set.

But, I think, again, when we're looking at elective deliveries and antenatal steroids, I do think that they may actually belong better in the child core set because of the CHIPRA work and then document with who's working on that.

MS. DOUGHERTY: Hi, this is Denise Dougherty. Can you hear me?

CO-CHAIR GESTEN: Yes, Denise.

MS. DOUGHERTY: Okay, hi. I just wanted to, since there are questions about why some things are in the child set and why in the adult set. And the previous speaker was exactly right in her first comment that in the CHIPRA legislation, it asked for measures of the

quantity of services to promote healthy birth.

So, the focus of those measures, even though the measures treat the woman and the child, are really on the healthy birth which is one reason we didn't have a postpartum measure in the child core set even though postpartum services affect the child, too.

The other thing is what -- you wonder why is behavioral risk assessment in the child core set and not in the adult, I think that's just a matter of timing when CHIPRA had provisions just as the adult core set had provisions for improving the core set.

But the CHIPRA work started much earlier than the ACA work. So, in 2012, one of the CHIPRA COEs, Centers of Excellence, submitted a measure for the CHIPRA core set on behavioral risk assessment for pregnant women and that was taken up by CMS and recommended to the states for reporting.

So, it was just a matter of these two core sets coming from different pieces of

legislation being kind of on the same, you know, parallel tracks, but not overlapping and it's great that today, everyone is taking the fresh look and thinking about the overlaps and whether there can be better alignment and so forth.

So, I hope that helps.

CO-CHAIR GESTEN: That is helpful, Denise. Thank you for doing that.

And I want to make sure that I understand this point because it was partly the question I was asking before.

Is there a legislative reason, for example, that we couldn't decide today that measures that currently, by virtue of history or timing in the child core are actually in the adult core but they include younger children?

Is there a reason when it's a CHIPRA legislation that there needs to be -- Cesarean section needs to be in the child core set?

DR. SMITH: I would say no.

MS. DOUGHERTY: I would agree.

DR. SMITH: Yes, but we can go back.

MS. DOUGHERTY: I don't think so, either.

CO-CHAIR GESTEN: And is it a wrong presumption to think that the major issue around alignment, there may be nuance issues about which set it's in but the bigger issue is to make sure that there aren't -- there's no pregnant women left behind.

That is, the measure includes -- if the measure relates to pregnant women, that there's no reason why any particular age group should be excluded from the measure. There may be reasons to stratify which we can talk about. But which bucket it belongs to is, I will just speak for myself, who cares? Right?

These are measures for reporting of state performance of the Medicaid program. Whether it's in one bucket or another, report under roof or another, it does seem like this has a major point anyway as sort of the coverage issues, making sure that it's reported and potentially stratified, if that's important to be

stratified.

Does that make sense? I see some heads nodding, but --

Andrea?

DR. BENIN: Foster, to my mind, when I look at these and hear what you're saying, I don't know how the states go about impacting change but, from my point of view, if I were going to impact change, I would either be going obstetricians or pediatricians, depending on which problem I was solving.

And so, to have the obstetrical metrics be like broken up into two different kind of groups or something seems more complicated than to be able to say, this is the group we're taking to the women's providers. This is the stuff we're taking to the children's providers.

Because they're different providers, though, it's not the, you know, pediatric providers who are impacting Cesarean rates necessarily except for, you know, a little bit of direction.

CO-CHAIR GESTEN: The quality work with providers is driven by the issue and who the relevant providers are. It's not driven by whether it's in a child core measure or an adult core measure.

DR. BENIN: So, making sure that the metrics are not split up in some weird way would make sense in that.

CO-CHAIR GESTEN: Alvia?

DR. SIDDIQI: So, just a reminder, that family physicians also see children and women, pregnant women and adults, so all the way from cradle to grave.

But, just also I wanted to make a point that I do still think that the elective deliveries and the antenatal steroid measures are, again, targeting the newborn health.

And so, I do think those two measures align well with the child core and, again, with the work of CHIPRA. And a lot of the work that those folks within states are doing I think keeping it in the pediatric core set makes sense

for alignment.

I do think the postpartum care rate should stay in the adult, again, because that's where it's taking place and it's impacting the health of the woman once she's postpartum.

CO-CHAIR GESTEN: Here's the sneaky thing. If we move them to the adult, then we have more room for other measures on the child. I'm just speaking as the child chair there.

But, in terms of the postpartum measure, I just want to make sure I understood your response, Marsha. Your response is there is no younger woman who's pregnant that's excluded from that measure that's under the age of 18?

MS. LILLIE-BLANTON: Yes, Megan or --

DR. LIU: Junqing Liu, I'm a scientist from NCQA. You are correct about the measure that the measure does not have an age for a definitions. All pregnant women are included.

CO-CHAIR GESTEN: So, I'm not sure I heard a conclusion about this issue about -- to the specific question that you teed up about how

we want to go about doing this.

This slide represents the current as is. Again, I saw heads nodding around making sure that we've covered all pregnant women for these measures regardless of which bucket they're in.

And then some back and forth about keeping the things that relate to child health in the child core that was, Alvia, that you were just articulating.

So, I think you said it is on the table and if folks feel that it's important to move this around or to make sure that there's a measure that's in one set that should be in the other set. But, I guess I'm not hearing a clear indication yet except, potentially, for the issue around the behavioral health risk assessment for pregnant women about that being in the child core set and not being in the adult set.

But, Anne?

DR. SIDDIQI: Just to speak to that again, I think that is important -- that is just

in the child core set, right, the behavioral health assessment?

What about the timeliness of prenatal care, is that also just in the child core set?

CO-CHAIR GESTEN: But it doesn't have an age restriction.

DR. SIDDIQI: But it doesn't have an age restriction?

CO-CHAIR GESTEN: Or does it? In other words, it doesn't --

DR. SIDDIQI: Does it?

PARTICIPANT: You're asking about the timeliness of the specific --

DR. SIDDIQI: Does that have an age restriction or is that --

PARTICIPANT: No, it's the same denominator. It's every pregnant women is included, it's not age dependent.

DR. SIDDIQI: But, the behavioral health risk assessment is age dependent?

CO-CHAIR GESTEN: No, I don't think it is either.

DR. SIDDIQI: Okay, then none of these are age dependent?

CO-CHAIR GESTEN: Right.

DR. SIDDIQI: None.

CO-CHAIR GESTEN: So, I think what we're looking at --

MS. THOMAS: Can I just make one general comment? This is Megan Thomas from CMS.

I believe that all pregnant women are included in these measures regardless of, you know, despite age, regardless of which core set it falls under.

CO-CHAIR GESTEN: So, I mean unless I'm wrong, it seems like the open question is, does it really matter? Right?

Cindy? Cindy, did you have your card up?

MS. PELLEGRINI: I did, sorry.

So, I really appreciate this conversation because it's making me think about this whole paradigm in a different way.

If I am remembering correctly from

some of the past, well past, long past conversations in the Adult Task Force.

I think the concern was raised at points that there might be, let's say, a disproportionate number of perinatal measures in the adult set and there was a concern that they didn't want there to be that sort of emphasis within the adult set.

Any heads nodding here. That, you know, we couldn't have six or eight or ten measures in a 25 measure set focused on perinatal.

Now, I'm not sure I agree with that because I'm from the March of Dimes so, I think that, you know, we could consider having a whole separate perinatal measure set that was just all shared, right, and that's maybe something to put in the parking lot.

But, one of the principles that I would suggest we ought to be thinking about here is, while I really appreciate the practical considerations about things like which provider

are you actually measuring performance of from a patient center perspective, the question perhaps ought to be who's health is primarily being impacted by this measure.

So, if that were the focus, I would actually think there could be an argument made for putting the C-section rate in the adult set because, while it certainly has implications for the child's health, it has arguably more implications for the mother's health and for subsequent pregnancies and that you could put elective delivery in the child core set because that is probably more important for the infant's health than for the mother's health.

So, I think maybe we need to get to a fundamental issue here about are we really measuring the impact on the health of the patient here? Is that our core concept?

CO-CHAIR GESTEN: I've got to say, that the difference between which buckets it's in is which part of the form it goes on when we submit it. I don't see any consequence of which

bucket these measures are in.

There is the issue about if there is some finite amount in each of these, where should they go? And the issues, the health issues are accrued to or relate to both child and adult health which is the appropriate bucket to put it in.

But, otherwise, again, other states should jump in. I can't see a reason why it should matter.

But, there's a question up there? I'm sorry, I'm not -- this is the --

MS. HIRAI: Hi, Ashley from the Maternal and Child Health Bureau.

I was just going to say that's basically exactly what Cindy said that the Cesarean rate, that lowest Cesarean is actually one of our maternal women's health measures. It's not a perinatal infant measure for us at the Bureau.

And I would also concur that elective delivery and antenatal steroids, it has an impact

on infant health and outcomes.

But, if you're saying that states have to report these regardless, then it doesn't matter.

CO-CHAIR GESTEN: Harold?

CO-CHAIR PINCUS: So, you know, I think this is a very illuminating discussion and it's particularly appropriate for this, you know, having both groups together because it raises the question about, you know, in some ways, the reason why we have two different groups is historical artifact. And the question is, are there any sort of negative side effects of that?

And I mean, you hypothesis is, or at least from your perspective, is that there isn't any, that, in fact, that, you know, each state sort of has a list then, you know, from their perspective, it's a single kind of list and as long as we're attending to, you know, what are the impacts on either the child or the mom, it, you know, it gets captured.

But I would be interested to hear from

some of the other states about whether or not are there any sort of unintended consequences of having this sort of separate approach?

MS. COHEN: So, I'm just speaking from experience in the State of Oregon where it used to be a part of it as well. And we always had agency remarks on a constant basis and it was, at one point, historically child services were split from adult Medicaid, Disability Services were split and there were separate people that did them and there were funding streams.

I don't think that's the case in most states anymore. But that's something I think historically that might led down this path.

CO-CHAIR GESTEN: So, let me ask Rebekah and the Beverly or Dan from your points of view from the state. Does it matter which bucket these fall into?

DR. LESSLER: You know, I don't think it matters which bucket it falls into. Frankly, I find the whole framework very confusing.

I mean, you know, to the point of the

discussion earlier about what's going in what bucket and so forth. And I'm trying to have some sort of rational understanding of why we're doing this.

Actually, the comment that makes the most sense to me was the earlier comment around, and I know this was for the parking lot, is sort of more of a perinatal health measure and, you know, group, and they all go in there.

But, from, you know, just in terms of if you're going to create a taxonomy and so forth, then it would seem to me that you want it to have, you know, some rationale behind it.

But, in terms of reporting it, as you point out, it doesn't make any difference.

DR. GEE: I think that it's, you know, we think about women's health over a life course and it, you know, in terms of reproductive health, it begins at puberty and ends with menopause. And so, it really doesn't make sense to, you know, have adult and child measures in this regard. They are life course measures that

relate to the reproductive years.

So, I don't know how you want to operationalize that.

CO-CHAIR GESTEN: No clue. It doesn't seem like one of the options on the table.

But, Harold?

CO-CHAIR PINCUS: I mean it seems to me that one potential consequence of this might be something that was alluded to earlier. If there's a perception among the adult group that, oh, we have too many perinatal measures, you know, and so that we need to have a discussion about, you know, are there limits to how many of which category can you have?

It seems to be the only, you know, potential concern I would have in terms of the consequence.

CO-CHAIR GESTEN: We're going to get to that soon because we're going to get to -- we're about to show that there's about 20 other measures waiting in the wings with a few that are recommended. So, the issue about quantity

related to other issues and other populations is going to come up pretty quickly.

But, Marsha and maybe we should get to the specific measures next.

MS. LILLIE-BLANTON: So, I just wanted to explain that one of the things we have done to try to make this a more rational approach is we have created what we call the Maternal and Infant Health Core Set which is drawn from the child and adult core set.

So, on our website, you can find the list of all the measures regardless of whether they're in the child or the adult core set that relate to perinatal health.

And that is an attempt to help bring together the two parts which reflect, you know, as was said, an artifact of history and the fact that one was created with the CHIPRA legislation and one was created from the Affordable Care Act at two separate times.

But, we have tried to help our partners make sense of this both at the state

level and the provider level.

And, the other thing we started last year that we'll do this year is that we now have -- we are producing a report, what we call a domain-specific report that focus on perinatal health. And that way, we can combine from the child and the adult core set the measures that cut across the two and reflect more of a kind of life course perspective.

So, I just wanted to say that.

CO-CHAIR GESTEN: Thanks, Marsha.

Alvia?

DR. SIDDIQI: So, Marsha, that helped because I was going to ask you a question about sort of the impact of what we are doing here for the pediatric and adult core set on what the work of the CMS is based on these quality measures and these core sets.

And I'm looking at those two reports, there's the child health quality report and then there's the adult health quality report. And, interesting enough, in the child health quality

report there was a discussion of elective deliveries pulled from the adult core set measures.

So, I suppose my concern, obviously, again, would be, you know, if you're looking at that report and you're trying to look at what are the measures that correlate with that report, if you're a plan, if you're a provider, if you're a Government agency, to have some consistency there, I think may be helpful which, again, would speak to like we talked about the C-sections for adults and then the elective and the antenatal steroids again in the pedes core set.

CO-CHAIR GESTEN: Rebekah, did you still have --

DR. GEE: I'll wait. I just wanted to say quickly on the number of measures is that Medicaid as a payer nationally covers approximately 40 percent of delivers and, in my state, 70 percent. So, in my opinion, there are not enough measures. I don't think we ought to worry about a glut in the market.

If we think about, you know, and Medicare has been driving quality measurement for many years. We have a lot of more in-hospital relevant measures for inpatient elderly folks than we do for maternity. And I think what we have needs to be more strongly developed. So, I wouldn't worry about a glut.

CO-CHAIR GESTEN: Carol?

MS. SAKALA: So, I'm seeing a vend diagram here with overlapping area of both and I can't speak to the state issues and challenges, but personally, I love this because mothers and babies health are intertwined and also the implications are short term and long term, as Rebekah said, though the life course.

I just want to point out that moving forward, that might consign us to shared meetings like this because our fates will be intertwined as two groups.

CO-CHAIR GESTEN: Great. Great discussion.

I think before we go to the specific

measures, why don't we take the opportunity for some public comment on this issue since it raises a lot of issues and both folks in the room or maybe folks on the phone who want weigh in.

So, why don't we start with folks in the room and then we'll go to folks on the phone if anyone wants to make a public comment, come to the mic.

And, operator, anyone on the phone? Sorry?

MR. CURRIGAN: Just to remind you that I realize that there is a heavy data collection burden for the elective delivery measure and some of the other measures that require chart review.

But ICD-10 does give us gestational age by week and makes a lot of the data collection a little bit easier for hospitals to do.

So, when you're doing your prioritization, please keep that in mind.

CO-CHAIR GESTEN: Operator, anyone on the phone who would like -- from the public would

like to make a comment?

OPERATOR: If you would like to make a public comment, please press star then the number one on your telephone keypad.

And there are no public comments on the phone line.

CO-CHAIR GESTEN: Thank you very much.

Shaconna, you've been quiet for a while.

MS. GORHAM: All right.

So, as you saw in your meeting materials, the staff made sure that you had an abundance to read just in case, you know, you got bored at night. We wanted to make sure you had enough materials.

So, if I can direct your attention to the Excel file that we sent, if you can pull that up now and if anyone needs a laptop, we have extra laptops for you.

So, I'll give you a quick second to pull that Excel file up.

Okay, so in preparation for this

year's review, the staff conducted an analysis of all of the available measures.

We compiled a list of NQF endorsed measures as well as PQMP measures based on MAPs recommendation to review PQMP measures under development and other available measures such as the ACOG measures for your consideration.

As we reviewed available measures to consider for potential addition, we remained mindful that while different states have different levels of available resources, resources are usually limited and it requires resources for each new measure addition to the sets.

So, with that in mind, the list of available measures highlighting a few measures that the staff thought would add quality across the core sets and most strengthen the core sets. So, we affectionately called those staff picks.

So, over the next couple of slides, three slides to be exact, we will review all of the available measures and then I'll highlight

those staff picks.

Can I have the next slide?

Okay, and just as a reminder before we start, Sarah went over our measure selection criteria. So just to give you kind of a background, well not a background, but just a recap of how we chose our quote, unquote staff picks.

So, of course, we considered those measures that are NQF endorsed. So, when looking at two very similar measures, we generally lean towards the measure that has undergone the endorsement process.

We also chose the measures that we thought were important to the Medicaid population as a whole and could be effectively implemented across the community level.

And then we also, of course, picked measures that are promoted parsimony and alignment.

Yes?

MS. LACEY: Just some technical

assistance. When you start to go through these here that are aggregated, can you tell us which tab on the spreadsheet you're looking at so we don't have to struggle to find it? Thanks.

MS. GORHAM: So for the perinatal measures, we want to focus that tab, focus our attention on that tab.

So, there's a number of different tabs, be we want to focus on maternal and perinatal.

DR. ADIRIM: Is that on the SharePoint site?

MS. GORHAM: It is on your SharePoint site.

MS. PELLEGRINI: There's one called the Medicaid Adult Core Set and Measure Gap Analysis, is that the one on the SharePoint?

MS. GORHAM: Okay, let me get the -- yes.

Are we good? Can I continue?

DR. WHITE: Are the same measures the same perinatal measures are within the child core

set tab? Are those the same? Okay, good.

MS. LACEY: And if you have explained this, I apologize, can you tell us about the color coding when you're talking about one?

MS. GORHAM: Yes.

MS. LACEY: Okay, thanks.

MS. GORHAM: I'm sorry, I'm having technical difficulties with my mic.

Okay, the color coding, let's go back one slide. Okay.

So, the Measure 0477 and 0480 that you see in bold, those are recommendations from the 2014 Child Task Force.

The measures that are grayed out, if you will, those are our quote, unquote staff picks.

MS. LACEY: And the color coding on the spreadsheet?

MS. GORHAM: Yes, so the color coding on the spreadsheet is the same. For the Maternal -- you're talking about the Maternal and Perinatal tab? Yes, okay.

So, the measures at the top, again, the 0480, 0477, they are highlighted in gray. Those are the recommendations from last year, the Child Task Force recommendations.

If you move down, the non-endorsed contraceptive measures, they're also gray but they're a different color gray, those are the staff picks.

So, one is a lighter gray, those are the recommendations, the darker gray are the staff picks.

CO-CHAIR GESTEN: Marc, did you have a question? It looks like your mic is on. Do you have a question?

MS. GORHAM: Okay. So, the two contraceptive measures highlighted in gray are non-endorsed measures stewarded by CDC and OPA. One appears on two lines because it targets the different age groups, therefore, the younger age group would be considered for the potential addition to the child core set and the older age group would be considered for the adult core set.

The non-endorsed effective postpartum contraceptive access measure could potentially be a good fit for both of the core sets.

Those that you see on the slide in front of you are other available measures and our judgment as we review, these measures are more effective for a facility to apply than a state Medicaid agency.

There are numerous structural measures and measures of temperature management for neonates, and so, we did not choose those as staff picks.

The next slide?

Again, here are more measures and all of these measures are added to your Excel sheet.

The next slide?

Okay, so the 0477, again, was a Medicaid Child Task Force 2014 recommendation. The task force last year, and will do the same this year, prioritized this recommended measure and the measure tied number four with the suicide risk assessment measures.

The suicide risk assessment measure was added to the child core set but this measure was not picked up.

So, this measures a missed opportunity to provide treatment and guidance for high risk pregnancies in a regional manner that promotes care coordination across facilities.

And as it's an outcome measure with multiple data sources. It's possible the data source is why CMS has not been able to add this particular measure.

So, 0480 is the PC-05 exclusive breast milk feeding measure. This also was a 2014 recommendation from the MAP Medicaid Child Task Force.

This measure is a set of five, it's a part of a set of five measures. We discussed some of them earlier that effective delivery, the PC-01, elective delivery PC-02, Cesarean section PC-03, antenatal steroids PC-04, the health care associated bloodstream infections of newborns and compliments other perinatal measures in the child

and adult core sets.

It is a process measure with multiple data sources. The Joint Commission is implementing significant revisions that I'll discuss over the next two slides.

So, with the revisions to this measure, medical conditions are no longer excluded. This change was made because these conditions are unusual and they cannot be modeled in the electronically specified version of PC-05.

The removal of measure exclusions significantly reduces the burden of data extraction. The revised measure is similar to the PC-02, Cesarean birth included in the child core set which reports the Cesarean birth weight with no exclusions.

PC-05 will continue to be publically reported on the Joint Commission's Quality Check website.

However, because some women do not want to exclusively breast feed despite recommendations, the Joint Commission is not

accounting for these preferences.

And since the Joint Commission is not accounting for these preferences, the Joint Commission expects that performance on PC-05 will remain well below a hundred percent.

Available as evidence suggests that a performance rate of 70 percent on PC-05 is an achievable target for hospitals to strive to achieve.

The Joint Commission has compiled a list of resources to help educate staff and patients on the importance of exclusive breast milk feeding and strategies to help hospitals improve their exclusive breast milk feeding rates.

The Joint Commission is retiring the subset of PC-05, so the PC-05a effective with October 1, 2015 discharges.

Feedback from key stakeholders indicates that capturing data on mothers' preferences to not exclusively breast feed has been challenging.

Some organizations may concentrate on data collection much more than on strategies to increase exclusive breast milk feeding.

The retirement of PC-05a allows hospitals to focus their resources on improving rates for PC-05 exclusive breast milk feeding.

Performance on this measure continues to be below 50 percent at approximately half of Joint Commissions accredited hospitals.

CO-CHAIR GESTEN: So, we actually have two discussion we want to have. We want to have a conversation both about exclusive breast milk feeding and the delivery of infants under 1,500 grams at appropriate facilities.

Just to recap, these are two measures that have previously been recommended by the child MAP last year. They did not -- I don't think either of them made the prioritization list.

MS. LASH: They were all listed as supported by MAP but they didn't make the cut for the annual update.

CO-CHAIR GESTEN: Okay. And so, that's part of the reason why we're revisiting them. One of the measures, as Shaconna just went through on exclusive breast milk feeding has been changed or is in the process of being changed by the developer, by the Joint Commission in the way that she just described.

So, we invite some conversation or questions about these measures. We should do them one at a time.

Did you have exclusive breast milk feeding first and is there a 1,500 gram or should we just do that without a slide?

MS. LASH: We could go backwards to the slide the showed the measure itself.

CO-CHAIR GESTEN: Why don't we start with that one, if that's okay?

MS. LASH: Yes, it's easy.

CO-CHAIR GESTEN: And we want to keep going and invite questions about the measure and then, again, sorry, one more time.

So, the measure will be voted on by

the two different groups, by both the child group and the adult group or it doesn't exist in either.

MS. LASH: Definitely the child because it was their initial recommendation. I don't see it --

CO-CHAIR GESTEN: Does the adult group need to?

MS. LASH: -- a strong justification for why it would also need to be in the adult core set. So I think we can just take one vote.

CO-CHAIR GESTEN: I agree. Okay.

