NATIONAL QUALITY FORUM

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MEASURE APPLICATIONS PARTNERSHIPS

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MEDICAID CHILD TASK FORCE IN-PERSON MEETING

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FRIDAY
OCTOBER 17, 2014

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The Task Force met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 9:30 a.m., Foster Gesten, Chair, presiding.

PRESENT:

FOSTER GESTEN, Chair, National Association of Medicaid Directors
TERRY ADIRIM, American Academy of Pediatrics
ANNE COHEN, Harbage Consulting*
BETH FELDPUSH, America's Essential Hospitals
SUSAN FLEISCHMAN, Kaiser Permanente
MARSHA LILLIE-BLANTON, Centers for Medicare & Medicaid Services
SUSAN LACEY, American Nurses Association
KAREN LLANOS, Centers for Medicare & Medicaid Services
MARC LEIB, Marc Leib, MD, LLC
CINDY PELLEGRINI, March of Dimes
CAROL SAKALA, National Partnership from Women & Families
ALVIA SIDDIQI, American Academy of Family Physicians*
MARSHA SMITH, Centers for Medicare & Medicaid Services*
SANDRA WHITE, Aetna

NQF STAFF:

HELEN BURSTIN, Chief Scientific Officer
BETH CAREY, Project Manager
ANN HAMMERSMITH, General Counsel
SARAH LASH, Senior Director

ALSO PRESENT:

KRISHNA ARAVAMUDHAN, Dental Quality Alliance

WILLIAM GOLDEN, Arkansas Medical*

DAVID KELLEY, Pennsylvania Department of Public Welfare Office of Medical Assistance Programs

DENISE REMUS, All Children's Hospital, Johns Hopkins Medicine

MARSHA SMITH, CMS, Federal Liaison*

MARK SCHUSTER, Children's Hospital Boston*

*** present by teleconference**

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

9:37 a.m.

CHAIRMAN GESTEN: Good morning everyone. Welcome to the meeting. Thank you all for coming near and far.

We have a great -- I'm so used to being in this room and having it be a huge table. I've never been here with such an intimate group. And I think that's terrific. It will be a great day.

We have a pretty ambitious agenda I would say. So we're going to try to get you out of here on time, but also cover all the things that we're here to do.

As you will go through some of the specific objectives, but we're on an accelerated time frame to do a review of measures which will be a prelude for a much longer and hopefully more leisurely period of time in which we can review the measures that exist for CHIPRA and make comments.

But I appreciate those of you who

are able to either review materials, review notes or be on the previous webinar that we had to go over our task. We'll do a little bit of repeating of that for today.

I want to welcome all of you and folks on the phone and the public and the folks in the room as well. And there will be opportunities for everyone to make comments.

I think the ground rules are, it's helpful to use the microphones so that folks on the phone and in the room can hear you. And turn your mic off when you're done speaking. And it's typical to use the -- put your card up like this when you want to say something and try to call on folks in order as well.

We're going to do introductions in a second. Let me just -- if you go to the next slide. We'll go through what our objectives are today.

We're going to hear from early in the morning, the States talking about their

experience in implementing the Medicaid Child Core Set. We have two, three if you count me, States represented around the table that will make some comments.

And our goal for today is to make some concrete, actionable recommendations. Recommendations to both NQF and CMS for strengthening the existing Child Core Set.

Really focusing on two tasks that we are going to, I think for the sake of logistics, segment into looking at and prioritizing measure gap areas. And then prioritizing and looking at specific measures within those prioritized gaps. And we'll talk more about how we're going to do that as well.

We'll also have an opportunity to talk some about other larger or strategic implementation issues around data and alignment and overall challenges that States have and opportunities that States have in terms of collection of measures.

Before we go to -- go around and

do introductions and conflict of interest statements and so on, why don't I just see first Marsha, if you have any opening remarks that you want to make to this group?

DR. SMITH: I'm thankful for everyone that's here today. I'm looking forward to reviewing the measures and going forward with improved, enhanced core set for children. And just want to get started. Thanks.

MEMBER LILLIE-BLANTON: So thank you Marsha. That's Marsha Smith. Dr. Marsha Smith who is with our Center for Clinical --

DR. SMITH: Oh, I'm sorry, I thought it was me. Excuse me.

MEMBER LILLIE-BLANTON: That's fine, that's fine. We're glad you spoke up.

CHAIRMAN GESTEN: Well first of all, are there any other Marsha's before you go? I can see I need to be more specific. Go ahead Marsha.

MEMBER LILLIE-BLANTON: We now

know your name. So I just want to also welcome you. But also I really, truly want to thank you for taking the time to be with us today.

I want to send a special thanks to those of you who have been with us from the very beginning. I know that there are some of you around the table who have been working with us on our core measures for many years.

And so it's nice to have the continuity and the experience to share with others. And I certainly want to thank our state partners.

But I really, truly also want to thank NQF because I feel like we have moved from having a support, an ongoing support for this work. Because it's easy to get started. It's hard to sustain this work with you know, credible, experience and knowledge. And you have given us that resource.

So I want to thank you. And I am looking forward to this discussion.

Unfortunately I'm going to be popping in and out, I have a couple of meetings that I have to listen to on the phone and be a part of.

But I will certainly be here for the entire meeting. And certainly look forward to the discussion and the report.

CHAIRMAN GESTEN: Thank you so much, Marsha. And I neglected to add my thanks to the NQF staff who for many of you who have been involved in NQF know how critical a role and wonderful role that they play.

So to my left, Sarah, to my right, Beth, have been just terrific in terms of setting up the logistics. Putting the materials together, being responsive I think to some of the needs that were articulated in the first webinar about additional data or additional resources. So thank you both very much.

And let me just -- Helen from NQF, do you want to make any opening comments

before we get started?

DR. BURSTIN: Good morning, Helen Burstin, Chief Scientific Officer at NQF. Just delighted that you could join us today, both those at the table and great to see so many people in the audience as well. It shows that this is an incredibly important topic.

And I'm so glad with the help of CMS we're able to help -- continue to help in the standardization around these measures. Thanks.

CHAIRMAN GESTEN: Logistics. Beth are there?

MS. CAREY: Sure, just some housekeeping items. I think most of you have been able to log into the internet. But if you haven't and you have a guest, NQF guest password that you have to login.

Restrooms are located past the elevators to your right. And we do have some coffee and some breakfast items in the back. We'll be breaking once in the morning. We'll

be breaking for lunch and then we'll be breaking once again in the afternoon.

If you need anything during those breaks, if you need to step out to make a phone call in a quiet room, anything like that, just let us know and we'll try to facilitate your participation today.

CHAIRMAN GESTEN: Great, let's go back. Can we go back to the previous slide? Yes, the names are up there.

So I want to turn things over to Ann Hammersmith, who's the General Counsel for NQF. And we'll in the context of this do both introductions and disclosures of interest. Ann?

MS. HAMMERSMITH: Thank you. I see some familiar faces around the tables. So some of you have done this before. But just to refresh everybody's memory, I'll do a little explanation and then we'll do introductions and disclosures.

Because this is a MAP group, I

would say in this case most of you sit as organizational members. When you sit as an organizational member, you do indeed represent the interests of the organization that you're associated with for purposes of sitting on this committee. It may be your employer. It may be a professional society.

So because you're here to represent those interests, we ask for a very abbreviated disclosure of interest. Which is do you have an interest of $10,000.00 or more that is related to something that is going to be discussed today, related to the work of the Committee, directly related to the work of the Committee.

The subject matter experts, you have a -- you received a longer disclosure form. And we'll deal with you separately because it's a little bit easier, it gets confusing if we mix them all together.

Our federal government liaisons, you do not have to disclose. I think you've

already introduced yourselves. So we've taken care of that.

I'm going to read the names of the subject matter experts just to refresh everybody's memory. Your Chair, Foster Gesten is a subject matter expert. Anne Cohen is a subject matter expert. And so is Marc Leib.

If you're on the phone, I will call your name when it's time for you to introduce yourself and disclose. So let's start with the organizational members. Tell us who you are, who you're with or who you're representing. And then if you have anything to disclose. And again, that's the $10,000.00 or greater interest in something directly related to the Committee's work.

So let's start with Susan Lacey since she's right next to me.

MEMBER LACEY: Susan Lacey representing the American Nurses Association and I have nothing to disclose. Thanks.

MEMBER SAKALA: Good morning,

Carol Sakala from the National Partnership for Women and Families. And I have nothing to disclose.

MEMBER FLEISCHMAN: Good morning, Susan Fleischman from Kaiser Permanente, and we take care of 590 thousand Medicaid and CHIP members. So we have a greater than $10,000.00 interest in this, in that we are a reporting health plan.

MEMBER WHITE: Good morning, I'm Sandra White, Dr. Sandra White. I'm the Executive Director of Aetna Medicaid National Quality Management. We're also a reporting organization.

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

MEMBER ADIRIM: I am Terry Adirim. I am a pediatrician representing the American Academy of Pediatrics. I don't have anything

to disclose.

MEMBER FELDPUSH: Hi, I'm Beth Feldpush, I'm the Senior Vice President for Policy and Advocacy at America's Essential Hospitals. And I have nothing to disclose.

MS. HAMMERSMITH: Is Alvia Siddiqi on the phone?

MEMBER SIDDIQI: Yes, I'm on the phone. Good morning everyone. This is Alvia Siddiqi. I sit on the Commission of Quality and Practice for the American Academy of Family Physicians. And my day job, I'm the Medical Director for Illinois Health Connect, we're a State PCCM program. And I have nothing to disclose.

MS. HAMMERSMITH: Okay, thank you. Now we'll move onto the subject matter experts who got a longer form, or you should have gotten a longer form.

Because you sit as individuals, we are more interested in your personal dealings in terms of consulting, research, speaking.

But we only want to hear about it if it directly pertains to the work of this Committee. So in other words we don't want you to recite your resume.

Obviously you sit as individuals. You're individual subject matter experts. So you sit in a different position then the organizational members. So we'll start with Marc Leib.

DR. LEIB: Marc Leib. I spent ten years with the Arizona Medicaid Program, but for the last four months I've been doing independent consulting work. None of the work I've done is in any way a conflict or a conflict of interest in either financial or the subject matter of this Committee.

MS. HAMMERSMITH: And the Chair?

CHAIRMAN GESTEN: Good morning, Foster Gesten. I'm Medical Director in the Office of Quality and Patient Safety at the New York State Health Department. I previously was the Medicaid Medical Director

in New York. And still have a role in quality measurement and improvement for the Medicaid Program in New York.

We're a part of a consortium of the Center of Excellence grant led by Mount Sinai related to the development of CHIPRA measures. I have received no funds related to that, but the Department receives -- has a grant, has a partial grant through that to work to develop pediatric measures.

I also sit on the NCQA CPM, which also reviews and makes recommendations regarding measurements. And am part of a team that is involved in implementing the CHIPRA core measures in New York State.

