

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

2 9:02 a.m.

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

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

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

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

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

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

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

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

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

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

15 MS. LILLIE-BLANTON: Oh, I'm sorry.
16 This is what we learned yesterday and
17 I've already forgotten. So, this is a reminder,
18 if you want to be heard, you have to turn on your
19 mic.

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

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

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

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

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

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

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

19 MS. LASH: Sure.

20 CO-CHAIR PINCUS: First, the
21 introductions.

22 CO-CHAIR GESTEN: Yes, how about the

1 NQF staff first?

2 CO-CHAIR PINCUS: Yes.

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

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

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

18 Zehra?

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

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

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

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

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

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

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

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

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

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

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

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

5 Cindy?

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

11 MS. LASH: Thank you so much.

12 All the other organizational members
13 have already disclosed.

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

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

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

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

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

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

15 If we could ask Carol to begin?

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

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

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

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

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

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

22 I'm a consultant, working with the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 Thanks.

22 MS. DAWSON: Hello, my name is Kirstin

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

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

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

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

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

1 New York State and here as a subject matter
2 expert.

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

7 I also serve on the MAP Duals
8 Workgroup.

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

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

22 Thank you.

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

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

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

19 MS. LASH: Thank you, everyone.

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

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

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

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

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

1 voting.

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

6 Okay, let's talk about meeting
7 objectives.

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

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

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

22 We're going to need to also come up

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5 So, Sarah?

6 MS. LASH: Thank you.

7 Can I have the next slide?

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

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

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

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

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

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

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

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

1 choice of measures.

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

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

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

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

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

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

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

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

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

22 There was a strong case made for

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

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

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

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

1 discussion.

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

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

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

18 Next slide, please?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 Next slide, please?

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

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

1 remove a measure are on this slide.

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

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

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

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

1 not available.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 addicted and using illegal drugs.

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

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

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

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

19 Sure, Andrea?

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

22 The summary of the commentary about

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

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

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

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

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

3 MS. LASH: Thanks for that
4 clarification.

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

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

14 MS. LILLIE-BLANTON: Both.

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

1 other is. Is that right?

2 So, some of the --

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

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

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

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

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

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

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

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

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

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

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

1 back from them in terms of their direct
2 experience.

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

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

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

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

1 we will.

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

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

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

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

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

22 And the postpartum care rate is in the

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

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

10 Next slide?

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

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

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

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

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

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

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

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

22 CO-CHAIR PINCUS: And I think people

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

5 Susan?

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

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

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

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

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

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

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

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

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

1 the first principles into the particular
2 opportunities and strategies.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 CO-CHAIR PINCUS: Foster?

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

1 for collection.

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

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

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

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

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

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

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

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

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

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

5 DR. LARSEN: Yes, I can take that.

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

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

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

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

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

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

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

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

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

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

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

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

22 And within that council, you have from

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

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

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

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

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

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

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

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

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

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

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

1 effective way?

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

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

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

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

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

21 Andrea?

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

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

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

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

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

22 Because the things that we measure and

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

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

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

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

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

5 CO-CHAIR PINCUS: Other comments?
6 Questions?

7 This will have -- oh.

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

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

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

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

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

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

5 CO-CHAIR PINCUS: Anne?

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

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

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

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

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

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

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

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

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

7 (Whereupon, the above-entitled matter
8 went off the record at 10:07 a.m. and resumed at
9 10:20 a.m.)

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

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

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

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

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

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

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

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

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

10 CO-CHAIR PINCUS: Talk about
11 alignment.

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

1 contend with.

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

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

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

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

18 Shaconna, are you up?

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

22 And there are 11 measures in the area

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

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

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

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

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

22 This group will need to discuss how

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

3 Next slide, please?

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

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

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

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

1 present in both the adult and the child core set?

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

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

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

18 Marsha?

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

1 you said?

2 MS. GORHAM: Technical difficulties.

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

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

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

13 Sue?

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

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

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

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

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

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

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

22 But there will be a time, I think, for

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

5 Marc?

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

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

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

1 to be purposeful.

2 DR. LEIB: Oh, yes.

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

5 DR. LEIB: Okay.

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

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

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

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

22 MS. LILLIE-BLANTON: Well, the way we

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

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

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

12 Postpartum care starts at, what, 18 or
13 19? The measure?

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

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

1 what happens after.

2 So, it is not divided up just by age.

3 So, but, it is the same denominator and that is
4 something that we have tried to stress to the
5 states that the women who are counted for
6 prenatal care, in theory, should be the same in
7 the postpartum care bucket.

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

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

18 CO-CHAIR GESTEN: Alvia?

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

1 benefit for?

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

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

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

22 Again, you're talking about maybe a

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

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

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

16 CO-CHAIR GESTEN: Yes, Denise.

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

1 quantity of services to promote healthy birth.

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

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

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

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

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

6 So, I hope that helps.

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

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

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

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

20 DR. SMITH: I would say no.

21 MS. DOUGHERTY: I would agree.

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

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

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

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

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

1 stratified.

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

4 Andrea?

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

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

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

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

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

9 CO-CHAIR GESTEN: Alvia?

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

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

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

1 for alignment.

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

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

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

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

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

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

1 we want to go about doing this.

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

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

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

20 But, Anne?

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

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

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

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

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

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

11 DR. SIDDIQI: Does it?

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

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

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

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

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

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

3 CO-CHAIR GESTEN: Right.

4 DR. SIDDIQI: None.

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

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

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

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

16 Cindy? Cindy, did you have your card
17 up?

18 MS. PELLEGRINI: I did, sorry.

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

22 If I am remembering correctly from

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

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

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

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

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

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

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

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

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

1 bucket these measures are in.

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

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

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

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

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

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

1 on infant health and outcomes.

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

5 CO-CHAIR GESTEN: Harold?

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

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

22 But I would be interested to hear from

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

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

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

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

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

22 I mean, you know, to the point of the

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

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

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

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

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

1 relate to the reproductive years.

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

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

6 But, Harold?

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

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

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

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

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

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

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

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

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

1 level and the provider level.

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

10 So, I just wanted to say that.

11 CO-CHAIR GESTEN: Thanks, Marsha.

12 Alvia?

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

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

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

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

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

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

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

8 CO-CHAIR GESTEN: Carol?

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

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

20 CO-CHAIR GESTEN: Great. Great
21 discussion.

22 I think before we go to the specific

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

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

9 And, operator, anyone on the phone?
10 Sorry?

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

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

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

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

1 like to make a comment?

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

5 And there are no public comments on
6 the phone line.

7 CO-CHAIR GESTEN: Thank you very much.
8 Shaconna, you've been quiet for a
9 while.

10 MS. GORHAM: All right.

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

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

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

22 Okay, so in preparation for this

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

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

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

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

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

1 those staff picks.

2 Can I have the next slide?

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

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

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

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

21 Yes?

22 MS. LACEY: Just some technical

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

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

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

11 DR. ADIRIM: Is that on the SharePoint
12 site?

13 MS. GORHAM: It is on your SharePoint
14 site.

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

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

20 Are we good? Can I continue?

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

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

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

5 MS. GORHAM: Yes.

6 MS. LACEY: Okay, thanks.

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

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

11 So, the Measure 0477 and 0480 that you
12 see in bold, those are recommendations from the
13 2014 Child Task Force.

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

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

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

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

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

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

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

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

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

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

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

13 The next slide?

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

16 The next slide?

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

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

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

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

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

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

1 and adult core sets.

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

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

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

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

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

1 accounting for these preferences.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18 MS. LASH: Yes, it's easy.

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

22 So, the measure will be voted on by

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

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

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

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

12 CO-CHAIR GESTEN: I agree. Okay.

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

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

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

1 issue?

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

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

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

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

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

1 still not aligned properly.

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

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

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

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

16 CO-CHAIR GESTEN: Alvia?

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

22 And I would ask CMS sort of trying to

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

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

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

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

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

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

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

6 CO-CHAIR GESTEN: Thanks. Susan?

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

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

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

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

1 facilities.

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

4 CO-CHAIR GESTEN: Yes, Rebekah?

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

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

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

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

22 And it's very important because it's

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

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

8 CO-CHAIR GESTEN: Ashley?

9 MS. HIRAI: Thank you.

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

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

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

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

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

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

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

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

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

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

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

15 CO-CHAIR GESTEN: Harold?

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

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

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

3 So, do we know how the degree of
4 consistency?

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

8 MS. HIRAI: I agree.

9 (Simultaneous speaking)

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

13 MS. HIRAI: There is a flaw.

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

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

18 CO-CHAIR PINCUS: Yes.

19 MS. HIRAI: But I mean for --

20 CO-CHAIR GESTEN: There's gambling.

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

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

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

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

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

22 MS. LILLIE-BLANTON: I just wanted to

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

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

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

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

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

1 We have now gotten to the point where
2 we will have -- I think we are just at 25, maybe
3 26 states and, remember, our threshold for public
4 reporting of data is that we have at least 25
5 states reporting.

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

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

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

17 CO-CHAIR GESTEN: Thank you.

18 Beverly?

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

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

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

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

13 CO-CHAIR GESTEN: Thank you.

14 Rebekah? Brock?

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

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

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

12 Number one.

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

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

21 CO-CHAIR GESTEN: Alvia?

22 DR. SIDDIQI: I was just going to say

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

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

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

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

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

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

6 CO-CHAIR GESTEN: Thank you.

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

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

17 So, that was a comment that he made.

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

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

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

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

8 CO-CHAIR GESTEN: Okay, thanks.

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

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

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

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

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

1 now?

2 MS. LASH: Run through the whole
3 roster?

4 CO-CHAIR GESTEN: Yes.

5 MS. LASH: Okay, just a second.

6 CO-CHAIR GESTEN: Who are the voting
7 folks?

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

11 CO-CHAIR GESTEN: Okay.

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

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

19 CO-CHAIR GESTEN: What a great
20 suggestion.

21 MS. GORHAM: -- pretty well.

22 MS. LASH: All right, on the Child

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

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

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

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

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

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

22 Shaconna went through what the measure

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

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

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

11 CO-CHAIR GESTEN: Okay.

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

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

20 CO-CHAIR GESTEN: So, questions or
21 conversation?

22 Anne?

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

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

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

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

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

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

1 to include support for breast feeding post-
2 discharge.

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

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

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

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

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

1 Alvia?

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

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

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

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

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

1 CO-CHAIR GESTEN: Carol?

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

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

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

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

21 CO-CHAIR GESTEN: Andrea?

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

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

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

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

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

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

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

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

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

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

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

4 CO-CHAIR GESTEN: Thanks.

5 Luther?

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

10 CO-CHAIR GESTEN: Terry?

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

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

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

1 CO-CHAIR GESTEN: Ashley? Thank you.

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

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

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

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

20 CO-CHAIR GESTEN: Ann?

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

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

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

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

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

22 So, it's your definition of exclusive.

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

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

10 CO-CHAIR GESTEN: Marc?

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

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

22 CO-CHAIR GESTEN: Anne, I think you

1 may get the last.

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

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

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

22 So, I would encourage the term ever

1 being used.

2 CO-CHAIR GESTEN: Okay, thanks.

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

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

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

16 Cindy? Yes?

17 MS. PELLEGRINI: Yes, I nominate it.

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

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

22 MS. LASH: With three, it fails to

1 gain support.

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

6 MS. GORHAM: I did the overview.

7 CO-CHAIR GESTEN: You did the
8 overview?

9 MS. GORHAM: I did the overview. I'll
10 go into more details since we have discussed the
11 2014 recommendations from the child core set.
12 Now we'll look at three staff picks.

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

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

22 It also looks at the adoption or

1 continual use of LARCs.

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

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

9 So, we can move to the next slide.

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

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

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

1 set or the child core set.

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

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

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

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

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

1 And, yes?

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

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

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

14 DR. CUNILL: Well, I'd like to offer,
15 you know, a change to that age range, less than
16 21 years old or less than 20. I know you can't
17 change the measure but --

18 CO-CHAIR GESTEN: Susan?

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

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

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

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

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

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

15 CO-CHAIR GESTEN: Susan?

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

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

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

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

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

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

12 MR. CURRIGAN: It's all claims.

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

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

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

3 But, Sandra, did you have a comment?

4 DR. WHITE: Yes, I do.

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

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

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

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

22 The barrier is to the facility for

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

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

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

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

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

4 CO-CHAIR GESTEN: Thank you.

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

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

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

16 CO-CHAIR GESTEN: Okay.

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

1 C and already listed.

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

5 Alvia?

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

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

1 high priority for AAFP as well.

2 Again, recognizing that perinatal
3 health measures are really important, I do think
4 the other two which age 15 to 20 and then 21 to
5 44 are measures that could be adopted by states
6 that they could report on. And I would insert
7 the clause of pending NQF endorsement for those
8 two in terms of support.

9 CO-CHAIR GESTEN: Cindy and then
10 Rebekah?

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

21 CO-CHAIR GESTEN: Rebekah?

22 DR. GEE: So, to these --

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

4 MS. PELLEGRINI: Sorry?

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

7 MS. PELLEGRINI: Yes.

8 CO-CHAIR GESTEN: Okay.

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

11 CO-CHAIR GESTEN: Does that help?

12 Rebekah?

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

16 I agree with Sandra. I think,
17 although in Louisiana and I would say there are
18 11 states approximately that have changed this,
19 we pay in addition to the global per diem for
20 insertion and for the device. So, many states
21 have policy approaches to overcome this.

22 I think that if you wanted to simplify

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

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

15 My thoughts are that this is really
16 trying to get at that postpartum period. Sixty
17 days is when most women lose their Medicaid, so I
18 think 60 is a more appropriate time frame than
19 99.

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

22 On the use of -- going back to the use

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

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

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

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

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

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

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

11 CO-CHAIR GESTEN: Thank you.

12 Ashley?

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

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

22 They're engaged in different learning

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

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

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

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

21 CO-CHAIR GESTEN: Andrea?

22 DR. BENIN: You know, when I was

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

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

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

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

1 have babies.

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

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

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

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

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

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

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

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

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

1 is that we think we want to drive.

2 DR. GEE: so, we have --

3 CO-CHAIR GESTEN: Anne?

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

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

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

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

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

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

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

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

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

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

4 CO-CHAIR GESTEN: So, can I --

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

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

9 So, Anne, next?

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

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

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

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

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

9 CO-CHAIR GESTEN: Okay. Sue?

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

15 But the postpartum one alone is only
16 going to address interconception whereas the
17 first two are going to address their health prior
18 to that first pregnancy which I think it's
19 important in going to Cindy's point in terms of
20 perinatal outcomes.

21 I would strongly support adding Part
22 C to the postpartum measure because that is often

1 a very -- once women are discharged and they
2 leave the premises, they have difficulty for a
3 variety of reasons, not just because they don't
4 want to come back, they have difficulty coming
5 back.

6 And the 60-day cliff is especially
7 problematic for our most vulnerable populations.
8 So, I think that is something we really need to
9 look at.

10 In terms of the ethical argument, I
11 would also invite us to consider that the access
12 issue or lack of access has also been an ethical
13 problem in placing undue barriers to, again, our
14 most vulnerable populations, particularly those
15 who are going to fall off of that Medicaid cliff
16 with no recourse.

17 CO-CHAIR GESTEN: Marc, do you have a
18 clarification on the measure?

19 DR. LEIB: Yes, the clarification on
20 the 99 days, part of that has to do with
21 lactational amenorrhea and women's choices. So,
22 and it might get at your Part C, the age bands

1 that we have requested to be reported -- I mean
2 no the age bands, the weeks spans for the 99 days
3 so, zero to seven days would get at your
4 immediate postpartum, seven to 21 days gets you
5 at a two week postpartum visit and then there's
6 another band, I think to 56 to get to your six
7 week postpartum visit and then the 99 days gets
8 you at anybody that didn't want to go on
9 contraception because they were breast feeding
10 and that why there's the 99 days to get you at
11 the scope of what women could be choosing during
12 that time period.

13 CO-CHAIR GESTEN: Yes, but those bands
14 don't get at Sandra's issue about immediately in
15 the hospital.

16 DR. LEIB: Well, the zero to seven
17 days gets you the immediate postpartum LARC.

18 CO-CHAIR GESTEN: Okay. That may or
19 may not satisfy her. But okay.

20 DR. WHITE: One must remember that the
21 number of days postpartum is two, 48 hours, for a
22 normal delivery, 72 hours for C-sections. So,

1 that's why I'm going for the three days.

2 CO-CHAIR GESTEN: Marc?

3 DR. LEIB: I'm not going to repeat all
4 the other arguments here even though I have lots
5 of comments I could make, but sensitive to time.

6 But my question is the following,
7 where did November 5th and 6th as the cutoff
8 dates come from? It doesn't fit with the 99
9 days. It doesn't fit -- I'm trying to figure out
10 why that magical date appears there a starting
11 and ending point of the year measure rather than
12 something else.

13 MS. LASH: I can't speak for the
14 developer, but I would speculate, and this is
15 speculation that the technical specs, if it was
16 to be used in the child and adult core sets might
17 look at a different date range because the
18 reporting year starts and ends at a different
19 time.

20 (Off mic comment)

21 MS. LASH: There have been some tweaks
22 to facilitate state reporting.

1 CO-CHAIR GESTEN: And can I just
2 clarify, this is not endorsed. We came up
3 yesterday day with a question about what that
4 means.

5 In this case, it doesn't mean it
6 hasn't been presented yet or was it rejected?

7 MS. LASH: Has not been presented.

8 CO-CHAIR GESTEN: Not presented?

9 MS. LASH: None of them have.

10 CO-CHAIR GESTEN: Okay.

11 Susan?

12 MS. LACEY: So, it got a little -- we
13 got a little excited about the piece about
14 whether or not we were going to give people an
15 option.

16 So, it clearly says adopt or continue.
17 I'm going back to the language.

18 So, I guess my question would be
19 directed towards you about, is there an objection
20 to put something in there about the mother having
21 an option?

22 I mean I'm sensitive to all of that

1 other stuff, but, you know, some people don't
2 want to put things in their body. My daughter's
3 really weird like that. She's like I'm not
4 putting anything like that in my body.

5 I mean is there an objection to adding
6 that the woman has a choice?

7 CO-CHAIR GESTEN: So --

8 MS. GORHAM: So, just to answer that,
9 the measure -- the first part of the measure says
10 most effective or moderately effective adoption
11 of contraception. So, it doesn't necessarily
12 have to be a LARC.

13 The second part says, a adopt or
14 continue use the LARC. So, there is a -- they do
15 divide the two.

16 DR. LESSLER: Thanks.

17 So, this is really a very interesting
18 discussion.

19 Actually, first, I just want to
20 reiterate something that was said earlier around
21 the payment for LARC at the time of delivery and
22 that that's something that we've struggled with

1 and I think it resolved just recently in
2 Washington. I think other states are doing the
3 same. So, it can be addressed and it is a policy
4 decision.

5 The second point I want to make is,
6 you know, I think this really -- the question
7 around, you know, is the target a hundred percent
8 or not and so forth really begs the question as
9 to why do we measure and what do we do with
10 measurement?

11 And I don't think we measure in order
12 to get to a hundred percent. Sometimes we
13 measure in order to get to a hundred percent but
14 sometimes we measure in order to better
15 understand how our systems are performing.

16 So, I don't know what the right number
17 is and certainly this issue comes up a lot around
18 preference sensitive conditions where if somebody
19 can choose to or not to and yet you'd want to
20 know sort of what is happening.

21 And I think it gets back to the point
22 that was made by Anne about benchmarking. And,

1 you know, within a state, we have six plans now.

2 It would be very helpful to know where those
3 plans are at relatively with respect to, you
4 know, use of contraceptive methods by women.

5 And if they differ, it would beg the
6 question of us asking so, why? Are there good
7 reasons for that or not?

8 And so, I think that, you know, I just
9 -- I think we just have to keep in mind the
10 purpose of measurement, the multiple purposes of
11 measurement.

12 And then the final point I would make,
13 and I really agree with Sandra about I guess
14 Option C as you're calling.

15 I would also say, as I look at these,
16 Option C and some of the issues that have come up
17 around the difficulty in measurement the 99 days,
18 why November 5th, November 6th, Election day? I
19 don't know.

20 And the -- I actually think Option C
21 is probably the easiest to measure. So, you
22 know, so I would endorse all of these but I

1 actually think from the measurement standpoint,
2 Option C is probably the easiest to get one's
3 arms around.

4 CO-CHAIR GESTEN: Alvia?

5 DR. SIDDIQI: So, I'm a little
6 confused sitting here in terms of my role here
7 with the MAP. But when we are making
8 recommendations like in Option C for a measure
9 that hasn't gone through the NQF endorsement
10 process, that's really, I don't think, the role
11 of our -- or the objective of what we're trying
12 to do here in terms of trying to say whether or
13 not this measure is one that we would recommend
14 as is, right now, again, pending NQF endorsement
15 to CMS for the Medicaid core set for pedes.