So, why don't we stop here and see if there's any questions that folks have about this particular measure. I don't whether you want to, but --

Anne, do you want to start on this one, on this measure? On the other one? Okay. On this measure.

DR. ADIRIM: I just have a question for anyone who may be more expert about this, but do we have any data that this is a very big

issue?

I mean, yes, I agree that, you know, children, you know, pre-term should be at specialty centers, but I just am not aware that it's --

CO-CHAIR GESTEN: Cindy, do you have an answer to that question?

MS. PELLEGRINI: I'd be happy to share more with the group is people want. I can take a few minutes and do the actual research, pull the stuff off our website.

It definitely is an issue. It's more of what we're dealing with is a series of conflicting incentives. Right? That there are a lot of low volume hospitals that want to take care of these babies even though the evidence overwhelmingly shows that the outcomes are far superior at the most experienced centers.

And we're seeing this on a couple of different levels. We're seeing it, the plans are trying to drive, you know, more in this direction and the payers. But, the payment incentives are

still not aligned properly.

So, this would be I think a really important and influential step in the right direction.

What we also see right now is on a policy level state by state many attempts to take the AAP recommendations and change them and say, well, actually, you know, even if you do only ten births a year, you can still be a Level II or a Level III NICU.

And because you're out in the middle of nowhere and, you know, you serve people that have a hard time getting to the other center.

So, this is actually a very significant issue on a lot of levels.

CO-CHAIR GESTEN: Alvia?

DR. SIDDIQI: So, when we talk about coordination of care on a high level from a plan level, this measure does matter. And I do think it definitely matters in terms of perinatal health.

And I would ask CMS sort of trying to

understand why this data's not available, I tried to look at a similar measure, or at least not the same, but our low birth rate measure percentage of live birth less than 2,500 grams, we have 21 states who reported in 2013 and it went up to 24 states in 2014.

So, that measure has strong adoption and I do think this one, although it's not as easy because you're looking at location of care in addition to just the weight of the baby and what weight the baby had when born.

I still think that this one is a measure that states need to strive towards, but it does, again, somewhat correlate well with maybe even some of the CMS proposed rules now for Medicaid managed care.

Again, trying to align with care coordination of these really high risk cases.

And so, I would strongly recommend that we, once again, submit this one.

MS. PELLEGRINI: And, can I just add briefly, I've talked to NICU directors who say

that even when they belong to system, they have a hard time getting the low volume deliveries, delivery hospitals even to send their moms across town 20 minutes to the high volume center. So, it's an issue.

CO-CHAIR GESTEN: Thanks. Susan?

MS. LACEY: So, I agree, it's a terribly complicated issue. And they're able to actually recruit neonatologists and to manage these kids. So, it's a big problem.

So, then my concern is, it says the electronic clinical data registry other in terms of the data source. So, for the people who report this, Beverly and those folks, where is it one something that says the appropriate, you know, that earmarks that hospital as a whatever, Level II, Level III, nothing?

I'm trying to figure out how it's going to be operationalized.

CO-CHAIR GESTEN: It's a crosswalk between vital records and, in our state, and the list that designates hospitals at different

facilities.

MS. COURT: So, we would have to create that list? We'd have to maintain it?

CO-CHAIR GESTEN: Yes, Rebekah?

DR. GEE: I think co-chairing -- I'm sorry.

Oh, the process of releveling our NICUs in our state, and so I've spent a lot of time looking at this data and looking at the recent ACOG, SMFM and AAP guidelines.

There are two issues here. One is how effective is the state at leveling their NICUs? And the second is, do babies get delivered at the appropriate level?

I would say this is an important measure because it's the only way, you know, it's really not within national quality measures, organizations purview to tell states how to level, but it is an important measure to see are they following the guidelines and it's one of the only ways we can police that.

And it's very important because it's

one of the few modifiable areas where you can affect infant mortality towards the null.

So, I think it's a good measure. It was important for us to get in our state. Many states are engaged in releveling of NICUs currently, so it's very relevant at the national level.

CO-CHAIR GESTEN: Ashley?

MS. HIRAI: Thank you.

So, this measure, not exactly, it's actually the inverse, so the proportion of very low birth weight infants born at risk appropriate facilities. So, Level III or higher.

That would align with our measure that we've used for decades with Title V and it has been reported across the majority of states for two decades.

So, we know that states can report this data and then it would just be a matter of stratifying by the Medicaid population.

And it is a very important issue, as has been said. A systematic review that was

published in JAMA showed a 60 percent increased risk of death for being born outside of a Level III or IV NICU.

The real issue, I think, and it all depends on the financial reforms and incentives to promote antenatal transfer to the appropriate facility. And because of those perverse financial incentives that exist now, we have a huge measurement problem because a lot of those Level IIs designate themselves as having more capacity than they actual have for reimbursement purposes.

And so, we have this data, we just don't know how accurate it is. It's something that we're working with, you know, very well with the CDC. They've developed a survey of hospitals that kind of objectively assess their staffing and equipment levels that would designate them to be appropriate AAP level of care.

But that would have to be kind of rolled out and we're hoping that that would get tacked on to an AAP survey actually because there

is some AAP data as well. It's older now, a 2012 directory that does more independently objectively assess the levels.

But, many states are self-designated so that's when you really can't trust, you know, the quality of the data.

So, it's definitely an important issue. I would just caution for alignment but it would be the inverse in terms of aligning with Title V and what states are already reporting and that we just have a ways to go to improve the measure. But it's obviously something that can really help reduce infant mortality and improve infant outcomes.

CO-CHAIR GESTEN: Harold?

CO-CHAIR PINCUS: So, given the discussion, I'm not sure whether you were arguing in favor of the measure or against the measure.

I mean how much inconsistency is there across states in how they designate Level III? Because it seems to me that if part of this is, you know, that reporting requirement is part of

that, then, you know, we're not going to have an effective way to compare.

So, do we know how the degree of consistency?

CO-CHAIR GESTEN: She was arguing in favor of the measure. Is that right, Ashley? I think I got that part right.

MS. HIRAI: I agree.

(Simultaneous speaking)

CO-CHAIR PINCUS: You're saying it's an important measure, but you were saying that there is a flaw in the measure --

MS. HIRAI: There is a flaw.

CO-CHAIR PINCUS: -- in that there's such --

CO-CHAIR GESTEN: There's a flaw in the measure.

CO-CHAIR PINCUS: Yes.

MS. HIRAI: But I mean for --

CO-CHAIR GESTEN: There's gambling.

MR. HIRAI: -- for aspirational purposes and the need to move the needle on this

issue, I think you have to start somewhere and that might create the incentive to improve the measure.

CO-CHAIR GESTEN: I apologize. I think we have some other ones that we have to get to and I'm just concerned about time.

So, if folks want to speak against this measure, I think we get there's been a chorus of folks in support of this measure, as I said, it's been supported previously. I think you highlight as do Rebekah some of the challenges or potential issues in terms of comparability that may plague this measure, probably not the only measure where issues around data capture or the way in which data is collected or terminology between states, I would submit, probably varies, including vital statistics period.

But, Marsha, you wanted to make a point and then we'll go through the questions and then we'll take a vote.

MS. LILLIE-BLANTON: I just wanted to

say that CMS actually viewed this as a very important measure. The question was feasibility.

But, there is evidence from some work that we have done using the ARC data on National Hospital Cost Reporting System that shows poor outcomes as well for infants delivered not at the appropriate site.

So, but, I wanted to just explain one thing or clarify one thing that I think Alvia mentioned.

This measure requires being able to document low birth weight infants. And while 24 states reporting this year in that data and we are now at 25 states reporting, is admirable.

This measure has been in our data set since -- or the measure on low birth weight -- since 2010 and we have yet to report it. 2015 will be the first year that we are reporting any data from Medicaid state agencies on low birth weight infants. And that is because of the challenge states have had in linking claims data with their vital records.

We have now gotten to the point where we will have -- I think we are just at 25, maybe 26 states and, remember, our threshold for public reporting of data is that we have at least 25 states reporting.

So, we don't consider this to be a well reported or the low birth weight measure to be a well reported measure.

So, to add another measure to our data set that we thought would be problematic for states to report did not make good sense to us at this point. We thought that the burden of reporting it would be a challenge.

And so, it would have -- it's an important measure but just problematic for states.

CO-CHAIR GESTEN: Thank you.

Beverly?

MS. COURT: From the State of Washington perspective or the state's perspective, it's not so much the measure, it's how the measure will be used.

If you're a state like our state which has a substantial rural population, there's other states that have substantial frontier populations, that could be a real determent in terms of comparability between states.

So, if the measure is used to compare largely rural or largely urban to largely urban other states, then that makes it a fair even playing field.

But I am concerned about the types of profiles it's going to have of states that have large rural populations.

CO-CHAIR GESTEN: Thank you.

Rebekah? Brock?

MS. SLABACH: Well, thank you. I'll just piggyback on Barbara's comment because I think that when I look at this, you tell a hospital that they can't do something, it automatically becomes problematic and in the sense of low volume hospitals, if you have 250 deliveries a year or less is generally defined as a sustainable OB program in a hospital.

I have a lot of hospitals out there that are on the bubble and if you're going to be excluding a certain population of deliveries, then it could reduce their volumes and putting at risk the entire program.

I'm just curious, and it may be the answer to -- you hinted at the question a second -- my question a second ago, how many low birth weight babies are there and what percentage of total deliveries are they? And how would that impact some of these low volume facilities? Number one.

Number two, if you don't regionalize perinatal care within a state, how are these distant hospitals supposed to coordinate their care with providers along the continuum to make this happen?

And I think that's a real important question in terms of outcomes in this particular measure.

CO-CHAIR GESTEN: Alvia?

DR. SIDDIQI: I was just going to say

that your comment is actually highlighting to me the fact that states need to start looking at this data. If they're not even looking at it, then there's really probably not much that can be done in terms of trying to improve those outcomes.

Now, this measure does not mean, again, that a Level II could not take care of a newborn that has special needs. But the question is, if it's a low birth weight, you know, less than 1,500 grams, how often is this occurring across different states? Are states even looking at this?

And so, I think it begs the question that if you at least put it out there as a measure that's being reported on, and again, this is voluntary reporting. This is not mandated reporting. And this is not tied to any incentives or penalties or withholds.

So, I just think in terms of measuring quality and moving towards quality data for states to be able to use, and recognizing that

more than 50 percent of births are covered in most states by Medicaid.

So, again, this is I think hugely impactful to that maternal child health experience.

CO-CHAIR GESTEN: Thank you.

Carol? Alvia, did you have another one or are you -- thanks.

MS. SAKALA: I just want to share a comment that I heard Dr. Elliott Main say. He's the developer of this and has led a lot of the testing. That the rural hospitals do very well on this measure because they know they need to do this prenatally. It's the urban hospitals that think, well, we can just slide over to another facility if we need to after the birth.

So, that was a comment that he made.

CO-CHAIR GESTEN: Sue, you get the last word before we vote.

MS. KENDIG: Okay. Well, I'm actually speaking in favor. Having worked on this issue in a largely rural state for two years and

looking at the data, even in self-designation, there are instances where the antenatal transfer doesn't occur.

So, I think this measure would be extremely helpful as we look also toward improving quality through regionalized systems in helping to collect that data.

CO-CHAIR GESTEN: Okay, thanks.

So, this was the easy one, I think, but we'll see.

So, what we're going to do next is to by a show of hands from the Child MAP, take a vote on whether you recommend this measure to be added to the child core measures.

I'm told that we need eight votes just as we did yesterday for passage.

MS. LASH: Do you all know who you are? Do you know which you're a member of because some people are on both and I'd be happy to clarify.

CO-CHAIR GESTEN: Why don't you clarify just in case? Do you want to do that

now?

MS. LASH: Run through the whole roster?

CO-CHAIR GESTEN: Yes.

MS. LASH: Okay, just a second.

CO-CHAIR GESTEN: Who are the voting folks?

MS. LASH: Oh, the eligible voting members are the organizations and subject matter experts.

CO-CHAIR GESTEN: Okay.

MS. LASH: She's got a roster for me, sorry.

MS. GORHAM: And while Sarah's looking for that, we actually tried to make it easy and put the Child Task Force to the right of the room and the Adult Task Force to the left of the room. So, you should be divided --

CO-CHAIR GESTEN: What a great suggestion.

MS. GORHAM: -- pretty well.

MS. LASH: All right, on the Child

Task Force, Foster, Sandra, Alvia, Terry, Susan, Denise Cunill, Carole Flamm, Andrea, Jeff, Cindy, Carol, Luther Clark, Anne Cohen, Marc Leib and some non-voting Federal liaisons.

CO-CHAIR GESTEN: And usually, the non-voting Federal liaisons know that they don't vote.

So, again, by a show of hands, how many folks on the Child MAP are in favor of adding this measure to the recommended list of core measures?

MS. LASH: That's 14, the measure will be recommended with full support.

CO-CHAIR GESTEN: Great. Next, should we go to breast feeding?

So, in case anyone lost the thread of this, this was, again, a measure that had been recommended by the previous Child MAP, recognizing that I think we have maybe half of the folks that were on that that are on the current one and new members as well.

Shaconna went through what the measure

is, the changes that are happening. This is NQF endorsed.

In terms of the revisions, can you just refresh my memory? Are they -- is the Joint Commission going to be submitting their revisions for the NQF or are they in the process of doing that right now?

MS. LASH: I do expect the revisions would be part of the next annual update of the measure.

CO-CHAIR GESTEN: Okay.

MS. LASH: So, the question really to the group, I think it's 144, sort of given that there'll be a little bit of lag between the NQF endorsed version and what the Joint Commission is calling for.

Shall we update the standing the standing MAP recommendation to continue to recommend the new version?

CO-CHAIR GESTEN: So, questions or conversation?

Anne?

MS. COHEN: I actually have quite a bit of opinions about this. I am for breast feeding.

CDC produces an annual breast feeding report card and this measure has helped drive those goals. And Healthy People 2020 has a breast feeding goal of, can't remember the exact number, but it's well over 80 percent.

And nationwide, we now have 79 percent rate of breast feeding. And in California where it's been a huge driver, we have over 92 percent.

That being said, I know, personally, I know talking to other moms support groups, the pressure on the moms and the hospital to breast feed has gotten very extreme and they're not going to support and postpartum is very, very difficult.

So, while the breast feeding is post-discharge, you're good, three months out, it drops to 40 percent or even lower.

So, I'm concerned that while we should support this measure, it should have an asterisk

to include support for breast feeding post-discharge.

I've heard lots of stories from moms saying that in the hospital themselves, there would be bleeding, they won't be taught how to breast pump and, you know, the nurse merely says to them, well, you need to breast feed because we're rated on this.

So, it is something to just really keep in mind about how a measure creates an incentive, but doesn't necessarily create the environment or the support for the mother when it's needed.

CO-CHAIR GESTEN: So, the asterisk sounds like a new measure. So, maybe we --

MS. COHEN: And I looked, but there is no measures in NQF's portfolio for breast feeding other than this measure that I found, but I could be wrong.

CO-CHAIR GESTEN: Okay. So, we'll get back to what to do about the asterisk when we get closer to voting.

Alvia?

DR. SIDDIQI: So, although I think this is extremely important and I strongly support it, and AAFP strongly supports exclusive breast milk feeding, I don't think that this measure should be recommended by the MAP.

I think it's extremely difficult to -- and challenging for states to be able to report on this.

I think hospitals and working with AAP, certainly there's a lot of support for moving hospitals along the continuum to try and promote breast feeding like you had given in your example, nurses are being measured on this, providers and hospital systems are.

But, I think in terms of the measure and trying to use claims data, first of all, wouldn't be able to work. You would have to do this probably primarily through chart review, possibly EHR from the hospital systems.

But, it would be very challenging at this stage to be able to report on this.

CO-CHAIR GESTEN: Carol?

MS. SAKALA: So, I just wanted to step back to the idea of the interrelationship between the woman's health and the baby's health and also the framing and the relevance to the adult set.

Because, for mothers, breast feeding has been associated with lower risk of breast and ovarian cancer, hypertension, myocardial infarction and Type II diabetes.

And, of course, for babies, I think those figures are better known of prevention of shorter term infections and SIDS. And, increasingly, longer term multiple childhood chronic diseases that we don't really want to be dealing with on the side of when they have developed.

So, I just want to say that I think it's a measure that has relevance to both groups and longer and shorter term implications, life course implications.

CO-CHAIR GESTEN: Andrea?

DR. BENIN: I am a, you know, big

supporter of breast feeding for all of the reasons that the AAP recommends it, you know, strongly for the first year of life and, of course, it has innumerable benefits to both the baby and the mother.

But, this is not the measure to measure this. I have never supported this measure in any opportunity that I've had to not support it.

So, exclusive breast feeding at discharge, there are really no -- the exclusions for this metric are pretty -- the ones that were there before apparently the Joint Commission wanted to take them all out, or, you know, HIV, HTLV, chemotherapy, radiation, like really, you know, not having breasts that, you know, like breasts that have been surgically altered.

And so, those were the exclusions but there are many reasons why it is very appropriate to top a baby off occasionally when a baby is in the hospital and should get a little bit of formula or some other supplementation.

And, especially, you know, babies who may be developing jaundice, there may be other things going on. There's a lot of psychosocial stuff.

And so, a metric that is not really measuring kind of success over the duration of the breast feeding opportunity, if you will.

I think it's ill advised. So, you know, just because you get topped off a couple of times in the hospital doesn't mean you're not going to have a successful breast feeding run.

And all of those supports that Anne alludes to are really what we need to do. There's very little, you know, one of the first things that gets cut when things get cut are the lactation consultants, right, in a hospital because it's sort of this -- it's like, you know, you cut the massage therapists and the lactation consultants, you know, the things that are hard to quantify sometimes as to what they're doing.

But, regardless, you know, there's this idea that this metric, in and of itself,

represents this desire that we all have for infants to be breast fed, but it doesn't quite represent that.

CO-CHAIR GESTEN: Thanks.

Luther?

DR. CLARK: I just have a question for a point of clarification. So, is this metric at discharge? Three months? One year? It's at discharge? Okay, thank you.

CO-CHAIR GESTEN: Terry?

DR. ADIRIM: Yes, and I was going to say exactly what Andrea was saying. I don't think that this measure gets at what we really want to do.

I think there's plenty of evidence that shows just because you breast feed in the hospital doesn't mean that you continue to breast feed. I think it drops precipitously.

So, I probably, for all the reasons that were mentioned here, would not support this particular measure, but would like to see a breast feeding measure in the measure set.

CO-CHAIR GESTEN: Ashley? Thank you.

MS. HIRAI: And I might have one to offer. So, what we use, and I learned yesterday that you're also using for immunization measures is the National Immunization Survey. And so, that is the Healthy People source for breast feeding goals. It's also the data source we're using for the Title V Block Grant.

And we're using a dual measure capturing initiation and then exclusivity to six months which is the gold standard.

So, if you have used NIS previously, it may be an option. It is a Federal measure, although not apparently having gone through NQF endorsement.

But, it is, I think, highly reliable data. Women or birth cohorts are followed up and you have information on insurance status just as you get for the immunization.

CO-CHAIR GESTEN: Ann?

MS. SULLIVAN: Just to speak to the Joint Commission approach to an indicator like

this that says rather than get a whole list of exclusions, have a kind of a benchmark. I think it's something to think about, not just separate from whether you want this particular measure, but for other measures as well.

Because I think that there is a lot of extra stuff that goes into pulling out all those separate exclusions and, if you can come up with a reasonable benchmark, but your benchmarks have to be done very well so that you're not really over, you know, expecting too much or too little.

I think it's an interesting approach that we can consider with other measures as we go along versus a whole list of fancy exclusions that you have to get from charts.

And the, secondly, just from my experience in the hospital system, I would like to echo what's being said. I think that it drives hospitals crazy, this concept that you can't top off a little bit, you can't do anything, people get strident in some ways.

So, it's your definition of exclusive.

If your exclusive is truly nothing, nothing else, then I think you've got a little bit of an issue with this kind of a measure.

I'm not sure exactly what you're measuring. You know, when people come out so high, I'm often wondering exactly what they're doing and whether they are doing some things that, you know, because it's extremely difficult to reach.

CO-CHAIR GESTEN: Marc?

DR. LEIB: Well, it seems like there's a lot of support for breast feeding and I agree with all those measures. But it seems that really this maybe belongs to the hospital measure because we're talking about the hospital discharge where then a Medicaid program or a, you know, measure itself, which is not just as narrowly focused.

I mean we can measure it, but it's measured elsewhere, might be able to focus it on what this wants to do.

CO-CHAIR GESTEN: Anne, I think you

may get the last.

MS. COHEN: Yes, I think, and this is in the CDC report in the 2020 goals, one of the goals is to have every breast fed and I think that that's a much more realistic term and I think if we look for measures that, instead of exclusive, look at every, I think would be a helpful.

To your point, the reason why it seems the rates are high is if I've -- and I don't hear a lot of stories about nurses topping off babies behind sort of the nurse managers back.

And then the reason why it's checked as the exclusive breast fed is because the mom is not sent home with any formula. That's where that -- and that becomes extremely dangerous because the mom doesn't know what to do in that situation when she needs formula and, for whatever reason, can't get out to get it. And I think it creates a really bad disincentive at that first month to three months of life.

So, I would encourage the term ever

being used.

CO-CHAIR GESTEN: Okay, thanks.

So, I guess the measures sometimes have unintended consequences, right, more than one or two measures.

So, I would suggest that we tee this up for a vote and, again, what we're voting for and this is the Child MAP voting of a recommendation, actually, I guess I need a -- maybe we should do a nomination. We didn't do it last time, just to make sure that we should even take the vote.

Is there a nomination for this measure proposing this measure to be added to the child set from one of the child members?

Cindy? Yes?

MS. PELLEGRINI: Yes, I nominate it.

CO-CHAIR GESTEN: Is there a second? Carol seconds. Okay.

So, all those in favor of adding this to the child core measure set, raise your hand.

MS. LASH: With three, it fails to

gain support.

CO-CHAIR GESTEN: Okay. I think next is the contraception. And I don't think -- you didn't do the overview of these yet, is that right? Oh, no, you did.

MS. GORHAM: I did the overview.

CO-CHAIR GESTEN: You did the overview?

MS. GORHAM: I did the overview. I'll go into more details since we have discussed the 2014 recommendations from the child core set. Now we'll look at three staff picks.

So, the first, we would like to look at use of contraceptive methods by women age 15 to 20.

Of course, this would be a potential addition to the child core set. This measures young women who are at risk of unintended pregnancy and the adoption or continual use of the most effective or moderately effectively method of contraception.

It also looks at the adoption or

continual use of LARCs.

Now, this is non-endorsed. It is an immediate outcome measure stewarded by CDC and OPA.

The denominator of this measure is the eligible population at risk of unintended pregnancy. However, there is some uncertainty on how the denominator is defined.

So, we can move to the next slide.

This is the identical measure but this is measuring or looking at women age 21 to 44. And this would, of course, be potential for addition to the adult core set.

So, it looks at the identical things that I just mentioned. And again, the denominator of this measure is the eligible population at risk for unintended pregnancy, but there is some uncertainty in how the denominator is defined.