MS. HAMMERSMITH: Okay, thank you. And is Anne Cohen on the phone?

MS. COHEN: Yes I am. This is Anne Cohen. I'm your disability related subject matter expert. I'm a disability and health policy consultant. And I'm experienced about disability-targeted quality measures and

serve under Duals Disability MAP.

I have no conflicts to disclose.

MS. HAMMERSMITH: Okay, thank you. Any questions or comments from anyone based on the disclosures? Anybody on the phone have questions or comments?

Okay, thank you. Parting words are, we rely on you to help us make our conflict of interest process work. If you believe that someone on the Committee is acting in a biased way, or if they have a conflict, please speak up in real time.

You can always bring it up in the meeting itself. If you would rather not do that, you can go to your Chair, who will go to NQF staff. Or you can go directly to NQF staff. Have a good meeting.

CHAIRMAN GESTEN: Thank you Ann and thanks everyone. So let's just go through the agenda.

As I said, we're aiming to conclude around 4:00. In the morning we're

going to hear from a couple of states and get their views on some of the challenges and opportunities and experience in implementing and using current CHIPRA Core Measures.

After that, we are going to have a panel which will talk about and address some of the questions and issues that came up on our web meeting. And present a little bit more data that was requested by some of the members to expand some of the data and background and backdrop of Medicaid and CHIP.

We're going to hear a bit about some of the measures and issues related to oral health. And then that discussion in the morning really sets the stage for us to have a more specific conversation in which we talk about some of the measure gap areas.

And you'll see the gap areas that we talked about in the previous webinar come up and we'll have a more explicit conversation about that. And attempt to prioritize those areas.

And then attached to or connected to looking at those gap areas, we'll be looking at measure specific recommendations to strengthen the core set related to those prioritized gap areas.

In the later afternoon, we'll have a conversation about some of the broader, what's described here as crosscutting recommendations regarding strengthening the core set, which go beyond a conversation about gap areas and measures specifically to get into more implementation and broader issues and then an opportunity for public comment.

Are there any questions about the agenda that folks have before we kind of get started and talk about what our objectives are? Okay.

So this should be familiar to folks. Our charge in this expedited review. And we'll go over the -- you'll see at the bottom, the time frame, it describes exactly how expedited this review is.

Our charge today is to review states' experience in reporting the measures. To identify and prioritize gap areas to fill. And we've had a significant down payment on that conversation. And then recommending potential measures for addition to the set.

We have folks as was mentioned earlier by Ann and others, our task force consists of both current MAP members from the Coordinating Committee and individuals from some of the various MAP workgroups that are relevant to the objective and the task in front of us.

We began our convening in September with a webinar. And we have a report that's due to CMS by November 14. So you can see that it's a fairly accelerated time frame in which we have to do our work.

As I mentioned, we have a second in-depth report due to CMS by September 1, 2015. And I believe that work starts in earnest sometime in the spring of 2015, is

that right? So we'll be back again.

There'll be issues that we may not be able to resolve or that may be open issues. Or we may need -- be waiting for certain developments in measure testing that we'll get into later on this afternoon. So understand that there will be a second chance to really be able to look at the core set and make recommendations.

The next slide. So I think the good news is, that this is not the first time at this rodeo in terms of looking at measures and trying to improve the set. CMS -- the CHIPRA core set has been around a little bit longer than for example, the adult core set, which some of you may be familiar with.

There have been I believe at least two and possibly three different rounds of looking at and trying to improve and iterate the core measure set. And the goals of the child core set, which are the same goals for the adult set as I recall, are really

threefold.

And these I think are going to be important as we get into the issues of both gap areas and measures specifically. And that is to increase the number of states that are reporting the core set measures. And we'll talk later today about state reporting.

Increase the number of measures that are reported by each state. And I think importantly the reason that brings us to this work is to increase the number of states and the ability for states to use the measures to drive quality improvement, which is really I think, what the measures, the purpose that measures serve.

So we are, and again, Marsha Lillie-Blanton, feel free to jump in here if you have things to add to and -- I'm sorry? And Karen -- hey, Karen. I'll let you introduce yourself in a sec.

This focus is really -- the focus has been on incremental changes. As we

continue the states and CMS continues to better understand what's working and what's not working.

We have -- as you'll hear about, there are significant always resource and time issues that states deal with. But frankly, all healthcare organizations, state down, are dealing with time constraints, resource issues, alignment issues relative to measures. A plethora of measures and obligations that we have to respond to.

So I think that's important contextual information. We know that MAP and this task force can help strengthen the existing core set. There is a major opportunity and obligation on the part of states and CMS with respect to child health through Medicaid and CHIP.

So this is serious work, important work. So filling gap areas, aligning the measures that we have with CMS' quality domains, aligning measures with other programs

that CMS and HHS has are important goals and aspirations not only of our work, but of the MAP generally.

And there will be conversation in the next year about which measure -- about retirement of measures. That issue may come up today in terms of measures you might want to replace or retire.

Although we see more of that work going on in 2015 when we have a longer period of time. With a focus of today and this accelerated work really around making recommendations for gap areas.

But let me -- Karen, let you introduce yourself. And if you want to make any comments or additions to.

MEMBER LLANOS: Hi everyone, and I apologize for being late. I forgot what DC traffic is like.

So my name is Karen Llanos. I am at the Center for Medicaid and CHIP Services. And up until recently led the work related to

the adult core -- or the children's core set. And I want to say we're so excited to have the child core set in the MAP.

It's proven to be such an effective method of getting stakeholder engagement. And as you will hear, an expedited and in the longer term, because we did an expedited review for the first time, the adult core set came into MAP as well.

And I think we're just extremely happy to have folks around the table thinking about these issues and how we can align better and fill the gaps in. And I think we're looking forward to hearing your feedback. And it's an expedited review, but it's a process, right.

So I think what you'll hear today, you know, we've got David Kelley and Dr. Golden to give you the state perspective. But that really is kind of our ultimate guidepost. Is we hear from our state partners and want to make sure that the measures that we select for

the core set are ones that are most doable and they're reliable and that they will be ones that resonate with the needs of other quality measurement needs in their state.

So I think we welcome a broad discussion. And just to let you know, that that's some of the filters that we use when we think about what really needs to go into the core set is efforts, capacity, data collection, variations across the states. So there's lots of different things.

And I think I'll just echo one thing that I said to the adult MAP when we first met was, I think for those of you that serve on other MAP Committees, the children and adult core set measures are a little bit different than the other measurement reporting programs in that they are at the state level. So it's a state reporting program. There's no payment or incentive tied to it.

And we ask states to really kind of work hard to try to standardize across for

different delivery systems, which can be challenging. So we're asking a lot from states and we're asking a lot from measures. And it's a voluntary program as well.

So thank you and I look forward to hearing more about your feedback.

CHAIRMAN GESTEN: Thank you so much Karen. Before we get into the state perspectives, and David if you can actually come up to the mic, that would be great.

Let me just see if folks have any clarifying questions they want to ask about the objective or why we're here. You guys have been very quiet, which makes me very nervous, but I know you're just saving yourselves for the real meat of the meeting.

But any questions about our objectives or about the agenda? Okay, great. Bill, are you on the phone?

DR. GOLDEN: Yes, sure.

CHAIRMAN GESTEN: Hi Bill.

DR. GOLDEN: Hi.

CHAIRMAN GESTEN: So we -- I'm pleased to introduce colleagues from Pennsylvania and Arkansas Medicaid programs who will give state perspectives on the implementation and use of CHIPRA measures. We really welcome their comments and we'll have a chance to interrogate them afterwards and talk about some of the issues that their experience reveals.

We'll start with Dr. David Kelley who is the Chief Medical Officer at the Pennsylvania Department of Public Welfare Office of Medical Assistance Programs. David, I don't know if you have slides or not?

You do not. David does not have slides if folks are wondering. And I'll turn things over to you. David?

DR. KELLEY: Thank you. I appreciate the opportunity to come here and give you Pennsylvania's perspective on the core measure set, the CHIPRA core measure set.

Just a little bit of background.

Pennsylvania has had managed care, mandatory managed care for over 17 years. In 2013 we moved to statewide mandatory managed care. That included over those 17 years, dual eligible adults as well as dual eligible kids.

So when we are measuring the quality of care, we're not cherry picking and just measuring normal healthy kids. We are measuring and looking at the entire spectrum of our pediatric population that Pennsylvania covers. So I know there's been a lot of discussion about you know, risk adjustment and what not around certain measures.

I can tell you that for 17 years, our plans have been measuring and reporting and they've been compared nationally to what other states have done that have perhaps not included those populations. And we're very proud of that.

I've been asked to talk about the purpose and use of the core set measures, various implementation and measure gap areas.

I'll start with really the purpose and use of the core measure set.

In Pennsylvania we applaud CMS' efforts in developing the core measure set. Within our managed care organizations, we have over time asked them to report on -- to us all of the pediatric core measures. There are still one or two I think that are off the list that operationally our approach was to have them actually report in a staggered fashion.

So things that required chart review or were more administratively burdensome, we tried not to make our plans do all of them all at once. And we staggered the implementation of some of those measures.

So one of our purposes is to really have our managed care plans very rigorously measure. And we actually go through the EQRO process in that those measures are validated as what we call Pennsylvania Performance Measures.

So our EQRO actually, these are

validated measures. So we're very rigorous. We want our plans to be very rigorous in how they measure the core set. Our plans also report to NCQA, so it's also very nice when there is overlap of the NCQA set.

So one of the key purposes is really to have our managed care plans do the core measure set and then we report those measures publically. So that is one of our key purposes is to publically report the measures that have been established.

The other area that we have -- we happily receive the CHIPRA grants to actually work with seven key partners. One of those initiatives was actually the extraction -- the electronic extraction of the core measure set.

We worked with two institutions, especially Geisinger Health System and Children's Hospital of Philadelphia as well as St. Chris in Philadelphia and other institutions. A very -- the University of Pittsburgh.

So it was a very high volume child serving institutions have over the last several years have been actually electronically extracting the core -- several of the core quality set measures and reporting them to us. And I think if you go to AHRQ's website, we have some reports that we've filed about some of those efforts.

The other area that we also were working on around electronic health records is actually several of those institutions have implemented the developmental delay measure into actually their workflow, where that screen is actually being done as part of the workflow while parents and kids are sitting in the waiting room. I can say that we have now screened thousands more kids.

And again, a lot of the impetus was really around this was a core measure set. We must focus on this. It allowed us to set our priorities within the state. And I can say that as part of that grant, several of

those institutions are going to sustain that activity.

Also, we are hoping as best we can to link the core set to our Meaningful Use Program, which I also help to oversee, our High-Tech Incentive Program. And I would highly encourage what I call the QRDA-1 packaging of measures.