16 So, I guess my point would be, again,
17 if we do have challenges with that one, the
18 postpartum effective contraception measure that
19 my recommendation is that we don't support it as
20 it stands currently. We've given feedback to NQF
21 through this meeting in terms of what we'd like
22 to see there, it sounds like there's been

1 consensus on that.

2 But, again, going back to these two
3 measures, in terms of access to LARCs, I do think
4 that that is really important. As Daniel stated,
5 you know, we need some baselines. The states do
6 need to start looking at this. It is helpful to
7 see different plans and what their rates of
8 access is for unintended pregnancies.

9 Again, this one is still pending NQF
10 endorsement. So, the denominator I think may be
11 teased out even more as part of that process.

12 So, I would just call the vote.

13 CO-CHAIR GESTEN: In terms of the
14 process question that she asked, do you want --
15 should you answer it? I've got my answer, but
16 I'm not sure it's the same as yours.

17 MS. LASH: I can answer it and you can
18 add on.

19 It is most important to be very clear
20 about the measure as it is currently written.

21 I think I'm hearing from the
22 conversation that there are multiple conditions

1 for the postpartum measure, that there's a strong
2 interest in the group in further measure
3 development and testing to incorporate some type
4 of stratification or a subset rate for the
5 hospitalization period immediately after birth
6 and also that the measure be submitted and
7 receive NQF endorsement.

8 So, I would maybe use that as the
9 default for voting on that particular measure.

10 On the others about general access and
11 use to contraception and the two age groups,
12 there might also be the condition that it be
13 submitted for endorsement but I didn't hear
14 concrete suggestions for other things you would
15 like to see changed about the structure of the
16 measure itself.

17 CO-CHAIR GESTEN: So, the process
18 would be somebody would nominate the measure, the
19 postpartum as a support with conditions with the
20 following conditions. There would be a vote on
21 that if that got voted, then so be it.

22 If it didn't pass, then somebody could

1 say, I want to nominate it as is. Right?

2 Let's see, where are we? I think
3 we're at Ann.

4 DR. SULLIVAN: Just to go back just a
5 minute, I think that I really appreciate the need
6 to measure this and to know what's going on in
7 the system and then to come up with benchmarks.

8 But, when we put out an indicator like
9 this, it tends to -- a measure like this, people
10 also take to something they should be doing.

11 And we just heard the unintended
12 consequences of some of the breast feeding issue.
13 So, I think you've got to be a little careful
14 here whether this -- and I'm not sure how you
15 would amend it, whether this goes out as
16 something that should be measured and looked at
17 versus something that we're saying, while I
18 personally agree with this -- I mean you can get
19 a lot of controversy about this kind of thing in
20 terms of --- and then you're -- for people who
21 think you should never use, you know,
22 contraception and that the Medicaid is saying

1 we're going to be ---

2 I'm just saying you have to be
3 sensitive to the issue that was brought up here.
4 And therefore, if you're going to put something
5 like this out and say well, we're really doing it
6 to measure and understand first to get to
7 benchmarks so that we leave that leeway for
8 people who really don't want to do it, then let's
9 say that and not put it out as a measure that's
10 already been set and everything else.

11 I think you could be setting up
12 something you don't want to do.

13 CO-CHAIR GESTEN: Andrea?

14 DR. BENIN: No, I obviously agree with
15 Ann Marie. And I -- you know, it comes back to a
16 comment that I mentioned yesterday, Foster, about
17 how the --- part of it is about the framework of
18 the measure set so that if there was an axis or a
19 component of the framework that was really for
20 epidemiological study which is what Dan is
21 getting at, which is we need to understand the
22 numbers.

1 We need to understand the numbers for
2 C-section, we need to understand the numbers for
3 contraception. That's different than a quality
4 metric so that there's that distinction in my
5 mind between epidemiological understanding which
6 is what Healthy People 2010 or some of these
7 other things might be more about.

8 But, and a quality metric that's ready
9 for action where we know we want X, Y, Z percent
10 performance on it.

11 And so, in my mind, there is that
12 distinction. And with the denominator having
13 some questions and all of these other things,
14 this isn't the only metric where we have this
15 desire to understand something epidemiologically,
16 and therefore, put it in a set, but yet we don't
17 really know what we want the performance to look
18 like which makes it a pretty complicated quality
19 metric and so --

20 CO-CHAIR GESTEN: Jeff? Thanks.

21 Jeff?

22 DR. CONVISSAR: I was just going to

1 start with by saying that I actually support both
2 of these. And I mean, to your point and the
3 point that's being made, it's valid that we don't
4 have targets. We don't.

5 We have other measures in our core set
6 that don't have targets. We have ED visits. The
7 answer isn't zero. People have to go to the
8 emergency department and we seem very comfortable
9 with that uncertainty.

10 And we know that -- and the reason for
11 that is because we know that people are using it
12 way too much now and that there's so much room to
13 go.

14 And I would say, based on what we
15 heard from some of our experts, that people are
16 so not having access or use when they don't want
17 to get pregnant that there's so much room to go
18 and while we don't know where it should top out,
19 that, to me, isn't a reason not to think that
20 this is a really important quality measure.

21 CO-CHAIR GESTEN: Marsha?

22 MS. LILLIE-BLANTON: So, let me just

1 say, I have certainly benefitted from the
2 conversation and your input and I think it's good
3 to hear how stakeholders view this issue.

4 I do want everyone to know that one of
5 our improvement initiatives in maternal and
6 infant health is to increase the use of moderate
7 and more effective methods of contraception.

8 So, we have as a Medicaid program
9 defined this as an improvement goal,
10 understanding the controversy and understanding
11 the concerns and understanding that we still want
12 women to have choice.

13 This is not about saying that every
14 woman should be using the most effective method
15 of contraception. This is about saying that
16 should a woman choose, we want to make sure that
17 she is using the most effective method of
18 contraception.

19 Now, I also want to agree with Jeff
20 that we don't set targets. I mean but this is an
21 improvement goal where we're trying to improve,
22 we're trying to increase, in this case, the rates

1 of use of effective contraception.

2 And we think it's important for the
3 health of the mother and the health of the
4 infant, that if there is greater or improvements
5 in the spacing of births, we think that an infant
6 has a better chance of being healthy.

7 And, of course, in terms of the timing
8 of the birth, that the mother also could be
9 healthier.

10 So, it is something that we are
11 concerned about how others perceive it and what
12 we definitely don't want is the perception or
13 that we are trying to force contraception on
14 women who are covered by Medicaid. But we do
15 want women to have the choice and we do want to
16 better improve our performance.

17 And just one more tidbit on the data.
18 What we know from the data is that about 11
19 percent of women now are using LARCs. And that
20 compares to about eight percent nationwide.

21 So, Medicaid -- women covered by
22 Medicaid already are higher users of LARC. But

1 we think that that could be a higher rate and
2 it's something that we are encouraging.

3 So, one more thing that you all should
4 know is that we are using the CDC measures as a
5 developmental measure in our improvement
6 initiative. So, we will be working and
7 supporting states in collecting the two CDC
8 measures as a way to better judge our performance
9 on this goal.

10 It is developmental and your decision
11 would help us in knowing whether or not this is a
12 measure that ultimately should be a part of the
13 core set.

14 We do think we need, you know, you
15 could call this kind of like the pilot testing
16 similar to what we're doing with the child
17 hospital CAHPS.

18 There are some measures that we're not
19 sure it's where we're really -- it's feasible for
20 states to collect and collect it accurately,
21 collect it well.

22 And the denominator of this one is a

1 challenge when you're trying to define the
2 population at risk of unintended pregnancies.
3 So, we're still trying to work out in some of the
4 details of this. But knowing your thinking on
5 this measure or either of these two measures
6 helps us because I can at least tell you that we
7 also considered the latter measure, the ARC
8 measure and one that ACOG had developed and we
9 were concerned about just promoting LARCs after a
10 mother had already delivered.

11 It seems as if, if you want to promote
12 effective contraception, you want to do it before
13 a mother delivers or is pregnant as well as after
14 a mother has delivered.

15 CO-CHAIR GESTEN: Thank you.

16 MS. LILLIE-BLANTON: So, that was our
17 thinking.

18 CO-CHAIR GESTEN: Thanks, Marsha.

19 So, can I just ask a question? States
20 have a means in which they report on unintended
21 pregnancy rates, because I've seen our colleagues
22 whether it's from -- survey data.

1 That seems like the outcome of
2 interest here. Is there a reason why that could
3 not or should not be used to get at the issue of
4 unintended pregnancies? I mean I can guess at
5 what some of the challenges related to that data
6 set, but every data has challenges.

7 So, I'm just wondering, Marsha, either
8 for the initiative or for others in the room, is
9 there a reason to not simply look at self-
10 reported data about whether a pregnancy was
11 intended or not versus looking at access? Is
12 there a compelling reason to not use that?

13 Rebekah?

14 DR. GEE: The reason it's compelling
15 is because it's not readily available. You have
16 -- we've been working with the CDC and both the
17 BRFSS and PRAMS to get Medicaid identifiers. But
18 these surveys are filled out presumably by women
19 so they're not going to be information that's
20 shared with their insurance plans, et cetera.

21 And so, it's not, you know, even
22 though we've been working a lot with the CDC on

1 making those surveys more actionable on a
2 population level, they were not designed to be
3 used for those purposes.

4 So, ideally, you would use that, the
5 woman's perceptions, but I would just say that I
6 think we're trying to hold this measure to a
7 higher standard than we hold our other measures.

8 You know, when we measure cholesterol,
9 we're not saying, hey, what does the patient want
10 their cholesterol to be or asthma.

11 I mean I think we're just holding this
12 to a higher standard. I mean I also don't think,
13 as Jeff so eloquently said, that we need to think
14 -- this is not a standard setting body. This is,
15 is it a valid measurement body, in my
16 understanding.

17 Is it valid to measure this? Heck,
18 yes, because we know that very few women are
19 getting these devices, that our rates do not meet
20 up with what other developed countries have. It
21 doesn't mean that there might be issues with, you
22 know, coercion, et cetera, but that could exist

1 for anything. It could exist for Alc, maybe
2 diabetics don't want their Alcs to be less than
3 seven.

4 I mean, so I think it's for every
5 issue that we have, I think the patient
6 preference has an important role. And I don't
7 know that that's our job.

8 And so, I would agree with everything
9 that Jeff and Marsha said. And I do think the
10 denominator, though problematic, is definable.

11 CO-CHAIR GESTEN: Thanks.

12 Anne?

13 MS. COHEN: So, there's a couple
14 things and I'm Anne Cohen, there's two Ann's in
15 the room.

16 And I wanted to address what Ann
17 Sullivan said. She said, you know, the
18 problematic nature of breast feeding and
19 unintended consequences in measurement, and I did
20 bring that up as an issue for the other measure
21 that not being said that breast feeding wasn't
22 important but that was a different realm for this

1 body, we might want to consider measurement of.

2 That being said, I think all policy
3 has unintended consequences that we can't always
4 see. But we also have to look at the historic
5 nature in which we're implementing the measure.

6 So, the LARCs issue historically was
7 something in the '80s that was -- and '90s --
8 that was a bigger issue about pressuring women on
9 Medicaid to be on LARCs.

10 If you look at the historic nature
11 today, that's not the case. There's been cuts to
12 Planned Parenthood. There has been the recent
13 Supreme Court case. There's been issues of state
14 by state reexamining their Medicaid coverage for
15 contraception and access to abortion and other
16 things.

17 So, I think that given that, I think
18 we need to consider what the access availability
19 is today on this policy issue while keeping the
20 historic nature in mind about pressuring women to
21 take LARCs that otherwise wouldn't necessarily
22 want to be on them, if that makes sense.

1 So, I just want to put that in the
2 context. But, I think we really need to think
3 about what the policy considerations are today
4 and moving forward in the next 48 years as where
5 the benchmark about whether or not to adopt this
6 measure.

7 CO-CHAIR GESTEN: Thanks, Anne.

8 Jeff, did you have another comment?

9 DR. CONVISSAR: I do. I got so
10 excited about the last thing I forgot that I had
11 two things I wanted to say.

12 CO-CHAIR GESTEN: So, we're at the
13 point where we need new things.

14 DR. CONVISSAR: Oh, no, it is, it is.

15 CO-CHAIR GESTEN: That's fine.

16 DR. CONVISSAR: The access one, I
17 think what I heard -- so maybe I'm asking for
18 some clarification and if I think if I heard it
19 right, then perhaps there's a potentially useful
20 point here, that there was the ability to sort of
21 band those 99 days, that while zero to seven days
22 isn't to Sandra's point, you know, the hospital

1 stay, the reality, I would think -- if that's
2 true that we can actually know who got them
3 within zero to seven days, the reality is, if
4 they're getting them in that zero to seven days,
5 it's happening in the hospital.

6 I mean those folks aren't coming back
7 somewhere like two days later and probably -- so
8 I just wonder if that really, the ability to band
9 while we could make conditional changes and I
10 have no idea how easy or hard that process is, in
11 reality, if the current sort of definition allows
12 for us to really stratify that out, is it
13 possibly good enough?

14 CO-CHAIR GESTEN: Carol?

15 MS. SAKALA: I just want to say that
16 I think we've been discussing a kind of
17 professionals going rouge situation this morning
18 of like we want to protect women from
19 professionals not behaving as professionals.

20 And I think our health care system
21 overall, our National Quality Strategy, we want
22 to do patient and family engagement. We want to

1 do shared decision making. We want to provide
2 reasonable access to high quality services.

3 And so, I think we need to kind of
4 raise our bar of how we're thinking about these
5 issues and expect that moving forward, we're
6 raising the bar for our system as a whole.

7 CO-CHAIR GESTEN: Marsha, do you have
8 another comment or is that -- your card is up.
9 Is that a hold over?

10 So -- yes?

11 DR. BENIN: So, for the child MAP, are
12 we going to vote -- we're not voting on all three
13 of these?

14 CO-CHAIR GESTEN: We'll vote -- I
15 think it's a process.

16 MR. CURRIGAN: Can we just clarify on
17 the November 5th is to align with the HEDIS
18 measure for prenatal and postpartum care on
19 identifying births.

20 So, they would only have to pull the
21 denominator once to do the measure for all the
22 measures as opposed to a separate denominator.

1 CO-CHAIR GESTEN: Thank you.

2 So, in terms of process, it looks to
3 me, unless my colleague disagrees that we have
4 one measure for the child MAP and two measures
5 for the adult MAP to vote on.

6 And the challenge will be that each of
7 the measures, folks have things that they wanted
8 to see different. So, as was mentioned before,
9 my suggestion, it depends on the measure, I think
10 my suggestion for the -- let's start with the
11 child measure --

12 MS. LASH: Could we go to Slide 148?

13 CO-CHAIR GESTEN: Yes, that's what I
14 wanted to say. Not that one, no, other way,
15 other way.

16 So, my suggestion would be that we
17 start with the measure as is which includes the
18 15 to 20. I know that there was an early
19 conversation about potentially this going down to
20 ten or below.

21 My suggestion would be that we start
22 with that measure and see if it passes as is and

1 if it does not, then there could be a proposal to
2 change the -- to endorse it with a conditional
3 put on it that the age change happens, unless --
4 Sarah, do you see it differently?

5 MS. LASH: If you also want a
6 condition that it be NQF endorsed.

7 CO-CHAIR PINCUS: So, just to be
8 clear, are the options that we would give them is
9 to endorse, to endorse with conditions or to not
10 endorse?

11 MS. LASH: So, it's support which is
12 green light, CMS can use it immediately. Support
13 with conditions, we would specify those
14 conditions, we've heard that it gain NQF
15 endorsement or that some further respecification
16 of the age range might take place.

17 So, we'll take a -- we'll have a
18 motion and then we'll take a binary vote.

19 CO-CHAIR PINCUS: Okay.

20 CO-CHAIR GESTEN: So, I'll start with
21 do we have a motion to -- this is for the child
22 MAP, to endorse this measure with the condition

1 that it become NQF -- go for NQF endorsement?

2 That's one. Second?

3 DR. SIDDIQI: Second.

4 CO-CHAIR GESTEN: So, the motion is
5 endorsement with the condition that this go
6 through NQF endorsement.

7 All those in favor on the child MAP of
8 that proposal, raise your hand.

9 MS. LASH: I count 12.

10 CO-CHAIR GESTEN: Okay.

11 MS. LASH: So, that passes.

12 CO-CHAIR GESTEN: Passes.

13 Now, for the -- sorry, Harold, but
14 let's go to the next one.

15 CO-CHAIR PINCUS: Okay. So, now on
16 the adult side.

17 CO-CHAIR GESTEN: Go to the next slide
18 that --

19 So, this is -- we're not getting the
20 postpartum yet, right?

21 CO-CHAIR PINCUS: Oh, right.

22 So, on the adult side, is there a

1 motion to endorse this measure with the condition
2 that it go for NQF endorsement?

3 DR. SIDDIQI: So moved.

4 CO-CHAIR PINCUS: Second?

5 So, should we vote?

6 MS. COHEN: Can I clarify? I believe
7 I'm supposed to be on both, is that correct?
8 Okay.

9 CO-CHAIR PINCUS: Okay.

10 MS. KENDIG: Can you explain -- the
11 vote is for support which means it would go into
12 effect right now or for NQF endorsement. I guess
13 I'm just not remembering any kind of conditions
14 that were attached.

15 CO-CHAIR PINCUS: The support -- it's
16 support with the condition --

17 MS. KENDIG: Got it.

18 CO-CHAIR PINCUS: -- that it be
19 endorsed by NQF.

20 MS. KENDIG: Okay, thank you.

21 CO-CHAIR PINCUS: Okay, so all those
22 in favor of this measure as is going for

1 endorsement by NQF, raise your hand. In the adult
2 group.

3 MS. LASH: Conditional support pending
4 NQF endorsement.

5 CO-CHAIR PINCUS: Conditional support
6 pending NQF endorsement.

7 MS. LASH: For the adult core set.

8 That's ten, the threshold was seven,
9 so the motion passes, or Harold as well, 11.

10 CO-CHAIR PINCUS: Next slide,
11 postpartum?

12 So, the postpartum one is also for the
13 adult.

14 CO-CHAIR GESTEN: Right.

15 MS. LASH: This could be both, it
16 really could. Let's see how the vote goes.

17 CO-CHAIR GESTEN: So, I'll just -- I
18 mean I think what I heard was going around, at
19 least some support for a support with the
20 condition that the measure be -- that there be an
21 additional component to this measure added by the
22 steward which would be zero to three --- was that

1 your proposal? I want to make sure that I have
2 it right.

3 But there would be an additional
4 stratification of access postpartum between zero
5 and three days.

6 So, I don't know, what do you think?
7 Is that what we should put forward so that this
8 would -- with the other conditions would be NQF
9 endorsement as well. I assume so, NQF
10 endorsement and a addition or modification to the
11 measure that the measure steward would need to
12 agree to.

13 I don't know how big a bar -- how high
14 a bar that is but --

15 MS. LASH: It could mean that the
16 measure would take an additional year or so to
17 make it into use.

18 There is a stratification table that
19 includes the zero to seven day period. It's not
20 as specific as Sandra's proposal, but that is a
21 part of the current measure design.

22 DR. WHITE: So, just let me clarify,

1 will the zero to seven day period also provide
2 access while they are still in the hospital?

3 MS. LASH: Yes.

4 DR. WHITE: Okay. I can accept that.

5 MS. LASH: So, then I think the --

6 CO-CHAIR PINCUS: So, the only
7 condition then would be the NQF endorsement?

8 CO-CHAIR GESTEN: So, is this a vote?
9 Are we voting on the adult and the child side?
10 Which side are we voting on for this one?

11 MS. LASH: Let's start with the adult
12 and then take a vote for child inclusion as well.

13 CO-CHAIR PINCUS: So, is there a
14 motion to support this measure with the condition
15 that it go for NQF endorsement?

16 MS. PELLEGRINI: So moved.

17 CO-CHAIR PINCUS: Is there a second?

18 DR. WHITE: Yes.

19 CO-CHAIR PINCUS: All those who vote
20 in favor of supporting this measure with the
21 condition of going for NQF endorsement, raise
22 your hand.

1 MS. LASH: This is Adult Task Force
2 members.

3 Nine, the motion passes. Please raise
4 your hands once more. That is ten. Thank you.

5 CO-CHAIR GESTEN: Okay, kids. It's
6 for the child MAP. The proposal is -- I guess we
7 need a motion to propose this measure with the
8 conditional support with the condition being that
9 it goes through NQF approval. Do we have a
10 motion?