The last staff pick we have is the elective postpartum contraception access measure. This could potentially be added to the adult core

set or the child core set.

And it is a process measure stewarded by AHRQ. This measure utilizes the utilization of postpartum contraception for women who have had a live birth between November 6th of the year prior to the measurement year and November 5th of the actual measurement year.

In contrast to the other two measures I just presented, it's easier to identify a woman who has just given birth.

So, those are the three staff picks. We want to look at that and take a vote.

CO-CHAIR GESTEN: So, this is fun because both sides get to potentially vote and both sides may have different opinions about this measure.

So, why don't we start with questions or clarifications about any of these three measures, again, one of them is the same measure, different age group. So, essentially, we're talking about two measures but two different age groups.

And, yes?

DR. CUNILL: Can someone clarify how we came up with the age range starting at 15? Was the mature minor law considered at all with the age range?

I mean every state is different. In the State of Illinois, a patient can receive contraceptive counseling and treatment at the age of 12, 13.

MS. GORHAM: That's a good question. That is how the measure was presented to us by the developer. So, I'm not quite sure that I can answer that question.

DR. CUNILL: Well, I'd like to offer, you know, a change to that age range, less than 21 years old or less than 20. I know you can't change the measure but --

CO-CHAIR GESTEN: Susan?

DR. GEE: Can I just respond quickly to that point as an obstetrician?

The reason it's a great idea and I agree with the intent that you have, but it's

problematic as an obstetrician. You have to think about when most girls go into menarche.

And because not all girls -- to measure someone about what percentage are on these methods when you're measuring a population that may not be in menarche and it really may not be appropriate, I think it's problematic.

So, although I agree with your intent, I would not agree with lowering the age range.

DR. CUNILL: It would be missing a huge population though. Coming from the City of Chicago, you're representing the State of Louisiana, you know that we have sexually active young adolescents.

CO-CHAIR GESTEN: Susan?

MS. LACEY: Can you go back and put up the last -- okay.

So, I'm curious down here, the steward is AHRQ, but the data source is blank. Right?

Just from practical perspective, how the heck would you ever get this information? And not because you left it blank. Okay, he's

going to tell us how. He's raising his hand.

MR. CURRIGAN: I don't know if this is the same measure that we helped put together. But, you can identify live births through the HEDIS methodology and you use the same codes tables that HEDIS uses for the chlamydia screening measure which is all contraception to identify what kind of contraception they've been given within the 99 days since the live birth.

DR. GEE: Yes, I mean you know when the --

MR. CURRIGAN: It's all claims.

DR. Gee: -- occurred because you've got a claim for the delivery and you know when the contraception -- especially if it's a long acting or birth so you know when it was given because there's a J insertion code. So, you just need to do a time analysis.

CO-CHAIR GESTEN: It's a linked data set and I think we're going to talk later on this afternoon about issues like linked data sets and the exclusion issues, Anne, that you brought up

may come up in the context of challenges relative to reporting.

But, Sandra, did you have a comment?

DR. WHITE: Yes, I do.

I'd like to speak to the measure, the effective postpartum contraception access.

I would like to see this measure added with modifications and that is because the literature supports, and I also believe, that women should have access to LARCs immediately postpartum which means within three days of the delivery before they leave the hospital.

The barrier has been mainly one of reimbursement. So, I'm looking to the states to be the convener, the catalyst as well as the change agent for this measure.

Postpartum contraception services is not reimbursed separately in the inpatient setting, so the barrier is to payment of the physician or the education as well as the procedure.

The barrier is to the facility for

stocking in the pharmacy the devices and that is because Medicaid pays for pregnancy as a global fee and all of its related care.

If we are truly serious about preventing unintended pregnancy and particularly pregnancy in teen moms, where 12 to 49 percent of them will be pregnant again within the first year, if we are serious about improving the interpregnancy interval, reducing pre-term birth, reducing low birth weight and all of the indirect costs associated with teen pregnancy, where 20 percent of the teen pregnancy are repeat pregnancies, then I believe that we should strongly consider supporting paying or reimbursing appropriately for LARCs immediately postpartum.

We also see this as a challenge in getting our moms to follow-up for postpartum. You know, that measure remains a struggle and an area of opportunity for my health plans.

So, I believe that adopting this measure will get up that -- will help to cure the

root cause of what we see in those 1,500 gram, 2,400 gram babies by adopting this particular measure fully.

CO-CHAIR GESTEN: Thank you.

So, Sandra, let me just clarify again for the folks that weren't here yesterday and hear you make the comment.

You're advocating for an additional measure, as I understand it, correct me if I'm wrong, to this or a different stratification that would specifically look for immediate, as in during the hospital phase, access to reproductive contraceptive. Is that right?

DR. WHITE: Yes, Foster, you've got that correct.

CO-CHAIR GESTEN: Okay.

DR. WHITE: I'm looking for the stratification to be Part A, B and C rather than just a Part A and B where Part A would be measurement of the percentage of women who receive their contraception within three days following birth. And then, of course, Part B and

C and already listed.

CO-CHAIR GESTEN: Okay. So, we'll figure out how we handle that when we get to voting and so on.

Alvia?

DR. SIDDIQI: So, I believe that this is a complex measure. It has a Part A, it has a Part B. Part B is really challenging to be able to tell from, again, I'm looking at claims data and trying to figure out from a state's perspective in reporting that you prescribe birth control pills, you could pretty much tie in pharmaceutical claims but you have to tie in pharmaceutical with the postpartum visit and, again, whether or not providers are actually coding for specific procedures appropriately.

I just think this one's a complex one. It would take a lot of time on a state's perspective to try and report on this. Whereas, the other two that we're looking at, if we're specifically talking about LARCs, I think it is a high priority for ACOG. I think it is a really

high priority for AAFP as well.

Again, recognizing that perinatal health measures are really important, I do think the other two which age 15 to 20 and then 21 to 44 are measures that could be adopted by states that they could report on. And I would insert the clause of pending NQF endorsement for those two in terms of support.

CO-CHAIR GESTEN: Cindy and then Rebekah?

MS. PELLEGRINI: I'll try to be brief and just say that I agree very, very strongly with Sandra about this for prematurity, at least, interpregnancy interval is increasingly recognized as a very, very important risk factor. Those pregnancies that happen within 18 months after birth and that 99 days is far, far too long an interval. We're going to miss a huge percentage of those short term pregnancies or short interval pregnancies.

CO-CHAIR GESTEN: Rebekah?

DR. GEE: So, to these --

CO-CHAIR GESTEN: She wanted -- you agreed with adding a Part C. And I assume we're also saying you like A and B, Cindy?

MS. PELLEGRINI: Sorry?

CO-CHAIR GESTEN: Were you saying that you liked A and B as well?

MS. PELLEGRINI: Yes.

CO-CHAIR GESTEN: Okay.

MS. PELLEGRINI: I'm not opposed to either one of those.

CO-CHAIR GESTEN: Does that help?

Rebekah?

DR. GEE: So, I agree strongly with both measures, very important with first starting with this measure.

I agree with Sandra. I think, although in Louisiana and I would say there are 11 states approximately that have changed this, we pay in addition to the global per diem for insertion and for the device. So, many states have policy approaches to overcome this.

I think that if you wanted to simplify

this measure, you could focus solely on long acting reversible contraceptives. Those have J Codes, they're very easy to measure. The provider gets an insertion fee and the hospital gets paid for the device.

I do agree with Cindy about the timing. Ninety-nine days I don't think is a good time line. I think that we could either try to, even though we don't agree with the 56 days which is used for the HEDIS measure for postpartum, I would either use something like that or 60 as we're trying to move the HEDIS measure to something that really is more accurate in terms of when a postpartum visit would happen.

My thoughts are that this is really trying to get at that postpartum period. Sixty days is when most women lose their Medicaid, so I think 60 is a more appropriate time frame than 99.

This is an extremely important measure for all the reasons described.

On the use of -- going back to the use

of effective postpartum contraception or the use of -- can we go back to that other measure and show it just quickly -- use of that.

I do think this is a very important measure and it's one of the measures that we can actually hold managed care plans accountable for now, especially states that have state plan amendments because women will be continuing an insurance product even if you don't expand Medicaid that's limited and focus on delivering family planning services.

So, this is a great measure for life course. It's one of the most important areas where you can prevent a future premature birth.

And, as noted earlier by Kevin, this is one of the issues that was in the Institute of Medicine was unintended pregnancy. That's one of the national measures that ought to be looked at.

Just to say, we've been working with Lorrie Gavin at OPA and with the CDC on this measure and have spent a lot of time looking at this data. We've also looked at the denominator.

Shaconna mentioned that there was some lack of clarity. We've spent a lot of time clarifying that.

So, I don't know, there might have been some changes because I know we've done a lot of work on this recently. It's an important measure. I think you can clarify the denominator and I do think that it needs to be one of the priorities both for women's health and infant health.

CO-CHAIR GESTEN: Thank you.

Ashley?

MS. HIRAI: I totally concur with everything Dr. Gee just said.

And I just wanted to mention with alignment with other Federal initiatives, that the Collaborative Improvement and Innovation Network treated infant mortality which engages states in collaborative learning using QI methods to accelerate progress in common priority areas that can reduce infant mortality.

They're engaged in different learning

networks and one of them in which Medicaid medical directors are really engaged is pre and interconception care. And the focus of that team is on promoting the adolescent and postpartum visit and improving access to moderately to highly effective contraceptives.

So, it's a measure that actually is being used and piloted in Medicaid programs right now.

Dr. Mary Applegate, the Medical Director in Ohio, is a proponent of this measure. And to accomplish that kind of rapid cycle learning that the CoIIN fosters with quality improvements, she's actually developing this measure to be used on a monthly basis to have more timely data to make realtime decision making and feedback.

So, I would just, you know, support this measure which has been piloted in a number of states.

CO-CHAIR GESTEN: Andrea?

DR. BENIN: You know, when I was

looking at these prior to coming here and even last night, I was feeling as though I could support them.

But, as I'm sitting here, thinking about this a little bit, I'm just wondering about the ethical consequences of these measures where we're sort saying that, you know, a hundred percent of women in Medicaid should be on contraception and that we're going to be driving towards that and that's --

Like, I'm not sure that I fully understand the full ramifications. You know, between these two metrics, we're saying women postpartum or 15 to 44 years or which ever version that you're saying, and we don't - and they are claims metrics, so we don't have a good way of saying that what if there are women who don't want to be on contraceptives but have access to them but didn't want them? Or who wanted to have babies?

You know, we're saying that we are, as a program, saying that these women should not

have babies.

Like, I'm just concerned -- I don't -- maybe that ethical conversation has happened elsewhere and I'm not in this loop of circles. But that's when I look at this at first blush. That's what I'm feeling. So, I'm not sure if anybody has any insights into that.

DR. WHITE: You know, I'd like to speak to that.

I think that is exactly what we are not saying. I think that what we're saying is that we want to give women the option. This is still a woman's choice, but it would certainly make it more convenient for her to have that access in multiple settings.

So, she will have access in the setting of inpatient or immediately in the ambulatory center within the hospital immediately postpartum before she goes home and she will continue to have that access once she is discharged and then follow-up for her postpartum care.

But, it's just -- it's another setting of access for her should she make that decision that she wants the contraception.

DR. BENIN: And so, Sandra, I hear what you're saying and I completely agree with what you're saying. But that's not what the measure is going.

The measure is measuring who is on it. Like how many people had something stuck in their arm, you know. I mean that's what the measure is saying if I'm understanding it correctly. It's a claims based measure. Did you get LARC? It's not saying were you offered LARC? Did you have five counseling visits with your adolescent provider?

It's not saying any of that. What I'm readying is a claims measure that said did we pay for you to have LARC? And the higher the better. So, I don't know.

I mean I'm not totally sure how to solve this problem, but I'm not saying that this measure, that this metric is a measure of what it

is that we think we want to drive.

DR. GEE: so, we have --

CO-CHAIR GESTEN: Anne?

DR. GEE: -- spent a lot of time on this. Let me just say this, this is not something that just came up. This has been very much in consideration over the past three years and why it's taken so long to get this measure.

I'd like Sean to weigh in here, too.

But, I've been part of many national conversations including just wrote an article about reproductive coercion and the history there. So, I'm very sensitive to this issue and have brought up multiple times, particularly I think in the area of LARCs, them being problematic in terms of coercion or minority women.

I think that's why this measure us broad. It gets it moderate contraception which is just about anything other than withdrawal and condoms. I mean it's very broad in terms of use of birth control.

I also think it's where you set your benchmark. So, for example, if our goal was a hundred percent of women, I would agree, you know, I would really agree more with the concerns that that is not appropriate because a hundred percent of women don't not want to be pregnant or may not want to use contraception. But it depends on how you set your benchmark.

We do know that the use of the most effective methods, particularly LARCs, is exceeding low in this country, much performance improvement is needed.

So, again, I think that we have to have the conversation in light of that concern, understanding the history of reproductive coercion, but also understanding how poorly we perform on unintended pregnancy and the need for something to drive change.

And so, I think we need to continue to have this conversation, as we said, benchmarks and also include the women who are affected by this in those conversations. But I don't think

that means we shouldn't measure it. I think it's vital to women's health.

DR. BENIN: So, that to me is --

CO-CHAIR GESTEN: So, can I --

DR. BENIN: -- is an epidemiological measure, not necessarily a --

CO-CHAIR GESTEN: Can we go, we have like seven folks who want to get in as well.

So, Anne, next?

MS. COHEN: Yes, I mean, you know, it's historic issues around this measure. I agree with it. It's helpful for Dr. Gee to clarify that. So, thank you.

I did want to put one other point that I don't think anybody's necessarily thought of and the fact that the recent Supreme Court case regarding the Hobby Lobby and there, I believe, refused for birth control is a significant factor.

I was thinking about what Foster was saying about charting off Medicaid on to the exchange back and forth and knowing some of the

small privately held companies that pay a lower -- - sometimes a lower wage might be where those individuals end up employed is something to consider because Medicaid may end up being the last resort for birth control for that population.

So, I think we should also kind of keep that in mind as well.

CO-CHAIR GESTEN: Okay. Sue?

MS. KENDIG: Yes, I would agree. We would strongly support these measures in their totality simply because this is getting at both the preconception and the interconception wellness of women.

But the postpartum one alone is only going to address interconception whereas the first two are going to address their health prior to that first pregnancy which I think it's important in going to Cindy's point in terms of perinatal outcomes.

I would strongly support adding Part C to the postpartum measure because that is often

a very -- once women are discharged and they leave the premises, they have difficulty for a variety of reasons, not just because they don't want to come back, they have difficulty coming back.

And the 60-day cliff is especially problematic for our most vulnerable populations. So, I think that is something we really need to look at.

In terms of the ethical argument, I would also invite us to consider that the access issue or lack of access has also been an ethical problem in placing undue barriers to, again, our most vulnerable populations, particularly those who are going to fall off of that Medicaid cliff with no recourse.

CO-CHAIR GESTEN: Marc, do you have a clarification on the measure?

DR. LEIB: Yes, the clarification on the 99 days, part of that has to do with lactational amenorrhea and women's choices. So, and it might get at your Part C, the age bands

that we have requested to be reported -- I mean no the age bands, the weeks spans for the 99 days so, zero to seven days would get at your immediate postpartum, seven to 21 days gets you at a two week postpartum visit and then there's another band, I think to 56 to get to your six week postpartum visit and then the 99 days gets you at anybody that didn't want to go on contraception because they were breast feeding and that why there's the 99 days to get you at the scope of what women could be choosing during that time period.

CO-CHAIR GESTEN: Yes, but those bands don't get at Sandra's issue about immediately in the hospital.

DR. LEIB: Well, the zero to seven days gets you the immediate postpartum LARC.

CO-CHAIR GESTEN: Okay. That may or may not satisfy her. But okay.

DR. WHITE: One must remember that the number of days postpartum is two, 48 hours, for a normal delivery, 72 hours for C-sections. So,

that's why I'm going for the three days.

CO-CHAIR GESTEN: Marc?

DR. LEIB: I'm not going to repeat all the other arguments here even though I have lots of comments I could make, but sensitive to time.

But my question is the following, where did November 5th and 6th as the cutoff dates come from? It doesn't fit with the 99 days. It doesn't fit -- I'm trying to figure out why that magical date appears there a starting and ending point of the year measure rather than something else.

MS. LASH: I can't speak for the developer, but I would speculate, and this is speculation that the technical specs, if it was to be used in the child and adult core sets might look at a different date range because the reporting year starts and ends at a different time.

(Off mic comment)

MS. LASH: There have been some tweaks to facilitate state reporting.

CO-CHAIR GESTEN: And can I just clarify, this is not endorsed. We came up yesterday day with a question about what that means.

In this case, it doesn't mean it hasn't been presented yet or was it rejected?

MS. LASH: Has not been presented.

CO-CHAIR GESTEN: Not presented?

MS. LASH: None of them have.

CO-CHAIR GESTEN: Okay.

Susan?

MS. LACEY: So, it got a little -- we got a little excited about the piece about whether or not we were going to give people an option.

So, it clearly says adopt or continue. I'm going back to the language.

So, I guess my question would be directed towards you about, is there an objection to put something in there about the mother having an option?

I mean I'm sensitive to all of that

other stuff, but, you know, some people don't want to put things in their body. My daughter's really weird like that. She's like I'm not putting anything like that in my body.

I mean is there an objection to adding that the woman has a choice?

CO-CHAIR GESTEN: So --

MS. GORHAM: So, just to answer that, the measure -- the first part of the measure says most effective or moderately effective adoption of contraception. So, it doesn't necessarily have to be a LARC.

The second part says, a adopt or continue use the LARC. So, there is a -- they do divide the two.

DR. LESSLER: Thanks.

So, this is really a very interesting discussion.

Actually, first, I just want to reiterate something that was said earlier around the payment for LARC at the time of delivery and that that's something that we've struggled with

and I think it resolved just recently in Washington. I think other states are doing the same. So, it can be addressed and it is a policy decision.

The second point I want to make is, you know, I think this really -- the question around, you know, is the target a hundred percent or not and so forth really begs the question as to why do we measure and what do we do with measurement?

And I don't think we measure in order to get to a hundred percent. Sometimes we measure in order to get to a hundred percent but sometimes we measure in order to better understand how our systems are performing.

So, I don't know what the right number is and certainly this issue comes up a lot around preference sensitive conditions where if somebody can choose to or not to and yet you'd want to know sort of what is happening.

And I think it gets back to the point that was made by Anne about benchmarking. And,

you know, within a state, we have six plans now. It would be very helpful to know where those plans are at relatively with respect to, you know, use of contraceptive methods by women.

And if they differ, it would beg the question of us asking so, why? Are there good reasons for that or not?

And so, I think that, you know, I just -- I think we just have to keep in mind the purpose of measurement, the multiple purposes of measurement.

And then the final point I would make, and I really agree with Sandra about I guess Option C as you're calling.

I would also say, as I look at these, Option C and some of the issues that have come up around the difficulty in measurement the 99 days, why November 5th, November 6th, Election day? I don't know.

And the -- I actually think Option C is probably the easiest to measure. So, you know, so I would endorse all of these but I

actually think from the measurement standpoint, Option C is probably the easiest to get one's arms around.

CO-CHAIR GESTEN: Alvia?

DR. SIDDIQI: So, I'm a little confused sitting here in terms of my role here with the MAP. But when we are making recommendations like in Option C for a measure that hasn't gone through the NQF endorsement process, that's really, I don't think, the role of our -- or the objective of what we're trying to do here in terms of trying to say whether or not this measure is one that we would recommend as is, right now, again, pending NQF endorsement to CMS for the Medicaid core set for pedes.

So, I guess my point would be, again, if we do have challenges with that one, the postpartum effective contraception measure that my recommendation is that we don't support it as it stands currently. We've given feedback to NQF through this meeting in terms of what we'd like to see there, it sounds like there's been

consensus on that.

But, again, going back to these two measures, in terms of access to LARCs, I do think that that is really important. As Daniel stated, you know, we need some baselines. The states do need to start looking at this. It is helpful to see different plans and what their rates of access is for unintended pregnancies.

Again, this one is still pending NQF endorsement. So, the denominator I think may be teased out even more as part of that process.

So, I would just call the vote.

CO-CHAIR GESTEN: In terms of the process question that she asked, do you want -- should you answer it? I've got my answer, but I'm not sure it's the same as yours.

MS. LASH: I can answer it and you can add on.

It is most important to be very clear about the measure as it is currently written.

I think I'm hearing from the conversation that there are multiple conditions

for the postpartum measure, that there's a strong interest in the group in further measure development and testing to incorporate some type of stratification or a subset rate for the hospitalization period immediately after birth and also that the measure be submitted and receive NQF endorsement.

So, I would maybe use that as the default for voting on that particular measure.

On the others about general access and use to contraception and the two age groups, there might also be the condition that it be submitted for endorsement but I didn't hear concrete suggestions for other things you would like to see changed about the structure of the measure itself.

CO-CHAIR GESTEN: So, the process would be somebody would nominate the measure, the postpartum as a support with conditions with the following conditions. There would be a vote on that if that got voted, then so be it.

If it didn't pass, then somebody could

say, I want to nominate it as is. Right?

Let's see, where are we? I think we're at Ann.

DR. SULLIVAN: Just to go back just a minute, I think that I really appreciate the need to measure this and to know what's going on in the system and then to come up with benchmarks.

But, when we put out an indicator like this, it tends to -- a measure like this, people also take to something they should be doing.

And we just heard the unintended consequences of some of the breast feeding issue. So, I think you've got to be a little careful here whether this -- and I'm not sure how you would amend it, whether this goes out as something that should be measured and looked at versus something that we're saying, while I personally agree with this -- I mean you can get a lot of controversy about this kind of thing in terms of --- and then you're -- for people who think you should never use, you know, contraception and that the Medicaid is saying

we're going to be ---

I'm just saying you have to be sensitive to the issue that was brought up here. And therefore, if you're going to put something like this out and say well, we're really doing it to measure and understand first to get to benchmarks so that we leave that leeway for people who really don't want to do it, then let's say that and not put it out as a measure that's already been set and everything else.

I think you could be setting up something you don't want to do.

CO-CHAIR GESTEN: Andrea?

DR. BENIN: No, I obviously agree with Ann Marie. And I -- you know, it comes back to a comment that I mentioned yesterday, Foster, about how the --- part of it is about the framework of the measure set so that if there was an axis or a component of the framework that was really for epidemiological study which is what Dan is getting at, which is we need to understand the numbers.

We need to understand the numbers for C-section, we need to understand the numbers for contraception. That's different than a quality metric so that there's that distinction in my mind between epidemiological understanding which is what Healthy People 2010 or some of these other things might be more about.

But, and a quality metric that's ready for action where we know we want X, Y, Z percent performance on it.

And so, in my mind, there is that distinction. And with the denominator having some questions and all of these other things, this isn't the only metric where we have this desire to understand something epidemiologically, and therefore, put it in a set, but yet we don't really know what we want the performance to look like which makes it a pretty complicated quality metric and so --

CO-CHAIR GESTEN: Jeff? Thanks.

Jeff?