So any measures that you come up with in the future, or even current measures, I would highly recommend that you put them into a standardized QRDA package so that providers can actually extract out of their EHRs and report. Our quality strategy is really to move forward with that type of extraction and reporting.

So again, having the core set out there, it has given us an additional set of quality measures that we can put forth to our providers, to our consumers, to say this is what's important. We -- lastly, we have used the measure set to also really push linkage to

our statewide immunization registry.

And again, we think that again, this is -- having the core set there has helped to drive that process along with some of the Meaningful Use requirements.

Lastly as far as purpose and use, as far as dental goes, CMS has given us the task of increasing our dental preventative rates by ten absolute percentage points. Again, having the measure set there for prevention, our plans are able to actually measure how many of their kids are getting preventative services.

They have always measured the HEDIS rate. But again, having the core set has really allowed us in our managed care plans to not only measure that, but actually work on quality improvement. So again, the purpose and use of the core measure set within Pennsylvania I think has been very valuable.

Moving to barriers. I don't know if you want me to just move through and then

have questions later. As far as barriers, and again, I'll be -- try to be brief on this.

This are some technical spec issues. I'm not going to get into all of them. Our EQRO as I mentioned is working with us as well as all of our managed care plans to operationalize the measures.

We have identified and we can send documentation of some of the specific areas of where we have -- our plans have struggled around again the developmental delay. There's some inconsistencies or some definitional issues around that.

There are also another -- so one of the barriers are some of the technical specs perhaps need to be -- could be a little bit tighter. Another issue is looking again, I mentioned previously around chart review and the added expense of chart review.

Again, our plans are out there typically in providers' offices doing a lot of other chart reviews related to NCQA HEDIS.

But every time there's a measure that involves chart review, that's extra time and energy. That's why again, I'll come back and keep plugging the electronic extraction of measures whenever possible in a very consistent fashion.

The other area specific to extraction is hospital records. Our health plans typically are very good in getting into providers' offices and extracting records. When it comes to hospitals and health systems, there are sometimes technical and/or legal questions or challenges or barriers.

We've had to on a few occasions cite our state regulations and our authority to do any chart review we want to do based on the fact that we paid for that service. But again, there are some barriers associated with that. Again, looking at the live birth and the class measure.

One other issue in Pennsylvania, we have a carve out between physical health

and behavioral health. And there are some measures that carve out issue makes things somewhat difficult.

Again, follow up after hospitalization for mental illness. And I think there are one or two more. I think the ADHD medication, there's some barriers around because of our carve out model.

One of the things that we've done though is, we've worked with our EQRO because we do a counter validation through our EQRO for both physical and behavioral health plans. We actually have been able to have our EQRO help out and really kind of crosswalk some of those measures.

But it is in a carve out state. There are some challenges when the behavioral health and physical health services are -- the claims are sitting, or the provider networks are sitting in different managed care organizations.

The -- one other comment that I'd

like to make around the weight management measure is that before NCQA had their measure, we had a Pennsylvania Performance Measure that actually included looking at what is your BMI or BMI percentile. The current measure doesn't really allow us to assess our population -- the rate of obesity.

So you're really just looking -- you're checking off boxes and looking at outcomes. I would highly encourage that you move towards -- folks are out there charting this anyway. We should really be reporting on BMI percentiles and then you can roll that up to your population so you can actually have an understanding of those kids that are at risk or that are obese.

So just a comment. And again, I think that is now an NCQA measure. But it's something that I think warrants a little additional investigation.

So those are the major barriers. Again, I can certainly share some specific

concerns. I know our health plans and our EQROs have had some issues around the live birth measure and also the C-section measure, and the developmental delay measure.

And we could certainly, if folks want to hear, or get specific documentation, we can have our -- we can send those documents to you if there is interest in doing that.

Next I'd like to move to what I think is probably the most important part of today is really what are the measure gap areas. And again I'll start off by saying that we need to electronically extract and focus on you know, where are we headed in the next four or five years, into the brave new electronic world and packaging them into the standardized QRDAs that ONC has put forth.

Again, there are not enough core measures that are actually a part of meaningful use when you look at that crosswalk. So to me that is a huge gap. I'm helping to manage the Meaningful Use Program.

My pediatricians come to me and say there's only a couple of measures.

Then you have us measuring the core set. And then you have us doing this, and you have us doing that. Align those measures and allow for electronic extraction and reporting. And the development of specific QRDA-1s for those particular measures.

One of the areas that I think was previously mentioned in this Committee was looking at screening for abuse and neglect. And also looking at -- underneath that is injury and trauma and actually those things might actually be linked.

And I think that it really needs to be using or leveraging claims data to really look at and get better. And perhaps earlier detection of potential abuse and neglect. I think that that is an area that has not been addressed. It's a very important area.

Coming from -- we're still called Pennsylvania Department of Public Welfare. We still run a child welfare program. That name is changing in November.

But again, I think focusing on those kids I think is extremely important. And developing measures that would look at coming through emergency room claims and other claims to look for areas where there potentially may be abuse and neglect.

Especially you know, if kids are being brought to various EDs. Those EDs, the emergency departments are not seeing the whole picture. Whereas health plans have the ability to really look at and see the entire picture. They can look at hospitalizations, they can look at ED visits across the spectrum.

Another area that I actually want to continue to focus on is we really need to pay attention to our kids in foster care. And we know that from the mental health standpoint

to assure that there is excellent access to outpatient ambulatory mental health services. Wraparound services I think are extremely important.

These are kids that need trauma based care. They need to be aggressively managed so that in their time of need, we're here for them. We in Pennsylvania have looked at some of our use of wraparound services, especially as it has been linked to kids in foster care that are also on antipsychotics.

I can tell you that there is a significant -- there's significant room for improvement. And getting those kids better, on antipsychotics, getting them more comprehensive behavioral health wraparound services is absolutely essential.

Playing on that same note, many of us around this table for many years worked on looking at the antipsychotic medication use in kids. Happily that is now an NCQA measure. I would highly recommend that you add that to

the core set.

The CMS Quality Conference several years ago, I think I got up and passionately said that we need to make this a focus. It needs to be part of the core set. And again, I'll reiterate that.

It's now a HEDIS measure. And we need to really be looking at that and measuring that aggressively for all kids. But especially for those kids that are in foster care. And then also making sure that those kids are getting the behavioral health services that they deserve and need.

Also I think on your list was appropriate use of CAT scans. And we would highly advocate that. That again, health plans have the ability to look across the spectrum of multiple emergency rooms, multiple places of service to look at how often our kids are being exposed either appropriately or inappropriately to radiation.

Then looking at cost measures.

And the consideration of looking at the cost of care in certain chronic diseases that we know are fairly prevalent in our populations.

Looking at the cost of care of asthma and the cost of care of Type 1 diabetes or even Type 1 or Type 2 diabetes since we have more of a problem of adolescent obesity and diabetes. Again, I think it's important to look at the cost of care if you can do that in a risk adjusted fashion, which I think is a definite possibility.

I'll come back to dental and that I think that the measures that we have right now are fine. We are able to focus on both prevention and other services. We also in Pennsylvania use the HEDIS measure.

So I think what we have, what we're measuring currently is adequate. We -- is it perfect? No. In Pennsylvania we have a measure where we actually look at dental services that are provided for I believe it's kids, but it may be kids and adults with

special needs, something that we've been monitoring and measuring for many years. Our health plans measure that. So again, that addresses some of the special needs populations.

The other thing that we're really starting to look at and push for, I think we've also have been measuring sealants for many years, sealant use. The other thing that we're looking at now is actually developing kind of a preventative dental episode of care that doesn't just say well oh, I got a preventative dental service.

But there are three or four preventative dental codes that translate into, and I always look at my dental directory for what those codes are. But there are three or four of them that equal an excellent episode of care for prevention. And that might be a more robust way of actually looking for whether or not that child is actually getting the full episode of care of preventative

services.

Again, I would like to thank everyone for the opportunity to come here and share our experience. I again applaud CMS for all the great work that they have done over the past four or five years in really putting out these core quality measures both for kids and adults.

I think speaking for the State of Pennsylvania, I think it's helped to drive and improved the quality of care that we deliver, that our managed care plans deliver. And again, we find that there is great utility in the measures and as you are thinking about developing new measures, please keep in mind some of the challenges that I've raised.

One last additional plug that I'll make is that in a quality improvement cycle, it takes time to implement and then actually measure baseline. So whenever you're dropping or adding measures, be aware of the time frame. And perhaps a three to four year time

frame is kind of a minimum time frame in which to really put forth new measures and keep them there.

It's not productive if a measure is dropped after a year or two. Unless again, there have been you know, huge challenges nationally doing that measure.

Again, I would like to thank everyone for the opportunity to share Pennsylvania's perspective. Thank you.

CHAIRMAN GESTEN: David, thank you so much. What a great -- threw out a lot of issues, a lot of experience. Very thoughtful. I really appreciate you coming and sharing those.

Why don't we -- I would suggest maybe if folks have clarifying questions, to ask David, to do that now. And then save broader discussion issues perhaps after we get a chance to hear from Dr. Golden.

But does anybody have any specific clarifying questions? While you guys are

thinking, I have a couple.

Can you, just for -- go ahead, was there somebody on the phone? Okay.

Can you for the uninitiated, two things. Can you briefly describe, because I want people to be on the same page, what QRDA-1 packaging is? Because I'm not sure everyone knows what that means.

And you said a little bit about carve out which is very familiar for the folks who are in the biz. But can you -- can you say a little bit more about why -- what challenges the state has in being able to take information from two separate organizations and put them together.

Because my working assumption is even when things are carved out, the state still has access to information from both organizations. So how the carve out relates to actually putting measures together.

DR. KELLEY: Sure. I'll address the QRDAs, I'll have to -- I'll blank on the

exacts -- what it exactly stands for, but it is -- these are the quality, the meaningful use quality measures that I believe ONC has defined.

They are standardized ways of extracting in a common language, computerized language set, that an electronic health record that meets meaningful use standards of being interoperable. Those providers that are using that system should be able to extract and package a quality measure that has specific data elements that are prepackaged and predefined so that everybody's extracting and reporting on as best as possible, exactly the same measure.

So for instance, if you're looking at BMI or BMI percentile, there is a QRDA package, I believe that's one of them that does exist, where you actually -- the providers, EHRs should be able to report on the you know, typical demographics you know, age, sex. And then look at things like BMI,

BMI percentile, height weight.

There's a prepackaged set that can be pulled out of the EHR and reported in a standardized way. And then transported securely to whomever. Whether that is to a health plan. In Pennsylvania we're planning to have them packaged and sent to us, the state as part of the Meaningful Use Program in the future.

So that is what I meant by that packaging. It's a standardized approach. And I believe it's ONC that actually defines them. The HL7, yes.

DR. SMITH: Yes, HL7 defines the standards. ONC sets the requirements for what the e-measures must include.