11 Yes, do we have a second? Yes?

12 DR. LEIB: Do we have to have an age
13 range like we did before, 15 or 20 or something
14 because there are no ages in this measure?

15 MS. LASH: Right, there is a --

16 CO-CHAIR PINCUS: Postpartum is --

17 MS. LASH: -- stratification for less
18 than 18 years.

19 CO-CHAIR GESTEN: So, I think I saw a
20 second.

21 MS. LACEY: So, is this with the zero
22 to seven days? Is that correct? Okay, just like

1 -- I just wanted to make sure.

2 CO-CHAIR GESTEN: Same measure, all
3 those in favor? The condition is NQF, yes,
4 conditional support.

5 MS. LASH: I got 11.

6 CO-CHAIR GESTEN: One more time.

7 MS. LASH: Eleven.

8 CO-CHAIR GESTEN: Wait, we've got a
9 discrepancy. Let's do it again one more time,
10 sorry. Just keep them up.

11 Eleven, okay.

12 So, thank you everybody, great
13 conversation.

14 So, we have -- I think we were going
15 to have that public comment at this point and
16 then a slightly delayed lunch, but --

17 Yes? Go ahead. Shaconna's in real
18 trouble back there. So, she wants to know
19 whether we wanted to offer you to recommend any
20 additional measures.

21 MS. GORHAM: I just want to be fair.

22 CO-CHAIR GESTEN: She just wants to be

1 fair. So, we, again, I think if we had had more
2 time, we would, but if it's -- I think we can
3 make time if there's somebody who wants to offer
4 from the list or from otherwise a suggestion for
5 a measure for us to take up. I think it's
6 probably fair and right for us to do that right
7 now.

8 MS. COHEN: Is this only for the
9 maternal health category?

10 CO-CHAIR GESTEN: Yes, yes.

11 MS. COHEN: Okay.

12 MS. LASH: This would be for available
13 measures that could be added. I will have a
14 continuing gap discussion.

15 CO-CHAIR GESTEN: We're kind of hoping
16 you're hungry enough and tired enough that you --
17 but Jeff has one. Go ahead.

18 DR. CONVISSAR: The -- it's line 17 in
19 the spreadsheet that healthy -- this is for the
20 child -- the healthy term newborn.

21 I mean a lot of these measures are --
22 well, it feels like a really important, really

1 patient-safety measure in that domain and I just
2 -- I don't know much about the measure but it's
3 already NQF endorsed. I think I checked before I
4 opened my mouth that it was like administrative
5 kind of thing or maybe I was wrong about that
6 one. Oh, yes, administrative claims.

7 I was trying to use your all -- all
8 your rubrics. So, I guess the question I would
9 have is since you did review all these and it
10 wasn't a staff pick, why? What am I not thinking
11 about?

12 MS. LASH: The rationale was first
13 that we were already picking out multiple
14 measures and the contraceptive topic was a little
15 primary to the birth outcomes.

16 The title of this measure is very
17 deceiving, so I just want to be really clear with
18 everyone that it's not measuring the percentage
19 of healthy term newborns, it's like the converse
20 or the inverse that it's looking at the rate of
21 birth complications within the hospital and the,
22 you know, immediate days following.

1 So, the numerator statement reads,
2 this is the absence of conditions or procedures
3 reflecting morbidity that happened during birth
4 and nursery care to an otherwise normal infant.

5 It could be very well an important
6 facility level quality improvement measure.

7 I think another thing that maybe
8 worked against it in our initial calculus was
9 that it seemed like something that hospitals
10 would particularly want to focus on but maybe
11 less so the statewide program.

12 But we could open for discussion on
13 that to see if people agree or disagree with that
14 judgment.

15 CO-CHAIR GESTEN: Discussion on that
16 measure?

17 Carol?

18 MS. SAKALA: Oh, I didn't immediately
19 bring it up but that was the one that I was
20 thinking of discussing.

21 From the point of view of what Kevin
22 said yesterday and you said today, Sarah, about

1 measures that have the potential to impact
2 improvement for a large segment of the
3 population, I think this is really a good one and
4 I might even, you know, prioritize it over
5 delivered at the -- you know, low birth weight
6 infant delivered at the right place of care.

7 I can also share with you that it's
8 been tested very well but when it comes up for
9 NQF endorsement again, it's going to be flipped.

10 So, and that also has been tested very
11 well through the California Maternal Quality Care
12 Collaborative and maybe elsewhere.

13 The new name is going to be Unexpected
14 Newborn Complications and the idea is when you --
15 babies who you had no reason to expect an
16 untoward outcome and something happens in the
17 course of the birth or the hospital stay
18 afterwards, so it's monitoring that.

19 And the developer, Dr. Main, feels
20 that it's a balancing measure. So that, you
21 know, this fear of oh, we're going too far, for
22 example, on reducing the Cesarean rate or other

1 kinds of concerns with overuse that this will be
2 a red flag if we suddenly start to see an
3 increase rather than improvement in this area.

4 CO-CHAIR GESTEN: Ashley?

5 MS. HIRAI: I just wanted to mention
6 the severe maternal morbidity measure just to put
7 it on people's radar that it is something that is
8 now a Title V National Outcome Measure.

9 And that we do feel it is very
10 sensitive to quality improvement and have an
11 alliance for innovation and maternal health
12 that's working with national, state and hospital
13 partners to implement bundles of care to reduce
14 that severe maternal morbidity which is a hundred
15 times more common than an actual death and twice
16 as common as actual infant death.

17 And many women can be severely
18 disabled. So, it's an important indicator.

19 We have tools to address it through
20 these hemorrhage bundles, preeclampsia, deep vein
21 thrombosis, that's also work done by Dr. Main.

22 But it is something that multiple

1 programs are now working on at the federal and
2 state hospital level and I just wanted to make
3 sure people were aware.

4 I know it's not going to be voted on.

5 CO-CHAIR GESTEN: It's not on the
6 list?

7 CO-CHAIR PINCUS: No, it is.

8 CO-CHAIR GESTEN: Oh, it is?

9 CO-CHAIR PINCUS: On the bottom, the
10 last one.

11 MS. HIRAI: I guess maybe I just shot
12 myself in the foot. Maybe somebody would
13 nominate it, but I just wanted to raise the
14 issue.

15 CO-CHAIR GESTEN: Got it.

16 Harold?

17 CO-CHAIR PINCUS: So, and this may
18 come -- and this will -- actually, it will come
19 up again in our discussion after lunch is for
20 both these measures, to what extent is there --
21 have risk adjustment methodologies been developed
22 and applied in this -- you know, for these

1 measures?

2 Because it's, you know, we're getting
3 closer to outcome measures here and we're going
4 to be having a discussion about moving from
5 process to outcomes. And I just want to get a
6 sense of that with regard to these two measures.

7 CO-CHAIR GESTEN: My understanding,
8 there isn't -- I guess the question is, unlike
9 measurement at the facility level, does it matter
10 at the state level or not? Do we need to adjust
11 for differences between Louisiana and New York
12 and Nebraska? I mean I think it's a fair point.

13 I'm thinking that this would welcome,
14 sort of, a nomination for the measure that you
15 had, Jeff, or any other measure. This is the
16 time if you want to nominate one. We'll look for
17 a second, we take a vote.

18 Again, assuming we figure out which
19 group it's in, I think that, obviously, the one
20 that you talked about clearly goes in the child's
21 MAP and do you want it -- I would ask if there's
22 a nomination for that measure?

1 DR. CONVISSAR: Yes, I nominate it.

2 CO-CHAIR GESTEN: Is there a second?

3 MS. SAKALA: I just -- clarify, do we
4 need to specify conditions like should we wait
5 for the measure to be flipped so there's not a
6 lot of confusion? Would it be after it goes
7 through endorsement again? I just wanted to ask
8 you how it was.

9 DR. CONVISSAR: I see the one minus,
10 I don't know, it seems okay to me. But if
11 there's a --

12 CO-CHAIR GESTEN: So, your nomination
13 is for the measure as it's written here?

14 DR. CONVISSAR: Yes.

15 CO-CHAIR GESTEN: Is there a second?

16 MS. GORHAM: And just a point of
17 clarification, if we're talking about the healthy
18 term newborn, it is already NQF endorsed.

19 CO-CHAIR GESTEN: Carol's -- they're
20 changing it, right?

21 (Off mic comment)

22 CO-CHAIR GESTEN: Okay. I appreciate

1 the kindness, but you seconded the motion, so we
2 have a motion and a second. So, we're going to
3 take a vote for the child MAP on the healthy
4 newborn measure. All those in favor of
5 recommending this be added to the measurement
6 set, raise your hand.

7 MS. LASH: That's four, so the motion
8 fails.

9 CO-CHAIR GESTEN: Dare I ask, is there
10 a motion -- anyone want to make a motion for any
11 other measure for consideration?

12 Marc?

13 DR. LEIB: Well, I'll seek a
14 clarification. Would it be inappropriate to
15 nominate the flipped version of this when it
16 comes forward and has NQF certification?

17 MS. LASH: That would be a conditional
18 support with that condition that the measure
19 complete its respecification and review prior to
20 --

21 DR. LEIB: I will nominate it that way
22 to see if this information was desired in a

1 different format.

2 DR. CONVISSAR: I'll second that.

3 CO-CHAIR GESTEN: Okay, so just so
4 everyone understands, the nomination on the floor
5 that's been seconded is conditional support of
6 the healthy newborn and the conditions are that
7 it go through this process of changing from a
8 flip, it's actually from a negative to a
9 positive, right, and that it subsequently go
10 through NQF endorsement. Did I get that right?

11 MS. SAKALA: Unexpected Newborn
12 Complications is the new name.

13 CO-CHAIR GESTEN: Okay, and it has a
14 new name.

15 So, we have the nomination, we have
16 the second. All those in favor on the child MAP
17 of that recommendation, raise your hand.

18 MS. LASH: Five, six. All right.
19 That's --

20 CO-CHAIR GESTEN: Six.

21 MS. LASH: Six.

22 CO-CHAIR GESTEN: It does not pass.

1 MS. LASH: So, it does not pass.

2 CO-CHAIR GESTEN: Before we go to
3 lunch, which you guys have definitely earned, do
4 we need to do anything -- give any instructions
5 to the Child Task Force?

6 MS. LASH: Yes. We will be adding to
7 the flip chart behind me the other measures
8 supported this morning by the Child Task Force
9 for addition.

10 We will also give each of you a fewer
11 number of these round stickers to add to the flip
12 chart about which measures you would prioritize
13 for CMS's immediate implementation.

14 And we will review the results as a
15 group when we finish lunch.

16 CO-CHAIR GESTEN: How many do we get?
17 How many -- oh, yes, public comment, I'm sorry.

18 How many stickers do we get?

19 MS. LASH: Let's see, so we have a
20 total of --

21 MS. GORHAM: Six.

22 MS. LASH: -- new measures this

1 morning?

2 MS. GORHAM: No, three new measures,
3 a total of six.

4 MS. LASH: Three new measures from
5 this morning and --

6 MS. GORHAM: Three from yesterday.

7 MS. LASH: -- three from yesterday.

8 MS. GORHAM: For a total of six that
9 they're prioritizing.

10 MS. LASH: Got it. Thank you.

11 CO-CHAIR GESTEN: Yes, but how many
12 stickers do we get?

13 MS. LASH: So --

14 CO-CHAIR GESTEN: It's all well and
15 good, how many stickers do we get? Three?

16 MS. LASH: Does the chair advise three
17 or four?

18 CO-CHAIR GESTEN: I'm going to suggest
19 three, but -- to the group.

20 MS. LASH: Force some additional
21 choices?

22 CO-CHAIR GESTEN: What's that?

1 MS. LASH: I think it forces the
2 choice.

3 DR. LEIB: Is there a difference in
4 terms of the need for prioritizing those that
5 have been sort of fully recommended because
6 they're ready and those that are going to await
7 NQF endorsement which I don't know how long that
8 really means. Is that even going to happen
9 before the year ends? So, is that something we
10 should be considering?

11 MS. LASH: Yes, I would say that the
12 readiness should --- could affect your
13 prioritization. However, if you feel really
14 strongly that CMS's first priority should be
15 working on a measure that only gained conditional
16 support, you would still have that option.

17 I will also clarify, you are allowed
18 to put multiple stickers on the same measure if
19 you have a strong favorite.

20 Any other points of clarification?
21 Please do approach a member of the staff during
22 the lunch break if you have questions about this.

1 And before we break, we are due,
2 overdue probably, for a public comment period.

3 CO-CHAIR GESTEN: So, let's start on
4 the phone. Operator, can you ask folks on the
5 phone if they have a question or a comment they
6 want to make from the public? Now is the time.

7 OPERATOR: At this time, if you would
8 like to make a public comment, please press star
9 then the number one on your telephone keypad.
10 Again, that's star one.

11 And there are no public comments at
12 this time.

13 CO-CHAIR GESTEN: Thank you very much.

14 In the room? Any public comments?
15 Yes? Step up to the mic and introduce yourself.

16 PARTICIPANT: Could you clarify what
17 the vote meant on the postpartum? All I heard
18 was a number somebody had.

19 CO-CHAIR GESTEN: So, the question was
20 clarifying the vote on the postpartum. Both of
21 them passed, is that right? So, they passed
22 meaning that they get recommended and added to

1 the list of recommended measures to CMS.

2 Any other public comments or
3 questions?

4 Yes?

5 (Off mic comment)

6 CO-CHAIR GESTEN: Yes, they were
7 conditional.

8 Lunch and stickers. What time are we
9 going to come back? We're running a little
10 behind, right?

11 MS. LASH: We'll take a 30 minute
12 break and --

13 CO-CHAIR GESTEN: Twenty after?

14 MS. LASH: At 20 after.

15 CO-CHAIR GESTEN: Twenty after.

16 Thanks everyone.

17 (Whereupon, the above-entitled matter
18 went off the record at 12:49 p.m. and resumed at
19 1:21 p.m.)

20 CO-CHAIR GESTEN: So, we're going to
21 give a brief conclusion to the prioritization
22 exercise once we have all the counts, but

1 otherwise, I think the afternoon is mostly around
2 cross-cutting issues, both -- that go across
3 adult and child.

4 And some of you have brought up issues
5 and wondered if there's a time or opportunity to
6 talk about issues, other issues about other
7 measures or alignment or some of the challenges
8 that states have and I would say that we're going
9 to tee up, I think, a number of very broad
10 questions that will give people the opportunity
11 to talk about that.

12 Again, with a focus on is the program
13 of measurement really delivering on the things,
14 the goals that CMS and we all have for the
15 program which is more states reporting, more
16 states being able to report more measures and
17 importantly, use of those measures for
18 improvement.

19 So, I think that that's going to be
20 kind of the rallying flag with some specific
21 questions about measurement issues and outcomes
22 versus process that we want to tee up.

1 So, I'm just stalling here. Sarah, do
2 you have the vote count or Shaconna?

3 MS. LASH: That was well done.

4 All right, first, I want to clarify
5 that all six measures that gained conditional or
6 full support of the Task Force will be included
7 in the report and recommended. They'll simply go
8 in a rank order that will be determined by the
9 vote that was just taken.

10 There was a tie for first place with
11 ten votes each for the measure of Multiple
12 Concurrent Antipsychotic Medications in Children
13 and Adolescents and the Under 1,500 Gram Infant
14 Not Delivered at the Appropriate Level of Care.

15 The next most prioritized measure is
16 Effective Postpartum Contraception Access.

17 MS. PELLEGRINI: I'm sorry, Sarah,
18 it's just hard to hear you down here, can you
19 just say what the top one was again?

20 MS. LASH: Of course.

21 The first two measures are the -- and
22 it was a tie at ten votes each, Use of Multiple

1 Concurrent Antipsychotics in Children and
2 Adolescents, the 1,500 Gram Infant Not Delivered
3 at the Appropriate Level of Care.

4 So, then in third place with seven
5 votes -- hold tight. Foster, you can keep
6 stalling, if you like. Anyone know any good
7 jokes?

8 CO-CHAIR GESTEN: Did everybody vote?
9 Did everybody have stickers and votes, probably a
10 good time to ask, anyone else? Okay.

11 MS. LASH: Okay, we're good.

12 CO-CHAIR GESTEN: Okay. Anything need
13 to be revised?

14 MS. LASH: It remained a tie for first
15 place between the Multiple Concurrent
16 Antipsychotics and the 1,500 Gram Infant
17 Delivered at the Wrong Level of Care for first
18 place.

19 The next most prioritized measure was
20 Effective Postpartum Contraception Access,
21 followed by Use of Contraceptive Methods Women 15
22 to 20 Years Old and then finally, another tie

1 between Audiological Evaluation No Later Than
2 Three Months and Pediatric All Condition
3 Readmissions.

4 CO-CHAIR GESTEN: Great. Any
5 comments, questions?

6 So, again, I want to thank everybody,
7 both groups, but especially the child MAP for
8 their work over the last day and a half, probably
9 to say thank you's again, but in case folks are
10 leaving early, this was a -- I look forward to
11 the afternoon conversation, but this was the work
12 that we had to do and it was hard choices.

13 Somebody said, you know, choosing
14 between your children and your grandchildren
15 around these measures.

16 I think the good news is that, you
17 know, we get to do this every year. Sort of a
18 good news, bad news story, right?

19 But, the fact that there is, you know,
20 such a deliberate and conscious effort to make
21 sure that the set is right each year, I think
22 it's really, you know, a testimony to the process

1 and, you know, it commends the amounts for paying
2 such close attention to is.

3 So, I think we want to do -- just have
4 some slides talking about some of the issues that
5 we've touched on over the course of the past day
6 and morning related to data collection, this
7 issue about appropriate balance of measures,
8 however you view balance.

9 But certainly, one of the things that
10 comes up very frequently is between process and
11 outcome measures. There's certainly other ways
12 in which we can think about balancing measures,
13 measures that are of interest to policymakers,
14 measures that are of interest to providers,
15 measures that are of interest to patients and
16 families. Hopefully, at least on a good day,
17 some of those measures are overlapping.

18 And then, as we've talked about if
19 really the point of this is motivating quality
20 improvement action and a combination of Jeff and
21 Rebekah and I assume you'll hear -- the adult
22 group will hear from David Kelley and others

1 about some of the tremendously impressive actions
2 and activities that are going on, I think, that
3 really describes sort of what it's for, you know,
4 what's the purpose of this and how measures can
5 be used.

6 So, I think we want to be able to
7 encourage that and see more of that and clearly
8 have measures that serve that really important
9 purpose.

10 As Harold said, it's not just measures
11 for measures sake but really measures to really
12 motivate states and clinicians and health care
13 organizations to improve.

14 So, what's on the next slide? Yes, go
15 ahead. Thanks.

16 MS. LASH: Sure. So, we have just a
17 few bullets that reflect back some of the themes
18 we've heard in last year's review and some that
19 have also been raised during this meeting about
20 these different aspects of balance and motivating
21 quality improvement action.

22 So, when we think about enabling

1 better measurements, we heard frequently that
2 inability to access data was the most consistent
3 barrier across the board for these measures.

4 We know that chart review and other
5 manual methods of data extraction are very
6 expensive, time-consuming and they might mean
7 that other priorities in the Medicaid program
8 would have to be sacrificed or the chart review
9 itself might end up getting sacrificed. There's
10 a real calculus as to what is the most bang for
11 your buck when it comes to quality measurement
12 and improvement.

13 We've heard a lot of discussion about
14 linkages to vital records providing highly useful
15 information, but it's a technical process that
16 requires a significant startup investment and we
17 could consider ways to reduce the amount of
18 initiation energy required there.

19 We also know that few states have EHRs
20 in fully wide use and also available to health
21 plans and Medicaid agencies to access. And
22 registries, although wonderful for lots of

1 specialty condition measurement are not as
2 feasible as the data source for this structure of
3 a program.

4 Another thing to consider about
5 whether those measure sets should favor process
6 outcome measures, structural, that outcome
7 measures are more likely to require risk
8 adjustment to gain buy-in about the people being
9 measured than are the process measures.

10 Some part of that erodes when you lump
11 up the data to report one statewide rate to CMS,
12 but for a state to be able to work within its own
13 network, there might be a greater ask for risk
14 adjustment to be present within the measure if
15 the administrators really do want to compare
16 their contracted health plans to one another or
17 all the state hospitals, for example. So, those
18 are just some little seeds -- food for thought.

19 On the next slide, we have a set of
20 discussion questions. We'd like to hear from our
21 state panelists any thoughts that they have on
22 these questions and then we'll have a very open

1 ended discussion within the group.

2 And if there are other questions you
3 would like to raise to each other that resulted
4 from the meeting that we didn't have pre-prepared
5 -- benchmarking comes to mind, do feel free to
6 introduce that into the conversation and we'll
7 capture it as best we can.