DR. CONVISSAR: I was just going to

start with by saying that I actually support both of these. And I mean, to your point and the point that's being made, it's valid that we don't have targets. We don't.

We have other measures in our core set that don't have targets. We have ED visits. The answer isn't zero. People have to go to the emergency department and we seem very comfortable with that uncertainty.

And we know that -- and the reason for that is because we know that people are using it way too much now and that there's so much room to go.

And I would say, based on what we heard from some of our experts, that people are so not having access or use when they don't want to get pregnant that there's so much room to go and while we don't know where it should top out, that, to me, isn't a reason not to think that this is a really important quality measure.

CO-CHAIR GESTEN: Marsha?

MS. LILLIE-BLANTON: So, let me just

say, I have certainly benefitted from the conversation and your input and I think it's good to hear how stakeholders view this issue.

I do want everyone to know that one of our improvement initiatives in maternal and infant health is to increase the use of moderate and more effective methods of contraception.

So, we have as a Medicaid program defined this as an improvement goal, understanding the controversy and understanding the concerns and understanding that we still want women to have choice.

This is not about saying that every woman should be using the most effective method of contraception. This is about saying that should a woman choose, we want to make sure that she is using the most effective method of contraception.

Now, I also want to agree with Jeff that we don't set targets. I mean but this is an improvement goal where we're trying to improve, we're trying to increase, in this case, the rates

of use of effective contraception.

And we think it's important for the health of the mother and the health of the infant, that if there is greater or improvements in the spacing of births, we think that an infant has a better chance of being healthy.

And, of course, in terms of the timing of the birth, that the mother also could be healthier.

So, it is something that we are concerned about how others perceive it and what we definitely don't want is the perception or that we are trying to force contraception on women who are covered by Medicaid. But we do want women to have the choice and we do want to better improve our performance.

And just one more tidbit on the data. What we know from the data is that about 11 percent of women now are using LARCs. And that compares to about eight percent nationwide.

So, Medicaid -- women covered by Medicaid already are higher users of LARC. But

we think that that could be a higher rate and it's something that we are encouraging.

So, one more thing that you all should know is that we are using the CDC measures as a developmental measure in our improvement initiative. So, we will be working and supporting states in collecting the two CDC measures as a way to better judge our performance on this goal.

It is developmental and your decision would help us in knowing whether or not this is a measure that ultimately should be a part of the core set.

We do think we need, you know, you could call this kind of like the pilot testing similar to what we're doing with the child hospital CAHPS.

There are some measures that we're not sure it's where we're really -- it's feasible for states to collect and collect it accurately, collect it well.

And the denominator of this one is a

challenge when you're trying to define the population at risk of unintended pregnancies. So, we're still trying to work out in some of the details of this. But knowing your thinking on this measure or either of these two measures helps us because I can at least tell you that we also considered the latter measure, the ARC measure and one that ACOG had developed and we were concerned about just promoting LARCs after a mother had already delivered.

It seems as if, if you want to promote effective contraception, you want to do it before a mother delivers or is pregnant as well as after a mother has delivered.

CO-CHAIR GESTEN: Thank you.

MS. LILLIE-BLANTON: So, that was our thinking.

CO-CHAIR GESTEN: Thanks, Marsha.

So, can I just ask a question? States have a means in which they report on unintended pregnancy rates, because I've seen our colleagues whether it's from -- survey data.

That seems like the outcome of interest here. Is there a reason why that could not or should not be used to get at the issue of unintended pregnancies? I mean I can guess at what some of the challenges related to that data set, but every data has challenges.

So, I'm just wondering, Marsha, either for the initiative or for others in the room, is there a reason to not simply look at self-reported data about whether a pregnancy was intended or not versus looking at access? Is there a compelling reason to not use that?

Rebekah?

DR. GEE: The reason it's compelling is because it's not readily available. You have -- we've been working with the CDC and both the BRFSS and PRAMS to get Medicaid identifiers. But these surveys are filled out presumably by women so they're not going to be information that's shared with their insurance plans, et cetera.

And so, it's not, you know, even though we've been working a lot with the CDC on

making those surveys more actionable on a population level, they were not designed to be used for those purposes.

So, ideally, you would use that, the woman's perceptions, but I would just say that I think we're trying to hold this measure to a higher standard than we hold our other measures.

You know, when we measure cholesterol, we're not saying, hey, what does the patient want their cholesterol to be or asthma.

I mean I think we're just holding this to a higher standard. I mean I also don't think, as Jeff so eloquently said, that we need to think -- this is not a standard setting body. This is, is it a valid measurement body, in my understanding.

Is it valid to measure this? Heck, yes, because we know that very few women are getting these devices, that our rates do not meet up with what other developed countries have. It doesn't mean that there might be issues with, you know, coercion, et cetera, but that could exist

for anything. It could exist for A1c, maybe diabetics don't want their A1cs to be less than seven.

I mean, so I think it's for every issue that we have, I think the patient preference has an important role. And I don't know that that's our job.

And so, I would agree with everything that Jeff and Marsha said. And I do think the denominator, though problematic, is definable.

CO-CHAIR GESTEN: Thanks.

Anne?

MS. COHEN: So, there's a couple things and I'm Anne Cohen, there's two Ann's in the room.

And I wanted to address what Ann Sullivan said. She said, you know, the problematic nature of breast feeding and unintended consequences in measurement, and I did bring that up as an issue for the other measure that not being said that breast feeding wasn't important but that was a different realm for this

body, we might want to consider measurement of.

That being said, I think all policy has unintended consequences that we can't always see. But we also have to look at the historic nature in which we're implementing the measure.

So, the LARCs issue historically was something in the '80s that was -- and '90s -- that was a bigger issue about pressuring women on Medicaid to be on LARCs.

If you look at the historic nature today, that's not the case. There's been cuts to Planned Parenthood. There has been the recent Supreme Court case. There's been issues of state by state reexamining their Medicaid coverage for contraception and access to abortion and other things.

So, I think that given that, I think we need to consider what the access availability is today on this policy issue while keeping the historic nature in mind about pressuring women to take LARCs that otherwise wouldn't necessarily want to be on them, if that makes sense.

So, I just want to put that in the context. But, I think we really need to think about what the policy considerations are today and moving forward in the next 48 years as where the benchmark about whether or not to adopt this measure.

CO-CHAIR GESTEN: Thanks, Anne.

Jeff, did you have another comment?

DR. CONVISSAR: I do. I got so excited about the last thing I forgot that I had two things I wanted to say.

CO-CHAIR GESTEN: So, we're at the point where we need new things.

DR. CONVISSAR: Oh, no, it is, it is.

CO-CHAIR GESTEN: That's fine.

DR. CONVISSAR: The access one, I think what I heard -- so maybe I'm asking for some clarification and if I think if I heard it right, then perhaps there's a potentially useful point here, that there was the ability to sort of band those 99 days, that while zero to seven days isn't to Sandra's point, you know, the hospital

stay, the reality, I would think -- if that's true that we can actually know who got them within zero to seven days, the reality is, if they're getting them in that zero to seven days, it's happening in the hospital.

I mean those folks aren't coming back somewhere like two days later and probably -- so I just wonder if that really, the ability to band while we could make conditional changes and I have no idea how easy or hard that process is, in reality, if the current sort of definition allows for us to really stratify that out, is it possibly good enough?

CO-CHAIR GESTEN: Carol?

MS. SAKALA: I just want to say that I think we've been discussing a kind of professionals going rouge situation this morning of like we want to protect women from professionals not behaving as professionals.

And I think our health care system overall, our National Quality Strategy, we want to do patient and family engagement. We want to

do shared decision making. We want to provide reasonable access to high quality services.

And so, I think we need to kind of raise our bar of how we're thinking about these issues and expect that moving forward, we're raising the bar for our system as a whole.

CO-CHAIR GESTEN: Marsha, do you have another comment or is that -- your card is up. Is that a hold over?

So -- yes?

DR. BENIN: So, for the child MAP, are we going to vote -- we're not voting on all three of these?

CO-CHAIR GESTEN: We'll vote -- I think it's a process.

MR. CURRIGAN: Can we just clarify on the November 5th is to align with the HEDIS measure for prenatal and postpartum care on identifying births.

So, they would only have to pull the denominator once to do the measure for all the measures as opposed to a separate denominator.

CO-CHAIR GESTEN: Thank you.

So, in terms of process, it looks to me, unless my colleague disagrees that we have one measure for the child MAP and two measures for the adult MAP to vote on.

And the challenge will be that each of the measures, folks have things that they wanted to see different. So, as was mentioned before, my suggestion, it depends on the measure, I think my suggestion for the -- let's start with the child measure --

MS. LASH: Could we go to Slide 148?

CO-CHAIR GESTEN: Yes, that's what I wanted to say. Not that one, no, other way, other way.

So, my suggestion would be that we start with the measure as is which includes the 15 to 20. I know that there was an early conversation about potentially this going down to ten or below.

My suggestion would be that we start with that measure and see if it passes as is and

if it does not, then there could be a proposal to change the -- to endorse it with a conditional put on it that the age change happens, unless -- Sarah, do you see it differently?

MS. LASH: If you also want a condition that it be NQF endorsed.

CO-CHAIR PINCUS: So, just to be clear, are the options that we would give them is to endorse, to endorse with conditions or to not endorse?

MS. LASH: So, it's support which is green light, CMS can use it immediately. Support with conditions, we would specify those conditions, we've heard that it gain NQF endorsement or that some further respecification of the age range might take place.

So, we'll take a -- we'll have a motion and then we'll take a binary vote.

CO-CHAIR PINCUS: Okay.

CO-CHAIR GESTEN: So, I'll start with do we have a motion to -- this is for the child MAP, to endorse this measure with the condition

that it become NQF -- go for NQF endorsement?

That's one. Second?

DR. SIDDIQI: Second.

CO-CHAIR GESTEN: So, the motion is endorsement with the condition that this go through NQF endorsement.

All those in favor on the child MAP of that proposal, raise your hand.

MS. LASH: I count 12.

CO-CHAIR GESTEN: Okay.

MS. LASH: So, that passes.

CO-CHAIR GESTEN: Passes.

Now, for the -- sorry, Harold, but let's go to the next one.

CO-CHAIR PINCUS: Okay. So, now on the adult side.

CO-CHAIR GESTEN: Go to the next slide that --

So, this is -- we're not getting the postpartum yet, right?

CO-CHAIR PINCUS: Oh, right.

So, on the adult side, is there a

motion to endorse this measure with the condition that it go for NQF endorsement?

DR. SIDDIQI: So moved.

CO-CHAIR PINCUS: Second?

So, should we vote?

MS. COHEN: Can I clarify? I believe I'm supposed to be on both, is that correct? Okay.

CO-CHAIR PINCUS: Okay.

MS. KENDIG: Can you explain -- the vote is for support which means it would go into effect right now or for NQF endorsement. I guess I'm just not remembering any kind of conditions that were attached.

CO-CHAIR PINCUS: The support -- it's support with the condition --

MS. KENDIG: Got it.

CO-CHAIR PINCUS: -- that it be endorsed by NQF.

MS. KENDIG: Okay, thank you.

CO-CHAIR PINCUS: Okay, so all those in favor of this measure as is going for

endorsement by NQF, raise your hand. In the adult group.

MS. LASH: Conditional support pending NQF endorsement.

CO-CHAIR PINCUS: Conditional support pending NQF endorsement.

MS. LASH: For the adult core set.

That's ten, the threshold was seven, so the motion passes, or Harold as well, 11.

CO-CHAIR PINCUS: Next slide, postpartum?

So, the postpartum one is also for the adult.

CO-CHAIR GESTEN: Right.

MS. LASH: This could be both, it really could. Let's see how the vote goes.

CO-CHAIR GESTEN: So, I'll just -- I mean I think what I heard was going around, at least some support for a support with the condition that the measure be -- that there be an additional component to this measure added by the steward which would be zero to three --- was that

your proposal? I want to make sure that I have it right.

But there would be an additional stratification of access postpartum between zero and three days.

So, I don't know, what do you think? Is that what we should put forward so that this would -- with the other conditions would be NQF endorsement as well. I assume so, NQF endorsement and a addition or modification to the measure that the measure steward would need to agree to.

I don't know how big a bar -- how high a bar that is but --

MS. LASH: It could mean that the measure would take an additional year or so to make it into use.

There is a stratification table that includes the zero to seven day period. It's not as specific as Sandra's proposal, but that is a part of the current measure design.

DR. WHITE: So, just let me clarify,

will the zero to seven day period also provide access while they are still in the hospital?

MS. LASH: Yes.

DR. WHITE: Okay. I can accept that.

MS. LASH: So, then I think the --

CO-CHAIR PINCUS: So, the only condition then would be the NQF endorsement?

CO-CHAIR GESTEN: So, is this a vote? Are we voting on the adult and the child side? Which side are we voting on for this one?

MS. LASH: Let's start with the adult and then take a vote for child inclusion as well.

CO-CHAIR PINCUS: So, is there a motion to support this measure with the condition that it go for NQF endorsement?

MS. PELLEGRINI: So moved.

CO-CHAIR PINCUS: Is there a second?

DR. WHITE: Yes.

CO-CHAIR PINCUS: All those who vote in favor of supporting this measure with the condition of going for NQF endorsement, raise your hand.

MS. LASH: This is Adult Task Force members.

Nine, the motion passes. Please raise your hands once more. That is ten. Thank you.

CO-CHAIR GESTEN: Okay, kids. It's for the child MAP. The proposal is -- I guess we need a motion to propose this measure with the conditional support with the condition being that it goes through NQF approval. Do we have a motion?

Yes, do we have a second? Yes?

DR. LEIB: Do we have to have an age range like we did before, 15 or 20 or something because there are no ages in this measure?

MS. LASH: Right, there is a --

CO-CHAIR PINCUS: Postpartum is --

MS. LASH: -- stratification for less than 18 years.

CO-CHAIR GESTEN: So, I think I saw a second.

MS. LACEY: So, is this with the zero to seven days? Is that correct? Okay, just like

-- I just wanted to make sure.

CO-CHAIR GESTEN: Same measure, all those in favor? The condition is NQF, yes, conditional support.

MS. LASH: I got 11.

CO-CHAIR GESTEN: One more time.

MS. LASH: Eleven.

CO-CHAIR GESTEN: Wait, we've got a discrepancy. Let's do it again one more time, sorry. Just keep them up.

Eleven, okay.

So, thank you everybody, great conversation.

So, we have -- I think we were going to have that public comment at this point and then a slightly delayed lunch, but --

Yes? Go ahead. Shaconna's in real trouble back there. So, she wants to know whether we wanted to offer you to recommend any additional measures.

MS. GORHAM: I just want to be fair.

CO-CHAIR GESTEN: She just wants to be

fair. So, we, again, I think if we had had more time, we would, but if it's -- I think we can make time if there's somebody who wants to offer from the list or from otherwise a suggestion for a measure for us to take up. I think it's probably fair and right for us to do that right now.

MS. COHEN: Is this only for the maternal health category?

CO-CHAIR GESTEN: Yes, yes.

MS. COHEN: Okay.

MS. LASH: This would be for available measures that could be added. I will have a continuing gap discussion.

CO-CHAIR GESTEN: We're kind of hoping you're hungry enough and tired enough that you -- but Jeff has one. Go ahead.

DR. CONVISSAR: The -- it's line 17 in the spreadsheet that healthy -- this is for the child -- the healthy term newborn.

I mean a lot of these measures are -- well, it feels like a really important, really

patient-safety measure in that domain and I just -- I don't know much about the measure but it's already NQF endorsed. I think I checked before I opened my mouth that it was like administrative kind of thing or maybe I was wrong about that one. Oh, yes, administrative claims.

I was trying to use your all -- all your rubrics. So, I guess the question I would have is since you did review all these and it wasn't a staff pick, why? What am I not thinking about?

MS. LASH: The rationale was first that we were already picking out multiple measures and the contraceptive topic was a little primary to the birth outcomes.

The title of this measure is very deceiving, so I just want to be really clear with everyone that it's not measuring the percentage of healthy term newborns, it's like the converse or the inverse that it's looking at the rate of birth complications within the hospital and the, you know, immediate days following.

So, the numerator statement reads, this is the absence of conditions or procedures reflecting morbidity that happened during birth and nursery care to an otherwise normal infant.

It could be very well an important facility level quality improvement measure.

I think another thing that maybe worked against it in our initial calculus was that it seemed like something that hospitals would particularly want to focus on but maybe less so the statewide program.

But we could open for discussion on that to see if people agree or disagree with that judgment.

CO-CHAIR GESTEN: Discussion on that measure?

Carol?

MS. SAKALA: Oh, I didn't immediately bring it up but that was the one that I was thinking of discussing.

From the point of view of what Kevin said yesterday and you said today, Sarah, about

measures that have the potential to impact improvement for a large segment of the population, I think this is really a good one and I might even, you know, prioritize it over delivered at the -- you know, low birth weight infant delivered at the right place of care.

I can also share with you that it's been tested very well but when it comes up for NQF endorsement again, it's going to be flipped.

So, and that also has been tested very well through the California Maternal Quality Care Collaborative and maybe elsewhere.

The new name is going to be Unexpected Newborn Complications and the idea is when you -- babies who you had no reason to expect an untoward outcome and something happens in the course of the birth or the hospital stay afterwards, so it's monitoring that.

And the developer, Dr. Main, feels that it's a balancing measure. So that, you know, this fear of oh, we're going too far, for example, on reducing the Cesarean rate or other

kinds of concerns with overuse that this will be a red flag if we suddenly start to see an increase rather than improvement in this area.

CO-CHAIR GESTEN: Ashley?

MS. HIRAI: I just wanted to mention the severe maternal morbidity measure just to put it on people's radar that it is something that is now a Title V National Outcome Measure.

And that we do feel it is very sensitive to quality improvement and have an alliance for innovation and maternal health that's working with national, state and hospital partners to implement bundles of care to reduce that severe maternal morbidity which is a hundred times more common than an actual death and twice as common as actual infant death.

And many women can be severely disabled. So, it's an important indicator.

We have tools to address it through these hemorrhage bundles, preeclampsia, deep vein thrombosis, that's also work done by Dr. Main.

But it is something that multiple

programs are now working on at the federal and state hospital level and I just wanted to make sure people were aware.

I know it's not going to be voted on.

CO-CHAIR GESTEN: It's not on the list?

CO-CHAIR PINCUS: No, it is.

CO-CHAIR GESTEN: Oh, it is?

CO-CHAIR PINCUS: On the bottom, the last one.

MS. HIRAI: I guess maybe I just shot myself in the foot. Maybe somebody would nominate it, but I just wanted to raise the issue.

CO-CHAIR GESTEN: Got it.

Harold?

CO-CHAIR PINCUS: So, and this may come -- and this will -- actually, it will come up again in our discussion after lunch is for both these measures, to what extent is there -- have risk adjustment methodologies been developed and applied in this -- you know, for these

measures?

Because it's, you know, we're getting closer to outcome measures here and we're going to be having a discussion about moving from process to outcomes. And I just want to get a sense of that with regard to these two measures.

CO-CHAIR GESTEN: My understanding, there isn't -- I guess the question is, unlike measurement at the facility level, does it matter at the state level or not? Do we need to adjust for differences between Louisiana and New York and Nebraska? I mean I think it's a fair point.

I'm thinking that this would welcome, sort of, a nomination for the measure that you had, Jeff, or any other measure. This is the time if you want to nominate one. We'll look for a second, we take a vote.

Again, assuming we figure out which group it's in, I think that, obviously, the one that you talked about clearly goes in the child's MAP and do you want it -- I would ask if there's a nomination for that measure?

DR. CONVISSAR: Yes, I nominate it.

CO-CHAIR GESTEN: Is there a second?

MS. SAKALA: I just -- clarify, do we need to specify conditions like should we wait for the measure to be flipped so there's not a lot of confusion? Would it be after it goes through endorsement again? I just wanted to ask you how it was.

DR. CONVISSAR: I see the one minus, I don't know, it seems okay to me. But if there's a --

CO-CHAIR GESTEN: So, your nomination is for the measure as it's written here?

DR. CONVISSAR: Yes.

CO-CHAIR GESTEN: Is there a second?

MS. GORHAM: And just a point of clarification, if we're talking about the healthy term newborn, it is already NQF endorsed.

CO-CHAIR GESTEN: Carol's -- they're changing it, right?

(Off mic comment)

CO-CHAIR GESTEN: Okay. I appreciate

the kindness, but you seconded the motion, so we have a motion and a second. So, we're going to take a vote for the child MAP on the healthy newborn measure. All those in favor of recommending this be added to the measurement set, raise your hand.

MS. LASH: That's four, so the motion fails.

CO-CHAIR GESTEN: Dare I ask, is there a motion -- anyone want to make a motion for any other measure for consideration?

Marc?

DR. LEIB: Well, I'll seek a clarification. Would it be inappropriate to nominate the flipped version of this when it comes forward and has NQF certification?

MS. LASH: That would be a conditional support with that condition that the measure complete its respecification and review prior to --

DR. LEIB: I will nominate it that way to see if this information was desired in a

different format.

DR. CONVISSAR: I'll second that.

CO-CHAIR GESTEN: Okay, so just so everyone understands, the nomination on the floor that's been seconded is conditional support of the healthy newborn and the conditions are that it go through this process of changing from a flip, it's actually from a negative to a positive, right, and that it subsequently go through NQF endorsement. Did I get that right?

MS. SAKALA: Unexpected Newborn Complications is the new name.

CO-CHAIR GESTEN: Okay, and it has a new name.

So, we have the nomination, we have the second. All those in favor on the child MAP of that recommendation, raise your hand.

MS. LASH: Five, six. All right. That's --

CO-CHAIR GESTEN: Six.

MS. LASH: Six.

CO-CHAIR GESTEN: It does not pass.

MS. LASH: So, it does not pass.

CO-CHAIR GESTEN: Before we go to lunch, which you guys have definitely earned, do we need to do anything -- give any instructions to the Child Task Force?

MS. LASH: Yes. We will be adding to the flip chart behind me the other measures supported this morning by the Child Task Force for addition.

We will also give each of you a fewer number of these round stickers to add to the flip chart about which measures you would prioritize for CMS's immediate implementation.

And we will review the results as a group when we finish lunch.

CO-CHAIR GESTEN: How many do we get? How many -- oh, yes, public comment, I'm sorry.

How many stickers do we get?

MS. LASH: Let's see, so we have a total of --

MS. GORHAM: Six.

MS. LASH: -- new measures this

morning?

MS. GORHAM: No, three new measures, a total of six.

MS. LASH: Three new measures from this morning and --

MS. GORHAM: Three from yesterday.

MS. LASH: -- three from yesterday.

MS. GORHAM: For a total of six that they're prioritizing.

MS. LASH: Got it. Thank you.

CO-CHAIR GESTEN: Yes, but how many stickers do we get?

MS. LASH: So --

CO-CHAIR GESTEN: It's all well and good, how many stickers do we get? Three?

MS. LASH: Does the chair advise three or four?

CO-CHAIR GESTEN: I'm going to suggest three, but -- to the group.

MS. LASH: Force some additional choices?