DR. KELLEY: Second question around "carve out." And again, this is in the State of Pennsylvania. We have eight physical health managed care plans. And we have five behavioral health managed care plans.

And so there is services that are

rendered and paid for by different sets of managed care plans. Our physical health plans in some of the measures, they only have access to their physical health information.

And in fact as of March of this year, we helped alleviate some of those issues by actually using our state and counter data set. And we're now actually pushing the behavioral health claim set to our physical health plans. We still have to pull out drug and alcohol and HIV information.

So some of those challenges are not as big as what they may have been. We've been able to work around -- that's one potential work around. That's only new. We only started that in March of this year.

We also do have the capability, our EQRO has -- we send them and they validate both physical and behavioral health claims. So they have that fuller data set. So they are able to pool several measures for us that go across both physical health and behavioral

health.

I don't know of other states that have carve outs though, have some of those capabilities. The encounter validation, I don't think that's a mandatory EQRO obligation.

So I don't know, just raising that as a potential issue in barriers for being able to measure those measures that go across both the physical and behavioral health realm.

CHAIRMAN GESTEN: Thanks. Thanks for clarifying both. And thanks to I'm not sure who it was on the phone who clarified that.

DR. SMITH: Marsha.

CHAIRMAN GESTEN: It's Marsha, okay. Thank you Marsha.

DR. SMITH: The other Marsha.

CHAIRMAN GESTEN: The other Marsha. The first Marsha.

Dr. Golden is the Medical Director for Arkansas Medicaid. And I believe Bill

that you have some slides that we could -- I'm sorry, there's a question from Susan? I'm sorry Susan.

MEMBER LACEY: No, that's fine. So my question to you is, I believe I got this right, it takes two to three years for making sure a core measure is fully integrated into your system, which is -- I think that's what you said.

So how then -- or can you give us a little bit of a time line, so our third goal here is to increase the number of states using core measures to drive quality improvement. So if it takes a couple or three years to get a core measure going, so how then does the State of Pennsylvania, or a typical state, say take the data, what kind of reporting can you give people, providers? And then how do you drive the quality?

I'm curious. I have no idea what you would do in that thing.

DR. KELLEY: Let me clarify. The

measures that are not NCQA HEDIS tend to take longer because they're not you know, a part of the "package" deal that our plans to get NCQA accreditation and then be recognized. It's not part of that package deal.

So some of those measures that are not NCQA and/or -- and also require chart review, are more difficult to operationalize.

MEMBER LACEY: Sure, sure.

DR. KELLEY: As far as getting to actual quality improvement, we -- within Pennsylvania, we work with our managed care plans, they are the ones that are really pretty aggressively measuring this.

We also have set aside funding for provider pay for performance where they are focused on particular measures. And unfortunately not enough of them are pediatric measures.

So that is one way in which all of our plans are working with their provider networks to improve the quality of care. The

other mechanism that we're using, and again it goes back to meaningful use, is that we now have I think over 2,500 providers that are now sending us the QRDA-3s, which are measures across their entire practice.

They are now sending us those measures and we're -- the results, numerators and denominators. So we're actually aggregating that and sharing you know, performance with them. And so that's another mechanism.

But what really needs to happen and part of what we did with the CHIPRA grant was those institutions, they're all very high volume child serving institutions, they're actually extrac -- they were extracting I think eight of the core measures. And actually looking at ways to improve those measures.

So for instance Children's Hospital in Philly, St. Chris, Children's in Pittsburgh, Hershey Medical Center. They all

participated in that program where they're not just measuring, but then they were taking those results and we would share those results with them.

And they would say well, are we really you know, of course the first reaction always was well, there must be something wrong with how we're extracting. And sometimes they were right about that.

But then we also kind of internally shared how they were doing compared to others within those seven institutions. And it got a little competition going too.

So what we're really pushing is that providers in their provider setting really need to start to leverage electronic health records. One of the great things that came out of our CHIPRA grant with Geisinger was they actually said okay, here's the core set, we're going to develop the pediatric quality bundle that our pediatricians are going to be measures on.

I'm not going to say that that came about because of the core set, because Geisinger was kind of looking at that anyway. But the core set help them, working with us helped them to really pick things that maybe they would not have picked.

Does that answer your question?

CHAIRMAN GESTEN: Great -- great question. I think we probably want to probably circle back to this when we start thinking about both gap areas and measure selection, which is you know, what are the characteristics of measures themselves that might facilitate the process that you're talking about David or what kinds of things may make it harder to use measures for quality improvement.

So thanks so much for that question. Bill, sorry for the false start. But you are up. And I believe you have some slides. And maybe we should go to the first slide.

Thank you so much for joining us remotely. And I appreciate and look forward to your input.

DR. GOLDEN: Well thank you very much for the invitation. I'm sorry I'm not there in person, I'd like to see everybody. I've decided I just want to limit how much airplane time I'm doing in the last few weeks, so.

But I -- the comments that I want to offer today, for those of you who don't know me, I've been involved with NQF in other measurement activities for a long time. But I wanted to just -- and again, it's always a risk to get involved with a conversation that you all have been having and not be aware of what your conversations have been.

But a lot of times what we have done and approached measurement in Arkansas Medicaid is really look at measures that are feasible, have validity and then what is their impact or their purpose. Or you know, what

can we do with the measurement itself to improve care.

And those are fundamental aspects of things that I think really should go into looking at the core set. Next slide.

We produce an annual HEDIS report. We've been using HEDIS data for a long time doing a variety of measures. And so we have a data subcontractor doing administrative claims data.

It's also kind of fueled some of our experience. We've used our recent CMS quality grant to revamp this book into an electronic compendium across multiple kinds of measures including CAS measures that we think will be of value to our state decision makers as well as to outside parties. Next slide.

We have an inpatient quality incentive program. And this gives you a sense of what we've used. We have a five percent bonus program for all of our hospitals. We're a non-managed care state. We're totally PCCM.

We've had this for about the last seven or eight years.

Here are some of the key measures we've been using. We've pushed improving transitions of care measurements. A joint commission has now standardized. Increased transition of care measures by about three or fourfold over the last five years.

Early elective delivery is the hospitals collect the data and then we data validate. We have reduced early elective deliveries in Arkansas by 90 percent, 95 percent over the last four years with this measure.

Exclusive breast milk feeding. An important measure. We were one of the lowest in the country. We've increased in the last two years 20 percent by this incentive program statewide.

And now we're targeting low-risk C-sections. We've already had about a ten percent drop statewide since that time. Next

slide.

So we use this kind of data not only for quality improvement, but also we publish it in the Arkansas Medical Journal. And this gets you a sense of when we put people on notice, how we're going to use the measure. And you can see that graphic there shows the practice variation in the different maternity hospitals in the state. Next slide.

We have used measures also, now we have a statewide payment reform program. We have a primary care medical home program which has gotten huge enrollment, now has 70 percent of the eligible Medicaid patients in the program.

And we have these metrics that are now tied to the bonus payments. And these are all now mostly administrative. And you can see there's quite a bit of variation of performance.

But if we go to the next slide, we have now looked at the practices that have

5,000 or more patients that would be eligible for shared savings. And you have to pass these metrics in order to receive their shared savings, or their bonus payments.

And you can see these larger practices are making quite a bit of progress in this regard. We've also added as a performance requirement to get you PMPMs in the medical home, the ability to extract data out of your medical records, much like Dave Kelley just talked about and the QRDs.

So we think that by 2016, we will be able to routinely extract clinical data out of EMRs and use them for the incentive bonus payment systems. Next year we're going to require this to be an activity that they have competency to do.

And I want to underscore the last set of comments. Electronic medical records have only been able to really do this reliably in the last calendar year. Next slide.

We also had other episodes of

care. We required people to -- we've looked at percentage of patients getting antibiotics for URIs. We have a new QIP or a quality grant about follow ups for hospitalizations.

And I'll talk about that after mental health. As I said, we regularly report to the medical community, the Arkansas Medical Journal this kind of data. Next slide.

This is an interesting slide. We did a big statewide quality improvement program with coloring books, television ads, alternative prescriptions in 2000-2001 that reduced antibiotics prescribing for colds and accomplished nothing.

One year of an episode-based incentive program for URIs, and you can see we reduced the use of antibiotics for viral URIs by 18 percent in one calendar year. Really striking and remarkable given the static nature of this measure over the previous efforts that we had with academic detailing. Next slide.

So we've learned some lessons about all this data work. And some of the things that might be useful if we reflect upon. National specifications can and do fail.

For example, we had reported our behavioral health follow-up visit rates and they were extraordinarily low. So we launched a quality improvement project and discovered that we were missing important data.

There were local codes that were not in the national specs. We put in the local codes that covered different kinds of providers and we increased our rates five to sixfold, a substantial change.

We have issues about how people define well child visits, which causes data variation between states. We have different ways of defining ER visits. Is it a triage visit, is it an emergency visit, is it a non-emergency visit? And that use in our state can drive different rates of ER visits that

again is non-standardized across states.

Then we have the problem with how FQHCs and rural health clinics bundle their services and do their billings that can distort data. And that is a problem in many States in terms of reporting this kind of data.

We've seen this with the adult quality grants. Good ideas come up as measures and then people find out you can't collect the data. Not probably a good tactic because there are lots of things we can measure and measure with feasibility and validity.

Clinical data is still missing in action as I think we were just talking about. The new ONC report underscores that. But as I say, I think we're on the verge of having the QRD data of being able to reliably extract data across large populations of clinics. Next slide.

So a question to ask is really why

is the data being collected? Is it for the statewide comparisons? Is it for accountability? Is it for quality improvement?

And depending on the function, you may use different data and different metrics and different use of those measures for stimulating activity. And so just because it's going to be -- a metric is used at the state level, it may be used in a different way with different kinds of specification if used for quality improvement.

Something to consider also as we move forward is what to do with private option States. There you start getting into fragmented populations. They're kind of Medicaid patients and they're kind of not. Next slide.

I'll give you an example of measures that you have on your list that we're not going to do. And frankly I have some questions about whether they should be used.

You can see this is a current measure, antenatal steroids to prevent respiratory distress syndrome. We did this analysis in 1997. And we discovered that the failure rate to -- we found a much higher rate than in the literature.

And we found that if the patient arrived -- the mom arrived four hours or more before delivery, 87 percent that got the meds got the steroids. And that about 50 or 60 percent of the failure to perform was because the mom delivered almost immediately after arrival.

So if you're going to collect this data, it has to be something you can impact. And in this case, very often the performance failure was a reflection more of a time of arrival at the hospital then it was the performance of the institution itself. And I'm not sure that's currently reflected in the current data collection techniques. Next slide.

So some thoughts on some specific measures. We've talked about the antenatal steroids, early elective deliveries. We use the joint commission protocol versus using birth certificates. And we have the hospitals collect the data with data validation.