8 So first, begging the question, is it
9 really a priority of the states to move towards
10 more outcome measurement? That is a truism in
11 measurement science sort of worth reexamining
12 here.

13 Are the states realistically able to
14 request plans and providers to give them more
15 information, more data?

16 If we were to add more outcome
17 measures to the core set, at this point in time
18 or even next year, would it have the effect of
19 hindering state participation?

20 And then, are there sort of lessons
21 learned from the broader measurement community
22 who have gradually adopted more outcome measures

1 to replace structures and process measures?

2 So, our chairs will, you know,
3 facilitate this discussion here.

4 CO-CHAIR PINCUS: So, for those of you
5 that are most involved in terms of state
6 administration of this, we'd like to hear from
7 you. So, you know, Dan, Rebekah, others.

8 CO-CHAIR GESTEN: So, before we get
9 started, I do want to do -- Dave Kelley, are you
10 on the phone? Are you still on the phone?

11 Okay, Dan, why don't you start us off?

12 DR. LESSLER: So, you know, it's
13 interesting to think -- there's a lot here to
14 think about. But -- and, you know, I think I'll
15 begin commenting just from a Washington state
16 perspective and sort of the broader milieu in
17 which measurement is playing out.

18 And so, actually, we had a
19 legislatively mandated effort to define a set of
20 core metrics for our state, which actually
21 involved a meeting -- several meetings that
22 actually remind me of a lot like this meeting

1 except it was in the other Washington with
2 different stakeholders around the table.

3 And the themes were, you know,
4 amazingly in line with those here in terms of
5 parsimony. I would say in terms of a measurement
6 toward outcome, and as a matter of fact, what was
7 most frustrating for -- actually, I would say for
8 those -- it's frustrating for everybody, the
9 inability to get to outcomes.

10 It was more accepted by the people
11 around the table who sort of were the measurement
12 experts who were pushing toward metrics that we
13 can actually measure.

14 So, whereas other groups, stakeholders
15 would typically push towards outcomes. And then
16 the question would always be, well, that's great,
17 but how are you going to measure it? So, similar
18 ---- you know, similar themes.

19 Having said that, you know, in our
20 state, I think -- and for Medicaid in the state,
21 I think we would very much like to find ways to
22 move toward outcomes. You know, I think that's a

1 high priority. It's just finding ways in which
2 to do it.

3 I think I really want to underscore
4 the parsimony. You know, I'm not -- we actually
5 ended up with 52 state measures across -- we did
6 it -- we sort of broke them out by prevention,
7 acute and chronic measures.

8 And I think a lot of people around the
9 table got a lot heartburn around that, you know,
10 52 measures, and of course, there are thousands
11 that are out there. So, I have my own
12 perspective on this and I think that of others is
13 really sticking to parsimony.

14 I don't think we need more measures.
15 I think we need to really grapple with, you know,
16 working with measures and getting them to work
17 for us in terms of really informing quality
18 improvement and seeing if we can actually make
19 this all work.

20 The only -- you know, the last comment
21 I would make and this is really relevant to the
22 earlier slide and I'm speaking in part in

1 ignorance, so excuse me if I say something that
2 is like totally out of bounds.

3 But with respect to outcome measures,
4 and with respect to measurement in Medicaid, what
5 strikes me is that, we do -- so we're 90 percent
6 managed care in the State of Washington and we do
7 contractually, you know, obligate our plans to
8 collect data and they are going in, and of
9 course, actually, they're either -- they're most
10 NCQA certified and if they're not, they have to
11 be by the end of this year. So, that's actually
12 in law now.

13 So, they're actually collecting data
14 on some outcome measures. For example, you know,
15 the one that you always round up is, for example,
16 blood sugar control in people with diabetes.

17 And, you know, they're collecting a
18 lot of these measures using HEDIS definitions and
19 so forth and I just, you know, wonder the extent
20 to which if -- and I think, Foster, you were
21 referring to this maybe earlier.

22 You know, if there's a way to get some

1 alignment there because if the plans are already
2 doing this, albeit and getting to outcome
3 measures or, you know, I just wonder if there
4 isn't ---- in the HEDIS context, I just wonder if
5 there isn't a way to be able to take advantage of
6 that at least to begin actually reporting on one
7 or two, you know, true outcome measures more
8 uniformly.

9 So, that's sort of what it looks like
10 from the other Washington.

11 CO-CHAIR GESTEN: Nothing out of
12 bounds about that. Although, your 52 measures
13 reminds me of wasn't it Bruce Springsteen 52
14 measures and nothing's on? Or was it 56
15 channels? That's what it was.

16 But the irony to me is there's so many
17 measures, and yet we spend a lot of time talking
18 about gaps and the inadequacy of measures and so
19 on. And there's that tension, as you described,
20 between what people might ideally want whether
21 it's outcomes or patient reported outcomes or
22 functional outcomes, and what we're stuck with

1 relative to, you know, the data that we have.

2 Beverly?

3 MS. COURT: Thank you, and I'll
4 probably repeat everything I aim to say in my
5 presentation tomorrow. So, this is it in a
6 nutshell. The things that I'm really passionate
7 about having people hear.

8 One is the technical specs, once these
9 HEDIS measures go to CMS and CMS gets to
10 interpret them. For example, if we had a family
11 planning only population, which we did, we had a
12 large population in 2012, that was to be included
13 in the denominator of some of the measures, even
14 though they couldn't be in the numerator of that
15 particular measure.

16 So, that makes that measure
17 meaningless for us. It's not -- and currently,
18 for example, those with third-party liability, we
19 have a lot of TRICARE in our state, for example,
20 large military population, and that is included
21 as well. None of those people will turn up in
22 the numerator, but they're included in the

1 denominator.

2 So, the way that we responsibly do
3 measurement in Washington State is we're very
4 selective about who is the denominator. It has
5 to be mathematically possible for them to be in
6 the numerator.

7 And that isn't part of the technical
8 specs currently with the adult quality measures
9 and some of the health home and managed fee-for-
10 service duals.

11 So that's one issue is that I'd really
12 -- that needs to be addressed because it makes
13 the measure then -- especially when you're
14 looking from one state to another.

15 Now, our state has had a lot of
16 expansion of ACA. So, our family planning only
17 population is quite small now. But it varies
18 state to state so what are we comparing? We're
19 comparing an apple to an orange.

20 And that's another concern is when
21 these profiles are put together, the natural --
22 when a state reports a measure, the first thing

1 that people want to do is to then publish this
2 comparison.

3 Let's compare Washington with another
4 state, but if that state has only -- for example,
5 if their method of collecting data is they were
6 able to collect it from two managed care plans,
7 then that's what they're reporting from in their
8 state.

9 It's not a reflection of their entire
10 state. It's a reflection of what they could get
11 their hands on to report, but that's being used
12 and that's being typified as that's showing the
13 entire state, and then one state is getting
14 compared to another.

15 So, if you have administrative only
16 method and versus a hybrid method, those two are
17 considered representative of your state, and
18 therefore, then the median and mean is calculated
19 from that reporting.

20 So, it creates -- so how that measure
21 is used, I guess, is a real concern of mine. So,
22 getting down to the technical specs of what's in

1 the numerator and denominator is one issue. The
2 other is comparing one state to another.

3 One thing about the CHAPS survey,
4 that's a number of measures are dependent on
5 being able to implement a CAHPS survey. The way
6 the HEDIS specs are -- or the CAHPS survey
7 protocol, if you follow it perfectly, first of
8 all, there tends to be low response rates.

9 Second of all, it's not actionable
10 because what you don't include in there is a way
11 to drill down to medical practice. There are
12 some states who've developed a kind of modified
13 CAHPS survey methodologies so that you can make
14 that CAHPS survey actionable.

15 But remember -- I guess if we're going
16 to invest that much money and time into CAHPS
17 surveys, it really matters that we make that
18 survey actionable, that we include information
19 that we can do drill downs to medical practices
20 so we can actually do something with that
21 information besides just say, okay, we did a
22 survey, here it is, let's put it on the shelf.

1 Okay, those are all my points. Thank
2 you for letting me get them out.

3 CO-CHAIR GESTEN: So, I just want to
4 ask a question about some of the issues that you
5 raised. I think we might get to them in later
6 slides.

7 But on the issue of outcomes, clearly,
8 some outcome measures like hemoglobin A1c which
9 Dan was talking about, I think most people
10 wouldn't say that that's an outcome that needs to
11 be risk adjusted.

12 However, there's a conversation for
13 other kinds of clinical outcomes, certainly
14 mortality. Some people are talking about some
15 adjustment for readmission. There's more concern
16 about that apples to apples comparison where
17 there's -- at the provider level particularly.

18 So, I guess the question that, based
19 on what you said, which raises concerns about
20 comparability from state to state, which clearly
21 is part of the goal of, you know, having
22 standardized measures across states.

1 But, do you see an issue with a move
2 to outcomes? Does a move of measures to more
3 outcomes create more problems, less problems
4 related to comparability of outcomes?

5 In other words, does the potential of
6 moving to more outcome measures raise the specter
7 of the need to risk adjust across states? In
8 other words to be able to know whether the
9 population for various outcomes really differs
10 between Washington state and Oregon?

11 MS. COURT: Yes, it is important. It
12 is important to start risk adjusting. It's
13 important to have Medicaid risk adjustment,
14 though we certainly don't have that now. We have
15 Medicare, we have commercial. Medicaid is
16 different.

17 Duals are different from Medicare, for
18 example, when we've been working with that
19 population. So, it's important to have relevant
20 risk adjustment methodologies.

21 CO-CHAIR GESTEN: Kevin, you've been
22 very patient.

1 DR. LARSEN: So, one of the fun parts
2 of my job is I now get to do some technical
3 assistance to states as they're standing up their
4 State Innovation Model programs. For those of
5 you that aren't familiar with that, it's the
6 single-line model and 36 or 37 states are
7 involved.

8 And one of the things that we see at
9 ONC as we go in and talk to these states is
10 they're building this same infrastructure for
11 measurement, three, four, five times over and
12 over again. And providers are having to report
13 to three, four, five different groups on a new
14 aligned set of measures.

15 So, the health plans are doing it and
16 the Medicaid office is doing it and the ACOs are
17 doing it and somebody -- a third-party system is
18 doing it and they're sending it to Washington.

19 So, one of the, I think, questions
20 that I have for this group is how to move to a
21 more shared infrastructure? You know, everyone's
22 having trouble getting the data. It makes it all

1 that much harder if we don't align.

2 And if we always think about how does
3 the health plan get the data as that's a direct
4 from provider to health plan as opposed to what's
5 the model in the state of a kind of shared
6 infrastructure of measurement and transparency?
7 And how can that be used for any number of
8 purposes that actually provides some more general
9 alignment opportunities as well?

10 Because all of a sudden, it's that
11 many less business associates agreements. It's
12 that many different less places the data has to
13 flow. It's that many less times you have to
14 figure out provider attribution because you do it
15 at a shared model way as opposed to each group
16 figuring it out on their own.

17 So, I'm really curious about that
18 particular question to this group and I think the
19 assumption here was that the health plan gets
20 this data and they're the ones that have to get
21 it all and have to do all the work.

22 CO-CHAIR GESTEN: Bev, then Dan?

1 MS. COURT: I just wanted to help
2 flesh out examples of what you were pointing out.
3 We have the same measure but different
4 specifications for health homes for fee-for-
5 service managed -- the fee-for-service duals.

6 For example, in that arena, it's a
7 requirement of health homes that the plans --
8 that the providers are reporting that
9 information. Well, if they're fee-for-service,
10 they don't have claims data. So how can they
11 report it? And so, they've been adamant that, in
12 fact, they be able to report it.

13 Well, we have the information, so
14 we're going to create the reports. We're going to
15 give it to those community-based fee-for-service
16 organization, then they're going to send it back
17 to us, and that's how we're going to meet that
18 measure or that reporting requirement.

19 So, there is an issue of even when you
20 start with the core specs, the differences that
21 each of the CMS programs are putting on these
22 measures, and so we can easily have three or four

1 even within the same definition of the measure.

2 CO-CHAIR GESTEN: Rebekah?

3 DR. GEE: I'm going to need to leave
4 in a minute. So, first of all, thank you for
5 inviting me. This has been wonderful and very
6 productive.

7 But just to say, I think -- to speak
8 to what Kevin said. I agree completely, for
9 maybe different reasons as well as in our process
10 of using a combination of measures that require
11 public health data.

12 We've had to work with the plans.
13 We've had to centralize data collection. It
14 allows us to learn from each other. It allows us
15 to make the measures better. It allows us to get
16 the denominators better. It allows us to do QI
17 together.

18 When you have a central database that
19 you're working with as a state rather than just
20 relying on individual health plans to go pull
21 their data and relying on them for the accuracy
22 and validity of it, it's really been a good

1 experience for us.

2 So, wherever that's possible, now
3 whether it's -- you know, ideally, you'd have an
4 all claims, all payers database. We don't have
5 that. But, I think one other area you can do
6 this is alignment is with public health and
7 Medicaid linked data sets.

8 CO-CHAIR GESTEN: Marc?

9 DR. LEIB: I have a question for all
10 you states that have been very successful in
11 reporting data because I'm embarrassed to say
12 Arizona, while we have all the quality measures a
13 lot, but we don't report it because we don't have
14 them for the January 1st to December 31st. We go
15 by our contract year with all the health plans
16 which is October 1st to September 30th.

17 Do all of you do a January to December
18 or does that correspond to your contract years?
19 Are you crossing contract years? Or how do you
20 get past that barrier so I can bring that
21 information back to Arizona?

22 DR. GEE: So, you've got change your

1 contract year to match HEDIS, which is what we
2 should have done. Although, we are ---- I'll
3 just with a caveat, our new contracts started
4 February 1st which is the -- so, there you have
5 it.

6 But we report HEDIS, so they're doing
7 -- for the first year, they're going to report a
8 pseudo-HEDIS that starts in February. But for
9 subsequent years, it's the January to January.

10 But, ideally, you'd have your contract
11 year starting January 1st.

12 DR. LEIB: That would be a politically
13 difficult thing to do, but -- so, you guys are
14 all doing the January and we're still being left
15 out in the cold because we can't do that yet.

16 CO-CHAIR GESTEN: It's not cold in
17 Arizona.

18 DR. LEIB: No, it's not. It's hot.

19 CO-CHAIR GESTEN: It's dry heat,
20 though, from what I understand.

21 DR. LEIB: Right. We're burning up.
22 Okay, thank you.

1 CO-CHAIR GESTEN: So, I'm going to
2 take -- put on the state hat and answer these
3 specific questions that are up on the slide
4 because I think they're reasonable questions.

5 You know, the first one about is it a
6 priority to move towards measures of outcomes? I
7 think, generally speaking, regardless of the
8 program that we're looking at, the answer to that
9 is yes but not slavishly.

10 Meaning that, you know, there are some
11 outcome measures that are not as good, in my
12 mind, as a process measure or maybe even there
13 are structural measures that even better than
14 process and outcome measures.

15 So, while generally speaking, I join
16 the chorus that, you know, if it's a choice
17 between a structure or a process, you know, why
18 not just look at the outcome?

19 Like the comment about asking women
20 about whether their pregnancy was intended, there
21 are challenges to getting outcome measures
22 including that one.

1 And the issues about risk adjustment,
2 when you move to process to outcome, then very
3 often the issue about risk adjustment becomes
4 more prominent, so it kind of shifts the
5 conversation and debate.

6 And you also have, I think, an
7 interesting conversation about what outcomes are
8 really -- outcomes that are influenced by the
9 delivery system but not completely controlled by
10 the delivery system is usually a vigorous and
11 fascinating conversation about quality measures
12 with clinicians.

13 I think it's the right conversation to
14 be having and I think that influence counts. But
15 it does raise other kinds of issues that
16 sometimes just lead to rejection of the idea of
17 the measure if clinicians don't have absolute 100
18 percent control.

19 Can states realistically request plans
20 and providers to provide more data? I mean we're
21 the state, you know, we can do it, we can ask.
22 Sometimes we can mandate just like the Feds can.

1 But I think in terms of winning over hearts and
2 minds and the issue of the crowded playing field,
3 I think that we're past saturation a long time
4 ago.

5 So, I think the issues of the path
6 forward are along the lines, Kevin, of what
7 you've described which is how do we build a more
8 efficient infrastructure?

9 It doesn't necessarily have to be some
10 one single mega-state data base, but I think the
11 conversations we've had over the past couple of
12 days of trying to make use of public health data
13 sets, trying to match data sets together,
14 stratifying data that we have by subpopulations,
15 aligning initiatives so that the measure can be
16 collected and you can get multiple checkoffs for
17 that.

18 I think those are all movements in the
19 right direction. So, adding entirely new burdens
20 to states is, I think, a real challenge.

21 I don't know that outcome measures
22 hinder states' participation, at least from my

1 point of view. It really -- it's not so much
2 because it's an outcome, it really depends on the
3 outcome and the complexity of the data that's
4 required and the burden of getting it and so on.

5 But, I don't think there's anything
6 specifically about outcome that makes it
7 necessarily harder. Although, again, it depends
8 on which outcome. Clearly, it's a lot easier to
9 measure whether somebody had a hemoglobin A1c
10 than what the actual result of that hemoglobin
11 A1c level is.

12 On the other hand, I think the world
13 is moving towards being able to collect things
14 like the actual lab data both at the health plan
15 level and at the practice level in electronic
16 health records. So, I think that we've come a
17 long way.

18 And, you know, are things
19 transferrable? I mean I think that they are. I
20 don't see why, you know, outcome measures for one
21 area hospitals and so on are not transferrable.

22 You know, many of the measures that we

1 have been talking about today were developed for
2 specific projects or initiatives, quality
3 improvement, not at a state level but at a
4 practice level or at a hospital level or at an
5 ACO level, whatever.

6 So, I think the experience that those
7 organizations have had in the measures and doing
8 outcome measures, I think, have importance and
9 relevance to states. And I think a lot of it,
10 though not all of it is transferrable.

11 CO-CHAIR PINCUS: So, a couple of
12 thoughts as we've been discussing this.

13 I think that, you know, we're not
14 going to move to outcome measurement over night.
15 And I think, as Kevin suggested, really we're
16 kind of encouraging people to move along the
17 developmental pathway to begin to build capacity
18 for measurement of outcomes.

19 And, in some ways -- you know, one of
20 the things that's happening also simultaneously
21 on a clinical level in a number of areas is this
22 sort of notion of measurement based care, that

1 really, to try to get at the point of care to
2 apply what -- actually we've begun to learn more
3 and more about which is that, you know, for many
4 of the chronic diseases we're dealing with, there
5 is no killer app that's going to, you know, sort
6 of wipe away the problem.

7 But, instead, what really needs to be
8 applied is more systematic longitudinal
9 assessment that's action oriented, that, in fact,
10 is not rocket science but really is looking at
11 whether people are better and if they're not
12 getting better sort of step-wise it in
13 intensifying care.

14 And that having various forms of
15 registries and other kinds of approaches that
16 allow people to collect that kind of data and
17 apply it, you know, supplemented by clinical
18 decisions, support and other kinds of things is
19 what's being encouraged. Also by some of the
20 structures that are being put in place by states
21 whether it's health homes or it's patient-
22 centered medical homes. The states are more and

1 more developing registries of different types.

2 All of this, these are steps in that
3 developmental pathway whether it's Rheos and
4 other kinds of things. And I think one of the
5 questions, how do we sort of actually solidify
6 some of that and actually make clear which states
7 are doing what and how we can learn from those
8 kind of things.

9 You know, so it's, you know, creating
10 these registries, thinking about how one applies
11 sampling tools so it doesn't have to be done
12 everywhere at every time.

13 The other thing is linking to other
14 initiatives that are going on. So, I know from,
15 you know, the work that we're doing in New York
16 that we in New York City have received a large
17 PCORI grant to develop a New York City wide
18 clinical data research network.

19 And we've been having, you know,
20 thoughts about how do we actually use that for --
21 -- not just for, you know, and PCORI and NIH
22 would want for engaging people to participate in

1 clinical trials but to actually do this in a way
2 that can create area wide improvement initiatives
3 and quality measurement. And there's 11 of these
4 clinical data research networks around the
5 country.

6 Again, is there some way to partner
7 with those kind of things? So, to think about,
8 you know, what's the developmental pathway? How
9 do we make us of sort of existing new initiatives
10 and structures that are being developed, you
11 know, within the health care system? And then
12 how do we link with other types of initiatives
13 that are going on in other places from other
14 sources?

15 CO-CHAIR GESTEN: Marc, you had your
16 card up, was that the vestige? Cindy?

17 MS. PELLEGRINI: So, I'll qualify this
18 by saying that, you know, I'm not in a state
19 program, I'm at an outside organization.

20 But it seems to me that one of the
21 things we have to keep in mind when we think
22 about these kinds of questions is that all of

1 these are taking place right now in the context
2 of tremendous upheaval and change.