CO-CHAIR GESTEN: What's that?

MS. LASH: I think it forces the choice.

DR. LEIB: Is there a difference in terms of the need for prioritizing those that have been sort of fully recommended because they're ready and those that are going to await NQF endorsement which I don't know how long that really means. Is that even going to happen before the year ends? So, is that something we should be considering?

MS. LASH: Yes, I would say that the readiness should --- could affect your prioritization. However, if you feel really strongly that CMS's first priority should be working on a measure that only gained conditional support, you would still have that option.

I will also clarify, you are allowed to put multiple stickers on the same measure if you have a strong favorite.

Any other points of clarification? Please do approach a member of the staff during the lunch break if you have questions about this.

And before we break, we are due, overdue probably, for a public comment period.

CO-CHAIR GESTEN: So, let's start on the phone. Operator, can you ask folks on the phone if they have a question or a comment they want to make from the public? Now is the time.

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

And there are no public comments at this time.

CO-CHAIR GESTEN: Thank you very much.

In the room? Any public comments? Yes? Step up to the mic and introduce yourself.

PARTICIPANT: Could you clarify what the vote meant on the postpartum? All I heard was a number somebody had.

CO-CHAIR GESTEN: So, the question was clarifying the vote on the postpartum. Both of them passed, is that right? So, they passed meaning that they get recommended and added to

the list of recommended measures to CMS.

Any other public comments or questions?

Yes?

(Off mic comment)

CO-CHAIR GESTEN: Yes, they were conditional.

Lunch and stickers. What time are we going to come back? We're running a little behind, right?

MS. LASH: We'll take a 30 minute break and --

CO-CHAIR GESTEN: Twenty after?

MS. LASH: At 20 after.

CO-CHAIR GESTEN: Twenty after.

Thanks everyone.

(Whereupon, the above-entitled matter went off the record at 12:49 p.m. and resumed at 1:21 p.m.)

CO-CHAIR GESTEN: So, we're going to give a brief conclusion to the prioritization exercise once we have all the counts, but

otherwise, I think the afternoon is mostly around cross-cutting issues, both -- that go across adult and child.

And some of you have brought up issues and wondered if there's a time or opportunity to talk about issues, other issues about other measures or alignment or some of the challenges that states have and I would say that we're going to tee up, I think, a number of very broad questions that will give people the opportunity to talk about that.

Again, with a focus on is the program of measurement really delivering on the things, the goals that CMS and we all have for the program which is more states reporting, more states being able to report more measures and importantly, use of those measures for improvement.

So, I think that that's going to be kind of the rallying flag with some specific questions about measurement issues and outcomes versus process that we want to tee up.

So, I'm just stalling here. Sarah, do you have the vote count or Shaconna?

MS. LASH: That was well done.

All right, first, I want to clarify that all six measures that gained conditional or full support of the Task Force will be included in the report and recommended. They'll simply go in a rank order that will be determined by the vote that was just taken.

There was a tie for first place with ten votes each for the measure of Multiple Concurrent Antipsychotic Medications in Children and Adolescents and the Under 1,500 Gram Infant Not Delivered at the Appropriate Level of Care.

The next most prioritized measure is Effective Postpartum Contraception Access.

MS. PELLEGRINI: I'm sorry, Sarah, it's just hard to hear you down here, can you just say what the top one was again?

MS. LASH: Of course.

The first two measures are the -- and it was a tie at ten votes each, Use of Multiple

Concurrent Antipsychotics in Children and Adolescents, the 1,500 Gram Infant Not Delivered at the Appropriate Level of Care.

So, then in third place with seven votes -- hold tight. Foster, you can keep stalling, if you like. Anyone know any good jokes?

CO-CHAIR GESTEN: Did everybody vote? Did everybody have stickers and votes, probably a good time to ask, anyone else? Okay.

MS. LASH: Okay, we're good.

CO-CHAIR GESTEN: Okay. Anything need to be revised?

MS. LASH: It remained a tie for first place between the Multiple Concurrent Antipsychotics and the 1,500 Gram Infant Delivered at the Wrong Level of Care for first place.

The next most prioritized measure was Effective Postpartum Contraception Access, followed by Use of Contraceptive Methods Women 15 to 20 Years Old and then finally, another tie

between Audiological Evaluation No Later Than Three Months and Pediatric All Condition Readmissions.

CO-CHAIR GESTEN: Great. Any comments, questions?

So, again, I want to thank everybody, both groups, but especially the child MAP for their work over the last day and a half, probably to say thank you's again, but in case folks are leaving early, this was a -- I look forward to the afternoon conversation, but this was the work that we had to do and it was hard choices.

Somebody said, you know, choosing between your children and your grandchildren around these measures.

I think the good news is that, you know, we get to do this every year. Sort of a good news, bad news story, right?

But, the fact that there is, you know, such a deliberate and conscious effort to make sure that the set is right each year, I think it's really, you know, a testimony to the process

and, you know, it commends the amounts for paying such close attention to is.

So, I think we want to do -- just have some slides talking about some of the issues that we've touched on over the course of the past day and morning related to data collection, this issue about appropriate balance of measures, however you view balance.

But certainly, one of the things that comes up very frequently is between process and outcome measures. There's certainly other ways in which we can think about balancing measures, measures that are of interest to policymakers, measures that are of interest to providers, measures that are of interest to patients and families. Hopefully, at least on a good day, some of those measures are overlapping.

And then, as we've talked about if really the point of this is motivating quality improvement action and a combination of Jeff and Rebekah and I assume you'll hear -- the adult group will hear from David Kelley and others

about some of the tremendously impressive actions and activities that are going on, I think, that really describes sort of what it's for, you know, what's the purpose of this and how measures can be used.

So, I think we want to be able to encourage that and see more of that and clearly have measures that serve that really important purpose.

As Harold said, it's not just measures for measures sake but really measures to really motivate states and clinicians and health care organizations to improve.

So, what's on the next slide? Yes, go ahead. Thanks.

MS. LASH: Sure. So, we have just a few bullets that reflect back some of the themes we've heard in last year's review and some that have also been raised during this meeting about these different aspects of balance and motivating quality improvement action.

So, when we think about enabling

better measurements, we heard frequently that inability to access data was the most consistent barrier across the board for these measures.

We know that chart review and other manual methods of data extraction are very expensive, time-consuming and they might mean that other priorities in the Medicaid program would have to be sacrificed or the chart review itself might end up getting sacrificed. There's a real calculus as to what is the most bang for your buck when it comes to quality measurement and improvement.

We've heard a lot of discussion about linkages to vital records providing highly useful information, but it's a technical process that requires a significant startup investment and we could consider ways to reduce the amount of initiation energy required there.

We also know that few states have EHRs in fully wide use and also available to health plans and Medicaid agencies to access. And registries, although wonderful for lots of

specialty condition measurement are not as feasible as the data source for this structure of a program.

Another thing to consider about whether those measure sets should favor process outcome measures, structural, that outcome measures are more likely to require risk adjustment to gain buy-in about the people being measured than are the process measures.

Some part of that erodes when you lump up the data to report one statewide rate to CMS, but for a state to be able to work within its own network, there might be a greater ask for risk adjustment to be present within the measure if the administrators really do want to compare their contracted health plans to one another or all the state hospitals, for example. So, those are just some little seeds -- food for thought.

On the next slide, we have a set of discussion questions. We'd like to hear from our state panelists any thoughts that they have on these questions and then we'll have a very open

ended discussion within the group.

And if there are other questions you would like to raise to each other that resulted from the meeting that we didn't have pre-prepared -- benchmarking comes to mind, do feel free to introduce that into the conversation and we'll capture it as best we can.

So first, begging the question, is it really a priority of the states to move towards more outcome measurement? That is a truism in measurement science sort of worth reexamining here.

Are the states realistically able to request plans and providers to give them more information, more data?

If we were to add more outcome measures to the core set, at this point in time or even next year, would it have the effect of hindering state participation?

And then, are there sort of lessons learned from the broader measurement community who have gradually adopted more outcome measures

to replace structures and process measures?

So, our chairs will, you know, facilitate this discussion here.

CO-CHAIR PINCUS: So, for those of you that are most involved in terms of state administration of this, we'd like to hear from you. So, you know, Dan, Rebekah, others.

CO-CHAIR GESTEN: So, before we get started, I do want to do -- Dave Kelley, are you on the phone? Are you still on the phone?

Okay, Dan, why don't you start us off?

DR. LESSLER: So, you know, it's interesting to think -- there's a lot here to think about. But -- and, you know, I think I'll begin commenting just from a Washington state perspective and sort of the broader milieu in which measurement is playing out.

And so, actually, we had a legislatively mandated effort to define a set of core metrics for our state, which actually involved a meeting -- several meetings that actually remind me of a lot like this meeting

except it was in the other Washington with different stakeholders around the table.

And the themes were, you know, amazingly in line with those here in terms of parsimony. I would say in terms of a measurement toward outcome, and as a matter of fact, what was most frustrating for -- actually, I would say for those -- it's frustrating for everybody, the inability to get to outcomes.

It was more accepted by the people around the table who sort of were the measurement experts who were pushing toward metrics that we can actually measure.

So, whereas other groups, stakeholders would typically push towards outcomes. And then the question would always be, well, that's great, but how are you going to measure it? So, similar ---- you know, similar themes.

Having said that, you know, in our state, I think -- and for Medicaid in the state, I think we would very much like to find ways to move toward outcomes. You know, I think that's a

high priority. It's just finding ways in which to do it.

I think I really want to underscore the parsimony. You know, I'm not -- we actually ended up with 52 state measures across -- we did it -- we sort of broke them out by prevention, acute and chronic measures.

And I think a lot of people around the table got a lot heartburn around that, you know, 52 measures, and of course, there are thousands that are out there. So, I have my own perspective on this and I think that of others is really sticking to parsimony.

I don't think we need more measures. I think we need to really grapple with, you know, working with measures and getting them to work for us in terms of really informing quality improvement and seeing if we can actually make this all work.

The only -- you know, the last comment I would make and this is really relevant to the earlier slide and I'm speaking in part in

ignorance, so excuse me if I say something that is like totally out of bounds.

But with respect to outcome measures, and with respect to measurement in Medicaid, what strikes me is that, we do -- so we're 90 percent managed care in the State of Washington and we do contractually, you know, obligate our plans to collect data and they are going in, and of course, actually, they're either -- they're most NCQA certified and if they're not, they have to be by the end of this year. So, that's actually in law now.

So, they're actually collecting data on some outcome measures. For example, you know, the one that you always round up is, for example, blood sugar control in people with diabetes.

And, you know, they're collecting a lot of these measures using HEDIS definitions and so forth and I just, you know, wonder the extent to which if -- and I think, Foster, you were referring to this maybe earlier.

You know, if there's a way to get some

alignment there because if the plans are already doing this, albeit and getting to outcome measures or, you know, I just wonder if there isn't ---- in the HEDIS context, I just wonder if there isn't a way to be able to take advantage of that at least to begin actually reporting on one or two, you know, true outcome measures more uniformly.

So, that's sort of what it looks like from the other Washington.

CO-CHAIR GESTEN: Nothing out of bounds about that. Although, your 52 measures reminds me of wasn't it Bruce Springsteen 52 measures and nothing's on? Or was it 56 channels? That's what it was.

But the irony to me is there's so many measures, and yet we spend a lot of time talking about gaps and the inadequacy of measures and so on. And there's that tension, as you described, between what people might ideally want whether it's outcomes or patient reported outcomes or functional outcomes, and what we're stuck with

relative to, you know, the data that we have.

Beverly?

MS. COURT: Thank you, and I'll probably repeat everything I aim to say in my presentation tomorrow. So, this is it in a nutshell. The things that I'm really passionate about having people hear.

One is the technical specs, once these HEDIS measures go to CMS and CMS gets to interpret them. For example, if we had a family planning only population, which we did, we had a large population in 2012, that was to be included in the denominator of some of the measures, even though they couldn't be in the numerator of that particular measure.

So, that makes that measure meaningless for us. It's not -- and currently, for example, those with third-party liability, we have a lot of TRICARE in our state, for example, large military population, and that is included as well. None of those people will turn up in the numerator, but they're included in the

denominator.

So, the way that we responsibly do measurement in Washington State is we're very selective about who is the denominator. It has to be mathematically possible for them to be in the numerator.

And that isn't part of the technical specs currently with the adult quality measures and some of the health home and managed fee-for-service duals.

So that's one issue is that I'd really -- that needs to be addressed because it makes the measure then -- especially when you're looking from one state to another.

Now, our state has had a lot of expansion of ACA. So, our family planning only population is quite small now. But it varies state to state so what are we comparing? We're comparing an apple to an orange.

And that's another concern is when these profiles are put together, the natural -- when a state reports a measure, the first thing

that people want to do is to then publish this comparison.

Let's compare Washington with another state, but if that state has only -- for example, if their method of collecting data is they were able to collect it from two managed care plans, then that's what they're reporting from in their state.

It's not a reflection of their entire state. It's a reflection of what they could get their hands on to report, but that's being used and that's being typified as that's showing the entire state, and then one state is getting compared to another.

So, if you have administrative only method and versus a hybrid method, those two are considered representative of your state, and therefore, then the median and mean is calculated from that reporting.

So, it creates -- so how that measure is used, I guess, is a real concern of mine. So, getting down to the technical specs of what's in

the numerator and denominator is one issue. The other is comparing one state to another.

One thing about the CHAPS survey, that's a number of measures are dependent on being able to implement a CAHPS survey. The way the HEDIS specs are -- or the CAHPS survey protocol, if you follow it perfectly, first of all, there tends to be low response rates.

Second of all, it's not actionable because what you don't include in there is a way to drill down to medical practice. There are some states who've developed a kind of modified CAHPS survey methodologies so that you can make that CAHPS survey actionable.

But remember -- I guess if we're going to invest that much money and time into CAHPS surveys, it really matters that we make that survey actionable, that we include information that we can do drill downs to medical practices so we can actually do something with that information besides just say, okay, we did a survey, here it is, let's put it on the shelf.

Okay, those are all my points. Thank you for letting me get them out.

CO-CHAIR GESTEN: So, I just want to ask a question about some of the issues that you raised. I think we might get to them in later slides.

But on the issue of outcomes, clearly, some outcome measures like hemoglobin A1c which Dan was talking about, I think most people wouldn't say that that's an outcome that needs to be risk adjusted.

However, there's a conversation for other kinds of clinical outcomes, certainly mortality. Some people are talking about some adjustment for readmission. There's more concern about that apples to apples comparison where there's -- at the provider level particularly.

So, I guess the question that, based on what you said, which raises concerns about comparability from state to state, which clearly is part of the goal of, you know, having standardized measures across states.

But, do you see an issue with a move to outcomes? Does a move of measures to more outcomes create more problems, less problems related to comparability of outcomes?

In other words, does the potential of moving to more outcome measures raise the specter of the need to risk adjust across states? In other words to be able to know whether the population for various outcomes really differs between Washington state and Oregon?

MS. COURT: Yes, it is important. It is important to start risk adjusting. It's important to have Medicaid risk adjustment, though we certainly don't have that now. We have Medicare, we have commercial. Medicaid is different.

Duals are different from Medicare, for example, when we've been working with that population. So, it's important to have relevant risk adjustment methodologies.

CO-CHAIR GESTEN: Kevin, you've been very patient.

DR. LARSEN: So, one of the fun parts of my job is I now get to do some technical assistance to states as they're standing up their State Innovation Model programs. For those of you that aren't familiar with that, it's the single-line model and 36 or 37 states are involved.

And one of the things that we see at ONC as we go in and talk to these states is they're building this same infrastructure for measurement, three, four, five times over and over again. And providers are having to report to three, four, five different groups on a new aligned set of measures.

So, the health plans are doing it and the Medicaid office is doing it and the ACOs are doing it and somebody -- a third-party system is doing it and they're sending it to Washington.

So, one of the, I think, questions that I have for this group is how to move to a more shared infrastructure? You know, everyone's having trouble getting the data. It makes it all

that much harder if we don't align.

And if we always think about how does the health plan get the data as that's a direct from provider to health plan as opposed to what's the model in the state of a kind of shared infrastructure of measurement and transparency? And how can that be used for any number of purposes that actually provides some more general alignment opportunities as well?

Because all of a sudden, it's that many less business associates agreements. It's that many different less places the data has to flow. It's that many less times you have to figure out provider attribution because you do it at a shared model way as opposed to each group figuring it out on their own.

So, I'm really curious about that particular question to this group and I think the assumption here was that the health plan gets this data and they're the ones that have to get it all and have to do all the work.

CO-CHAIR GESTEN: Bev, then Dan?

MS. COURT: I just wanted to help flesh out examples of what you were pointing out. We have the same measure but different specifications for health homes for fee-for-service managed -- the fee-for-service duals.

For example, in that arena, it's a requirement of health homes that the plans -- that the providers are reporting that information. Well, if they're fee-for-service, they don't have claims data. So how can they report it? And so, they've been adamant that, in fact, they be able to report it.

Well, we have the information, so we're going to create the reports. We're going to give it to those community-based fee-for-service organization, then they're going to send it back to us, and that's how we're going to meet that measure or that reporting requirement.

So, there is an issue of even when you start with the core specs, the differences that each of the CMS programs are putting on these measures, and so we can easily have three or four

even within the same definition of the measure.

CO-CHAIR GESTEN: Rebekah?

DR. GEE: I'm going to need to leave in a minute. So, first of all, thank you for inviting me. This has been wonderful and very productive.

But just to say, I think -- to speak to what Kevin said. I agree completely, for maybe different reasons as well as in our process of using a combination of measures that require public health data.

We've had to work with the plans. We've had to centralize data collection. It allows us to learn from each other. It allows us to make the measures better. It allows us to get the denominators better. It allows us to do QI together.

When you have a central database that you're working with as a state rather than just relying on individual health plans to go pull their data and relying on them for the accuracy and validity of it, it's really been a good

experience for us.

So, wherever that's possible, now whether it's -- you know, ideally, you'd have an all claims, all payers database. We don't have that. But, I think one other area you can do this is alignment is with public health and Medicaid linked data sets.

CO-CHAIR GESTEN: Marc?

DR. LEIB: I have a question for all you states that have been very successful in reporting data because I'm embarrassed to say Arizona, while we have all the quality measures a lot, but we don't report it because we don't have them for the January 1st to December 31st. We go by our contract year with all the health plans which is October 1st to September 30th.

Do all of you do a January to December or does that correspond to your contract years? Are you crossing contract years? Or how do you get past that barrier so I can bring that information back to Arizona?

DR. GEE: So, you've got change your

contract year to match HEDIS, which is what we should have done. Although, we are ---- I'll just with a caveat, our new contracts started February 1st which is the -- so, there you have it.

But we report HEDIS, so they're doing -- for the first year, they're going to report a pseudo-HEDIS that starts in February. But for subsequent years, it's the January to January.

But, ideally, you'd have your contract year starting January 1st.

DR. LEIB: That would be a politically difficult thing to do, but -- so, you guys are all doing the January and we're still being left out in the cold because we can't do that yet.

CO-CHAIR GESTEN: It's not cold in Arizona.

DR. LEIB: No, it's not. It's hot.

CO-CHAIR GESTEN: It's dry heat, though, from what I understand.

DR. LEIB: Right. We're burning up. Okay, thank you.

CO-CHAIR GESTEN: So, I'm going to take -- put on the state hat and answer these specific questions that are up on the slide because I think they're reasonable questions.

You know, the first one about is it a priority to move towards measures of outcomes? I think, generally speaking, regardless of the program that we're looking at, the answer to that is yes but not slavishly.

Meaning that, you know, there are some outcome measures that are not as good, in my mind, as a process measure or maybe even there are structural measures that even better than process and outcome measures.

So, while generally speaking, I join the chorus that, you know, if it's a choice between a structure or a process, you know, why not just look at the outcome?

Like the comment about asking women about whether their pregnancy was intended, there are challenges to getting outcome measures including that one.

And the issues about risk adjustment, when you move to process to outcome, then very often the issue about risk adjustment becomes more prominent, so it kind of shifts the conversation and debate.

And you also have, I think, an interesting conversation about what outcomes are really -- outcomes that are influenced by the delivery system but not completely controlled by the delivery system is usually a vigorous and fascinating conversation about quality measures with clinicians.

I think it's the right conversation to be having and I think that influence counts. But it does raise other kinds of issues that sometimes just lead to rejection of the idea of the measure if clinicians don't have absolute 100 percent control.

Can states realistically request plans and providers to provide more data? I mean we're the state, you know, we can do it, we can ask. Sometimes we can mandate just like the Feds can.

But I think in terms of winning over hearts and minds and the issue of the crowded playing field, I think that we're past saturation a long time ago.

So, I think the issues of the path forward are along the lines, Kevin, of what you've described which is how do we build a more efficient infrastructure?

It doesn't necessarily have to be some one single mega-state data base, but I think the conversations we've had over the past couple of days of trying to make use of public health data sets, trying to match data sets together, stratifying data that we have by subpopulations, aligning initiatives so that the measure can be collected and you can get multiple checkoffs for that.

I think those are all movements in the right direction. So, adding entirely new burdens to states is, I think, a real challenge.

I don't know that outcome measures hinder states' participation, at least from my

point of view. It really -- it's not so much because it's an outcome, it really depends on the outcome and the complexity of the data that's required and the burden of getting it and so on.

But, I don't think there's anything specifically about outcome that makes it necessarily harder. Although, again, it depends on which outcome. Clearly, it's a lot easier to measure whether somebody had a hemoglobin A1c than what the actual result of that hemoglobin A1c level is.

On the other hand, I think the world is moving towards being able to collect things like the actual lab data both at the health plan level and at the practice level in electronic health records. So, I think that we've come a long way.

And, you know, are things transferrable? I mean I think that they are. I don't see why, you know, outcome measures for one area hospitals and so on are not transferrable.

You know, many of the measures that we

have been talking about today were developed for specific projects or initiatives, quality improvement, not at a state level but at a practice level or at a hospital level or at an ACO level, whatever.

So, I think the experience that those organizations have had in the measures and doing outcome measures, I think, have importance and relevance to states. And I think a lot of it, though not all of it is transferrable.

CO-CHAIR PINCUS: So, a couple of thoughts as we've been discussing this.

I think that, you know, we're not going to move to outcome measurement over night. And I think, as Kevin suggested, really we're kind of encouraging people to move along the developmental pathway to begin to build capacity for measurement of outcomes.

And, in some ways -- you know, one of the things that's happening also simultaneously on a clinical level in a number of areas is this sort of notion of measurement based care, that

really, to try to get at the point of care to apply what -- actually we've begun to learn more and more about which is that, you know, for many of the chronic diseases we're dealing with, there is no killer app that's going to, you know, sort of wipe away the problem.

But, instead, what really needs to be applied is more systematic longitudinal assessment that's action oriented, that, in fact, is not rocket science but really is looking at whether people are better and if they're not getting better sort of step-wise it in intensifying care.

And that having various forms of registries and other kinds of approaches that allow people to collect that kind of data and apply it, you know, supplemented by clinical decisions, support and other kinds of things is what's being encouraged. Also by some of the structures that are being put in place by states whether it's health homes or it's patient-centered medical homes. The states are more and

more developing registries of different types.