Well child visits. We need standardization of definitions. And we have a problem with that minute clinics are starting to do this activity and may or may not be in your data set.

Immunizations. We have large amounts of data integrity issues. Fragmentation of where the immunizations are given and integrity of the registry systems currently in place. So again, inter-state comparisons are fraught with difficulties. Next slide.

BMI, we don't submit this data because it's collected by our school systems. And so it's really not something we get out of our billing systems and out of our

administrative data.

ADHD follow up. There's questions about definition of a provider. Technically speaking it's supposed to be a provider with prescribing authority. That would preclude a large amount of our mental health systems where the follow up could be with licensed social workers or psychologists.

Again, you have to question about the time frame. We have it by comparison across states in 30 days. We've added this other accountability measure for medical homes. And our primary care providers are saying why can't you have some leeway here? It's hard for patients as well as offices to get them in within 30 days.

If they come in a week later, is that really clinically meaningful. What is the intent of this measure in terms of being a gotcha or trying to drive clinical performance?

Prenatal care, we have issues of

Medicaid benefits. Many of these patients are getting prenatal care at health departments prior to the enrolling in Medicaid. So again, you have some issues about the value and the validity of what's being reported.

We have global fees that preclude the capacity sometimes to actually measure visit rates during pregnancy. Post-natal care is the same problem in terms of limitations on Medicaid benefits. Next slide.

So other ideas for metrics. Again, what do we want to accomplish? Do we want to stimulate activity or do we want to actually have these measures as quality metrics in and of themselves?

My guess is this large variation in tonsillectomy rate across States might stimulate review of those activities. Like previously mentioned by David, CT scans in kids, looking at CT scans before appendectomy, whether or not states are using a greater use of ultrasound.

Pertussis rates per 1,000 in kids might be an indicator of vaccination failure rates. We might want to look at a structural element. How many practices are still part of vaccines for kids? A lot of pediatric practices, a lot of primary care practices are dropping out of the immunization game.

Neonatal abstinence is important. Rates of pediatric HIV could be an indicator of failures of prenatal care. Rates of pediatric ADHD, huge practice variation. Might want to look at performance and gamesmanship of behavioral health providers.

An unused area, an unexamined area, patients who are getting stimulants and atypical antipsychotics. This in our state is about 45 percent. It is under reported and I think this is very common. This is a major area that I think is under appreciated and under studied.

Again, rates of adolescent suicide could be a marker for failures of an

adolescent behavioral health system performance. So again, a marker perhaps to drive other activities in the state. Next slide.

So here's a slide that comes out of the Secretary's report. And you can see there's tremendous variation in use of measures and reporting of measures by states.

So the final slide I have is some suggestions for additional activity. Should we do some root cause analysis of why some of these measures are static in terms of lack of improvement?

Should we look -- do a root cause analysis of why states are doing noncollection of data? Is it because of structural problems at the state, or because some of the issues I've disclosed, the measures themselves are not attractive or have issues about collection?

So perhaps the states should be surveyed for their confidence in the measure

results. And how in their perception of the utility of the data. We have many things we can measure. We should measure things that have potential for follow up impact and potential for change.

So I leave those comments. It's a bit of a buffet of thought as you move forward with this important task. As I think that this is an important area to drive change, and we should leverage this opportunity to maximize our time and our resources to do activities and to promote activities that can make an impact on our healthcare systems.

So thank you for listening and I'd be happy to respond to comments or questions.

CHAIRMAN GESTEN: Bill this is Foster, thank you so much. Again, extremely thoughtful presentation on some of the issues. And I think some of the tremendous opportunities to use measures to drive change.

And I think you teed up as did David, some specific issues related to gaps as

well as some crosscutting issues that I think we'll get into later this afternoon. So for both of you, I appreciate that very much.

Let me just ask if there are any questions, clarifications for Dr. Golden? And then David, if you don't mind, you're still here? Yes. I'll invite you back to the table because I think there are some issues we might want to have both of you comment on.

Questions for Bill?

MEMBER LACEY: Sorry, me again. So I believe you said Bill, that you're going to make a criterion for -- and help me if I didn't hear you right, a criterion for continuing to receive the incentives for outcomes that --

DR. GOLDEN: For the medical homes, yes.

MEMBER LACEY: Right.

DR. GOLDEN: We have two sets of metrics. One set is performance of medical homeness if you will, that we are investing in

these practices and to maintain the per member per month subsidies if you will, they have to have certain attributes in their practice.

And so we're adding to that attribute the next calendar year, the ability and capacity to extract clinical data out of their EMRs to profile their practices. In particular, we're going to be starting with a diabetes control and hypertension control.

And once they can extract their data on a regular basis, we then can add these kinds of metrics into the quality measures. The quality measures are paired with their eligibility to receive bonus payments for managing total cost of care.

So we have two silos of measures. One is for being a medical home and getting support dollars. The other is for bonus payments for shared savings.

MEMBER LACEY: And so have your practices shared with you the potential economic burden around this type of work that

they'll need to do with their electronic medical record vendor to make sure they can meet your standards to get these incentives? And I'm just -- in my previous work, I did a lot of work with electronic medical record implementation. And anytime things are mandated for reporting or what have you.

So the ROI for that, I guess in other words is going to be better for them to comply, even though they may have to work with a vendor in a different way and pay different amounts then nonparticipating to meet this criterion, is going to outweigh what the cost will be for them to do this potential measure?

DR. GOLDEN: Yes, I think so. We have an advisory committee that meets monthly, or twice a month at 7:30 on Wednesday mornings with about 15 or 20 docs. And they all come onboard. They're all comfortable with the request.

This is not an HIE request with handshakes that are very expensive. But the

capacity to extract data out of EMRs which is now a meaningful use expectation by the EMRs. So this would be something they would do inside their practice and then report to us.

So we believe it is economically feasible. Plus we are giving them $5.00 per member per month plus the qualified health plan in Medicaid expansion, we're going to do the same.

So there is a fair amount of new economic revenue coming to the practices for being a medical home. And that is our investment in them, which we are then designing activities that we expect them to invest in themselves as a part of this mutual program to enhance capacity in the State.

CHAIRMAN GESTEN: Thanks Susan. There's no limitation on how many questions you can ask by the way. So you're allowed --

MEMBER LACEY: So there's no quota?

CHAIRMAN GESTEN: No, there's no

quota. Cindy?

MS. PELLEGRINI: Thank you. And thank you Dr. Golden for that presentation. Can we go back a couple of slides to -- there was a list that Dr. Golden had in his slides of sort of challenges -- yes, back one or two more. This one, thank you.

Dr. Golden, listening to some of the examples that you gave here of kind of measures where you've had specific challenges, it didn't sound like most of those, with the possible exception of the one you mentioned about local codes. It seemed like most of those were probably not Arkansas specific issues.

So to what extent do you work with your peers in other States or have opportunities to find out how others -- because of course there are many others collecting these measures. How are others confronting and dealing with those challenges?

DR. GOLDEN: Yes, well one of our

data vendors works with many States for collecting the HEDIS data. So some of the comments -- I went over these slides with them. And so they're the ones that talked about FQACs and RACs are the major barrier.

And I talked with other States on Medicaid quality calls. I would say that's part of the problem is that people are making up their own rules and therefore you end up with data variation that limits the comparability across States.

So there really is I think a need for some of -- for a little closer inspection about some of the local kluges that are being used to collect this data. Or local interpretations of specs or lack thereof.

So for example, the ADHD one, I think people are using all sorts of definitions of what is a valid provider visit. And you'd be surprised that it's not going to be what the national specifications say.

And I don't think anybody has

quantitated exactly what that variation is across the States.

CHAIRMAN GESTEN: Other questions? And let me invite also folks on the phone, members of the task force. Anne or Alvia, if you have any questions, since I can't see your card.

MS. COHEN: Yes.

CHAIRMAN GESTEN: Go ahead.

MS. COHEN: This is Anne. I actually have a question for David.

You gave a really great description of sort of your measurement gap area for abuse and neglect. And you talked about some pretty creative ideas of areas in which that could be implemented.

Can you speak to any barriers that you would think of in terms of implementing a measure like that? Or a specific -- you know, we don't have a specific measure in front of us today, but I know NQF has several -- considered different areas regarding that.

So I'm just curious, so if you were to narrow down an area related to abuse and neglect, what would you see as a critical measurement area? And then also you know, any barriers to that?

DR. KELLEY: I was thinking more in terms --

MS. COHEN: I know it's a difficult question.

DR. KELLEY: I was thinking more in terms of looking at emergency department claims and/or inpatient claims. So I was thinking in terms of a claims-based measure that could perhaps look at repeat visits to emergency departments and/or other providers, or inpatient stays.

Again, there obviously are barriers and pitfalls to how you interpret that. I know that I've had some discussions with David Rubin at Children's Hospital of Philadelphia you know, that they are very interested in this area.

I have not gotten into any specific specification definition. But part of our discussion has been around looking at ED claims or looking at various, very specific e-codes, or areas where we think that guns, knives, other implements of destruction have been used and then resulting in emergency room visits.

But I think we also want to look more broadly at kids that repeatedly come in with contusions, not just fractures, but contusions and other issues that are going on. And again, you just have to be -- one of the barriers again obviously is this is claims-based.

You have to be I think very careful in how you sometimes interpret those particular types of measures. But I think it is just an area, and I saw it on your list in your previous meeting, on having some discussions with various pediatricians in Pennsylvania. That is one I think on

everyone's radar.

CHAIRMAN GESTEN: David and Bill, I want to pick up on a theme that both of you raised. And I think we got some comments from email from folks about this issue, which is the e-measures and EHR related measures and so on.

I think we understand that the landscape is very much in transition, very uneven in terms of the capacity of practices to be able to do this. Yet we -- I think everyone's on the same page that we see that that's where the world is going and that has a tremendous number of advantages.

I'm wondering if both of you, since you both mentioned it, can help the group think about what we're going to have to -- what we're going to be dealing with both in the afternoon and I guess in the next year, which is how we think about this time of transition relative to measures.

So I guess my specific question

would be hearing the suggestion that there be greater alignment with meaningful use and greater attention to electronically specified measures, given that we're living in this transition world, how should this group think about as it's choosing measures, that world?

In other words, I guess a concrete question would be, does this now become a filter for measures giving preference to those that are aligned with meaningful use or that have electronic specifications? Do measures that don't have electronic specifications, should they be rejected, or should they be second tier measures?

I mean hopefully you get what I'm angling at. And I would be curious about it. Sort of on a practical level, how we should think about this in the near term during this time?

DR. GOLDEN: Well part of this gets to my other comments about picking measures and for what purpose and where and

how. CPCI, we're a CPCI State, which is the Medicare/medical home program that's in about seven markets.

And they're requiring the medical homes, which were granted, early adopters, to do this kind of data reporting as part of the program. And it's interesting because as I said, they learned that the EMRs weren't ready to do the work until really January or February of this year.