3 And that we're trying to figure out
4 some of the answers when there are all kinds of
5 incentives and disincentives pushing these things
6 in often conflicting directions. Right?

7 And it's going to be a long time
8 before some of that settles out. So, the answers
9 that we come up with today, even if we came up
10 with concrete answers that we were all
11 comfortable with, won't necessarily be the same
12 answers in three or five years.

13 And so that it's that constant
14 evolution, that rapid dramatic constant evolution
15 that we're in right now, that adds an
16 unbelievable layer of complexity to this.

17 And I think in the midst of all of
18 that, one of the things that's changing is our
19 definition of an outcome. You know, right?
20 There's a clinical outcome versus, let's say,
21 what the patient desires as an outcome and those
22 may be totally different things. So, I think

1 even how we think about outcomes is going to
2 continue to shift.

3 CO-CHAIR GESTEN: Great points.
4 Kevin?

5 DR. LARSEN: In a past life, I was a
6 health services researcher and focused on
7 clinical care outcomes of Medicaid patients and
8 uninsured patients, especially around churning.

9 And, for those of you who don't know
10 what churning is, when you go on and off of
11 various programs. And I know I've, again, heard
12 from a number of states that, especially with the
13 new exchanges and the Medicaid expansion, that
14 they're seeing, again, a lot of people moving
15 between various types of insurance and insurance
16 products.

17 And I'm wondering how this group is
18 thinking about a kind of state level
19 accountability to those people and knowing that
20 they're getting good outcomes and not just
21 excluding people that move -- that happen to
22 bounce back and forth between multiple different

1 types of insurance or insurance programs?

2 CO-CHAIR GESTEN: Before I get to you,
3 Beverly, anybody have a response to that?

4 Anne, is your comment in response to
5 that or something different? Additive? Okay.

6 MS. COHEN: So, I would agree with the
7 churning issue and I think another piece that in
8 my ---- that in the disability, in the senior
9 community that is oftentimes talked about but
10 isn't always talked about in the Medicaid sense,
11 is for folks who have serious mental illness or
12 folks that have persistent or intermediate
13 homelessness.

14 Because they completely fall off the
15 radar entirely. So, they're not churning to
16 another pipeline, they're just churning out of
17 the system entirely.

18 So, I think that our measurement list
19 right now doesn't have anything that really helps
20 to capture that group. And so, I think it's a
21 big huge gap area that we need to kind of bang
22 through, and it's one of a huge cost driver for

1 states.

2 The State of Oregon has done amazing
3 jobs with some of their care management programs.
4 We heard about them in duals group in March. And
5 so, we might look to some of the work that
6 they've done around measurement and monitoring to
7 kind of capture that group that usually gets
8 missed.

9 CO-CHAIR GESTEN: Bev?

10 MS. COURT: Very similar to the
11 comment that Anne made. I think a lot of times
12 people look at these outcome measures at the
13 aggregate level, they're not really that useful.
14 They really need to be broken down if you want to
15 do action on them or really understand the
16 parameters is breaking them down.

17 For example, those with behavioral
18 health issues. I mean that's a far different
19 animal than another subset, for example. So, I
20 think really drilling down for these measures is
21 as important as ---- frankly, the aggregate is
22 fairly useless.

1 CO-CHAIR GESTEN: Yes, that's a really
2 point.

3 I heard yesterday -- when I was
4 listening to Jeff Schiff talk, I thought I heard
5 a conversation about yes, outcomes but outcomes
6 that can serve the purpose of quality
7 improvement.

8 And I think your point is partially
9 creates a challenge, which is outcomes are sort
10 of a nice one stop shopping parsimonious way of
11 getting at a whole host of concepts. That's the
12 good news.

13 The bad news is, it's a one stop
14 parsimonious way of looking at whole of things.
15 And if you want to actually improve it, you
16 actually may need ---- or there'd be value in
17 having specific process measures or even, you
18 know, subsetting outcomes.

19 Which is why this conversation always,
20 to me, of process versus outcomes is a specious
21 one because it's, well, which thing for which
22 purpose? And it's not an -- it's, you know, it's

1 never been an either/or in my mind. Yes?

2 MS. LILLIE-BLANTON: So, my question
3 isn't focused specifically on outcome measures,
4 but how do you improve measurement, whether it's
5 a process or an outcome?

6 And in our last MAP meeting, we talked
7 about those states that use their external
8 quality review organizations to help with
9 collecting data that needed to come from medical
10 records, particularly using a hybrid approach.

11 And the question I've -- you know, it
12 seems as if we've created one infrastructure for
13 collecting data for the purposes of accreditation
14 and another infrastructure for collecting data
15 for the purposes of reporting to CMS.

16 And my concern is, how do we begin to
17 merge those systems so that we can be more
18 efficient and more effective? Because we know
19 that some of our under-reporting comes because
20 we're just running claims data and that claims
21 data often times is not fully accurate for
22 different reasons.

1 For the immunizations, as I said,
2 because, for example, vaccines, you're not
3 actually paying for the vaccines.

4 But for different reasons, you find
5 that the claims, or maybe it's because it's
6 managed care and it's encounter data. And
7 sometimes the encounter data isn't complete.

8 So, the hybrid method to help us
9 improve the quality of our data and also could
10 get information on outcomes such as controlling
11 high blood pressure.

12 So, I just want to get thoughts on how
13 we begin to merge those more.

14 CO-CHAIR GESTEN: Alvia?

15 DR. SIDDIQI: I was just going to say
16 ---- and I'm looking at Kevin, too, because I
17 think a lot of this has to do with
18 interoperability between EHR systems to be able
19 to provide the data. A lot of data's being
20 captured, but being able to translate that data
21 into meaningful information -- no pun intended
22 there with the meaningful use reference.

1 But, you know, essentially, I think
2 what states are struggling with is to try and do
3 that kind of hybrid data analysis, you want to be
4 able to pull the data from EHR systems, but EHRs
5 are not interoperable.

6 And we look at MACRA, I believe one of
7 the key milestones in MACRA is that these EHRs
8 are going to be interoperable but the onus should
9 really be on those EHR vendors to make that
10 interoperable rather than let's just work through
11 the HIE, which I know in our state at least, HIE
12 is really not getting there in terms of being
13 able to communicate that information and
14 information sharing so that you're not doing
15 double duty work.

16 DR. LARSEN: Yes, I'll take a follow
17 on to that. Absolutely agree, and it's a huge
18 number one priority for us is to really enhance
19 interoperability.

20 One place that we see an ability to do
21 that that we haven't really tapped into very
22 much, if you think of the EHRs as sending

1 information in a format that the receiver wants.
2 If there are a thousand different ways, the
3 receivers want the data, it's very hard for the
4 senders to get it right to each of the thousand
5 different ways the receivers want it.

6 And you'd be surprised at a single
7 health system how many different ways they get
8 asked for the data, the same data, the diabetes
9 outcome, but for this place it has to be like
10 this, and for this place it has to be like that,
11 and it might even be the same measure but they
12 need it -- in this one in a PDF and this one in a
13 comma-delimited file and this one, oh, January to
14 January and this one in October to October.
15 Right?

16 And so, there's an opportunity for us
17 to advance that interoperability by us getting
18 this technical alignment between ourselves
19 because then it makes it easier that we lower the
20 burden of what those health systems and vendors
21 have to do for them to meet our needs.

22 If our needs are more similar than if

1 each of us have a technically different needs
2 that we express all the time.

3 CO-CHAIR GESTEN: Anne, did you --

4 MS. COHEN: Yes, I have a comment
5 related to your question.

6 So, from what I have seen at the plan
7 level in California, I think another added layer
8 to this is that the state could have sort of
9 their own quality metric goals and CMS kind of
10 their own.

11 And then at the plan level, there's
12 collaboration between the plans for quality
13 improvement projects. And the plans are required
14 to do annual quality improvement projects,
15 sometimes biannually. And then they devote funds
16 for pay-for-performance. So, that particular QIP
17 gets something technically fixed. And then, that
18 eventually translates up to CMS.

19 So, what I would say is going to the
20 health plan associations and the state and
21 saying, look, from the CMS's perspective, this is
22 a QIP area that's really critical and you might

1 want to think in your next QIP round to push for
2 this area and let's fix this.

3 And I think that the challenges in
4 many states, they echo -- it comes from another
5 entity that they deal with to funnel information
6 through and doesn't frequently drive the QIP
7 process. It's actually the health plan
8 collaborative groups that do that in
9 collaboration with the state.

10 And in some cases, it might be two or
11 three people in the plan and one person, or two
12 or three people at the state, is driving this
13 whole thing and that's where you can get the
14 biggest bang for your buck.

15 CO-CHAIR GESTEN: Andrea?

16 DR. BENIN: As I think about your
17 question, Marsha, I think about -- there's
18 different layers to that problem. Right?

19 So, the most base layer it sounds like
20 is this idea of even can the states connect the
21 data that they already have? The vital records?
22 You know, and some states can and some states

1 can't.

2 But, what it would seem to me that the
3 feds could do might be to create a data model
4 that could be developed in a way that was usable
5 by the states. And I don't know if this exists
6 or not, but if there was a generic or not so
7 generic data model that could be said to the
8 states, you know, here's the data model. We kind
9 of expect you to use it. It's working in
10 Minnesota, Louisiana, where ever it is or isn't
11 working and, you know, we'd like you to pilot
12 using it and then that starts pulling things
13 together.

14 I mean I guess I don't understand all
15 of the idiosyncrasies and the politics of all of
16 the various groups that own the different data.
17 there's these different layers of it. So,
18 there's that first layer that's even like, you
19 know, what? There's government-owned data
20 already and then there's should we go in and
21 start abstracting charts, or you know, adding EHR
22 data, et cetera, et cetera? Those, to me, kind

1 of like go up the pyramid of needs a little.

2 So, I guess if I were to chunk apart
3 that problem, I would kind of start chunking
4 those things little by little to create the
5 infrastructure over time.

6 I mean maybe there's a glide path that
7 the group creates that, you know, looks at X
8 number of years or, you know, I don't know.

9 MS. COHEN: Well, there is one thing
10 that I would be remissed if I didn't bring up.

11 One of the reasons why the data
12 interoperability is so, so very difficult is
13 because it's the MMIS vendor that's actually
14 doing the work.

15 And part of -- and I experienced this
16 in California, the duals project when we had to
17 comply with data stuff, I was the main guy
18 responsible for it. But the agency staff, we'd
19 go to them and say, okay, so CMS wants you to do
20 your X, Y and Z. And they'd say okay.

21 And then they would add -- hand the
22 list off to the data person. And then the data

1 person went to their contract person for the MMIS
2 vendor and they were like, oh, great. But we're
3 redoing the MMIS system right now?

4 And we have ten other things that we
5 have to do. Oh, and we have data exchange and
6 all that stuff. So, it falls so far down the
7 list that it doesn't meet CMS's timeline for
8 submitting the data. And that's what we found
9 for the duals project to be so problematic.

10 And so, I don't know an easy solution
11 for that other than sort of going to the MMIS
12 contract people and saying, when you're redoing
13 your contracts, add this to your list of
14 requirements for MMIS vendors because once it's
15 already in the contract, they have to do a
16 contract change in order to get that through.

17 So, I know it's way in the weeds, but
18 it's an area to look into.

19 CO-CHAIR GESTEN: Kevin?

20 DR. LARSEN: Yes, a couple of things.
21 So, ONC says that interoperability works at the
22 speed of trust, and people tend to think that

1 interoperability is a technical problem.

2 A lot of it is actually a trusting,
3 sharing problem. And that's where groups like
4 this can have an incredible benefit in their
5 states to help build what that trust looks like
6 and those business relationships that allow
7 people to say, yes, it's okay for me to share.
8 The trust is there. That frees up the technical
9 people to focus on the technical part.

10 And related to the sort of issue of
11 data model, MMIS systems, et cetera, the thing
12 that ONC has been charged with and continues to
13 put forward is a national set of standards that
14 we think are the standards should be followed.

15 And These are very technical documents
16 but they're exactly the kind of thing to hand to
17 an MMIS vendor and say, we expect you to do this
18 exactly like this. Here's the 500 page detailed
19 standards document.

20 And, by the way, here's the place you
21 can test that to be sure that you built it to the
22 way those standards work.

1 And that is what we are asking of EHR
2 vendors. It's a heavy lift. We know that.
3 We're all moving from the way we did it our own
4 way to a way that is more aligned to standards.

5 But we think that that's a more likely
6 path forward for interoperability than saying
7 there's one model. Everybody has to do it. It's
8 an APCD here, everybody has to do it through the
9 MMIS system. Everybody has --

10 States should, and are going to figure
11 out their own way. But, if we have a common set
12 of standards that we have tested to an agreed
13 upon, a lot of different ways can all work
14 together.

15 CO-CHAIR GESTEN: Beverly?

16 MS. COURT: Related to that, it's just
17 the timing issue and I'm sure other states have
18 brought this up that you come out with a
19 technical specs.

20 For example, if they come out in
21 November which they did for the AQM for the first
22 year, it's hard to get that into production to

1 produce it by January.

2 In addition, it takes at least a year
3 or even a year and a half to get any new measure
4 into a contract with managed care organizations.

5 So, the lead time is huge. You never
6 want to put the technical specs in that contract
7 because, low and behold, it's going to change the
8 next year.

9 So, those are some of the issues, MMIS
10 systems, every type of analysis we do for
11 legislature is built off of paid claims, not
12 denied claims, suspended, et cetera, et cetera.

13 So, you've got an apple and then you
14 need to develop a whole system that's going to
15 report an orange? Well, that's hard, that's a
16 lot of work and it's never going to compare with
17 what the legislature is asking about which is
18 paid claims.

19 So, those are some of the issues.
20 And, again, for example, now if I were to ask the
21 plans to please report this according to the
22 three different ways that I have to report it,

1 adult Medicaid, health homes, managed fee-for-
2 service duals.

3 Those are three different
4 specifications right now in the same measure.
5 So, for example, even rehospitalization, one is
6 using 2014 HEDIS specs. One is using 2015 for
7 the same time period. So, and then one is
8 weighted, one's not weighted.

9 Anyway, it's challenging. So, my
10 technical specs to the health plans, if I were to
11 meet all my CMS required reporting requirements
12 for these measures that even require medical
13 record review, it's going to be as long as my
14 arm.

15 CO-CHAIR GESTEN: So, great
16 conversation and comments.

17 We talked about outcome measurement,
18 but we obviously, as it's hard not to do, strayed
19 into lots of other issues about data access and
20 you can never had a conversation anywhere without
21 talking about interoperability. I think that's
22 kind of de rigueur at this point, and about the

1 vendors and so on, and so, lots of challenges.

2 Unless there's any other comments, my
3 suggestion would be that we open it up for public
4 comment on this issue or set of issues, actually,
5 that we opened up.

6 And then while we're scheduled to have
7 a break, again, I would suggest if folks want to
8 break, break, if you need to take a break. But
9 otherwise, kind of go through the next set of
10 questions, some of which we've already started to
11 talk about, some of which are new or more
12 precisely around use of measures by states.

13 Andrea, before we open up to public
14 comments, do you have something you wanted to
15 say?

16 DR. BENIN: I mean, Foster, do you
17 think that it's helpful for this group to -- I
18 guess if we -- have we commented strongly enough
19 for the purposes of writing up whatever report
20 that needs to be?

21 If I put on taxpayer hat, right, I
22 want to like cry at the waste, right? And I

1 think that that's really frustrating and we're
2 not going to get beyond that until there's a
3 pretty strong mandate in some way, shape or form.

4 And I guess I'm just curious if you
5 think that we have -- I mean we've discussed this
6 now, I think, kind of a couple of different ways.
7 Have we -- do we need to have a certain strength
8 to our thinking or recommendation or are we
9 strong enough already? I mean where is our --

10 CO-CHAIR GESTEN: Well, which raises
11 the question, who's the audience for these
12 questions, right? So, I see that since these
13 questions were teed up in part for CMS to get
14 input from the groups, so I would punt that
15 question about did you get enough and from the
16 conversation that's helpful to you, Marsha, and
17 then Sarah and Shaconna is the ones who are
18 actually going to have to the work of writing
19 this up, is it clear enough where the discussion
20 went and what was said?

21 So, maybe starting with Marsha, was
22 this -- well, now, she's got a funny -- I've

1 never seen that look on Marsha before.

2 MS. LILLIE-BLANTON: Well, we're
3 midway through the process. So, in terms of the
4 child measures and the maternity core set, I
5 think I'm still absorbing it. I'm still
6 processing it.

7 I still think we're trying to --I
8 think there's probably some reading I need to do
9 in kind of sorting through what we've heard,
10 taking back to our state partners to better
11 understand.

12 I think access to data and information
13 -- I mean we focused on outcome measurements but
14 I think, in general, the quality of the data that
15 we get, access to data and the quality of data
16 are key.

17 And so, I have to sort through some of
18 the recommendations for new measures with my
19 understanding of the challenges and barriers that
20 states face in getting access to the data.

21 So, I think this has been -- you know,
22 I think I've gotten a lot and the written report,

1 you know, the MAP really helps us in kind of
2 synthesizing and summarizing across. So, it's
3 hard to say right now, but I mean we certainly
4 will come back to you if we feel like we need
5 more.

6 And luckily, there's a report review
7 process. So, if in the course of the report
8 review process we feel like we have not gotten
9 what we need, we can still come back to you.

10 CO-CHAIR GESTEN: Yes. I mean I would
11 just point out that you have a number of
12 different forms that let you hear from states
13 about the issues related to core sets. So, this
14 isn't the only place to hear from states about
15 that.

16 And we are going to get to some more
17 specific questions about states and about the
18 goals that CMS has for the program shortly that
19 are a little more pointed.

20 The other, again, to point out,
21 there's at least two councils that I've heard of
22 plus the Measurement Application Partnership

1 itself which is in that direction.

2 I don't know if this what you meant
3 Andrea by taxpayer, but is trying to do this
4 issue about alignment, anyway, that are
5 specifically targeted around alignment which, I
6 think, is related to, but not the same thing, as
7 parsimony, not wasting resources, trying to have
8 this be effective.

9 So, it's not as if there is not at
10 least three stages that have been set that are
11 multi-stakeholder stages, one of them CMS, one of
12 them across all HHS and the third sort of this
13 combination of public/private setting of which
14 we're a part of in this group that's trying to do
15 this alignment issue and deal with these issues.

16 So, and there are multiple
17 recommendations that come from all those groups
18 headed in that direction.

19 But, Sarah and Shaconna, is there
20 enough to -- do we need to --

21 CO-CHAIR PINCUS: Let me just raise an
22 issue. I mean I guess the question I had through

1 Marsha and I guess also, maybe Sarah and Shaconna
2 might also respond.

3 Coming back to this issue of outcome
4 measurement specifically, you know, are there
5 specific recommendations that we could make that
6 would be helpful with regard to moving more
7 quickly or more appropriately or with greater
8 precision along this developmental pathway
9 towards outcome measurement?

10 MS. LASH: So, to get back to the
11 original question, I think that the biggest and
12 heaviest tool in the toolbox for MAP, I mean
13 these task forces, is the recommendation of the
14 specific measures to be used or not used in the
15 core sets.

16 The rest of the conversations have
17 certainly reinforced and reinterpreted in the
18 context of these two programs a number of very
19 well know health policy issues that, you know, do
20 get discussed in lots of forums like this one,
21 like interoperability and collaboration.

22 So, I think I would encourage the

1 group as we continue the conversation to think in
2 terms of making concrete requests of actions that
3 CMS could take. Not just, someone abstract
4 should fix dot, dot, dot.

5 That doesn't have as many teeth as
6 saying I have identified, you know, this small
7 but important factor that I believe is hindering
8 states' participation and I would like more
9 attention paid to that specific thing.

10 I guess that would be my request that
11 we just sort of be more detailed in some of the
12 conversations.

13 CO-CHAIR GESTEN: We also -- I mean we
14 also vote on this issue with our feet, right?
15 So, I'm looking at the six measures for the
16 child. If agree that readmission measure is an
17 outcome, again, somebody raised the question of
18 what do we really mean by an outcome, but I
19 think, generally, that's thought to be an outcome
20 measure.

21 It got the lowest votes for
22 prioritization on here along with audiologic

1 evaluation. Now, it's a measure that we put
2 forward for recommendation. But, again, I think
3 the way in which, as I think you're hinting at,
4 Sarah, the way in which people sort of vote
5 around this issue of measure preference moving
6 towards outcomes is to make decisions about which
7 things they recommend and which things they
8 prioritize.

9 MS. LASH: Right, I would argue that
10 my sense of the conversation is that we've heard
11 more people ask for measures that really matter
12 than measures of a particular type in the
13 taxonomy. And I think that would be something
14 we've got articulated in the report.