All of this, these are steps in that developmental pathway whether it's Rheos and other kinds of things. And I think one of the questions, how do we sort of actually solidify some of that and actually make clear which states are doing what and how we can learn from those kind of things.

You know, so it's, you know, creating these registries, thinking about how one applies sampling tools so it doesn't have to be done everywhere at every time.

The other thing is linking to other initiatives that are going on. So, I know from, you know, the work that we're doing in New York that we in New York City have received a large PCORI grant to develop a New York City wide clinical data research network.

And we've been having, you know, thoughts about how do we actually use that for -- -- not just for, you know, and PCORI and NIH would want for engaging people to participate in

clinical trials but to actually do this in a way that can create area wide improvement initiatives and quality measurement. And there's 11 of these clinical data research networks around the country.

Again, is there some way to partner with those kind of things? So, to think about, you know, what's the developmental pathway? How do we make us of sort of existing new initiatives and structures that are being developed, you know, within the health care system? And then how do we link with other types of initiatives that are going on in other places from other sources?

CO-CHAIR GESTEN: Marc, you had your card up, was that the vestige? Cindy?

MS. PELLEGRINI: So, I'll qualify this by saying that, you know, I'm not in a state program, I'm at an outside organization.

But it seems to me that one of the things we have to keep in mind when we think about these kinds of questions is that all of

these are taking place right now in the context of tremendous upheaval and change.

And that we're trying to figure out some of the answers when there are all kinds of incentives and disincentives pushing these things in often conflicting directions. Right?

And it's going to be a long time before some of that settles out. So, the answers that we come up with today, even if we came up with concrete answers that we were all comfortable with, won't necessarily be the same answers in three or five years.

And so that it's that constant evolution, that rapid dramatic constant evolution that we're in right now, that adds an unbelievable layer of complexity to this.

And I think in the midst of all of that, one of the things that's changing is our definition of an outcome. You know, right? There's a clinical outcome versus, let's say, what the patient desires as an outcome and those may be totally different things. So, I think

even how we think about outcomes is going to continue to shift.

CO-CHAIR GESTEN: Great points. Kevin?

DR. LARSEN: In a past life, I was a health services researcher and focused on clinical care outcomes of Medicaid patients and uninsured patients, especially around churning.

And, for those of you who don't know what churning is, when you go on and off of various programs. And I know I've, again, heard from a number of states that, especially with the new exchanges and the Medicaid expansion, that they're seeing, again, a lot of people moving between various types of insurance and insurance products.

And I'm wondering how this group is thinking about a kind of state level accountability to those people and knowing that they're getting good outcomes and not just excluding people that move -- that happen to bounce back and forth between multiple different

types of insurance or insurance programs?

CO-CHAIR GESTEN: Before I get to you, Beverly, anybody have a response to that?

Anne, is your comment in response to that or something different? Additive? Okay.

MS. COHEN: So, I would agree with the churning issue and I think another piece that in my ---- that in the disability, in the senior community that is oftentimes talked about but isn't always talked about in the Medicaid sense, is for folks who have serious mental illness or folks that have persistent or intermediate homelessness.

Because they completely fall off the radar entirely. So, they're not churning to another pipeline, they're just churning out of the system entirely.

So, I think that our measurement list right now doesn't have anything that really helps to capture that group. And so, I think it's a big huge gap area that we need to kind of bang through, and it's one of a huge cost driver for

states.

The State of Oregon has done amazing jobs with some of their care management programs. We heard about them in duals group in March. And so, we might look to some of the work that they've done around measurement and monitoring to kind of capture that group that usually gets missed.

CO-CHAIR GESTEN: Bev?

MS. COURT: Very similar to the comment that Anne made. I think a lot of times people look at these outcome measures at the aggregate level, they're not really that useful. They really need to be broken down if you want to do action on them or really understand the parameters is breaking them down.

For example, those with behavioral health issues. I mean that's a far different animal than another subset, for example. So, I think really drilling down for these measures is as important as ---- frankly, the aggregate is fairly useless.

CO-CHAIR GESTEN: Yes, that's a really point.

I heard yesterday -- when I was listening to Jeff Schiff talk, I thought I heard a conversation about yes, outcomes but outcomes that can serve the purpose of quality improvement.

And I think your point is partially creates a challenge, which is outcomes are sort of a nice one stop shopping parsimonious way of getting at a whole host of concepts. That's the good news.

The bad news is, it's a one stop parsimonious way of looking at whole of things. And if you want to actually improve it, you actually may need ---- or there'd be value in having specific process measures or even, you know, subsetted outcomes.

Which is why this conversation always, to me, of process versus outcomes is a specious one because it's, well, which thing for which purpose? And it's not an -- it's, you know, it's

never been an either/or in my mind. Yes?

MS. LILLIE-BLANTON: So, my question isn't focused specifically on outcome measures, but how do you improve measurement, whether it's a process or an outcome?

And in our last MAP meeting, we talked about those states that use their external quality review organizations to help with collecting data that needed to come from medical records, particularly using a hybrid approach.

And the question I've -- you know, it seems as if we've created one infrastructure for collecting data for the purposes of accreditation and another infrastructure for collecting data for the purposes of reporting to CMS.

And my concern is, how do we begin to merge those systems so that we can be more efficient and more effective? Because we know that some of our under-reporting comes because we're just running claims data and that claims data often times is not fully accurate for different reasons.

For the immunizations, as I said, because, for example, vaccines, you're not actually paying for the vaccines.

But for different reasons, you find that the claims, or maybe it's because it's managed care and it's encounter data. And sometimes the encounter data isn't complete.

So, the hybrid method to help us improve the quality of our data and also could get information on outcomes such as controlling high blood pressure.

So, I just want to get thoughts on how we begin to merge those more.

CO-CHAIR GESTEN: Alvia?

DR. SIDDIQI: I was just going to say ---- and I'm looking at Kevin, too, because I think a lot of this has to do with interoperability between EHR systems to be able to provide the data. A lot of data's being captured, but being able to translate that data into meaningful information -- no pun intended there with the meaningful use reference.

But, you know, essentially, I think what states are struggling with is to try and do that kind of hybrid data analysis, you want to be able to pull the data from EHR systems, but EHRs are not interoperable.

And we look at MACRA, I believe one of the key milestones in MACRA is that these EHRs are going to be interoperable but the onus should really be on those EHR vendors to make that interoperable rather than let's just work through the HIE, which I know in our state at least, HIE is really not getting there in terms of being able to communicate that information and information sharing so that you're not doing double duty work.

DR. LARSEN: Yes, I'll take a follow on to that. Absolutely agree, and it's a huge number one priority for us is to really enhance interoperability.

One place that we see an ability to do that that we haven't really tapped into very much, if you think of the EHRs as sending

information in a format that the receiver wants. If there are a thousand different ways, the receivers want the data, it's very hard for the senders to get it right to each of the thousand different ways the receivers want it.

And you'd be surprised at a single health system how many different ways they get asked for the data, the same data, the diabetes outcome, but for this place it has to be like this, and for this place it has to be like that, and it might even be the same measure but they need it -- in this one in a PDF and this one in a comma-delimited file and this one, oh, January to January and this one in October to October. Right?

And so, there's an opportunity for us to advance that interoperability by us getting this technical alignment between ourselves because then it makes it easier that we lower the burden of what those health systems and vendors have to do for them to meet our needs.

If our needs are more similar than if

each of us have a technically different needs that we express all the time.

CO-CHAIR GESTEN: Anne, did you --

MS. COHEN: Yes, I have a comment related to your question.

So, from what I have seen at the plan level in California, I think another added layer to this is that the state could have sort of their own quality metric goals and CMS kind of their own.

And then at the plan level, there's collaboration between the plans for quality improvement projects. And the plans are required to do annual quality improvement projects, sometimes biannually. And then they devote funds for pay-for-performance. So, that particular QIP gets something technically fixed. And then, that eventually translates up to CMS.

So, what I would say is going to the health plan associations and the state and saying, look, from the CMS's perspective, this is a QIP area that's really critical and you might

want to think in your next QIP round to push for this area and let's fix this.

And I think that the challenges in many states, they echo -- it comes from another entity that they deal with to funnel information through and doesn't frequently drive the QIP process. It's actually the health plan collaborative groups that do that in collaboration with the state.

And in some cases, it might be two or three people in the plan and one person, or two or three people at the state, is driving this whole thing and that's where you can get the biggest bang for your buck.

CO-CHAIR GESTEN: Andrea?

DR. BENIN: As I think about your question, Marsha, I think about -- there's different layers to that problem. Right?

So, the most base layer it sounds like is this idea of even can the states connect the data that they already have? The vital records? You know, and some states can and some states

can't.

But, what it would seem to me that the feds could do might be to create a data model that could be developed in a way that was usable by the states. And I don't know if this exists or not, but if there was a generic or not so generic data model that could be said to the states, you know, here's the data model. We kind of expect you to use it. It's working in Minnesota, Louisiana, where ever it is or isn't working and, you know, we'd like you to pilot using it and then that starts pulling things together.

I mean I guess I don't understand all of the idiosyncrasies and the politics of all of the various groups that own the different data. there's these different layers of it. So, there's that first layer that's even like, you know, what? There's government-owned data already and then there's should we go in and start abstracting charts, or you know, adding EHR data, et cetera, et cetera? Those, to me, kind

of like go up the pyramid of needs a little.

So, I guess if I were to chunk apart that problem, I would kind of start chunking those things little by little to create the infrastructure over time.

I mean maybe there's a glide path that the group creates that, you know, looks at X number of years or, you know, I don't know.

MS. COHEN: Well, there is one thing that I would be remissed if I didn't bring up.

One of the reasons why the data interoperability is so, so very difficult is because it's the MMIS vendor that's actually doing the work.

And part of -- and I experienced this in California, the duals project when we had to comply with data stuff, I was the main guy responsible for it. But the agency staff, we'd go to them and say, okay, so CMS wants you to do your X, Y and Z. And they'd say okay.

And then they would add -- hand the list off to the data person. And then the data

person went to their contract person for the MMIS vendor and they were like, oh, great. But we're redoing the MMIS system right now?

And we have ten other things that we have to do. Oh, and we have data exchange and all that stuff. So, it falls so far down the list that it doesn't meet CMS's timeline for submitting the data. And that's what we found for the duals project to be so problematic.

And so, I don't know an easy solution for that other than sort of going to the MMIS contract people and saying, when you're redoing your contracts, add this to your list of requirements for MMIS vendors because once it's already in the contract, they have to do a contract change in order to get that through.

So, I know it's way in the weeds, but it's an area to look into.

CO-CHAIR GESTEN: Kevin?

DR. LARSEN: Yes, a couple of things. So, ONC says that interoperability works at the speed of trust, and people tend to think that

interoperability is a technical problem.

A lot of it is actually a trusting, sharing problem. And that's where groups like this can have an incredible benefit in their states to help build what that trust looks like and those business relationships that allow people to say, yes, it's okay for me to share. The trust is there. That frees up the technical people to focus on the technical part.

And related to the sort of issue of data model, MMIS systems, et cetera, the thing that ONC has been charged with and continues to put forward is a national set of standards that we think are the standards should be followed.

And These are very technical documents but they're exactly the kind of thing to hand to an MMIS vendor and say, we expect you to do this exactly like this. Here's the 500 page detailed standards document.

And, by the way, here's the place you can test that to be sure that you built it to the way those standards work.

And that is what we are asking of EHR vendors. It's a heavy lift. We know that. We're all moving from the way we did it our own way to a way that is more aligned to standards.

But we think that that's a more likely path forward for interoperability than saying there's one model. Everybody has to do it. It's an APCD here, everybody has to do it through the MMIS system. Everybody has --

States should, and are going to figure out their own way. But, if we have a common set of standards that we have tested to an agreed upon, a lot of different ways can all work together.

CO-CHAIR GESTEN: Beverly?

MS. COURT: Related to that, it's just the timing issue and I'm sure other states have brought this up that you come out with a technical specs.

For example, if they come out in November which they did for the AQM for the first year, it's hard to get that into production to

produce it by January.

In addition, it takes at least a year or even a year and a half to get any new measure into a contract with managed care organizations.

So, the lead time is huge. You never want to put the technical specs in that contract because, low and behold, it's going to change the next year.

So, those are some of the issues, MMIS systems, every type of analysis we do for legislature is built off of paid claims, not denied claims, suspended, et cetera, et cetera.

So, you've got an apple and then you need to develop a whole system that's going to report an orange? Well, that's hard, that's a lot of work and it's never going to compare with what the legislature is asking about which is paid claims.

So, those are some of the issues. And, again, for example, now if I were to ask the plans to please report this according to the three different ways that I have to report it,

adult Medicaid, health homes, managed fee-for-service duals.

Those are three different specifications right now in the same measure. So, for example, even rehospitalization, one is using 2014 HEDIS specs. One is using 2015 for the same time period. So, and then one is weighted, one's not weighted.

Anyway, it's challenging. So, my technical specs to the health plans, if I were to meet all my CMS required reporting requirements for these measures that even require medical record review, it's going to be as long as my arm.

CO-CHAIR GESTEN: So, great conversation and comments.

We talked about outcome measurement, but we obviously, as it's hard not to do, strayed into lots of other issues about data access and you can never had a conversation anywhere without talking about interoperability. I think that's kind of de rigueur at this point, and about the

vendors and so on, and so, lots of challenges.

Unless there's any other comments, my suggestion would be that we open it up for public comment on this issue or set of issues, actually, that we opened up.

And then while we're scheduled to have a break, again, I would suggest if folks want to break, break, if you need to take a break. But otherwise, kind of go through the next set of questions, some of which we've already started to talk about, some of which are new or more precisely around use of measures by states.

Andrea, before we open up to public comments, do you have something you wanted to say?

DR. BENIN: I mean, Foster, do you think that it's helpful for this group to -- I guess if we -- have we commented strongly enough for the purposes of writing up whatever report that needs to be?

If I put on taxpayer hat, right, I want to like cry at the waste, right? And I

think that that's really frustrating and we're not going to get beyond that until there's a pretty strong mandate in some way, shape or form.

And I guess I'm just curious if you think that we have -- I mean we've discussed this now, I think, kind of a couple of different ways. Have we -- do we need to have a certain strength to our thinking or recommendation or are we strong enough already? I mean where is our --

CO-CHAIR GESTEN: Well, which raises the question, who's the audience for these questions, right? So, I see that since these questions were teed up in part for CMS to get input from the groups, so I would punt that question about did you get enough and from the conversation that's helpful to you, Marsha, and then Sarah and Shaconna is the ones who are actually going to have to the work of writing this up, is it clear enough where the discussion went and what was said?

So, maybe starting with Marsha, was this -- well, now, she's got a funny -- I've

never seen that look on Marsha before.

MS. LILLIE-BLANTON: Well, we're midway through the process. So, in terms of the child measures and the maternity core set, I think I'm still absorbing it. I'm still processing it.

I still think we're trying to --I think there's probably some reading I need to do in kind of sorting through what we've heard, taking back to our state partners to better understand.

I think access to data and information -- I mean we focused on outcome measurements but I think, in general, the quality of the data that we get, access to data and the quality of data are key.

And so, I have to sort through some of the recommendations for new measures with my understanding of the challenges and barriers that states face in getting access to the data.

So, I think this has been -- you know, I think I've gotten a lot and the written report,

you know, the MAP really helps us in kind of synthesizing and summarizing across. So, it's hard to say right now, but I mean we certainly will come back to you if we feel like we need more.

And luckily, there's a report review process. So, if in the course of the report review process we feel like we have not gotten what we need, we can still come back to you.

CO-CHAIR GESTEN: Yes. I mean I would just point out that you have a number of different forms that let you hear from states about the issues related to core sets. So, this isn't the only place to hear from states about that.

And we are going to get to some more specific questions about states and about the goals that CMS has for the program shortly that are a little more pointed.

The other, again, to point out, there's at least two councils that I've heard of plus the Measurement Application Partnership

itself which is in that direction.

I don't know if this what you meant Andrea by taxpayer, but is trying to do this issue about alignment, anyway, that are specifically targeted around alignment which, I think, is related to, but not the same thing, as parsimony, not wasting resources, trying to have this be effective.

So, it's not as if there is not at least three stages that have been set that are multi-stakeholder stages, one of them CMS, one of them across all HHS and the third sort of this combination of public/private setting of which we're a part of in this group that's trying to do this alignment issue and deal with these issues.

So, and there are multiple recommendations that come from all those groups headed in that direction.

But, Sarah and Shaconna, is there enough to -- do we need to --

CO-CHAIR PINCUS: Let me just raise an issue. I mean I guess the question I had through

Marsha and I guess also, maybe Sarah and Shaconna might also respond.

Coming back to this issue of outcome measurement specifically, you know, are there specific recommendations that we could make that would be helpful with regard to moving more quickly or more appropriately or with greater precision along this developmental pathway towards outcome measurement?

MS. LASH: So, to get back to the original question, I think that the biggest and heaviest tool in the toolbox for MAP, I mean these task forces, is the recommendation of the specific measures to be used or not used in the core sets.

The rest of the conversations have certainly reinforced and reinterpreted in the context of these two programs a number of very well know health policy issues that, you know, do get discussed in lots of forums like this one, like interoperability and collaboration.

So, I think I would encourage the

group as we continue the conversation to think in terms of making concrete requests of actions that CMS could take. Not just, someone abstract should fix dot, dot, dot.

That doesn't have as many teeth as saying I have identified, you know, this small but important factor that I believe is hindering states' participation and I would like more attention paid to that specific thing.

I guess that would be my request that we just sort of be more detailed in some of the conversations.

CO-CHAIR GESTEN: We also -- I mean we also vote on this issue with our feet, right? So, I'm looking at the six measures for the child. If agree that readmission measure is an outcome, again, somebody raised the question of what do we really mean by an outcome, but I think, generally, that's thought to be an outcome measure.

It got the lowest votes for prioritization on here along with audiologic

evaluation. Now, it's a measure that we put forward for recommendation. But, again, I think the way in which, as I think you're hinting at, Sarah, the way in which people sort of vote around this issue of measure preference moving towards outcomes is to make decisions about which things they recommend and which things they prioritize.

MS. LASH: Right, I would argue that my sense of the conversation is that we've heard more people ask for measures that really matter than measures of a particular type in the taxonomy. And I think that would be something we've got articulated in the report.

MS. LILLIE-BLANTON: Your question seemed to imply that there is a big push for outcome measures.

And I would say what the push is for is measures that are meaningful. So, if it's a process measure or a structure measure or a structure measure that is well linked to an outcome, you know, my sense is that that is fine

with CMS and certainly with our state partners.

I mean the main concern with the state partners is burden. I mean I think as you heard from Beverly several times, I mean she's looking at three different measurement sets and trying to make sure that she can report on those measurement sets according to the technical specifications.

And, you know, one's at the level of state, the other's at the level of a provider. I mean and so, you do have to have different technical specifications. But that is when you've got limited staff resources at a state level, whether it's financial or staff, all of those specifications for multiple measures, even though it's the same measure, is time consuming and could be a burden.

So, at this point, I would not say our big push is for more outcome measures. I mean if we look, we talked about the low birth weight measure, I mean that's a measure that we have thought to be very important. And only this

year, we'll have enough states reporting that we can say something about it.

And I have a sense, I've looked at the data and I think the data will surprise when you see it. But it is an outcome measure that gives us a broad sense of how at least those 26 states are doing.

But, it is measure that will be hard to then link to the next issue of quality improvement. You know, I mean some outcome measures, you can directly say what do you do to change the trajectory of that outcome?

In others, because you know there's so many things that contribute to that outcome will take -- it gives you a sense of how you're doing, how you're performing. But it's not something -- it's not the kind of measure that helps you -- that you know -- that you can immediately say this is what you need to do to improve upon it.

So, that's why I think, you know, we have to -- as we say, do we want more outcome measures, we have to really make sure that it's

an outcome measure that we can do something about.

So, last year, I think adding the controlling high blood pressure is a good outcome measure because our health care system knows what to do about that. You know? It's well defined evidence of what to do, how to address it, how to monitor it, how to fix it.

There are other outcome measures that are less precise or represent such a cluster of contributing factors, that it's much harder.

So, I think outcomes are important. I can, you know, on the adult side, I think that there are more of the kind of function outcomes that we feel like we need to better measure that -- and some of those functional outcomes, there might be a little easier way to direct interventions to make a difference.

But broad outcomes, I'm less focused on and I don't hear the big push for. And not to say that there aren't those out there, I'm just saying they're not coming to me and saying, this

is what you need to do immediately.

MS. GORHAM: I just wanted to say to your question, Andrea, and definitely agreeing with Sarah's point, as we write the report, I just kind of want to remind you all of the process.

So, as we write the report, we'll definitely do a very good job in capturing the conversation. And we have the transcripts to look at.

But, just wanted to highlight the fact that you definitely do have input in the draft that we put out. And just wanted to remind that, you know, that our comment period opens July 6th.

And so, just be on a lookout for the draft and if there are comments or additions, deletions, whatever, just, you can make those comments.

CO-CHAIR GESTEN: A couple of cards up there. I don't know what the order was, but how about from close to far?

DR. SIDDIQI: I just had a question

and a comment sort of related.

But the first question was, when a state partially reports, so for example, they did only have their fee-for-service data or they had their managed care data, does that count as state reported? Okay, so that's sort of helpful to know.

MS. LILLIE-BLANTON: If -- not try. As long as the state reported what they reported, there will be a note at the end of the table that says that data.

DR. SIDDIQI: I see.

MS. LILLIE-BLANTON: So, for example, one of the big completeness of reporting that we've trying to improve upon is making sure states report data on Medicaid and CHIP enrollees. And we now have only, I think, it's six states that are not reporting data on both.

But when we started, I mean almost half the states, I don't really remember the number, but we've made incredible strides in improving completeness of reporting.

And that information is fully transparent. So, I mean I think the concern about are we comparing apples to apples is a legitimate one. But what's important is for a state to use that data.

I mean we're using it, we're not using as much for comparisons across states. I mean certainly, that's a part of what we're doing, but we want our state partners to use the data so that they understand performance in their own state. And that's what's first and foremost important.

And then, we also need to have that kind of national data.

DR. SIDDIQI: And that sort of ties in with my comment then I think in terms of writing our recommendations.

One recommendation certainly is to strongly explain to in you TA webinars or just in the specs when you're offering even at the survey of, you know, why or why are you not reporting on this measure, to remind states that they can

report even on whatever data they have for whom ever sets of populations they have them for.

But on the other side, I think another recommendation I would specifically recommend is that states do report on their different types of Medicaid plans so if they do have fee-for-service, what does the data look like? If they do have managed care, what does that data look like? If they have, you know, separate programs, what does that look like?

In our state, we have about up to nearly 40 Medicaid managed care plans that have just rolled out in this past year. So, there's a lot of chaos in our state.

And a lot of states with the ACA expansion or have continued to expand Medicaid managed care, and with CMS asking for proposed rules, it begs the question, you know, states need to look at the data, not just in aggregate, but this is our whole state and this is what the data looks like, but also specific to the different types of plans that are being offered,

you know, the provider plan option versus the typical commercial insurance type plan option.