So they're doing that work. And that gave us motivation to extend that to our Medicaid medical home program, which is another 100 practices. And again, these are volunteer practices.

And I think that we're on the verge of getting there, but it may be two or three years. And having said that, I'm not sure that this kind of data extraction is ready for statewide measures because it's not going to be universally in play.

But it's certainly going to be

ready for more local programs, maybe managed at the State level, to drive quality improvement. But for statewide reporting, it might be early. If you can catch my drift.

So if you use the measures for clinical improvement with dedicated and targeted sites, it's going to be there in the next two or three years. But for universal data reporting, it may take a while.

CHAIRMAN GESTEN: Thanks. David?

DR. KELLEY: I would start with looking at your current measure set and those measures that you think are going to stay within this set. And if they're not part of meaningful use, I think that CMS needs to talk to our ONC partners and say put them all on the list, and then oh, by the way, come up with a way to package them as QRDA-1s.

That would be my first concrete recommendation is take again, the current list and turn them all into meaningful use measures for pediatricians and family medicine

physicians. So I would start with that.

And then as far as new measures that you come up with or recommendations, I don't think it should be a barrier that there's no e-measure equivalent. But certainly if something does get put on the list that moving forward, you would have a time frame in which the ONC would put that on the meaningful use list and package it as a QRDA.

To Bill's point about using this and leveraging this statewide and requiring everyone to do it, it's difficult. In Pennsylvania, what we're going to be doing over the next two years is taking a very incremental approach.

We're reaching out to key partners, larger health systems. ACO wannabes that we think have the capability, or they think they may have the capability to extract the QRDA-1 level and to start to report to us.

We're already building the

infrastructure to receive those packages with a plan to actually then send those measures to our managed care plans. So we view this as a supplement to what our health plans are currently collecting in hopes of alleviating chart review.

So I would especially advocate for the measures that as I previously mentioned, are chart review, if they could be turned into QRDAs, I think that would alleviate some of the barriers that our health plans find in being able to extract and nationally collate those measures and report on them.

CHAIRMAN GESTEN: Thanks so much David.

DR. GOLDEN: A quick follow up to David's comment. If we do that, I would potentially, you'd want to potentially annotate for the States, what percentage of their universe had the capacity to report so you could make some sense of comparisons.

Because you know, you can't

necessarily conclude that when you get the QRD data, that that's reflective of the entire State's performance.

CHAIRMAN GESTEN: Dr. Fleischman?

MEMBER FLEISCHMAN: Thank you. Can we go back to the slide with all the various number of States reporting and where? And I hope we have a chance to go back to this in the afternoon.

But I have a -- yes, one more. Yes, what do we under -- do we understand, I mean we've got really engaged States here presenting today. Do we understand what's happening in States that are less engaged and that you know, either not measuring, not using the core set or using very few measures?

Because that seems to be like the fundamental question. You know, do we have the wrong measures and that's why they're not doing it? Or no matter how much we improve the measures, there are other reasons that they don't participate or they participate so

minimally.

I think that's for me without that context, it's hard to understand what we're solving to here today.

DR. GOLDEN: As an aside on this slide, you'll see that there are two dental measures at 51 States. That's because it is a requirement in order for the programs to get paid.

And I was told by my data subcontractor that there's quite a bit of variation in terms of what goes into that data.

MEMBER LLANOS: So this is Karen, I'll start and Marsha can jump in. So I would say I think it's hard for us to know exactly. I think Dr. Golden raised a great question in terms of a survey. Surveys are really hard for CMS to do.

I think what we've been trying to do through our technical systems and analytic support program is when we see that a State's

not reporting or that they've not reported the same number one year versus the other, we've worked with our TA team to contact the State to try to get a little bit more of a sense of what the issues are. And they vary. I think that's the hard part.

So it could be because sometimes they rotate the measures. They don't have the resources and capacity to collect the same exact measures. I think CAHPS is probably a good example of that.

And then I think probably most recently I think what we heard, at least last year, was a dip in measures because there was a huge focus on improving their data systems.

So we know there's lots of factors at play in terms of whether or not a State can keep up the number of states that it's once reported. I'm trying to remember, I think we actually did a couple of deep dives with States that just weren't able to move in terms of the numbers.

And I think it sometimes did relate to the delivery system. So managed care penetration rates. The lower they are, the harder it is probably for a State to collect some of these measures.

And I don't know Marsha, I missed other things.

MEMBER LILLIE-BLANTON: Let me just talk about a couple of the measures in particular that are less than 25. So just so long as you know, we only report the data publically if we have at least 25 States. Which you see there a number of where they're even between the 25 and 36 States.

But so two of the measures that are fewer than 25 States are measures that require linkage of birth certificate and vital records. And so that is an additional, you could call it burden, responsibility, challenge on States.

But, let me just say that what we have done, working with CDC, is included, we

have an effort with AcademyHealth training States, developing their skill set in linking of data. So we recognize the burden and have tried to support -- better support States who have not been able to -- at least didn't have the staff resources to do the linkage.

The State that -- I want to talk a little bit about the developmental screening in the first three years of life because that's a measure that requires a set of screening tools which are not you know, routinely used. But yet it is a very important measure.

And we are undertaking an effort this year, working with a subcontractor, NORC and NASHP, the National Academy of State Health Policy to better understand the barriers that States are experiencing in collecting that data. And I would suspect a lot of it has to do with -- that it's the screening tools.

The States for example that we

know have done a good job, Oregon, Illinois, North Carolina, have financial incentives for the extra cost of that screening tool. And so sometimes it's a burden of data collection, sometimes it's the cost of the tool that's being used to collect the measure.

So it varies. But certainly, but I think the data source and cost of collecting it is part of the challenge.

And the last issue that I want to raise with a couple of the measures is something that Dr. Golden mentioned. And that is, or I can't remember whether it was Dr. Golden or Kelley.

But if a measure requires collecting information from a hospital, that is a different level of chart review then a provider who is under contract or with a managed care organization. And it does add a different level of -- you know, if it's a claims measure it's a lot easier.

But once you have to do reviews

with either a provider or a hospital, it's an extra challenge. And so you know, and of course the CAHPS is a measure, it's a survey data. So that's, I think the problem with that.

So I think there is no uniform as Karen mentioned, there is no uniform one reason why States are not very engaged. But data sources becomes -- and costs of the data sources becomes a major challenge.

CHAIRMAN GESTEN: I would just add a couple of things. I think they're important contextually.

One is I wouldn't make the assumption that States that don't report many measures report no measures or have no measures. So again, the -- my understanding of the landscape is that many States may be doing either homegrown measures or may choose not to report.

So the lack of reporting on some of these measures does not necessarily mean

that nothing is going on. Sometimes it does and sometimes it doesn't.

The other thing is, that many of the conversations that I've been a part of regarding putting together the measure set, often includes some measures that folks acknowledge are "a stretch -- a stretch goal" that is an understanding. And we've talked about some of them today and they've been proposed I think by both Bill and David. Will probably be proposed later on.

These are measures that we think are important, but understand that the capacity to be able to measure them right now is not quite in place. But yet a decision might be made to include it as a part of not just accepting what it is that's easy, but trying to also include things that are important.

So I think it's important, it makes sense to look at what's not being reported. I think it's even more important

probably to see year to year whether anything's changing in that regard.

Other comments?

DR. GOLDEN: A concept to consider, and I had it on my slide. About do health plans compete on quality?

We're an any willing provider State. So it really -- and we have somebody doing this, but it doesn't make sense for individual plans to collect the same data from the same doctors. And it's basically burdensome to the plans and to the providers.

There are some States beginning to develop umbrella systems to do this in a coordinated way like Minnesota and Massachusetts where you don't have five plans walking into everybody's office to collect the same data.

CHAIRMAN GESTEN: So I actually wanted to ask about that. Because neither -- if you talked about it, I missed it.

Which is the issue of alignments,

how important it is to align measures for pediatricians and those that are taking care of children and adolescents with other payers. And the degree to which that's both you know, an opportunity if there is alignment or a barrier if there's not.

I know both of you work in Medicaid, but you probably have some awareness of -- I mean you talked about -- Bill just mentioned it and you talked about some of the challenges of having non-alignment in multiple measure sets.

Is that do you think, has that been an important criteria that is the issue of whether measures are aligned with other payers or not so much in your experience? And again, helping this group think about both gap areas and measures for the afternoon. How important that thought about whether it's aligned with other -- what other payers are collecting?

DR. GOLDEN: In Arkansas, we pay

for two-thirds of all pediatric care. So we're the big player. And so alignment is not as critical here as it would be for adults.

DR. KELLEY: I would agree that alignment is not as big of an issue. We insure I think 1.1 million children. And many of the measures that are on here are again NCQA. And are you know, typically collected in the commercial world as well.

So it's less of an issue in the pediatric world versus the adult world where there are different age bands and differences in what Medicare and/or Medicaid versus commercial products offer as far as NCQA. So I think it's less of an issue in the pediatric population.

CHAIRMAN GESTEN: Other questions? We're about out of time, but if we probably -- if somebody has a burning question, either Anne or Alvia on the phone as well, feel free to jump in if you have something.

MEMBER LLANOS: Can I just make a

quick contact setting for the meaningful use alignment issue because I think it's an important one. I think I'm happy both doctors raised it.

And I'll just clarify a couple of things. So when we first -- so the initial core set and meaningful use one were kind of around the same time. And we've been partnering with the Office of the National Coordination for HIT to help us.

So when we first started down the path, we wanted to do exactly what Dr. Kelley said, was take the core set and make it e-specs. And we've learned a lot in the past four years. And the biggest lesson learned is, it's very hard to retrofit or to re-spec a paper measure.

So what we ended up after stage one, was a bunch of one off measures at the provider level that kind of seemed like they were very similar to the core set measures but not exactly. So after -- and that took us two

years to kind of realize along with ONC and our contracting partners.

Our newest -- or the person that we've used for the past two years has tried to pick up a measure that only has a paper one or that is in development. So we've been partnering with our other measurement development work.

And then -- so as the paper ones coming, the e-measure is also coming at the same time. And that is what we are submitting into stage three for meaningful use.

So that's been kind of the biggest change and our biggest kind of evolution. We've evolved and the field has evolved.

I think that the other thing that I just wanted to raise was we do have an e-only based measure that we added a couple of years ago. And that's behavioral health risk assessment for pregnant women.

It's been a challenging one to collect. It's not part of meaningful use.

And the feedback that we've gotten from a couple of States the first year, so that we released was, where are the paper specs to this.

So again, I'm just raising that to -- it really depends on who the State is in terms of whether they are comfortable with an e-spec. I think we've had a couple of States just try to apply the e-specifications to claims based. And we've had to say no, that's not going to work.