15 MS. LILLIE-BLANTON: Your question
16 seemed to imply that there is a big push for
17 outcome measures.

18 And I would say what the push is for
19 is measures that are meaningful. So, if it's a
20 process measure or a structure measure or a
21 structure measure that is well linked to an
22 outcome, you know, my sense is that that is fine

1 with CMS and certainly with our state partners.

2 I mean the main concern with the state
3 partners is burden. I mean I think as you heard
4 from Beverly several times, I mean she's looking
5 at three different measurement sets and trying to
6 make sure that she can report on those
7 measurement sets according to the technical
8 specifications.

9 And, you know, one's at the level of
10 state, the other's at the level of a provider. I
11 mean and so, you do have to have different
12 technical specifications. But that is when
13 you've got limited staff resources at a state
14 level, whether it's financial or staff, all of
15 those specifications for multiple measures, even
16 though it's the same measure, is time consuming
17 and could be a burden.

18 So, at this point, I would not say our
19 big push is for more outcome measures. I mean if
20 we look, we talked about the low birth weight
21 measure, I mean that's a measure that we have
22 thought to be very important. And only this

1 year, we'll have enough states reporting that we
2 can say something about it.

3 And I have a sense, I've looked at the
4 data and I think the data will surprise when you
5 see it. But it is an outcome measure that gives
6 us a broad sense of how at least those 26 states
7 are doing.

8 But, it is measure that will be hard
9 to then link to the next issue of quality
10 improvement. You know, I mean some outcome
11 measures, you can directly say what do you do to
12 change the trajectory of that outcome?

13 In others, because you know there's so
14 many things that contribute to that outcome will
15 take -- it gives you a sense of how you're doing,
16 how you're performing. But it's not something --
17 it's not the kind of measure that helps you --
18 that you know -- that you can immediately say
19 this is what you need to do to improve upon it.

20 So, that's why I think, you know, we
21 have to -- as we say, do we want more outcome
22 measures, we have to really make sure that it's

1 an outcome measure that we can do something
2 about.

3 So, last year, I think adding the
4 controlling high blood pressure is a good outcome
5 measure because our health care system knows what
6 to do about that. You know? It's well defined
7 evidence of what to do, how to address it, how to
8 monitor it, how to fix it.

9 There are other outcome measures that
10 are less precise or represent such a cluster of
11 contributing factors, that it's much harder.

12 So, I think outcomes are important.
13 I can, you know, on the adult side, I think that
14 there are more of the kind of function outcomes
15 that we feel like we need to better measure that
16 -- and some of those functional outcomes, there
17 might be a little easier way to direct
18 interventions to make a difference.

19 But broad outcomes, I'm less focused
20 on and I don't hear the big push for. And not to
21 say that there aren't those out there, I'm just
22 saying they're not coming to me and saying, this

1 is what you need to do immediately.

2 MS. GORHAM: I just wanted to say to
3 your question, Andrea, and definitely agreeing
4 with Sarah's point, as we write the report, I
5 just kind of want to remind you all of the
6 process.

7 So, as we write the report, we'll
8 definitely do a very good job in capturing the
9 conversation. And we have the transcripts to
10 look at.

11 But, just wanted to highlight the fact
12 that you definitely do have input in the draft
13 that we put out. And just wanted to remind that,
14 you know, that our comment period opens July 6th.

15 And so, just be on a lookout for the
16 draft and if there are comments or additions,
17 deletions, whatever, just, you can make those
18 comments.

19 CO-CHAIR GESTEN: A couple of cards up
20 there. I don't know what the order was, but how
21 about from close to far?

22 DR. SIDDIQI: I just had a question

1 and a comment sort of related.

2 But the first question was, when a
3 state partially reports, so for example, they did
4 only have their fee-for-service data or they had
5 their managed care data, does that count as state
6 reported? Okay, so that's sort of helpful to
7 know.

8 MS. LILLIE-BLANTON: If -- not try.
9 As long as the state reported what they reported,
10 there will be a note at the end of the table that
11 says that data.

12 DR. SIDDIQI: I see.

13 MS. LILLIE-BLANTON: So, for example,
14 one of the big completeness of reporting that
15 we've trying to improve upon is making sure
16 states report data on Medicaid and CHIP
17 enrollees. And we now have only, I think, it's
18 six states that are not reporting data on both.

19 But when we started, I mean almost
20 half the states, I don't really remember the
21 number, but we've made incredible strides in
22 improving completeness of reporting.

1 And that information is fully
2 transparent. So, I mean I think the concern
3 about are we comparing apples to apples is a
4 legitimate one. But what's important is for a
5 state to use that data.

6 I mean we're using it, we're not using
7 as much for comparisons across states. I mean
8 certainly, that's a part of what we're doing, but
9 we want our state partners to use the data so
10 that they understand performance in their own
11 state. And that's what's first and foremost
12 important.

13 And then, we also need to have that
14 kind of national data.

15 DR. SIDDIQI: And that sort of ties in
16 with my comment then I think in terms of writing
17 our recommendations.

18 One recommendation certainly is to
19 strongly explain to in you TA webinars or just in
20 the specs when you're offering even at the survey
21 of, you know, why or why are you not reporting on
22 this measure, to remind states that they can

1 report even on whatever data they have for whom
2 ever sets of populations they have them for.

3 But on the other side, I think another
4 recommendation I would specifically recommend is
5 that states do report on their different types of
6 Medicaid plans so if they do have fee-for-
7 service, what does the data look like? If they
8 do have managed care, what does that data look
9 like? If they have, you know, separate programs,
10 what does that look like?

11 In our state, we have about up to
12 nearly 40 Medicaid managed care plans that have
13 just rolled out in this past year. So, there's a
14 lot of chaos in our state.

15 And a lot of states with the ACA
16 expansion or have continued to expand Medicaid
17 managed care, and with CMS asking for proposed
18 rules, it begs the question, you know, states
19 need to look at the data, not just in aggregate,
20 but this is our whole state and this is what the
21 data looks like, but also specific to the
22 different types of plans that are being offered,

1 you know, the provider plan option versus the
2 typical commercial insurance type plan option.

3 So, I just think that it's helpful for
4 us, at least our recommendations in this report,
5 to ask CMS to actually capture that bucket data,
6 you know, in different buckets, not just in
7 aggregate the whole data for every state. Because
8 eventually, when this data hopefully does become
9 more transparent, I do think it will help drive
10 some quality initiatives across the board for
11 different plans and to really identify where some
12 issues are and what's some benchmarks that are
13 out there and how to really compare apples to
14 apples like you were talking about.

15 CO-CHAIR GESTEN: Ashley?

16 MS. HIRAI: Yes, I just wanted to
17 offer on the process and outcome measures is just
18 it's a different perspective because I'm in Title
19 V which is more public health integrating with
20 clinical care.

21 But when we kind of revised our
22 performance measurement framework, we kind of

1 used a logic model of having these evidence-based
2 informed strategy measures which are like
3 structure process measures that then feed into
4 intermediate outcomes and then longer term
5 outcomes like ultimate morbidity and mortality.

6 And that is something that maybe you
7 could think about when you have a process measure
8 to pair it with an outcome measure to really be
9 able to demonstrate impact and that was the whole
10 design and thinking behind this transformation is
11 really to be able to improve accountability and
12 tell the story of our program.

13 And I know that the new Secretary is
14 all about demonstrating impact. And just food
15 for thought, I mean I'm just trying to think of
16 some of the things like we have a safe sleep
17 measure. And so, some of the process measures
18 are about, you know, hospitals that adopt safety
19 sleep policies. And then the longer term outcome
20 measure is SIDS.

21 And so, that's something, Kevin, you
22 were mentioning about mortality data, being able

1 to track that and link that to Medicaid, it could
2 be, you know, something to explore, depending on
3 the measure.

4 And definitely adolescent well visit
5 is something we also track and it's related to so
6 many outcomes. The unintended pregnancies, you
7 know, all of the risk behaviors and even
8 subsequent birth outcomes.

9 So, just another perspective to think
10 about pairing process and outcomes measures if
11 possible.

12 CO-CHAIR GESTEN: Jeff?

13 DR. CONVISSAR: So, I guess we also
14 just wanted to encourage or maybe underline and
15 emphasize some of the comments that were made
16 around patient centeredness, functional outcomes
17 to be really sort of challenging ourselves and I
18 think it's going to be challenge, but challenging
19 ourselves to really engage with beneficiaries
20 directly to really understand, you know, the
21 notion metrics that matter. But that's really
22 not, it's a nice slogan, but it's to whom?

1 And one of the important, I would say
2 constituents, if not I would say the most
3 important constituent would be the Medicaid
4 beneficiary in this space.

5 You know, I don't have a solution
6 exactly. I mean we can't even get to medical
7 record like data extraction and surveys are, you
8 know, scary to us. And the thought of how we
9 would actually capture that information is hard
10 and I think really important.

11 CO-CHAIR GESTEN: Carol?

12 MS. SAKALA: So, thanks, that was a
13 perfect segue to my question which is to ask you,
14 Marsha, for clarification about whether person or
15 patient reported outcomes would equally apply to
16 your comments about CMS's view of outcomes?

17 MS. LILLIE-BLANTON: Well, within our
18 core set, we have the CAHPS survey. And we have
19 been somewhat challenged in getting that
20 information, but it is the health plan CAHPS
21 survey, so it's not even necessarily statewide
22 data. And for, of course, children, it's parents

1 responding.

2 But that is a very, very important --
3 I mean trying to understand how, first of all,
4 beneficiaries perception of the experiences and
5 obtaining care, how timely it is, whether they're
6 getting the right kind of care. I mean we place
7 a lot of stock in getting that information.

8 Our challenge is in getting it and
9 that's one of the reasons why we are doing the
10 nationwide survey for adults because we're
11 directly getting it.

12 But last year, maybe it's the last two
13 years, we were unable to get data on CAHPS from
14 the ARC Benchmarking Database because it was
15 closed in the course of contracting challenges it
16 faced. But it's now open and so next year, not
17 in the 2015 report, but in the at least 2016
18 report, we shall have access to that data and we
19 can get some directly reported perception of
20 experiences in the health care system from that
21 survey data.

22 But it is a very important piece of

1 information that we think we're missing. And we
2 know that Medicare has it. Medicare almost
3 routinely does CAHPS surveys in all different
4 kinds of settings. I mean whether it's a
5 hospital, hospice, physician practices. I mean
6 there are lots of Medicare CAHPS surveys and
7 Medicare Advantage as well.

8 And Medicaid is just slower at doing
9 this and we've delegated that to the state and
10 the states generally do it only for health plans.

11 So, we value it but we just don't have
12 a good capability of getting that information.

13 MS SAKALA: Oh, I totally agree with
14 you about experience of care but I'm just
15 wondering about outcomes that may not be
16 available yet, patient reported outcomes, per se,
17 rather than experience.

18 MS. LILLIE-BLANTON: So, can you give
19 me a concrete example?

20 MS. SAKALA: Functional status at the
21 end of some, you know, episode of care.

22 MS. LILLIE-BLANTON: Right. Now, so

1 that's particularly with elderly and disabled
2 individuals and also, you know, not just persons
3 with disabilities. But we definitely view that
4 as being something we want and we have one test
5 and we have one grant program that -- it's called
6 the TEFAT, the Testing Experience and Functional
7 Assessment Tools.

8 So, we are doing some testing, pilot
9 testing, of the ability to get that information.
10 And it's, I think, we've got about four years and
11 we're in the midpoint of that.

12 But it's only for that population.
13 It's only for individuals with disabilities and
14 for seniors.

15 DR. LARSEN: If I could make a quick
16 comment, that was sort of the thing I was going
17 to mention as well.

18 So, Congress, in the SGR fix bill,
19 H.R. 2, has directed the Secretary under the new
20 merit-based incentive program, which is a
21 Medicare program, to prioritize patient reported
22 outcomes measures.

1 So, insomuch as alignment between
2 these Medicaid health plan measures and measures
3 that we anticipate will be happening for fee-for-
4 service Medicare, that is absolutely a
5 congressionally directed priority in that
6 legislation.

7 And we do have some of those measures
8 already in the Medicare set and we are developing
9 some of them for the meaningful use program, for
10 example, again, at the individual provider level.
11 They just haven't typically been developed at the
12 plan level.

13 CO-CHAIR GESTEN: Anne?

14 MS. COHEN: So, there is, well,
15 several things come to mind.

16 So, I totally agree with the
17 conditional status piece. People with
18 disabilities tend to have their one condition
19 managed and to them, maintaining a function and
20 improving function is what's more important.

21 And reducing the likelihood of a
22 secondary conditions that gets to that.

1 There's also the issue in the
2 community about quality of life outcomes
3 measurement which has been increasingly important
4 but doesn't necessarily fall into that bucket of
5 like outcome measurement that seems necessarily
6 meaningful to the medical community. So, that's
7 something to look at.

8 A couple of things that I was thinking
9 of, you know, in translating and getting it
10 meaningful to consumers, what we've seen in
11 California is that when you create a data report
12 card about the plans that's consumer friendly,
13 the plans are so worried about how they're going
14 to look on that that they actually go back and
15 really wordsmith how that's worded and how they -
16 - and what was the very specific measures to
17 drill down why aren't they improving.

18 In California, we have a whole agency
19 called the Office of the Patient Advocate that
20 produces a report card for all the plans in the
21 state. And it's amazing the amount of change
22 that that promotes.

1 And so, if you had grant funding and
2 our Center of Excellence had the ability to do
3 that and help develop those report cards, that
4 can be really useful and go a long way.

5 The last point is, in terms of how you
6 age consumers, the biggest barrier for CAHPS is
7 address and phone number. And what -- and you
8 know, we all know that's in Medicaid, but what we
9 plan level was that when somebody calls in every
10 single time, they ask them what their phone
11 number is. And every single time, they try to
12 capture the new phone then they try and bounce it
13 back to the state Medicaid agency to make sure
14 that it matches. And frequently, it's a cell
15 phone.

16 So, one pilot project was that they
17 ended up texting people and said, please respond
18 to this survey or can they send them the survey.
19 And even if it was only a few questions, they got
20 something. And then, if they responded, they got
21 a gift certificate. So, that really does drive -
22 -

1 And the other thing I heard is at the
2 pharmacy level when, particularly for people with
3 disabilities, when they pick up their
4 medications, if we have pharmacy that's
5 disproportionate Medicaid patients, they have the
6 pharmacist, the Walgreen's or whatever, I'm
7 looking to CVS, insert a flyer in the bag saying
8 do you want to get a gift certificate by
9 answering this survey? And then, you know, that
10 really increases the response rates for CAHPS
11 surveys.

12 So, just getting really creative and
13 thinking about it from the consumers perspective.

14 CO-CHAIR GESTEN: Thanks.

15 Terry?

16 DR. ADIRIM: Great, thanks.

17 My comment, I just wanted to piggyback
18 off of what Ashley was saying, that when it comes
19 to outcome measures, in child health, it's harder
20 than in adult health because, you know, most of
21 what we do in childhood is process and you don't
22 see the morbidity and mortality until adulthood,

1 later in life.

2 So, you know, we tend not to focus as
3 much on those kind of outcomes and that's why
4 there's more intermediate outcomes and so on.
5 And especially in child health, the patient
6 reported outcomes, family reported outcomes are
7 very important.

8 CO-CHAIR GESTEN: Okay. So, great
9 comments kind of that last lap. I thought there
10 was like nothing left and then there was like
11 this second wind you all got. It was amazing.

12 So, we do -- this is time for public
13 comment on the broad scope of issues we've been
14 talking about, again, not limited to outcomes
15 measurement.

16 As you'll see shortly when we come
17 back from a short break, we'll really start about
18 a lot of the issues that we're going to tee up
19 after the break as well around getting states
20 reporting, using measures for improvement and so
21 on. So, that's the good news.

22 So, why don't we start with in terms

1 of public comment, let's start with the operator
2 on the phone, if you could open up lines and
3 invite folks to -- give them instructions on how
4 they can make a comment at this time.

5 Do we still have the operator on the
6 phone? Do we still have anyone on the line who
7 might be able to make -- who might be wanting to
8 make a comment?

9 Okay. I don't know what to say about
10 that. How about folks in the room? Wake up back
11 there, come on.

12 Okay. About a half an hour ago, I was
13 going to say we should blow through break, but
14 now I'm tired. So, I mean it's just my opinion.
15 So, I'm thinking maybe we can take a ten minute
16 break and then get back if that's okay?

17 Do we have any state partners on the
18 line? Do we have anyone on the line who can
19 speak whose line is not muted?

20 DR. KELLEY: This is Dave Kelley from
21 Pennsylvania, I am still on the line. I just
22 have no comments.

1 MS. LILLIE-BLANTON: We just wanted to
2 make sure there was someone out there as we were
3 talking.

4 But also, we invited our state
5 partners and when we said we know this and we
6 think it's important for our state partners to
7 hear this and contribute.

8 CO-CHAIR GESTEN: So, David's a state
9 partner. David, you're not a quiet, shy,
10 wallflower kind of guy, at least the last I knew.
11 Do you want to make a comment before we break?

12 DR. KELLEY: No, I'm fine.

13 CO-CHAIR GESTEN: You'll get your
14 chance.

15 Okay, we'll be back in ten minutes.

16 (Whereupon, the above-entitled matter
17 went off the record at 2:42 p.m. and resumed at
18 2:57 p.m.)

19 CO-CHAIR PINCUS: Okay, so why don't
20 we reconvene?

21 So, we're going to have another sort
22 of broader discussion about how we can support

1 and engage states in terms of improving their
2 ability to report on these measures and to think
3 of ways in which we can have some crosscutting
4 recommendations about strengthening the core sets
5 across both child and adult.

6 And, Sarah's going to tee up some of
7 these issues.

8 MS. LASH: Great. The next slide,
9 please?

10 So, we have already started this
11 conversation in a lot of respects, but we're
12 going to, you know, try to really pin down some
13 concrete recommendations to the extent that we
14 can.

15 We've heard in the conversation at the
16 meeting and in past meetings, there are lots of
17 things that influence states ability to
18 participate in reporting core set measures at all
19 and then how many measures and then the
20 completeness of each measure and even maybe the
21 data validity within that.

22 So, lots of nesting dolls of levels of

1 participation.

2 But, some of the factors that would
3 influence that participation are the clarity of
4 the technical measure specifications, the
5 selection of each individual measure, even though
6 that's not in this list.

7 The feasibility of data collection,
8 the budgetary environment in the given year, the
9 perceived importance of maybe both the set and
10 the individual measures and the political will to
11 get it done, and there will be many others.

12 But keeping those factors in mind and
13 maybe offering others to your colleagues around
14 the table in discussion, what can be overcome by
15 HHS or MAP making recommendations to HHS to
16 bolster participation to the extent that we can?

17 On the next slide, I just want to
18 remind you of the CMS goals for these programs
19 once again because would be our North Star in
20 terms of what we're trying to achieve with these
21 recommendations.

22 So, go back to Slide 158, this is

1 really the discussion question we want to use the
2 next 45 minutes maybe to an hour at the most to
3 hear from you any further thoughts.

4 CO-CHAIR PINCUS: Thoughts? Comments?

5 DR. ADIRIM: Questions? I mean this
6 is sort of I know, probably what the answer is
7 but a hypothetical question.

8 Probably, the easiest way to get all
9 states to report is to require it. So, I know
10 you probably get asked that all the time. So,
11 like what are the issues around that versus some
12 other ideas that we could come up with?

13 Well, no, I mean, you know states, you
14 know, states have to report on all kinds of
15 things that they're required to report for, so
16 why can't, you know?

17 MS. LILLIE-BLANTON: So, I can start
18 with that and that is that Congress defined these
19 measures as voluntary with voluntary reporting.

20 CO-CHAIR PINCUS: Carol?

21 MS. SAKALA: So, Rebekah's
22 presentation and the year to year progress that

1 they made impressed me greatly and I don't know
2 all the factors, but clearly, you know,
3 leadership was important. And also the resources
4 that they had available to do it.

5 And as I heard you, Sarah, describe
6 budgetary environment, I don't think you were
7 thinking of like a special project to do the data
8 linkages and other things that they did that made
9 that great progress possible.

10 And I don't know about the IAP program
11 whether there might be resources there that kind
12 of do double duty or whatever.

13 CO-CHAIR PINCUS: Beverly?

14 MS. COURT: I would, first on the
15 clarity of measures specifications, so the
16 measure is relevant to a state because I think
17 the state is more willing to report if they feel
18 it's relevant, is the specification for the
19 denominator not containing those groups of
20 Medicaid clients that can't be counted in the
21 numerator.

22 So, that would eliminate third-party

1 -- those with third-party liability, those with
2 partial Medicaid benefits.