So, I just think that it's helpful for us, at least our recommendations in this report, to ask CMS to actually capture that bucket data, you know, in different buckets, not just in aggregate the whole data for very state. Because eventually, when this data hopefully does become more transparent, I do think it will help drive some quality initiatives across the board for different plans and to really identify where some issues are and what's some benchmarks that are out there and how to really compare apples to apples like you were talking about.

CO-CHAIR GESTEN: Ashley?

MS. HIRAI: Yes, I just wanted to offer on the process and outcome measures is just it's a different perspective because I'm in Title V which is more public health integrating with clinical care.

But when we kind of revised our performance measurement framework, we kind of

used a logic model of having these evidence-based informed strategy measures which are like structure process measures that then feed into intermediate outcomes and then longer term outcomes like ultimate morbidity and mortality.

And that is something that maybe you could think about when you have a process measure to pair it with an outcome measure to really be able to demonstrate impact and that was the whole design and thinking behind this transformation is really to be able to improve accountability and tell the story of our program.

And I know that the new Secretary is all about demonstrating impact. And just food for thought, I mean I'm just trying to think of some of the things like we have a safe sleep measure. And so, some of the process measures are about, you know, hospitals that adopt safety sleep policies. And then the longer term outcome measure is SIDS.

And so, that's something, Kevin, you were mentioning about mortality data, being able

to track that and link that to Medicaid, it could be, you know, something to explore, depending on the measure.

And definitely adolescent well visit is something we also track and it's related to so many outcomes. The unintended pregnancies, you know, all of the risk behaviors and even subsequent birth outcomes.

So, just another perspective to think about pairing process and outcomes measures if possible.

CO-CHAIR GESTEN: Jeff?

DR. CONVISSAR: So, I guess we also just wanted to encourage or maybe underline and emphasize some of the comments that were made around patient centeredness, functional outcomes to be really sort of challenging ourselves and I think it's going to be challenge, but challenging ourselves to really engage with beneficiaries directly to really understand, you know, the notion metrics that matter. But that's really not, it's a nice slogan, but it's to whom?

And one of the important, I would say constituents, if not I would say the most important constituent would be the Medicaid beneficiary in this space.

You know, I don't have a solution exactly. I mean we can't even get to medical record like data extraction and surveys are, you know, scary to us. And the thought of how we would actually capture that information is hard and I think really important.

CO-CHAIR GESTEN: Carol?

MS. SAKALA: So, thanks, that was a perfect segue to my question which is to ask you, Marsha, for clarification about whether person or patient reported outcomes would equally apply to your comments about CMS's view of outcomes?

MS. LILLIE-BLANTON: Well, within our core set, we have the CAHPS survey. And we have been somewhat challenged in getting that information, but it is the health plan CAHPS survey, so it's not even necessarily statewide data. And for, of course, children, it's parents

responding.

But that is a very, very important -- I mean trying to understand how, first of all, beneficiaries perception of the experiences and obtaining care, how timely it is, whether they're getting the right kind of care. I mean we place a lot of stock in getting that information.

Our challenge is in getting it and that's one of the reasons why we are doing the nationwide survey for adults because we're directly getting it.

But last year, maybe it's the last two years, we were unable to get data on CAHPS from the ARC Benchmarking Database because it was closed in the course of contracting challenges it faced. But it's now open and so next year, not in the 2015 report, but in the at least 2016 report, we shall have access to that data and we can get some directly reported perception of experiences in the health care system from that survey data.

But it is a very important piece of

information that we think we're missing. And we know that Medicare has it. Medicare almost routinely does CAHPS surveys in all different kinds of settings. I mean whether it's a hospital, hospice, physician practices. I mean there are lots of Medicare CAHPS surveys and Medicare Advantage as well.

And Medicaid is just slower at doing this and we've delegated that to the state and the states generally do it only for health plans.

So, we value it but we just don't have a good capability of getting that information.

MS SAKALA: Oh, I totally agree with you about experience of care but I'm just wondering about outcomes that may not be available yet, patient reported outcomes, per se, rather than experience.

MS. LILLIE-BLANTON: So, can you give me a concrete example?

MS. SAKALA: Functional status at the end of some, you know, episode of care.

MS. LILLIE-BLANTON: Right. Now, so

that's particularly with elderly and disabled individuals and also, you know, not just persons with disabilities. But we definitely view that as being something we want and we have one test and we have one grant program that -- it's called the TEFAT, the Testing Experience and Functional Assessment Tools.

So, we are doing some testing, pilot testing, of the ability to get that information. And it's, I think, we've got about four years and we're in the midpoint of that.

But it's only for that population. It's only for individuals with disabilities and for seniors.

DR. LARSEN: If I could make a quick comment, that was sort of the thing I was going to mention as well.

So, Congress, in the SGR fix bill, H.R. 2, has directed the Secretary under the new merit-based incentive program, which is a Medicare program, to prioritize patient reported outcomes measures.

So, insomuch as alignment between these Medicaid health plan measures and measures that we anticipate will be happening for fee-for-service Medicare, that is absolutely a congressionally directed priority in that legislation.

And we do have some of those measures already in the Medicare set and we are developing some of them for the meaningful use program, for example, again, at the individual provider level. They just haven't typically been developed at the plan level.

CO-CHAIR GESTEN: Anne?

MS. COHEN: So, there is, well, several things come to mind.

So, I totally agree with the conditional status piece. People with disabilities tend to have their one condition managed and to them, maintaining a function and improving function is what's more important.

And reducing the likelihood of a secondary conditions that gets to that.

There's also the issue in the community about quality of life outcomes measurement which has been increasingly important but doesn't necessarily fall into that bucket of like outcome measurement that seems necessarily meaningful to the medical community. So, that's something to look at.

A couple of things that I was thinking of, you know, in translating and getting it meaningful to consumers, what we've seen in California is that when you create a data report card about the plans that's consumer friendly, the plans are so worried about how they're going to look on that that they actually go back and really wordsmith how that's worded and how they -- and what was the very specific measures to drill down why aren't they improving.

In California, we have a whole agency called the Office of the Patient Advocate that produces a report card for all the plans in the state. And it's amazing the amount of change that that promotes.

And so, if you had grant funding and our Center of Excellence had the ability to do that and help develop those report cards, that can be really useful and go a long way.

The last point is, in terms of how you age consumers, the biggest barrier for CAHPS is address and phone number. And what -- and you know, we all know that's in Medicaid, but what we plan level was that when somebody calls in every single time, they ask them what their phone number is. And every single time, they try to capture the new phone then they try and bounce it back to the state Medicaid agency to make sure that it matches. And frequently, it's a cell phone.

So, one pilot project was that they ended up texting people and said, please respond to this survey or can they send them the survey. And even if it was only a few questions, they got something. And then, if they responded, they got a gift certificate. So, that really does drive --

And the other thing I heard is at the pharmacy level when, particularly for people with disabilities, when they pick up their medications, if we have pharmacy that's disproportionate Medicaid patients, they have the pharmacist, the Walgreen's or whatever, I'm looking to CVS, insert a flyer in the bag saying do you want to get a gift certificate by answering this survey? And then, you know, that really increases the response rates for CAHPS surveys.

So, just getting really creative and thinking about it from the consumers perspective.

CO-CHAIR GESTEN: Thanks.

Terry?

DR. ADIRIM: Great, thanks.

My comment, I just wanted to piggyback off of what Ashley was saying, that when it comes to outcome measures, in child health, it's harder than in adult health because, you know, most of what we do in childhood is process and you don't see the morbidity and mortality until adulthood,

later in life.

So, you know, we tend not to focus as much on those kind of outcomes and that's why there's more intermediate outcomes and so on. And especially in child health, the patient reported outcomes, family reported outcomes are very important.

CO-CHAIR GESTEN: Okay. So, great comments kind of that last lap. I thought there was like nothing left and then there was like this second wind you all got. It was amazing.

So, we do -- this is time for public comment on the broad scope of issues we've been talking about, again, not limited to outcomes measurement.

As you'll see shortly when we come back from a short break, we'll really start about a lot of the issues that we're going to tee up after the break as well around getting states reporting, using measures for improvement and so on. So, that's the good news.

So, why don't we start with in terms

of public comment, let's start with the operator on the phone, if you could open up lines and invite folks to -- give them instructions on how they can make a comment at this time.

Do we still have the operator on the phone? Do we still have anyone on the line who might be able to make -- who might be wanting to make a comment?

Okay. I don't know what to say about that. How about folks in the room? Wake up back there, come on.

Okay. About a half an hour ago, I was going to say we should blow through break, but now I'm tired. So, I mean it's just my opinion. So, I'm thinking maybe we can take a ten minute break and then get back if that's okay?

Do we have any state partners on the line? Do we have anyone on the line who can speak whose line is not muted?

DR. KELLEY: This is Dave Kelley from Pennsylvania, I am still on the line. I just have no comments.

MS. LILLIE-BLANTON: We just wanted to make sure there was someone out there as we were talking.

But also, we invited our state partners and when we said we know this and we think it's important for our state partners to hear this and contribute.

CO-CHAIR GESTEN: So, David's a state partner. David, you're not a quiet, shy, wallflower kind of guy, at least the last I knew. Do you want to make a comment before we break?

DR. KELLEY: No, I'm fine.

CO-CHAIR GESTEN: You'll get your chance.

Okay, we'll be back in ten minutes.

(Whereupon, the above-entitled matter went off the record at 2:42 p.m. and resumed at 2:57 p.m.)

CO-CHAIR PINCUS: Okay, so why don't we reconvene?

So, we're going to have another sort of broader discussion about how we can support

and engage states in terms of improving their ability to report on these measures and to think of ways in which we can have some crosscutting recommendations about strengthening the core sets across both child and adult.

And, Sarah's going to tee up some of these issues.

MS. LASH: Great. The next slide, please?

So, we have already started this conversation in a lot of respects, but we're going to, you know, try to really pin down some concrete recommendations to the extent that we can.

We've heard in the conversation at the meeting and in past meetings, there are lots of things that influence states ability to participate in reporting core set measures at all and then how many measures and then the completeness of each measure and even maybe the data validity within that.

So, lots of nesting dolls of levels of

participation.

But, some of the factors that would influence that participation are the clarity of the technical measure specifications, the selection of each individual measure, even though that's not in this list.

The feasibility of data collection, the budgetary environment in the given year, the perceived importance of maybe both the set and the individual measures and the political will to get it done, and there will be many others.

But keeping those factors in mind and maybe offering others to your colleagues around the table in discussion, what can be overcome by HHS or MAP making recommendations to HHS to bolster participation to the extent that we can?

On the next slide, I just want to remind you of the CMS goals for these programs once again because would be our North Star in terms of what we're trying to achieve with these recommendations.

So, go back to Slide 158, this is

really the discussion question we want to use the next 45 minutes maybe to an hour at the most to hear from you any further thoughts.

CO-CHAIR PINCUS: Thoughts? Comments?

DR. ADIRIM: Questions? I mean this is sort of I know, probably what the answer is but a hypothetical question.

Probably, the easiest way to get all states to report is to require it. So, I know you probably get asked that all the time. So, like what are the issues around that versus some other ideas that we could come up with?

Well, no, I mean, you know states, you know, states have to report on all kinds of things that they're required to report for, so why can't, you know?

MS. LILLIE-BLANTON: So, I can start with that and that is that Congress defined these measures as voluntary with voluntary reporting.

CO-CHAIR PINCUS: Carol?

MS. SAKALA: So, Rebekah's presentation and the year to year progress that

they made impressed me greatly and I don't know all the factors, but clearly, you know, leadership was important. And also the resources that they had available to do it.

And as I heard you, Sarah, describe budgetary environment, I don't think you were thinking of like a special project to do the data linkages and other things that they did that made that great progress possible.

And I don't know about the IAP program whether there might be resources there that kind of do double duty or whatever.

CO-CHAIR PINCUS: Beverly?

MS. COURT: I would, first on the clarity of measures specifications, so the measure is relevant to a state because I think the state is more willing to report if they feel it's relevant, is the specification for the denominator not containing those groups of Medicaid clients that can't be counted in the numerator.

So, that would eliminate third-party

-- those with third-party liability, those with partial Medicaid benefits.

And that's a -- in some years, that makes or breaks a measure as to whether it's at all useful for a state. And certainly, when you're comparing one state to another state, it's hugely impactful.

So, I would hope that this group could make that recommendation that the technical specs clarify that it has to be a reliable measure in terms of what it's actually measuring.

A second would be, again, in terms of making it so that if the state would to pursue, for example, a CAHPS survey or required of plans that there be technical specs that would enhance the current specs, to make that measure actionable.

That is, adding elements such as the medical practice sampling and subsampling protocols so that it would make it meaningful that if you're going to make that huge expenditure of both peoples' time, money and

particularly the Medicaid clients' time in responding to those surveys, that then those results can result in actually doing something with them.

In the State of Washington, for years and years and years we had CAHPS surveys as required by a managed care plan. Year after year, you know, can you get to your -- do you have a dedicated family practice provider?

And, so what if they said no? I mean what are you going to do about it? Well, there wasn't -- it wasn't -- you couldn't tie it to a geographic area of the state. You couldn't tie to a particular group. I mean so, what did you do with the information?

So, again, I think there's opportunities that if we're going to make these huge investments in primary data collection like CAHPS surveys, is to enhance those specifications so that we can fashion quality improvement efforts around those.

CO-CHAIR PINCUS: Carole?

DR. FLAMM: So, I want to make a comment also along the lines of what was being said on that end of the table and what Rebekah said.

In the potential to link the measures that are part of the core set to incentives that may exist across the different organizations and managed care organizations, one of the patterns that I think is observed in other product areas is sort of linking measurement to incentives helps to sort of drive both adoption and behavior and improvement and that sort of thing.

And as we think way ahead in the future as this program evolves, and I'll admit, I'm newer into the Medicaid space, so forgive me if I say anything a little off, but in the future, as it evolves and quality rating systems are put in place and alignment with accreditation and all of these sort of ways, is there some way of subsetting within the core measures?

Those measures that are, sort of as Jeff was saying yesterday, more fit for certain

purpose of measurement for that, you know, evolution of use into incentives or pay-for-performance or that kind of accountability side of and just kind of thinking about them subsetting within the measures.

CO-CHAIR PINCUS: And I was thinking something very similar to that. You know, what is motivating beyond requiring it in some way is actually finding a true, useful kind of purpose to it and highlighting how states have actually utilized case examples and how states have utilized this to make a different, I think, would also be helpful, you know, in some way.

Jeff?

DR. CONVISSAR: Yes, I mean, that's what I was going to ask. Why do the states report it at all?

I mean, so it's voluntary. The fact that the states report as much as they do might we be able to understand why they report and then sort of enhance those characteristics and figure out, you know, was it -- so there must be

something in it for them if they're actually reporting.

Well, then, how do we explain that perhaps? There's a measure on report.

(Simultaneous speaking)

CO-CHAIR PINCUS: Well, what the initial incentive?

MS. LILLIE-BLANTON: You know, I actually think Medicaid is transforming itself at the state level and certainly at the Federal level.

And our Medicaid partners realize that they are trying to understand what value they're getting for the dollars they are spending.

And the one way to do that is to give better information on performance.

So, I think they see some value in this as well. I mean there's a burden, but there's value.

So, I think we've got willing partners, there's just resource constrained partners. You know?

MS. COURT: It was also a requirement of the grant we received.

MS. LILLIE-BLANTON: Well, yes. That's with the adult measures, yes, that's true.

MS. COURT: Right. So, it will be interesting to see what the take up rate will be after that requirement is done.

MS. LILLIE-BLANTON: Beverly's my reality check here. Right? So, that's true.

But the adult -- but I can tell you, for the adult measures, so that's a little of history, I'm glad that you're reminding or are reminding me to make.

For the child measures, there was a history to reporting that was required for CHIPRA. Congress required CHIP to report on, I think it was four measures, three or four measures.

So, when I came in in 2010, we had some data just for CHIP. So, states, at least within most states, there was an infrastructure for reporting at least for children.

For adults, there is no such infrastructure for reporting, no history of it. And so, one of the reasons we could justify the grant program which made available about a million dollars per year for two years to states was that there was no history of reporting.

But we are concerned that when the grant funds dry up, which they are doing, that we don't have the same level of reporting.

But, having said that, I do think we have developed the infrastructure, the capacity. What we have begun to do is keep track, though, the staff that area leaving because staff were hired for these grants and now, some states have been able to bring them to other funding sources, some states have not.

So, we do think that there'll be some drop off. I mean we had 30 states reporting on, I think, a median of 17 adult measures. We had about 25 states that reported on about eight measures.

If we can just hold on to that, I will

be pleased. I mean it would be nice to hope for improvement, but if we can just maintain that with no funding, grant funding, I would think that we have accomplished a part of what we set out to do which was just kind of developed -- make routine reporting a part of the standard.

Because it's already there in managed care. For those states that have managed care, it is a part of the standard. I mean it is part of accepted. Most states are either applying for accreditation or are already requiring accreditation, as you heard, in Washington.

So, for managed care, it is pretty much the standard, it's just that it's not getting reported to CMS. It's going to the NCQA, the private accrediting agencies.

And, what we've been trying to do with our measures, and this is the other level of complication, is support states when they try to merge the data from a managed care entity with the data they collect from fee-for-service.

And that requires a level of technical

sophistication and knowledge in a state that some states have and others don't. I mean all states aren't New York and Pennsylvania and Washington, you know, that's just --- they're states that are -- most are better. There are states that are ahead of the curve, and there are other states that are learning.

But, we have states, you know, like Louisiana and Alabama which, you know, have come on the scene and have done, you know, amazingly remarkably well and are then -- are teaching other states.

So, we do feel like there is a learning curve for some states but the willingness and the interest, our sense is it's there. I mean there's a commitment to trying to show that there is value in the expenditure of public dollars. I mean I think it is a question of accountability for the dollars that taxpayers are investing in this program.

CO-CHAIR PINCUS: I think what you're also suggesting is that, you know, in some ways

states are a little bit like sort of transtheoretical model of going from pre-contemplation to contemplation as so forth and activation that, you know.

And there may be different states at different stages, and there may be different interventions to apply at those stages.

Jeff, did you want to say something?

DR. CONVISSAR: I just wanted to follow-up.

You know, so I mean, again, the way I think about this then maybe is really an analogous to actually the role that sort of I am part of in my organization.

We have, you know, mandatory things, and we've got a lot of voluntary things, and we don't have states but we have regions. I mean so there's actually a lot of analogies.

And, you know, at the state level, clearly, there's accountability. But like, again, I think what I hear and understand is, there isn't accountability to the Federal

Government for these reports since they're voluntary.

And so, then perhaps it's sort of changing our mindset at this level to driving to improvement, not holding to accountability. And that really changes sort of the dynamic in how you approach and think about things and starts, you know, creating collaboratives as opposed to sort of lists and tracking.

So, there are different tools that when you support collaboration and learning networks versus holding people for accountability, and it might be worthwhile to think about that.

CO-CHAIR PINCUS: Foster?

CO-CHAIR GESTEN: So, and just in terms of the last tongue-and-cheek answer about why, and this is going to make me feel very old, but a million years ago, a group of states along with Lee Partridge, who was then in APHA and NCQA, started a Medicaid HEDIS collection voluntary from states.

And the driving impetus was people wanted to know where they were. And they wanted some sort of a benchmark.

And I think that that's, you know, thankfully, is kind of innate in clinicians and healthcare organizations like yours, like ours, to kind of know.

And I think that the real value of this has been to provide potentially some benchmarking that's otherwise not available.

Now, that said, you know, NQCA's Quality Compass is helpful. It's a lot of plans and a lot of the -- represents a lot of Medicaid but not all of it.

So, I think that in terms of the why, that's part of the why.

The other why for me is, you know, where I come from, you know, if somebody pays half the bill, they're kind of entitled to know what they're getting.

So, I think it's kind of like, you know, a slam dunk that, you know, CMS should know

something about, you know, what's going on in terms of their investment, as should Congress, as should the public. I mean it's a huge, huge investment, growing investment.

So, I think it kind of just seems like the right thing to do as well as, you know, selfishly being able to kind of understand where you are.

Again, it doesn't change the internal -- you know, our state where our priorities are, how we see what areas that are particularly important, but does help like other metrics that we look at nationally, whether it's, you know, the Commonwealth Report Card or CDC's Healthy People.

And I'm sure that your organization and most of the organizations we work with have peer groups and they have comparison groups. It's not the only tool in the toolbox, but it can be very helpful in kind of gliding and navigating your programs by.

In terms of answering these questions,

I would say that -- I would pile on to Beverly about the specifications.

We've had some real -- some of the measures we've not been able to do have just been -- we've been stuck in problems related to the specifications which I think you know, Marsha.

And, again, some of that is related to the measure developer and challenges and so on.

So, if we can't work through the measure specifications, you know, that creates a real barrier for us to report it.

Other recommendations, you know, I think there's some measures and you hinted at them or there's sort of demonstration or pilot measures. And I think the idea of having some measures where we're not quite sure about, maybe they're a little aspirational, but you don't want to remove your aspirations and just live in the world of what you can do today.

So, I guess, denoting some of those measures as being that officially and maybe providing, you know, some degree of funding or

support to states who may want to test it out and can then serve to help the other states navigate some of the challenges to the data might be another way of going forward in terms of more measures reporting or being able to push the envelope, not expecting everyone to be able to do it sort all at once.

I think clearer funding matter having, you know, whether it's specific funds, as people have talked about for the grants clearly caught people's attention.

If there's an ability to do any kind of enhanced matching, which is the other trick that sometimes CMS can do around these activities, worth exploring.

And then alignment, just to again to beat a dead horse, the degree to which these measures differ from measures that are required of us from CMS for health homes or for our waiver programs or for SDRIP creates real challenges.

And we'll do the things we have to do and if something's voluntary in a list of

priorities like other humans, you know, those will be kicked to the bottom.

So, the degree to which that there's alignment, I think, you know, it makes good sense.

And then the last thing which is maybe more problematic, particularly given that where folks are going with this, but rotating measures.

Again, do you need to measure some things every year? I don't know that you do. I know that there's an issue about momentum and not wanting to lose track of things, but when you think about the cycle of improvement, I think there's a lot to be said for not necessarily needing to measure the same thing year after year.

Okay, now, it's 49 percent. Okay, now it's 49 and a half percent. Okay, now it's 50 percent.

So, it may be also a practical way of putting more measures on a list and doing some ability to rotate.

Now, that's -- we've been doing that for years in New York. We're now being challenged because NCQA is longer rotating measures for a variety of reason. And so, we're struggling with how to adapt to that.

But, I think it has, in the past, served the purpose of dealing with wanting to not have too many measures but also recognizing sort of the natural life cycle of measurement and improvement.

CO-CHAIR PINCUS: So, I have Alvia, George, Ashley, Nancy, Andrea and Anne on the list.

DR. SIDDIQI: So, I was just going to add that I do think that incentives that are out there with other programs, for example, I know, Marsha, you were talking about the CMS Innovations program or accelerator program for Medicaid.