So I think there's lots of learning in terms of kind of where States are. But I just wanted to raise the fact that e-only based measures I think also tend to be a bit challenging.

CHAIRMAN GESTEN: Thanks Karen. Any comments before we take a break?

For public comments, I think we're going to wait until after the next session and then we'll open up both to folks in the room and on the phone. So in case you're at that

burning question, just hang in there. We will get to it. So, seeing no cards raised.

Let me take the opportunity to thank both Bill and David for coming here -- coming and attending virtually in Bill's case. And then thank you so much.

And if you're able to stick with us for the rest of this, well, you're welcome to do that. I know you may have some planes to catch.

But thanks so much for coming here and sharing your experience. Thanks so much Bill.

DR. KELLEY: Thank you.

DR. GOLDEN: Thank you.

CHAIRMAN GESTEN: So we're going to take a 15 minute break. Actually 10 minutes, I lied. We'll be back and start promptly at 11:30.

We have some slides to get through and then some open discussion. So thanks.

(Whereupon, the above-entitled

matter went off the record at 11:17 a.m. and resumed at 11:32 a.m.)

CHAIR GESTEN: So for folks on the phone, this is Foster, we are going to get started with the next session.

We are going to go for about a half an hour, presentations and some discussion, then open things up for public comment, for folks both in the room and on the phone.

So we thought it would be helpful to re-steep a little bit in some of the background data around child health. This both does a little bit of recapitulation of what was presented on the webinar, but it also expands and tries to answer some of the questions that folks had when we had the webinar about some of the background information or additional information that was requested to help explain what it is that we were looking at.

So thanks very much, Sarah Beth, for exploring that.

And then we'll have a presentation about dental health and dental measures. But why don't we start with you, Sarah, and going through the slides?

MS. LASH: Sure, thank you. Next slide?

So the reason, excuse me, we're seeking to understand the health-related needs of this population is that we can select measures that correspond to what's most important.

So we have, during the web meeting, explored primary care access and preventive care, perinatal health issues, the management of acute and chronic conditions particularly with a lens to children with complex health needs, and also oral health.

And EPSDT and that set of benefits was sort of brought up as a potential gap area that the measure set could do more to relate

to.

So just to remind everyone, the nature of pediatric benefits are a little bit different than in adult-oriented health care. Lots of attention needs to be paid to development risks as opposed to acute conditions.

Acute health conditions in children have declined over the past several decades. But the relative important of chronic health conditions and those risks is growing.

So today, as opposed to historically, a more significant proportion of children are living with chronic illnesses like asthma and autism, sickle cell disease and CF, obesity, and birth conditions that might have been a lot more serious in the past need to be managed in an ongoing way.

So thinking about that epidemiological picture, it influences the way health care expenditures are allocated towards

pediatric population, and the health care system needs to continue to improve its capacity to detect, then treat, then manage, and then reduce the impact of physical and mental health conditions that affect development.

And the implications of all of this research and understanding are particularly important for the low-income children served by Medicaid, as they face the most significant health risks.

So that information and these recommendations are from a CHCS paper on the EPSDT benefits. They had highlighted some domains in preventive care with significant implications for long-term outcomes.

So these might correspond to our thinking about gap areas and opportunities for measurement: giving parents guidance about what to anticipate in their children's development; immunizations; preventive dental care; vision and hearing screening at an early

age; lead screening; mental health screening; development screening; and Body Mass Index.

Again, some of these topics are already covered in measures, and others are not.

We also discussed at the web meeting a potential missing piece about the impact of poor birth outcomes relatives to other conditions, so wanted to spend a few minutes filling that out for everyone.

In 2009, one of every eight babies in the U.S. was born premature as defined by birth before 37 weeks' gestation.

75 percent of infants who go on to use a NICU do so because they are premature. The other 25 percent would have some type of other medical problem.

An IOM analysis found that costs related to prematurity totaled at least $26.2 billion in 2005, or $51,000 and more per premature infant.

And more than half of hospital

stays related to short gestation, low birth weight, or inadequate fetal development were paid by Medicaid.

And so those discharges in particular cost even more, those were close to $65,000.

We had looked at an HCUP analysis of costly conditions and how those sort of drove spending across the system. On a case-by-case basis, infant respiratory distress syndrome, premature birth and low birth weight, and cardiac and circulatory birth defects are tremendously more expensive than any episode of care for mental disorders, asthma, trauma, bronchitis, and ear infections, as we saw.

However, if you look at the next slide, they're so much less common that the total costs for those conditions that you see in the red box were below the threshold that would have warranted them getting included in this chart.

So we still have significant spending, especially if you look at them maybe bundled, as a chunk of poor birth outcomes -- on the order of over 4 billion dollars, which would put it squarely in the middle of this analysis.

But again, because you have so many more children with asthma and mental disorders and whatnot, in the grand scheme of things, this is a smaller piece of the pie, but a very significant one.

There was also a question raised about was classified in that analysis as a mental disorder, as that top condition category. So these are the underlying codes that were included in the analysis.

It's a little bit of a mixed bag. But many significant and costly conditions represented here.

We also learned that about 40 percent of the associated mental health expenditures relate to use of medication.

So again, points to potential high leverage opportunity for measurement and quality improvement.

A few more views of this -- thinking about behavioral health, this is accounting for a disproportionate share of spending for children, given the relatively small number of children who are using behavioral health. It's about 10 percent of the enrollees and close to 40 percent of the expenditures.

And as kids grow up and reach their adolescent years, they are more likely to experience these conditions, so adolescents 13 to 18 are 25 percent of enrollees, but 45 percent of those using behavioral health services, and the majority of expenditures as well.

And the medication issue continues to be really salient. More than half are using psychotropic, or being prescribed psychotropic medications, often overlapping

with diagnosed behavioral health conditions, but not always.

That's all I wanted to highlight in follow-up to the questions that came up on the web meeting, but we can take any additional questions about this information if folks want to raise those now, just to clarify. Cindy?

MS. PELLEGRINI: All right, just a clarification. Can you go back to slide, I noted it was 37? Thank you, there we go.

So to make sure I am understanding these two bar graphs correctly, the 10 percent is children who are enrolled -- 10 percent of the child Medicaid population is receiving behavioral health services.

MS. LASH: Yes, that's how I read it.

MS. PELLEGRINI: Right, and then of the total spending on the Medicaid child health population, 38 percent is on mental health.

MS. LASH: Yes.

MS. PELLEGRINI: Okay, thank you.

MEMBER FLEISCHMAN: Can I ask a clarification on her clarification?

So 10 percent of the children are using behavioral health. The 38 percent, does that mean that 38 percent of the expenditures are on behavioral health, or those children are using 38 percent of the total spend in Medicaid?

Because those are different. Because they are using other services as well. So do we know which it is? I am suspecting it is the latter, because it's too big. Do we --

CHAIR GESTEN: I am looking --

MS. LASH: We're trying to read the fine print.

CHAIR GESTEN: And the fine print, unfortunately, doesn't tell us the answer to that.

So I am making the same assumption that you are, which is its total expenditures,

which makes sense to me.

MEMBER FLEISCHMAN: It's total expenditure, so it's not expenditure on behavioral health services.

CHAIR GESTEN: Correct. That would be my understanding on this. We can clarify --

DR. GOLDEN: Foster, I offer a comment.

We analyzed the top five percent spend in our state over the years. In the adolescent range, if you had a behavioral health hospitalization of any kind, that would immediately put you in the top five percent of spend for kids.

CHAIR GESTEN: Thanks, Bill. Other clarifying questions for Sarah?

MEMBER LACEY: Sarah, so the IOM data that you reported of the results, so they're defining their cost as direct cost for the child, correct, do you think?

MS. LASH: I believe that's the

case.

MS. PELLEGRINI: Sorry, that report actually looked at -- I won't remember the exact percentages -- of the $26.2 billion aid, the vast majority of that was for direct medical expenses, but they also factored in other things like lost work time for parents.

MEMBER LACEY: So that's where I was going, so trying to figure that out. And then economic burden on society as a whole, long term, for parents and caregivers.

And so then I guess I have a question, and maybe it's not for right now, but how much of that kind of information needs to be a filter, or the work that we're going to be doing?

MS. LASH: It's a good question for the group to consider, how you might prioritize the overall impact of various conditions.

I think that's why we've shown you a few lists of other groups that have taken a

more deliberate look at those high priority conditions with long-term impact.

I don't have, for the group, a full analysis of the lifelong costs for every possible diagnosis, unfortunately.

But I think we in the group have a good understanding of some of those primary drivers.

CHAIR GESTEN: It's a good question. I think the challenge is that there are so many potential filters that one can and should put on, thinking about measures.

And prevalence, opportunity for improvement, the strength of the measure, it's alignment characteristics, the practicality -- there are lots, and we are going to get into that, I think, particularly when we get down to sifting through the measures after we identify gap areas.

But clearly we are trying to respond to both burden of illness, costs both immediate and long-term, to give us some

backdrop in which we think about what could or should be priority areas.

Other questions? Again, either Anne or Alvia, if you have any questions, feel free to jump in.

Okay. Thank you, Sarah.

And again, I think that we can probably not due to the time frame, for this exercise, but certainly as we think about the longer term, may have more of an opportunity to dig into some of the data, and answer some of the questions, and bring more data forward as we think about the longer trajectory of reviewing measures.

So it's my pleasure to introduce Krishna Aravamudhan, who is the Director of the Council on Dental Benefit Programs, and we've asked her to talk a little bit about oral health measures in Medicaid specifically, and as you'll see, we'll be talking about that more this afternoon, both in terms of gap areas and opportunities relative to new

measures.

So Krisha, take it away.

MS. ARAVAMUDHAN: Thank you very much, and thank you for having us here today.

Just wanted to very quickly introduce and recognize a few people in the room as well as on the line: Dr. Lynn Mouden, who is the Chief Dental Officer at CMS, and Ms. Mary Foley, who is the President of MSDA.

Also on the phone are Dr. Ken Rich, he is the President of MSDA and Chair of the DQA; Jim Crall, professor at UCLA, Chair-Elect; Jill Herndon, who is a health economist at the University of Florida, who did most of the work for the DQA measure validation; and Dr. Ojha, who is the lead staff for the DQA.

So I wanted to jump in, I had about 15 slides. So I'm going to be really fast.

So I'll talk fast and hopefully answer questions in the end.

If you look at the oral disease, and if you've read the NQF report that was published, this is a big problem.

Caries, dental caries, is very prevalent and it causes a lot of hardship for our kids. It is something that we have preventive tools in our toolbox, but has resulted in some very, very unfortunate system failures, to the point that this is recognized as an essential health benefit in the Affordable Care Act.

To go into the -- Nadine? Next slide please.

So if you want to go into a quick explanation of the dental benefits market, this is very, very important to understand.

I know we have to look at the person as a whole, and you have so many topic areas that you have to prioritize later today, but the dental care system and the dental financing system, even within Medicaid, it's a separate system unto itself.