3 And that's a -- in some years, that
4 makes or breaks a measure as to whether it's at
5 all useful for a state. And certainly, when
6 you're comparing one state to another state, it's
7 hugely impactful.

8 So, I would hope that this group could
9 make that recommendation that the technical specs
10 clarify that it has to be a reliable measure in
11 terms of what it's actually measuring.

12 A second would be, again, in terms of
13 making it so that if the state would to pursue,
14 for example, a CAHPS survey or required of plans
15 that there be technical specs that would enhance
16 the current specs, to make that measure
17 actionable.

18 That is, adding elements such as the
19 medical practice sampling and subsampling
20 protocols so that it would make it meaningful
21 that if you're going to make that huge
22 expenditure of both peoples' time, money and

1 particularly the Medicaid clients' time in
2 responding to those surveys, that then those
3 results can result in actually doing something
4 with them.

5 In the State of Washington, for years
6 and years and years we had CAHPS surveys as
7 required by a managed care plan. Year after
8 year, you know, can you get to your -- do you
9 have a dedicated family practice provider?

10 And, so what if they said no? I mean
11 what are you going to do about it? Well, there
12 wasn't -- it wasn't -- you couldn't tie it to a
13 geographic area of the state. You couldn't tie
14 to a particular group. I mean so, what did you
15 do with the information?

16 So, again, I think there's
17 opportunities that if we're going to make these
18 huge investments in primary data collection like
19 CAHPS surveys, is to enhance those specifications
20 so that we can fashion quality improvement
21 efforts around those.

22 CO-CHAIR PINCUS: Carole?

1 DR. FLAMM: So, I want to make a
2 comment also along the lines of what was being
3 said on that end of the table and what Rebekah
4 said.

5 In the potential to link the measures
6 that are part of the core set to incentives that
7 may exist across the different organizations and
8 managed care organizations, one of the patterns
9 that I think is observed in other product areas
10 is sort of linking measurement to incentives
11 helps to sort of drive both adoption and behavior
12 and improvement and that sort of thing.

13 And as we think way ahead in the
14 future as this program evolves, and I'll admit,
15 I'm newer into the Medicaid space, so forgive me
16 if I say anything a little off, but in the
17 future, as it evolves and quality rating systems
18 are put in place and alignment with accreditation
19 and all of these sort of ways, is there some way
20 of subsetting within the core measures?

21 Those measures that are, sort of as
22 Jeff was saying yesterday, more fit for certain

1 purpose of measurement for that, you know,
2 evolution of use into incentives or pay-for-
3 performance or that kind of accountability side
4 of and just kind of thinking about them
5 subsetting within the measures.

6 CO-CHAIR PINCUS: And I was thinking
7 something very similar to that. You know, what
8 is motivating beyond requiring it in some way is
9 actually finding a true, useful kind of purpose
10 to it and highlighting how states have actually
11 utilized case examples and how states have
12 utilized this to make a different, I think, would
13 also be helpful, you know, in some way.

14 Jeff?

15 DR. CONVISSAR: Yes, I mean, that's
16 what I was going to ask. Why do the states
17 report it at all?

18 I mean, so it's voluntary. The fact
19 that the states report as much as they do might
20 we be able to understand why they report and then
21 sort of enhance those characteristics and figure
22 out, you know, was it -- so there must be

1 something in it for them if they're actually
2 reporting.

3 Well, then, how do we explain that
4 perhaps? There's a measure on report.

5 (Simultaneous speaking)

6 CO-CHAIR PINCUS: Well, what the
7 initial incentive?

8 MS. LILLIE-BLANTON: You know, I
9 actually think Medicaid is transforming itself at
10 the state level and certainly at the Federal
11 level.

12 And our Medicaid partners realize that
13 they are trying to understand what value they're
14 getting for the dollars they are spending.

15 And the one way to do that is to give
16 better information on performance.

17 So, I think they see some value in
18 this as well. I mean there's a burden, but
19 there's value.

20 So, I think we've got willing
21 partners, there's just resource constrained
22 partners. You know?

1 MS. COURT: It was also a requirement
2 of the grant we received.

3 MS. LILLIE-BLANTON: Well, yes.
4 That's with the adult measures, yes, that's true.

5 MS. COURT: Right. So, it will be
6 interesting to see what the take up rate will be
7 after that requirement is done.

8 MS. LILLIE-BLANTON: Beverly's my
9 reality check here. Right? So, that's true.

10 But the adult -- but I can tell you,
11 for the adult measures, so that's a little of
12 history, I'm glad that you're reminding or are
13 reminding me to make.

14 For the child measures, there was a
15 history to reporting that was required for
16 CHIPRA. Congress required CHIP to report on, I
17 think it was four measures, three or four
18 measures.

19 So, when I came in in 2010, we had
20 some data just for CHIP. So, states, at least
21 within most states, there was an infrastructure
22 for reporting at least for children.

1 For adults, there is no such
2 infrastructure for reporting, no history of it.
3 And so, one of the reasons we could justify the
4 grant program which made available about a
5 million dollars per year for two years to states
6 was that there was no history of reporting.

7 But we are concerned that when the
8 grant funds dry up, which they are doing, that we
9 don't have the same level of reporting.

10 But, having said that, I do think we
11 have developed the infrastructure, the capacity.
12 What we have begun to do is keep track, though,
13 the staff that area leaving because staff were
14 hired for these grants and now, some states have
15 been able to bring them to other funding sources,
16 some states have not.

17 So, we do think that there'll be some
18 drop off. I mean we had 30 states reporting on,
19 I think, a median of 17 adult measures. We had
20 about 25 states that reported on about eight
21 measures.

22 If we can just hold on to that, I will

1 be pleased. I mean it would be nice to hope for
2 improvement, but if we can just maintain that
3 with no funding, grant funding, I would think
4 that we have accomplished a part of what we set
5 out to do which was just kind of developed --
6 make routine reporting a part of the standard.

7 Because it's already there in managed
8 care. For those states that have managed care,
9 it is a part of the standard. I mean it is part
10 of accepted. Most states are either applying for
11 accreditation or are already requiring
12 accreditation, as you heard, in Washington.

13 So, for managed care, it is pretty
14 much the standard, it's just that it's not
15 getting reported to CMS. It's going to the NCQA,
16 the private accrediting agencies.

17 And, what we've been trying to do with
18 our measures, and this is the other level of
19 complication, is support states when they try to
20 merge the data from a managed care entity with
21 the data they collect from fee-for-service.

22 And that requires a level of technical

1 sophistication and knowledge in a state that some
2 states have and others don't. I mean all states
3 aren't New York and Pennsylvania and Washington,
4 you know, that's just --- they're states that are
5 -- most are better. There are states that are
6 ahead of the curve, and there are other states
7 that are learning.

8 But, we have states, you know, like
9 Louisiana and Alabama which, you know, have come
10 on the scene and have done, you know, amazingly
11 remarkably well and are then -- are teaching
12 other states.

13 So, we do feel like there is a
14 learning curve for some states but the
15 willingness and the interest, our sense is it's
16 there. I mean there's a commitment to trying to
17 show that there is value in the expenditure of
18 public dollars. I mean I think it is a question
19 of accountability for the dollars that taxpayers
20 are investing in this program.

21 CO-CHAIR PINCUS: I think what you're
22 also suggesting is that, you know, in some ways

1 states are a little bit like sort of
2 transtheoretical model of going from pre-
3 contemplation to contemplation as so forth and
4 activation that, you know.

5 And there may be different states at
6 different stages, and there may be different
7 interventions to apply at those stages.

8 Jeff, did you want to say something?

9 DR. CONVISSAR: I just wanted to
10 follow-up.

11 You know, so I mean, again, the way I
12 think about this then maybe is really an
13 analogous to actually the role that sort of I am
14 part of in my organization.

15 We have, you know, mandatory things,
16 and we've got a lot of voluntary things, and we
17 don't have states but we have regions. I mean so
18 there's actually a lot of analogies.

19 And, you know, at the state level,
20 clearly, there's accountability. But like,
21 again, I think what I hear and understand is,
22 there isn't accountability to the Federal

1 Government for these reports since they're
2 voluntary.

3 And so, then perhaps it's sort of
4 changing our mindset at this level to driving to
5 improvement, not holding to accountability. And
6 that really changes sort of the dynamic in how
7 you approach and think about things and starts,
8 you know, creating collaboratives as opposed to
9 sort of lists and tracking.

10 So, there are different tools that
11 when you support collaboration and learning
12 networks versus holding people for
13 accountability, and it might be worthwhile to
14 think about that.

15 CO-CHAIR PINCUS: Foster?

16 CO-CHAIR GESTEN: So, and just in
17 terms of the last tongue-and-cheek answer about
18 why, and this is going to make me feel very old,
19 but a million years ago, a group of states along
20 with Lee Partridge, who was then in APHA and
21 NCQA, started a Medicaid HEDIS collection
22 voluntary from states.

1 And the driving impetus was people
2 wanted to know where they were. And they wanted
3 some sort of a benchmark.

4 And I think that that's, you know,
5 thankfully, is kind of innate in clinicians and
6 healthcare organizations like yours, like ours,
7 to kind of know.

8 And I think that the real value of
9 this has been to provide potentially some
10 benchmarking that's otherwise not available.

11 Now, that said, you know, NQCA's
12 Quality Compass is helpful. It's a lot of plans
13 and a lot of the -- represents a lot of Medicaid
14 but not all of it.

15 So, I think that in terms of the why,
16 that's part of the why.

17 The other why for me is, you know,
18 where I come from, you know, if somebody pays
19 half the bill, they're kind of entitled to know
20 what they're getting.

21 So, I think it's kind of like, you
22 know, a slam dunk that, you know, CMS should know

1 something about, you know, what's going on in
2 terms of their investment, as should Congress, as
3 should the public. I mean it's a huge, huge
4 investment, growing investment.

5 So, I think it kind of just seems like
6 the right thing to do as well as, you know,
7 selfishly being able to kind of understand where
8 you are.

9 Again, it doesn't change the internal
10 -- you know, our state where our priorities are,
11 how we see what areas that are particularly
12 important, but does help like other metrics that
13 we look at nationally, whether it's, you know,
14 the Commonwealth Report Card or CDC's Healthy
15 People.

16 And I'm sure that your organization
17 and most of the organizations we work with have
18 peer groups and they have comparison groups.
19 It's not the only tool in the toolbox, but it can
20 be very helpful in kind of gliding and navigating
21 your programs by.

22 In terms of answering these questions,

1 I would say that -- I would pile on to Beverly
2 about the specifications.

3 We've had some real -- some of the
4 measures we've not been able to do have just been
5 -- we've been stuck in problems related to the
6 specifications which I think you know, Marsha.

7 And, again, some of that is related to
8 the measure developer and challenges and so on.

9 So, if we can't work through the
10 measure specifications, you know, that creates a
11 real barrier for us to report it.

12 Other recommendations, you know, I
13 think there's some measures and you hinted at
14 them or there's sort of demonstration or pilot
15 measures. And I think the idea of having some
16 measures where we're not quite sure about, maybe
17 they're a little aspirational, but you don't want
18 to remove your aspirations and just live in the
19 world of what you can do today.

20 So, I guess, denoting some of those
21 measures as being that officially and maybe
22 providing, you know, some degree of funding or

1 support to states who may want to test it out and
2 can then serve to help the other states navigate
3 some of the challenges to the data might be
4 another way of going forward in terms of more
5 measures reporting or being able to push the
6 envelope, not expecting everyone to be able to do
7 it sort all at once.

8 I think clearer funding matter having,
9 you know, whether it's specific funds, as people
10 have talked about for the grants clearly caught
11 people's attention.

12 If there's an ability to do any kind
13 of enhanced matching, which is the other trick
14 that sometimes CMS can do around these
15 activities, worth exploring.

16 And then alignment, just to again to
17 beat a dead horse, the degree to which these
18 measures differ from measures that are required
19 of us from CMS for health homes or for our waiver
20 programs or for SDRIP creates real challenges.

21 And we'll do the things we have to do
22 and if something's voluntary in a list of

1 priorities like other humans, you know, those
2 will be kicked to the bottom.

3 So, the degree to which that there's
4 alignment, I think, you know, it makes good
5 sense.

6 And then the last thing which is maybe
7 more problematic, particularly given that where
8 folks are going with this, but rotating measures.

9 Again, do you need to measure some
10 things every year? I don't know that you do. I
11 know that there's an issue about momentum and not
12 wanting to lose track of things, but when you
13 think about the cycle of improvement, I think
14 there's a lot to be said for not necessarily
15 needing to measure the same thing year after
16 year.

17 Okay, now, it's 49 percent. Okay, now
18 it's 49 and a half percent. Okay, now it's 50
19 percent.

20 So, it may be also a practical way of
21 putting more measures on a list and doing some
22 ability to rotate.

1 Now, that's -- we've been doing that
2 for years in New York. We're now being
3 challenged because NCQA is longer rotating
4 measures for a variety of reason. And so, we're
5 struggling with how to adapt to that.

6 But, I think it has, in the past,
7 served the purpose of dealing with wanting to not
8 have too many measures but also recognizing sort
9 of the natural life cycle of measurement and
10 improvement.

11 CO-CHAIR PINCUS: So, I have Alvia,
12 George, Ashley, Nancy, Andrea and Anne on the
13 list.

14 DR. SIDDIQI: So, I was just going to
15 add that I do think that incentives that are out
16 there with other programs, for example, I know,
17 Marsha, you were talking about the CMS
18 Innovations program or accelerator program for
19 Medicaid.

20 You know, CHIPRA worked demonstration
21 project grants that already received grant
22 funding from CMS certainly aligning with these

1 measures helps. And I think that's why, even in
2 our state which is really challenged right now
3 with managed care and the rollout, you'll see a
4 high number of reported measures for the child
5 core set because we do -- we are a percentage of
6 a CHIPRA demonstration grant.

7 So, I do think that, in addition, you
8 know, when you talk about these measures and
9 their importance, I think states are concerned,
10 and the reason they're also probably voluntarily
11 reporting is because they do believe that
12 incentives and penalties eventually are going to
13 be tied to these measures.

14 So, I do think that they are
15 considered to be very important. I think leaving
16 them on for a while is helpful because, for
17 example, in our state, it's taken years for
18 certain select measures to be continued to
19 improve upon by providers in the provider
20 community.

21 It takes time. It takes a long time
22 and sometimes, when you make too many shifts and

1 change, it can actually disrupt that process flow
2 that you're trying to achieve by at least getting
3 to the point where you can even report on some
4 measures.

5 So, I do think the TA assistance
6 grants and trying to work out some of those funds
7 would probably be really important because I am
8 concerned if those grant funds do dry out, it's
9 sounds like if there's no increased revenue
10 stream, we'll be seeing measures be reported upon
11 or not.

12 But, like you said, sometimes, you
13 know, you're getting just one or two or more
14 states for a specific measure. But, that's one
15 or two more states out of 50 that weren't
16 otherwise reporting on those measures.

17 So, I still think that it is a really
18 important process, and I do recommend
19 experiencing the data. I think it's time to
20 publish the table that we've been given here, and
21 I think it's time to sort of publish and have the
22 data put out there so that other states can say,

1 well, what is going on in my neighboring states,
2 and maybe I can learn from that.

3 And so, best practices would sort of
4 be the second, you know, goal, I think, about
5 this in terms of trying to share best practices,
6 provide linkages with other states that are doing
7 well in particular measures and trying to share
8 some of that data.

9 CO-CHAIR PINCUS: George, did you want
10 to say something?

11 DR. ANDREWS: Yes. I think what I was
12 going to note or it was touched nor discussed,
13 but you know, I'm just going to follow with a
14 point that Alvia made about incentives and
15 penalties.

16 I mean, as it is right now, there are
17 incentives and penalties that the Medicaid
18 programs do impose whether you are successful in
19 a certain meeting a performance measure or not.

20 And certainly, from the Federal
21 Government's perspective, there is no reason why
22 it cannot apply to the state through the

1 mandatory reporting of the information.

2 And like was already said, the
3 expectation is said that I'm going to hold you to
4 a standard and certainly, you're going to try
5 harder. That's the first.

6 The other thing is, you know, I think
7 we need to recognize the fact that, just like any
8 other population, the Medicaid population is
9 diverse. In different states, there are
10 different cultural, ethnic and other diverse
11 conditions that create the situation where
12 different states might have different items of
13 importance that they need to pursue or support or
14 report on.

15 And I think that that needs to be on
16 the table in terms of the kind of things that we
17 look at and the kind of things that we consider
18 in terms of our packaging of information that we
19 want to push back to them.

20 CO-CHAIR PINCUS: Ashley?

21 MS. HIRAI: Yes, I just wanted to
22 comment on what Jeff and Alvia were mentioning

1 with collaborative learning and how important
2 that can be to motivate change and learn best
3 practices from each other.

4 And that's what we were able to see
5 through that Collaborative Improvement/Innovation
6 Network. And Medicaid was a key partner in the
7 Regions 4 and 6, the south that started it.

8 But, one of the key benefits really
9 was improving data capacity through that. And
10 what we were really struggling with the
11 timeliness of vital statistics in particular.

12 And just through those peer
13 comparisons like putting that out -- seeing a
14 neighbor state being able to report within six
15 weeks of a close of a quarter -- it was amazing.
16 Like they all came along and were able to report.

17 And now, the northern and western
18 states are like, how did you do that? We don't
19 have access in our agency. And so, it is
20 something we're trying to build in more like
21 technical assistance and peer-to-peer exchange
22 about how to break down those political silos.

1 And, you know, to support that vitals
2 and Medicaid linkage, you really have to have the
3 capacity, as Rebekah mentioned, having an
4 epidemiologist, and Title V does support some of
5 that.

6 And we have some money, the State
7 Systems Development Initiative, that's designed
8 to support those linkages and improve data
9 quality and timeliness. So, that is a small pot
10 of money that can be used to help.

11 But we also want to support some more
12 Webinars around the Medical Vitals linkage to
13 build on what Marsha has done and show examples
14 where there's a value to it.

15 So, Michigan apparently linked their
16 Medicaid and vitals to show a return on
17 investment for their home visiting program. So,
18 these really kind of like innovative ideas to be
19 able to spread and scale through that
20 collaborative learning.

21 So, we're hoping to have some kind of
22 Webinar to feature that Academy Health

1 Collaborative that got the 22 states.

2 So, it's really just the other half of
3 states that needs to work on building those
4 linkages. And it's really just engaging that
5 leadership and breaking down the political
6 barriers between different divisions within
7 health, Medicaid, from public health and vitals.

8 And so, we really hope that NAMD can
9 be a good partner and, Daniel, I'm going to talk
10 to you later about signing some kind of data
11 leadership letter that reaches the highest level
12 of the state health officer to really advocate
13 for improved data sharing across/within states to
14 really improve maternal and child health.

15 So, those are just some things we're
16 planning to help facilitate these linkage issues.

17 CO-CHAIR PINCUS: Nancy?

18 DR. HANRAHAN: I've been doing
19 research for the past 12 years, and there have
20 been several revelations to me that really
21 parallel this process.

22 And that is that a lot of the data

1 that we have available to us now, and there is a
2 lot of it and there's going to be more of it and
3 more of it and more of it.

4 And the exercise of clarity of measure
5 specification is just such a one dimension of
6 that -- of the process of managing the quality.
7 And managing quality is, to me, a management
8 issue and that's what states -- why states, I
9 think, want to do this is because they want
10 better management of how they manage their
11 resources.

12 So, measure specificity is very
13 important, and I think there's been a lot of
14 progress made in that over the past ten years
15 that, and I've been involved in a lot of
16 different angles to that; much of it, for me, has
17 been in the behavioral health sector.

18 But I really read through the vital
19 signs from the IOM report, and it's really good.
20 And so, we really have a sense of: what are the
21 priorities and where are they?

22 We really don't have to like go over

1 that. Where we get caught is in the weeds around
2 measure specifications.

3 So, there's a big distance between the
4 two, and I think about so where have we seen some
5 of the -- some progress made in this area? And
6 I've been in Pennsylvania, two places, Geisinger
7 and Jeff Brenner's work over in Camden, New
8 Jersey, where both of these situations, they took
9 data and they really made meaningful inferences
10 and made meaningful change and then document it,
11 published it, and people are learning from it.

12 And so, you know, I think that we know
13 a lot about measures and we know about targets
14 and we know about the systematic way of
15 identifying hot spots in those systems.

16 So, where are the -- the issues to me
17 are that when we get that data, we get so
18 specific with it or we average out that it loses
19 its meaning.

20 So, one of the methods that I've been
21 moving towards in my research is away from
22 regression models, which is moving and

1 understanding the means, and moving more towards
2 some engineering methods -- one being agent-based
3 modeling, which is a way to bring the individual
4 or the specificity, the stakeholder, the, in this
5 case, the patient, and embrace the complex
6 systems that we're dealing with.