You know, CHIPRA worked demonstration project grants that already received grant funding from CMS certainly aligning with these

measures helps. And I think that's why, even in our state which is really challenged right now with managed care and the rollout, you'll see a high number of reported measures for the child core set because we do -- we are a percentage of a CHIPRA demonstration grant.

So, I do think that, in addition, you know, when you talk about these measures and their importance, I think states are concerned, and the reason they're also probably voluntarily reporting is because they do believe that incentives and penalties eventually are going to be tied to these measures.

So, I do think that they are considered to be very important. I think leaving them on for a while is helpful because, for example, in our state, it's taken years for certain select measures to be continued to improve upon by providers in the provider community.

It takes time. It takes a long time and sometimes, when you make too many shifts and

change, it can actually disrupt that process flow that you're trying to achieve by at least getting to the point where you can even report on some measures.

So, I do think the TA assistance grants and trying to work out some of those funds would probably be really important because I am concerned if those grant funds do dry out, it's sounds like if there's no increased revenue stream, we'll be seeing measures be reported upon or not.

But, like you said, sometimes, you know, you're getting just one or two or more states for a specific measure. But, that's one or two more states out of 50 that weren't otherwise reporting on those measures.

So, I still think that it is a really important process, and I do recommend experiencing the data. I think it's time to publish the table that we've been given here, and I think it's time to sort of publish and have the data put out there so that other states can say,

well, what is going on in my neighboring states, and maybe I can learn from that.

And so, best practices would sort of be the second, you know, goal, I think, about this in terms of trying to share best practices, provide linkages with other states that are doing well in particular measures and trying to share some of that data.

CO-CHAIR PINCUS: George, did you want to say something?

DR. ANDREWS: Yes. I think what I was going to note or it was touched nor discussed, but you know, I'm just going to follow with a point that Alvia made about incentives and penalties.

I mean, as it is right now, there are incentives and penalties that the Medicaid programs do impose whether you are successful in a certain meeting a performance measure or not.

And certainly, from the Federal Government's perspective, there is no reason why it cannot apply to the state through the

mandatory reporting of the information.

And like was already said, the expectation is said that I'm going to hold you to a standard and certainly, you're going to try harder. That's the first.

The other thing is, you know, I think we need to recognize the fact that, just like any other population, the Medicaid population is diverse. In different states, there are different cultural, ethnic and other diverse conditions that create the situation where different states might have different items of importance that they need to pursue or support or report on.

And I think that that needs to be on the table in terms of the kind of things that we look at and the kind of things that we consider in terms of our packaging of information that we want to push back to them.

CO-CHAIR PINCUS: Ashley?

MS. HIRAI: Yes, I just wanted to comment on what Jeff and Alvia were mentioning

with collaborative learning and how important that can be to motivate change and learn best practices from each other.

And that's what we were able to see through that Collaborative Improvement/Innovation Network. And Medicaid was a key partner in the Regions 4 and 6, the south that started it.

But, one of the key benefits really was improving data capacity through that. And what we were really struggling with the timeliness of vital statistics in particular.

And just through those peer comparisons like putting that out -- seeing a neighbor state being able to report within six weeks of a close of a quarter -- it was amazing. Like they all came along and were able to report.

And now, the northern and western states are like, how did you do that? We don't have access in our agency. And so, it is something we're trying to build in more like technical assistance and peer-to-peer exchange about how to break down those political silos.

And, you know, to support that vitals and Medicaid linkage, you really have to have the capacity, as Rebekah mentioned, having an epidemiologist, and Title V does support some of that.

And we have some money, the State Systems Development Initiative, that's designed to support those linkages and improve data quality and timeliness. So, that is a small pot of money that can be used to help.

But we also want to support some more Webinars around the Medical Vitals linkage to build on what Marsha has done and show examples where there's a value to it.

So, Michigan apparently linked their Medicaid and vitals to show a return on investment for their home visiting program. So, these really kind of like innovative ideas to be able to spread and scale through that collaborative learning.

So, we're hoping to have some kind of Webinar to feature that Academy Health

Collaborative that got the 22 states.

So, it's really just the other half of states that needs to work on building those linkages. And it's really just engaging that leadership and breaking down the political barriers between different divisions within health, Medicaid, from public health and vitals.

And so, we really hope that NAMD can be a good partner and, Daniel, I'm going to talk to you later about signing some kind of data leadership letter that reaches the highest level of the state health officer to really advocate for improved data sharing across/within states to really improve maternal and child health.

So, those are just some things we're planning to help facilitate these linkage issues.

CO-CHAIR PINCUS: Nancy?

DR. HANRAHAN: I've been doing research for the past 12 years, and there have been several revelations to me that really parallel this process.

And that is that a lot of the data

that we have available to us now, and there is a lot of it and there's going to be more of it and more of it and more of it.

And the exercise of clarity of measure specification is just such a one dimension of that -- of the process of managing the quality. And managing quality is, to me, a management issue and that's what states -- why states, I think, want to do this is because they want better management of how they manage their resources.

So, measure specificity is very important, and I think there's been a lot of progress made in that over the past ten years that, and I've been involved in a lot of different angles to that; much of it, for me, has been in the behavioral health sector.

But I really read through the vital signs from the IOM report, and it's really good. And so, we really have a sense of: what are the priorities and where are they?

We really don't have to like go over

that. Where we get caught is in the weeds around measure specifications.

So, there's a big distance between the two, and I think about so where have we seen some of the -- some progress made in this area? And I've been in Pennsylvania, two places, Geisinger and Jeff Brenner's work over in Camden, New Jersey, where both of these situations, they took data and they really made meaningful inferences and made meaningful change and then document it, published it, and people are learning from it.

And so, you know, I think that we know a lot about measures and we know about targets and we know about the systematic way of identifying hot spots in those systems.

So, where are the -- the issues to me are that when we get that data, we get so specific with it or we average out that it loses its meaning.

So, one of the methods that I've been moving towards in my research is away from regression models, which is moving and

understanding the means, and moving more towards some engineering methods -- one being agent-based modeling, which is a way to bring the individual or the specificity, the stakeholder, the, in this case, the patient, and embrace the complex systems that we're dealing with.

And then analyze those interactions using very sophisticated analytics that are growing and getting more popular.

A great example of that is the Watson that IBM developed. It takes data from multiple sources and makes meaning out of it.

So, I think that, you know, in a way I think we've got to be thinking very innovatively about where we're going to head. What would it look like if we were to solve this problem of: how do we make meaning out of this data?

I say that we need to be looking outside of what of the methods we've been using. I would dare to say that many of the states and Jeff Brenner and Geisinger, what they've got

behind the scenes are people that can analyze that data using more sophisticated, complex systems methodology to make meaning of them so that they get back to the clinician, to the patient, to the public, to the administrators so that they can then begin to perceive importance and drive the political will as well as drive the will of the individual towards incentivizing them to hire -- to better health and behavior set, bring them in that direction.

So, I think, you know, one of the things I've always loved is Star Trek, and ever since a kid, I lived by it because it gave me that sense of what is possible.

And I think what is possible here is that driving NQF to a place where they can actually bring in some of these systems, complex systems and analysts to help us solve some of these complex problems. Otherwise, we get bogged down in what's, you know, I call the weeds or measure specifications.

Just some thought.

CO-CHAIR PINCUS: Andrea?

DR. BENIN: So, at the risk of sounding like a broken record here and the risk of getting into some states' right federalism discussion that I might not know enough about to just step right into.

So, at our place, we are, you know, 60 percent of our patients are Medicaid. And so, we are closely aligned with what happens with the state budget and we watch that very closely.

It's not like the state has all this extra money sitting around, right? Like the states are really tight on resources; certainly Connecticut is extremely tight on resources.

And so, I would like us to be able to make a strong recommendation that there's a world here where CMS could look, you know, create a plan towards creating data infrastructure that could support what the states need to do at a single level. It seems really wasteful to me, again, that we pay over and over again at each state to accomplish these things instead of

having a unified data infrastructure.

And I don't think it does children well. Like, I don't think it's the right thing for children; I don't think it's the right thing for child health.

It's very frustrating to know that a child in Connecticut might be experiencing something completely different than they would in New York or in Massachusetts. And I think that is a shame on us for not being able to get out of our way.

And I have this fear that our organic approach to this of letting people, you know, sort of each state figure out their quote, unquote innovative approach is not -- it doesn't make sense to me in the sense that if you were running a large multinational company, right, you wouldn't necessarily let each one of the multinational places sort out their own thing.

I mean, maybe you would, but there would be some centralization to that. And I know that this is rooted in, you know, legislation and

whatnot that can't necessarily be changed.

But I think that if there's a way for us to be able to say that the degree to which there can be movement towards a more supportive data infrastructure that CMS could help to unify some of these things, I think that is what will move this conversation forward over time because what we're hearing about the barriers are around the idiosyncrasies in a lot of those data things.

So, I don't -- I just wanted to make sure that I said that strongly enough, Sarah and Shaconna.

CO-CHAIR PINCUS: Ann?

DR. SULLIVAN: I, you know, there's been a lot said about alignment and what piece of this that belongs to CMS, that CMS has control over?

Could we speed up their help with the states in aligning some of the measures?

At least what I've been hearing is that CMS has different pots of things that they want and that sometimes all those things that

come out of CMS, specifications, everything else isn't as aligned -- isn't aligned.

That sits in CMS's hands, I'm assuming. So, I'm just wondering if that could be speeded up a little bit, maybe with workgroups from the states?

It seems like that's something that might be doable. I know there's groups getting together in the Government, but a huge frustration for the states is multiple reporting of things that's very confusing.

So, is there some way that CMS could really take that on? To be keeping asking the states to do things and CMS not doing its part in trying to make it simpler and more straightforward, I think bristles with some of the states. That's one thing, so that one piece.

And then, yes, so let me just stop there.

CO-CHAIR PINCUS: Marsha, why don't you respond?

MS. LILLIE-BLANTON: So, let me tell

you, CMS is a big organization. So, within Medicaid --

DR. SULLIVAN: I know, I know.

MS. LILLIE-BLANTON: -- and CHIP, I want to at least say what we have done, and then I can take it to a bigger level.

So, within CMS, we have the child and adult core set and health homes, by and large, has drawn its measures from the child and adult core set. I think health homes has maybe two or three additional measures that are not within the child or adult core set, but no more than that. And looked like Beverly's looking at her notes. But I don't think there are any more than that.

The difference between the health homes measures and the child and adult core set measures is the denominator because we had to specify the measures for provider level data collection, as opposed to at the state level, it's state data collections.

So, the measures could be the same but the unit of analysis are the larger denominator.

So, in that respect, those are two of the big programs that we had some control over.

Then, Foster mentioned waivers and the district. And I can tell you that while there are some differences in the measures, we have encouraged within our -- the group that manages the waivers, it's the division that manages the waivers and the DSRIP, which is, those of you who don't live in our world, is the Delivery System Incentive Report Program.

We have encouraged them and, as we had input, I can't say required, but we drew from our child and adult core set.

So, I'm just trying to give you those examples to say that for the things that we had control over and largely influence over, we have tried to make a difference.

Now, as you move to a broader level, which is a whole set of measures that are on Hospital Compare and Physician PQRS, that's a little harder. But, and certainly -- well, let me step back and go back to meaningful use.

Because we have worked in partnership very much, as much as we can to recommend and support e-specification of measures as well as measures into the meaningful use that were a part of our core set.

There are limits to that because the measures have to be, from my understanding, e-specified. And so, we're still working on -- we're funding -- we're using some of our dollars to e-specify measures so that they can be a part of meaningful use.

But, that is not always perfectly aligned. And so, I do think that that's where there's probably some additional -- where we could do better at aligning.

So, let me go to the Medicare world. Well, maybe I can go at an easier level and that's the Marketplace, because the Marketplace then changes -- started from their base of our child and adult core measures.

So, there was an effort and there was I think a real strong effort to align.

The difference in part has to do with the population served. You know, we heard earlier that we serve far more women and children than either of Medicare or the exchange programs.

So, we have a much larger child core set than either the exchanges or, and of course, Medicare.

So, some of it just has to do with different populations being served where you can't have perfect alignment.

But, certainly, I do -- I would say that we have worked really hard at the issue of alignment, though there's not perfect alignment.

For Medicare, I think it is a different -- it's an issue in large part of the population because with elderly patients and persons with disabilities, there are some probably clinical conditions and problems that drive measurement, far greater hospital use than what you have in Medicaid. So, the hospital measures are far more expansive.

So, I don't want to say that we

couldn't do a better job, but I really do feel like we have prioritized alignment and certainly could do better, but I think we're --

DR. SULLIVAN: Yes, I truly appreciate the efforts. I really do. And I'm not trying to be -- I'm just saying that even with what you just described is an incredible burden on the state --

MS. LILLIE-BLANTON: Yes, it is.

DR. SULLIVAN: -- system, the hospital system, any system.

And that when that's where some financial assistance or some way to assist can help. That's all I'm saying.

And I know there's all true good and I know it's all to learn from. But, when you talk to management consultants, they tell you, measure a few things and pay a lot of attention to those and then measure another few. And we just have a big panoply right now.

And I'm not saying you're not trying, please don't take any of this --

MS. LILLIE-BLANTON: So, let me --

DR. SULLIVAN: But really, let's not make the panoply too much bigger because I think that frustration level will grow.

MS. LILLIE-BLANTON: Right, no.

So, one of the things we want to try to do, but I'm not sure it's going to help, as we move to TEMSIS, what we'd like to do is see how many of the measures that are largely claims driven, we can generate at the Federal level.

And that will then reduce the burden at the state. But, there's a tradeoff because now, when the states send us the data, our hope is that they're also reviewing it. But, once we start to generate it, the question is, does it become a Federal activity of collecting and reporting on measures versus the state effort that they then are reviewing it and using it?

And so, we still are going to try because we think that, as much as we can reduce the burden on states, in the long run, it may help. But we're not certain that that's the

answer.

But some of these measures are. I mean at least almost half of them are measures that largely are claims driven. So, I mean it'd be interesting to hear your thoughts on that and whether or not that is one of the ways we can reduce the burden on states and --

I mean it's something we're trying to do anyway, but the question is: is that part of the solution?

CO-CHAIR PINCUS: Beverly?

MS. COURT: Okay, so thank you for that opportunity.

One of the things that I know, TEMSIS, challenging to produce. Washington is struggling with that. So, it isn't easy to get that going.

When analysis is done, one thing that's not understood is how things have shifted in a state, and each state is a totally different country in some ways in terms of, for example, what have they done with their SSI population?

We talked about bifurcating between

fee-for-service and managed care; what I think is even more important is the disabled versus the nondisabled -- your duals versus the nondual elderly.

Even breaking down your SSI into the over age 65, elder, disabled and then those that are under 65; they're really different groups. I mean it's soup to nuts.

And so, when we want to do analysis at the state level, we have to break it down to those groups to do anything that's comparable.

Now, we've got ACA and that expansion. That took a lot of state only programs, and now those are federally funded. So, we moved a whole group of highly disabled people who are Medicaid only -- or state only programs, and now they're rolled into.

So, it's not just the healthy, you know, post-college kid that is now getting medical care; it's also that severely disabled person who just didn't meet the income qualifications previously.

So, we've had tremendous shifts year over year. I look at 2012 versus 2013 and 2014. It's almost like a different Medicaid program that we're comparing.

So, that's one of the concerns I would have at the Federal level. So, whether or not that nuance would be understood and taken into consideration so that, again, the apples to apples comparison.

One of the things that I think would really keep states from not participating is make it a friendly, benevolent place to be to report.

Right now, when we report, there's the immediate need to take a mean and a median of all these disparate things that states have reported.

So, one measure, one state may be reporting a subset; another may have just entered and they tried out this new measure. Maybe they don't have everything, you know, all the specs totally understood.

But immediately, fairly immediately, what's published is this median and mean of the

entire group. And so, immediately, it's, oh, you're a bad state. You know?

So, I'm afraid that if those kinds of comparisons are published too early, and if states are typified as being bad or poor performers right off the bat, it's going to really dissuade people from reporting. It's going dissuade reporting on measures where maybe you're not up to the median of --

You know, some of those measures had huge variants in them. And so, even though it's easy on an Excel spreadsheet to, you know, calculate mean, median and publish it, it would, I think really help if one didn't.

And instead, for example, have state to state year to year comparison so you can see how the state is managing that measure and perhaps improving it.

But the state to state comparison, you know, if you're at the lower end of that bell curve, I think you're going to get less reporting.

CO-CHAIR PINCUS: Kevin?

DR. LARSEN: I want to tie together some thoughts from Nancy. And Foster and Nancy, that was terrific. I totally agree that moving to this more engineering model of thinking how we do this.

And there's some examples we know from the Medicare hospital program that we've so narrowly defined some of the denominators of measures that we exclude nearly everybody so that we can get a consistent measurement.

But that doesn't actually help you improve very much because all of the sudden when you actually -- so, an example from the health system I came from, we had the acute MI measure in the hospital core measure set. And we were a heart hospital and we saw hundreds of acute MIs a year, and we would sometimes report two of those out of our core measure set because everything was an exclusion and an exception, and they didn't fit the sort of narrow band of people in the measure.

And that was to get at this consistency issue. But it doesn't actually let us really improve care for all the patients. We're just so busy excluding people that our signal is consistent place to place, but it's not very -- it doesn't have much utility locally.

And so, I think if we need to start thinking about how do we support this learning health system as is the president's PCAST report calls out and there's an IOM report about it, a continuous use of measurement, the continuous use of data to drive that improve. It becomes a set of strategies, behaviors and infrastructure.

It isn't about once a year reporting that's done six months after all the data's normalized, it's a constant activity on the data that you're constantly getting in place that lets you report, analyze and use that information for lots and lots of improvement purposes.

This is how the rest of the industry works. This is Amazon and Google and Walmart, how they are effective. And we need to

constantly challenge ourselves, how do we get there and not only do this in a way that we've always done it.

CO-CHAIR PINCUS: So, this has been a terrific discussion and so, just to summarize, I think one way of thinking about this in terms of encouraging state participation, supporting state participation, is that sort of like, you know, corporations are people, states are people, and your subject's the same behavioral forces as people in many ways.

And, it's all about reducing disincentives and encouraging incentives. And, you know, to make things simpler, easier, facilitate infrastructure, you know, to reduce those disincentives, to make things clear and useful.

And the incentives to build include both the extrinsic and intrinsic incentives. And it's clear that among the most important things are the intrinsic incentives that states perceive that they can actually do a better job if they

have this information and move towards the kind of continuous learning systems that Kevin was talking about.

So, I think it's been a really useful conversation and we have just a few more minutes. Do we also need to get public -- yes, go to public comment?

So, is the operator available? David, are you on?

DR. KELLEY: Hi, this is Dave Kelley, if I could just weigh in a little bit.

Again, from our standpoint, I'd like to reemphasize that a point that already has been made in alignment and especially around meaningful use and especially around electronic extraction in looking and working with ONC and the patient specific QRDA1 level of reporting, to really make as many of the CHIPRA and we've talked about the adult core measures, to make them an absolute part of meaningful use so that states --

Operationally, it's easier at the

provider level to extract and have them report to our MCOs and then have our MCOs actually report to us.

So, I think, again, all the comments about alignment I think are extremely important.

I also think in having a consistent definition is very, very important. I know that probably more so on the adult quality slide there was some ambiguity early on in some of the measures. I think less so on the CHIPRA core set.

I also think that, you know, from a quality of care standpoint, I'd like to commend CMS. I think that where we are today compared to three or four years ago, there's a huge difference. We have an approach of consistent measure across state Medicaid programs and I think that's vitally important.

I think as a taxpayer at both the state and Federal level, I think, to have transparency.

And, you know, when Pennsylvania does

not perform well compared to anyone else, we're going to do something about it. And to not know that and to not compare ourselves to somebody else where we would have concerns. We like being compared to others and we use that as a lever to say, you know what, we need to reinvent how we're doing something so that we can improve the quality of care.

So, you know, from my standpoint, I think we've come a long way in the last four or five years. And as we try to make the CHIPRA and adult core sets better, again, I think it's align the measures and be very consistent in how others are doing those same measures.

CO-CHAIR PINCUS: Thank you.

In the room, are there people that would want to speak? I think we're ready to conclude I think.

MS. LASH: I think so.

I thought Harold provided a really nice summary of the conversation we just had so we don't need to rehash everything that we did

today.

But I think we want to close with a very strong message of thanks to the Child Task Force members who won't be returning tomorrow and to Foster for his leadership of that group.

We have some upcoming dates in the time line just to share with you. Tomorrow, the most immediate date, the task force will be discussing measures in the adult core set and interpreting some measure-specific recommendations in the light of today's work.

You can look forward to the opportunity to weigh in during the public comment period on the draft report from, I think, approximately July 6th to August 5th.

And then, at some point in mid to late August, we will have the MAP Coordinating Committee review the draft report recommendations and the themes of public comment to see if there's anything from our broader stakeholder community that would need to be influential in changing a recommendation.

And then, finally, there will be final reports due from both groups on the two measurement programs individually to CMS August 31st.

MS. SCHLAIFER: During the open comment period, do you want us to comment through the general open comment function or direct?

MS. LASH: Yes.

MS. SCHLAIFER: Okay.

MS. LASH: Yes, I think that there's some value in letting the other people engaging in the comment process read those sort of in real time, although they all tend to come in on the last day, of course.

But, for anyone that is submitting their comments publically, those are sort of available to others to consult as they form their own.

Are there any other things?

CO-CHAIR PINCUS: Anything else?

CO-CHAIR GESTEN: So, again I think I'll just add my thanks and particularly starting

with thanks to the NQF staff and Sarah, Shaconna and Nadine and Severa and folks I probably don't know who helped put this together.

Thanks so much for all this hard work and staff work and the materials and so on.

Thank you all and I wanted to thank the Child Health MAP in particular since you're leaving. These other guys are continuing to work, but, you know, at least half of you, if not more, just did this a little while ago. So we really appreciate you coming here. You are all very smart, very passionate and all above average, which is amazing. How often does that happen?

So, thank you all.

Harold, anything else?

CO-CHAIR PINCUS: No, I think ditto with regard to my thanks to the staff and for the participation and we have a lot of work to get to tomorrow on the adult side.

CO-CHAIR GESTEN: Just one more -- I'm sorry. I just want to acknowledge, I mean I

think that I'm so pleased, Marsha, that you're able to be here and how responsive you are and I think, you know, again, I think back to 15, 20 years ago and other times when it was hurling bombs over the fence.

I mean I think we so much -- things have come such a long way, as David was pointing out. And I think not a small amount of that has to do with your leadership. So, thank you so much for being here.

MS. LILLIE-BLANTON: We appreciate your leadership and direction as well because I think having partners like you makes us stronger in the end and, of course, our core sets as well.

MS. LASH: Breakfast tomorrow is at 8:30 and we'll begin at 9:00.

(Whereupon, the above entitled matter went off the record at 3:54 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: Joint Meeting Map Medicaid Child and Adult Task Forces

Before: NQF

Date: 06-10-2015

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