7 And then analyze those interactions
8 using very sophisticated analytics that are
9 growing and getting more popular.

10 A great example of that is the Watson
11 that IBM developed. It takes data from multiple
12 sources and makes meaning out of it.

13 So, I think that, you know, in a way
14 I think we've got to be thinking very
15 innovatively about where we're going to head.
16 What would it look like if we were to solve this
17 problem of: how do we make meaning out of this
18 data?

19 I say that we need to be looking
20 outside of what of the methods we've been using.
21 I would dare to say that many of the states and
22 Jeff Brenner and Geisinger, what they've got

1 behind the scenes are people that can analyze
2 that data using more sophisticated, complex
3 systems methodology to make meaning of them so
4 that they get back to the clinician, to the
5 patient, to the public, to the administrators so
6 that they can then begin to perceive importance
7 and drive the political will as well as drive the
8 will of the individual towards incentivizing them
9 to hire -- to better health and behavior set,
10 bring them in that direction.

11 So, I think, you know, one of the
12 things I've always loved is Star Trek, and ever
13 since a kid, I lived by it because it gave me
14 that sense of what is possible.

15 And I think what is possible here is
16 that driving NQF to a place where they can
17 actually bring in some of these systems, complex
18 systems and analysts to help us solve some of
19 these complex problems. Otherwise, we get bogged
20 down in what's, you know, I call the weeds or
21 measure specifications.

22 Just some thought.

1 CO-CHAIR PINCUS: Andrea?

2 DR. BENIN: So, at the risk of
3 sounding like a broken record here and the risk
4 of getting into some states' right federalism
5 discussion that I might not know enough about to
6 just step right into.

7 So, at our place, we are, you know, 60
8 percent of our patients are Medicaid. And so, we
9 are closely aligned with what happens with the
10 state budget and we watch that very closely.

11 It's not like the state has all this
12 extra money sitting around, right? Like the
13 states are really tight on resources; certainly
14 Connecticut is extremely tight on resources.

15 And so, I would like us to be able to
16 make a strong recommendation that there's a world
17 here where CMS could look, you know, create a
18 plan towards creating data infrastructure that
19 could support what the states need to do at a
20 single level. It seems really wasteful to me,
21 again, that we pay over and over again at each
22 state to accomplish these things instead of

1 having a unified data infrastructure.

2 And I don't think it does children
3 well. Like, I don't think it's the right thing
4 for children; I don't think it's the right thing
5 for child health.

6 It's very frustrating to know that a
7 child in Connecticut might be experiencing
8 something completely different than they would in
9 New York or in Massachusetts. And I think that
10 is a shame on us for not being able to get out of
11 our way.

12 And I have this fear that our organic
13 approach to this of letting people, you know,
14 sort of each state figure out their quote,
15 unquote innovative approach is not -- it doesn't
16 make sense to me in the sense that if you were
17 running a large multinational company, right, you
18 wouldn't necessarily let each one of the
19 multinational places sort out their own thing.

20 I mean, maybe you would, but there
21 would be some centralization to that. And I know
22 that this is rooted in, you know, legislation and

1 whatnot that can't necessarily be changed.

2 But I think that if there's a way for
3 us to be able to say that the degree to which
4 there can be movement towards a more supportive
5 data infrastructure that CMS could help to unify
6 some of these things, I think that is what will
7 move this conversation forward over time because
8 what we're hearing about the barriers are around
9 the idiosyncrasies in a lot of those data things.

10 So, I don't -- I just wanted to make
11 sure that I said that strongly enough, Sarah and
12 Shaconna.

13 CO-CHAIR PINCUS: Ann?

14 DR. SULLIVAN: I, you know, there's
15 been a lot said about alignment and what piece of
16 this that belongs to CMS, that CMS has control
17 over?

18 Could we speed up their help with the
19 states in aligning some of the measures?

20 At least what I've been hearing is
21 that CMS has different pots of things that they
22 want and that sometimes all those things that

1 come out of CMS, specifications, everything else
2 isn't as aligned -- isn't aligned.

3 That sits in CMS's hands, I'm
4 assuming. So, I'm just wondering if that could
5 be speeded up a little bit, maybe with workgroups
6 from the states?

7 It seems like that's something that
8 might be doable. I know there's groups getting
9 together in the Government, but a huge
10 frustration for the states is multiple reporting
11 of things that's very confusing.

12 So, is there some way that CMS could
13 really take that on? To be keeping asking the
14 states to do things and CMS not doing its part in
15 trying to make it simpler and more
16 straightforward, I think bristles with some of
17 the states. That's one thing, so that one piece.

18 And then, yes, so let me just stop
19 there.

20 CO-CHAIR PINCUS: Marsha, why don't
21 you respond?

22 MS. LILLIE-BLANTON: So, let me tell

1 you, CMS is a big organization. So, within
2 Medicaid --

3 DR. SULLIVAN: I know, I know.

4 MS. LILLIE-BLANTON: -- and CHIP, I
5 want to at least say what we have done, and then
6 I can take it to a bigger level.

7 So, within CMS, we have the child and
8 adult core set and health homes, by and large,
9 has drawn its measures from the child and adult
10 core set. I think health homes has maybe two or
11 three additional measures that are not within the
12 child or adult core set, but no more than that.
13 And looked like Beverly's looking at her notes.
14 But I don't think there are any more than that.

15 The difference between the health
16 homes measures and the child and adult core set
17 measures is the denominator because we had to
18 specify the measures for provider level data
19 collection, as opposed to at the state level,
20 it's state data collections.

21 So, the measures could be the same but
22 the unit of analysis are the larger denominator.

1 So, in that respect, those are two of
2 the big programs that we had some control over.

3 Then, Foster mentioned waivers and the
4 district. And I can tell you that while there
5 are some differences in the measures, we have
6 encouraged within our -- the group that manages
7 the waivers, it's the division that manages the
8 waivers and the DSRIP, which is, those of you who
9 don't live in our world, is the Delivery System
10 Incentive Report Program.

11 We have encouraged them and, as we had
12 input, I can't say required, but we drew from our
13 child and adult core set.

14 So, I'm just trying to give you those
15 examples to say that for the things that we had
16 control over and largely influence over, we have
17 tried to make a difference.

18 Now, as you move to a broader level,
19 which is a whole set of measures that are on
20 Hospital Compare and Physician PQRS, that's a
21 little harder. But, and certainly -- well, let
22 me step back and go back to meaningful use.

1 Because we have worked in partnership
2 very much, as much as we can to recommend and
3 support e-specification of measures as well as
4 measures into the meaningful use that were a part
5 of our core set.

6 There are limits to that because the
7 measures have to be, from my understanding, e-
8 specified. And so, we're still working on --
9 we're funding -- we're using some of our dollars
10 to e-specify measures so that they can be a part
11 of meaningful use.

12 But, that is not always perfectly
13 aligned. And so, I do think that that's where
14 there's probably some additional -- where we
15 could do better at aligning.

16 So, let me go to the Medicare world.
17 Well, maybe I can go at an easier level and
18 that's the Marketplace, because the Marketplace
19 then changes -- started from their base of our
20 child and adult core measures.

21 So, there was an effort and there was
22 I think a real strong effort to align.

1 The difference in part has to do with
2 the population served. You know, we heard
3 earlier that we serve far more women and children
4 than either of Medicare or the exchange programs.

5 So, we have a much larger child core
6 set than either the exchanges or, and of course,
7 Medicare.

8 So, some of it just has to do with
9 different populations being served where you
10 can't have perfect alignment.

11 But, certainly, I do -- I would say
12 that we have worked really hard at the issue of
13 alignment, though there's not perfect alignment.

14 For Medicare, I think it is a
15 different -- it's an issue in large part of the
16 population because with elderly patients and
17 persons with disabilities, there are some
18 probably clinical conditions and problems that
19 drive measurement, far greater hospital use than
20 what you have in Medicaid. So, the hospital
21 measures are far more expansive.

22 So, I don't want to say that we

1 couldn't do a better job, but I really do feel
2 like we have prioritized alignment and certainly
3 could do better, but I think we're --

4 DR. SULLIVAN: Yes, I truly appreciate
5 the efforts. I really do. And I'm not trying to
6 be -- I'm just saying that even with what you
7 just described is an incredible burden on the
8 state --

9 MS. LILLIE-BLANTON: Yes, it is.

10 DR. SULLIVAN: -- system, the hospital
11 system, any system.

12 And that when that's where some
13 financial assistance or some way to assist can
14 help. That's all I'm saying.

15 And I know there's all true good and
16 I know it's all to learn from. But, when you
17 talk to management consultants, they tell you,
18 measure a few things and pay a lot of attention
19 to those and then measure another few. And we
20 just have a big panoply right now.

21 And I'm not saying you're not trying,
22 please don't take any of this --

1 MS. LILLIE-BLANTON: So, let me --

2 DR. SULLIVAN: But really, let's not
3 make the panoply too much bigger because I think
4 that frustration level will grow.

5 MS. LILLIE-BLANTON: Right, no.

6 So, one of the things we want to try
7 to do, but I'm not sure it's going to help, as we
8 move to TEMSIS, what we'd like to do is see how
9 many of the measures that are largely claims
10 driven, we can generate at the Federal level.

11 And that will then reduce the burden
12 at the state. But, there's a tradeoff because
13 now, when the states send us the data, our hope
14 is that they're also reviewing it. But, once we
15 start to generate it, the question is, does it
16 become a Federal activity of collecting and
17 reporting on measures versus the state effort
18 that they then are reviewing it and using it?

19 And so, we still are going to try
20 because we think that, as much as we can reduce
21 the burden on states, in the long run, it may
22 help. But we're not certain that that's the

1 answer.

2 But some of these measures are. I
3 mean at least almost half of them are measures
4 that largely are claims driven. So, I mean it'd
5 be interesting to hear your thoughts on that and
6 whether or not that is one of the ways we can
7 reduce the burden on states and --

8 I mean it's something we're trying to
9 do anyway, but the question is: is that part of
10 the solution?

11 CO-CHAIR PINCUS: Beverly?

12 MS. COURT: Okay, so thank you for
13 that opportunity.

14 One of the things that I know, TEMSIS,
15 challenging to produce. Washington is struggling
16 with that. So, it isn't easy to get that going.

17 When analysis is done, one thing
18 that's not understood is how things have shifted
19 in a state, and each state is a totally different
20 country in some ways in terms of, for example,
21 what have they done with their SSI population?

22 We talked about bifurcating between

1 fee-for-service and managed care; what I think is
2 even more important is the disabled versus the
3 nondisabled -- your duals versus the nondual
4 elderly.

5 Even breaking down your SSI into the
6 over age 65, elder, disabled and then those that
7 are under 65; they're really different groups. I
8 mean it's soup to nuts.

9 And so, when we want to do analysis at
10 the state level, we have to break it down to
11 those groups to do anything that's comparable.

12 Now, we've got ACA and that expansion.
13 That took a lot of state only programs, and now
14 those are federally funded. So, we moved a whole
15 group of highly disabled people who are Medicaid
16 only -- or state only programs, and now they're
17 rolled into.

18 So, it's not just the healthy, you
19 know, post-college kid that is now getting
20 medical care; it's also that severely disabled
21 person who just didn't meet the income
22 qualifications previously.

1 So, we've had tremendous shifts year
2 over year. I look at 2012 versus 2013 and 2014.
3 It's almost like a different Medicaid program
4 that we're comparing.

5 So, that's one of the concerns I would
6 have at the Federal level. So, whether or not
7 that nuance would be understood and taken into
8 consideration so that, again, the apples to
9 apples comparison.

10 One of the things that I think would
11 really keep states from not participating is make
12 it a friendly, benevolent place to be to report.

13 Right now, when we report, there's the
14 immediate need to take a mean and a median of all
15 these disparate things that states have reported.

16 So, one measure, one state may be
17 reporting a subset; another may have just entered
18 and they tried out this new measure. Maybe they
19 don't have everything, you know, all the specs
20 totally understood.

21 But immediately, fairly immediately,
22 what's published is this median and mean of the

1 entire group. And so, immediately, it's, oh,
2 you're a bad state. You know?

3 So, I'm afraid that if those kinds of
4 comparisons are published too early, and if
5 states are typified as being bad or poor
6 performers right off the bat, it's going to
7 really dissuade people from reporting. It's
8 going dissuade reporting on measures where maybe
9 you're not up to the median of --

10 You know, some of those measures had
11 huge variants in them. And so, even though it's
12 easy on an Excel spreadsheet to, you know,
13 calculate mean, median and publish it, it would,
14 I think really help if one didn't.

15 And instead, for example, have state
16 to state year to year comparison so you can see
17 how the state is managing that measure and
18 perhaps improving it.

19 But the state to state comparison, you
20 know, if you're at the lower end of that bell
21 curve, I think you're going to get less
22 reporting.

1 CO-CHAIR PINCUS: Kevin?

2 DR. LARSEN: I want to tie together
3 some thoughts from Nancy. And Foster and Nancy,
4 that was terrific. I totally agree that moving to
5 this more engineering model of thinking how we do
6 this.

7 And there's some examples we know from the
8 Medicare hospital program that we've so narrowly
9 defined some of the denominators of measures that
10 we exclude nearly everybody so that we can get a
11 consistent measurement.

12 But that doesn't actually help you
13 improve very much because all of the sudden when
14 you actually -- so, an example from the health
15 system I came from, we had the acute MI measure
16 in the hospital core measure set. And we were a
17 heart hospital and we saw hundreds of acute MIs a
18 year, and we would sometimes report two of those
19 out of our core measure set because everything
20 was an exclusion and an exception, and they
21 didn't fit the sort of narrow band of people in
22 the measure.

1 And that was to get at this
2 consistency issue. But it doesn't actually let
3 us really improve care for all the patients.
4 We're just so busy excluding people that our
5 signal is consistent place to place, but it's not
6 very -- it doesn't have much utility locally.

7 And so, I think if we need to start
8 thinking about how do we support this learning
9 health system as is the president's PCAST report
10 calls out and there's an IOM report about it, a
11 continuous use of measurement, the continuous use
12 of data to drive that improve. It becomes a set
13 of strategies, behaviors and infrastructure.

14 It isn't about once a year reporting
15 that's done six months after all the data's
16 normalized, it's a constant activity on the data
17 that you're constantly getting in place that lets
18 you report, analyze and use that information for
19 lots and lots of improvement purposes.

20 This is how the rest of the industry
21 works. This is Amazon and Google and Walmart,
22 how they are effective. And we need to

1 constantly challenge ourselves, how do we get
2 there and not only do this in a way that we've
3 always done it.

4 CO-CHAIR PINCUS: So, this has been a
5 terrific discussion and so, just to summarize, I
6 think one way of thinking about this in terms of
7 encouraging state participation, supporting state
8 participation, is that sort of like, you know,
9 corporations are people, states are people, and
10 your subject's the same behavioral forces as
11 people in many ways.

12 And, it's all about reducing
13 disincentives and encouraging incentives. And,
14 you know, to make things simpler, easier,
15 facilitate infrastructure, you know, to reduce
16 those disincentives, to make things clear and
17 useful.

18 And the incentives to build include
19 both the extrinsic and intrinsic incentives. And
20 it's clear that among the most important things
21 are the intrinsic incentives that states perceive
22 that they can actually do a better job if they

1 have this information and move towards the kind
2 of continuous learning systems that Kevin was
3 talking about.

4 So, I think it's been a really useful
5 conversation and we have just a few more minutes.
6 Do we also need to get public -- yes, go to
7 public comment?

8 So, is the operator available? David,
9 are you on?

10 DR. KELLEY: Hi, this is Dave Kelley,
11 if I could just weigh in a little bit.

12 Again, from our standpoint, I'd like
13 to reemphasize that a point that already has been
14 made in alignment and especially around
15 meaningful use and especially around electronic
16 extraction in looking and working with ONC and
17 the patient specific QRDA1 level of reporting, to
18 really make as many of the CHIPRA and we've
19 talked about the adult core measures, to make
20 them an absolute part of meaningful use so that
21 states --

22 Operationally, it's easier at the

1 provider level to extract and have them report to
2 our MCOs and then have our MCOs actually report
3 to us.

4 So, I think, again, all the comments
5 about alignment I think are extremely important.

6 I also think in having a consistent
7 definition is very, very important. I know that
8 probably more so on the adult quality slide there
9 was some ambiguity early on in some of the
10 measures. I think less so on the CHIPRA core
11 set.

12 I also think that, you know, from a
13 quality of care standpoint, I'd like to commend
14 CMS. I think that where we are today compared to
15 three or four years ago, there's a huge
16 difference. We have an approach of consistent
17 measure across state Medicaid programs and I
18 think that's vitally important.

19 I think as a taxpayer at both the
20 state and Federal level, I think, to have
21 transparency.

22 And, you know, when Pennsylvania does

1 not perform well compared to anyone else, we're
2 going to do something about it. And to not know
3 that and to not compare ourselves to somebody
4 else where we would have concerns. We like being
5 compared to others and we use that as a lever to
6 say, you know what, we need to reinvent how we're
7 doing something so that we can improve the
8 quality of care.

9 So, you know, from my standpoint, I
10 think we've come a long way in the last four or
11 five years. And as we try to make the CHIPRA and
12 adult core sets better, again, I think it's align
13 the measures and be very consistent in how others
14 are doing those same measures.

15 CO-CHAIR PINCUS: Thank you.

16 In the room, are there people that
17 would want to speak? I think we're ready to
18 conclude I think.

19 MS. LASH: I think so.

20 I thought Harold provided a really
21 nice summary of the conversation we just had so
22 we don't need to rehash everything that we did

1 today.

2 But I think we want to close with a
3 very strong message of thanks to the Child Task
4 Force members who won't be returning tomorrow and
5 to Foster for his leadership of that group.

6 We have some upcoming dates in the
7 time line just to share with you. Tomorrow, the
8 most immediate date, the task force will be
9 discussing measures in the adult core set and
10 interpreting some measure-specific
11 recommendations in the light of today's work.

12 You can look forward to the
13 opportunity to weigh in during the public comment
14 period on the draft report from, I think,
15 approximately July 6th to August 5th.

16 And then, at some point in mid to late
17 August, we will have the MAP Coordinating
18 Committee review the draft report recommendations
19 and the themes of public comment to see if
20 there's anything from our broader stakeholder
21 community that would need to be influential in
22 changing a recommendation.

1 And then, finally, there will be final
2 reports due from both groups on the two
3 measurement programs individually to CMS August
4 31st.

5 MS. SCHLAIFER: During the open
6 comment period, do you want us to comment through
7 the general open comment function or direct?

8 MS. LASH: Yes.

9 MS. SCHLAIFER: Okay.

10 MS. LASH: Yes, I think that there's
11 some value in letting the other people engaging
12 in the comment process read those sort of in real
13 time, although they all tend to come in on the
14 last day, of course.

15 But, for anyone that is submitting
16 their comments publically, those are sort of
17 available to others to consult as they form their
18 own.

19 Are there any other things?

20 CO-CHAIR PINCUS: Anything else?

21 CO-CHAIR GESTEN: So, again I think
22 I'll just add my thanks and particularly starting

1 with thanks to the NQF staff and Sarah, Shaconna
2 and Nadine and Severa and folks I probably don't
3 know who helped put this together.

4 Thanks so much for all this hard work
5 and staff work and the materials and so on.

6 Thank you all and I wanted to thank
7 the Child Health MAP in particular since you're
8 leaving. These other guys are continuing to
9 work, but, you know, at least half of you, if not
10 more, just did this a little while ago. So we
11 really appreciate you coming here. You are all
12 very smart, very passionate and all above
13 average, which is amazing. How often does that
14 happen?

15 So, thank you all.

16 Harold, anything else?

17 CO-CHAIR PINCUS: No, I think ditto
18 with regard to my thanks to the staff and for the
19 participation and we have a lot of work to get to
20 tomorrow on the adult side.

21 CO-CHAIR GESTEN: Just one more -- I'm
22 sorry. I just want to acknowledge, I mean I

1 think that I'm so pleased, Marsha, that you're
2 able to be here and how responsive you are and I
3 think, you know, again, I think back to 15, 20
4 years ago and other times when it was hurling
5 bombs over the fence.

6 I mean I think we so much -- things
7 have come such a long way, as David was pointing
8 out. And I think not a small amount of that has
9 to do with your leadership. So, thank you so
10 much for being here.

11 MS. LILLIE-BLANTON: We appreciate
12 your leadership and direction as well because I
13 think having partners like you makes us stronger
14 in the end and, of course, our core sets as well.

15 MS. LASH: Breakfast tomorrow is at
16 8:30 and we'll begin at 9:00.

17 (Whereupon, the above entitled matter
18 went off the record at 3:54 p.m.)
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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.

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