And Medicaid children, oral health -- very, very significant portion of this market.

So if you take a look at all the measures that are out there from CMS for all the different programs, I will let you look at this slide for a minute.

But if you look at this slide, the theme that keeps coming up through the slide is, you know, treatment services, preventive services, sealants, utilization -- that's the theme throughout this set. What's missing?

What's missing is outcomes. We cannot measure outcomes in dentistry because we do not have ICD codes transmitting through the claims process to the payer databases.

Providers record diagnoses as free text within their charts, within the patient records. But it isn't stored as structured data that goes up.

So not to make the perfect the enemy of the good, we have to base -- or use

process measures that are evidence-based in order to see whether the system is working or not.

Next slide, please. So I'll focus on the three measures, and the red line and the green line also represent the two Core Set measures that you will be evaluating.

These three measures, the blue line basically is any dental service. The red line is a preventive dental services. And then the green line is the dental treatment service.

Now, if you see, you have two measures within these three which track so closely. And so the question is, why are we tracking both of them? Why do they track closely? And there are reasons for that.

And then you have the treatment measure. But what is so difficult to understand with this set of measures is: what is this data telling us?

When you started this conversation

this morning, you talked about the need to measure, the need to make sure you had the data, but the focus was quality improvement.

So when we look at this chart and say wow, the treatment service is not going up, or it has gone down, does it mean that the disease burden has come down? No. Because all we are doing with these measures is counting services.

We are simply saying, okay, these kids got treatment, without knowing whether the kids needed treatment or whether the treatment helped.

So again with the preventive services, we are counting preventive services, and if you look at the code set that goes into this measure, it's a number of services, and one could sit and debate whether all those services are actually evidence-based services that have been shown to improve outcomes.

Next slide. So what we did at the DQA when we started this process is basically

understand, what are we trying to measure here?

If our focus is not to measure utilization, but to actually measure quality, then we hang our hats on this IOM definition that says: degree to which health services increase the likelihood of desired health outcomes.

So we try to make sure that we know that some service is going to improve health outcomes before we start measuring that service.

So come to NQF-land, and we have four dental measures that are endorsed by NQF so far. I don't want to go into details of these measures, but the first one is simply the HEDIS measure, again, counting services for just basic health services, number of kids who sit in the chair -- does not differentiate between whether they are sitting in the chair with cellulitis and their face swollen, or whether they are coming for their routine

recall visit.

The next one is topical fluoride by pediatricians. And the other two are measures based on the NCHS survey. Next slide, please.

So 2008, CMS actually started the Dental Quality Alliance. They had a survey of 16 states and said, okay, what do we need in terms of dental health?

And they had a number of initiatives. And one initiative that came out from that survey, really, is the Dental Quality Alliance. The Dental Quality Alliance was formed to -- next slide, please -- advance performance measurement, and the key thing among the Quality Alliance, or for the Quality Alliance, is the stakeholder involvement.

Everyone comes to the table to agree upon what is important to measure, and how it should be measured. So that really is the key in terms of who the DQA is.

And we started in 2008, the

Alliance came together. We started actually measure development in 2011, and this was the first set of measures we approved last year.

And I want to focus on that left panel first, it's the purpose of these measures. If you look, we are very, very clear in parsing measures out as utilization versus quality and cost.

And that's really, really important. You can count services, and that's great. But then are you improving the health of the population? Especially when you're not directly measuring the outcome. Next slide, please.

So we're very, very happy to note that last year -- actually, earlier this year, I should say -- we got five of these measures endorsed by NQF. We submitted a subset to NQF, we got them endorsed.

And so the set of four measures that actually target quality of care have now been endorsed. Next slide, please.

So advantages of these measures -- I mean, we heard in the morning about, biggest burden to states is a lack of clear specifications.

When we started the process, we were very lucky to have the NCQA, to have the joint commission, to show us what it takes to have clear specifications.

So we didn't do things on our own. We consulted both of them and said, okay, best of both worlds, what do we need to know for clear specifications?

We have a comprehensive set. Again, everyone wants to have, you know, one measure, let's just get that -- but is that what you really need?

It is a fully validated set with very, very clear specifications, and the good thing is, there are no chart audits, everything is based on claims data, and we routed these to all the state dental directors to make sure they all can program this, and

it's all feasible -- so all of that has been verified.

Because more than -- NQF endorsement and NQF rules are very important, but our own community should not be burdened. And so that was a big thing for us as we went into the process. Next slide.

So if you go back to the big picture as to what we would like to see, and Sarah and Beth said, okay, what would you like to see? Give us some guidance.

I think there has to be a continuity. We have to agree to what is the care goal, what are we trying to move the system towards? And then we have to measure access, process, outcome. Are we getting people there? Are we getting them what they need? And then, have we improved health?

This is really, you need a comprehensive measure. You don't have a magic bullet here. And if you want to support dashboards, then you need all of these

together. Last slide.

So I'd like to -- I was fascinated, I made these slides before I heard the discussion in the morning, and I was fascinated to hear the discussion e-measures and EHRs.

And I think what we've been working with ONC is trying to create this dashboard and vision for oral health. So you'll see the lefthand side starting from access, you'll see the process, and you see the outcome.

You cannot translate this directly, I'll warn you this cannot be translated directly to claims-based measures, but if you agree that the care goal ought to be these, we have the claims-based, the parallel claims-based measures for these.

Don't have outcomes yet because of no ICD codes, but you can create that parallel environment between the CHIPRA Core Set as well as meaningful use program.

So I'm going to stop there, because I think I heard a bell, and then give it back to Doctor ---

CHAIR GESTEN: Wow, you did it! Krishna, thank you so much. What a thoughtful articulation of a schema of thinking about measures that clearly applies beyond dental measures. So why don't we -- Terry, do you want to go first?

MEMBER ADIRIM: Thanks. And congratulations on getting measures endorsed by NQF, that's great, finally.

So I have a question for you. The current Core Set contains a measure for percent of eligibles that receive dental treatment services, and I can see why that's not an optimal measure.

So if you could choose one or two of the now NQF-endorsed measures, which ones would you recommend?

MS. ARAVAMUDHAN: I discussed this a little bit, and you know, when we try to

achieve something and make change, we have to be brave to make the change. Tweaking the system is not going to help.

There is no parallel measure for treatment --- okay, let's take treatment services out, and let's put this in. It's not going to help.

I think what you need, again, is a vision for the whole, and see what exists, and what the measure gaps are, and fill it in.

If -- an ideal system we'd like to see is to see the oral evaluation measure, it's a measure of access, it parallels the E/M codes you have in CPT. It does not look at the problem-focused and recall codes you have in CPT.

So think about a well child visit, and what goes into it -- oral evaluation, that's your access measure. You want fluoride, you want sealants. Those are the preventive services we have. And then, later, sometime, you want the outcome measure of

caries.

So that's the set you ought to be driving towards. Can you simply take out treatment services and replace it with one of these measures to start the process?

Sure, you can do that. But understand that that's the first step, and you should be committed to having the full set at a later day.

CHAIR GESTEN: Susan?

MEMBER FLEISCHMAN: Yes, I was actually trying to find this online, but so excuse my ignorance on this -- the fluoride measure, is that from the -- at the dentist's office, or in primary care?

MS. ARAVAMUDHAN: There are two measures, actually, within NQF -- the earlier endorsed measure is for pediatricians, and the new measure is for the dentist's office.

We have numbers that we can show. It's only three percent of the population that gets fluoride at the pediatrician office. So

when you're looking at the system as a whole, you are really targeting the bulk of the thing.

But both measures are available, and you can measure --

MEMBER FLEISCHMAN: So do you combine the data? You know, you got a kid who gets --

MS. ARAVAMUDHAN: You can't, because it's divided. Again, like I said, the dental system financing system is separate. And so if a medical NCO kind of is paying for that, that's different from the dental third party who might be paying for that, so you have to understand the mechanics of the financing system as you make measures, too.

CHAIR GESTEN: Beth?

MEMBER FELDPUSH: Thanks. Well, I think you've done a really excellent job kind of outlining for us where some of the gaps are.

In trying to think about where we

then kind of urge progress forward, I will admit I know very little about the processing of dental claims and the information that is either sent on claims or in EHRs.

So when you say that there's no ICD codes for this, can you help us kind of understand --- how would you expect the field to drive towards outcomes? Or what are sort of the first steps in even just beginning to address the information gaps before you could even address measurement gaps there?

MS. ARAVAMUDHAN: So Vermont Medicaid and Nevada Medicaid are the first early adopters. Vermont has actually mandated ICD codes in their system next month.

So we are very excited to see this development. Again, it's not that providers don't have it -- they have it, but it's in their record, no one can mine it.

So as we see more states getting into ICDs, and we see data quality stabilizing with these ICD codes, we will have the

measures ready to field test and get it into the system.

That's the big picture hope for the profession, that ultimately we will be able to measure.

But again, once we have the goal and the path, we have to start with what we have, and then fill as we go.

MEMBER FELDPUSH: And is there anything that could be done at the national level to move that forward?

MS. ARAVAMUDHAN: We are working on some proxy measures right now. ED use is a big problem, so we have some emergency department use, and follow-up within seven days off an ED visit for a preventable condition.

You should not be seeing kids with cellulitis coming to the ED. And those rates are very high. And so we have worked on two measures, they are getting approved by the DQA next week, I was asking Helen if the Health

and Well-Being Project remains, if it does, we are hoping to submit it this December.

So we are also working on another proxy measure called Early Extraction of Teeth. So you don't want to see kids having their teeth extracted for disease by age 12. Or whatever the age cutoff is, we're working on those validations.

So there are some proxy measures like that that you can do with claims data that you have, which we are already working on, we will submit to NQF. But in the long run, we're simply waiting for the ICD codes.

CHAIR GESTEN: Cindy?

MS. PELLEGRINI: Thanks. Just, hopefully a quick question here for Krishna, and maybe also for Marsha.

It sounds like pulling together the DQA has been an extremely successful undertaking in terms of generating the kinds of measures that we're looking for, distributed across out-process and outcome,

looking longitudinally across childhood.

Is this a model that you think can be used, perhaps, for other discrete areas of child health?

MS. ARAVAMUDHAN: We are very willing to share. Again, when we started, we didn't know what we were doing.

We looked at the PQA, the Pharmacy Quality Alliance, we looked at the NCQA, we looked at the Joint Commission and got them all in the room and said, what do we want to do?

So they showed us the way, and I think we've improved upon that.

There are some advantages -- just like everything that happens in medicine cannot be translated to dentistry. Everything that happens in dentistry can't be translated, but there are a few things you can do.

If you think about all the disciplines in medicine, and all the topic areas, disease areas, and you say okay, these

are our big buckets, as a strawman, and then let's prioritize what goal we want to improve in the next four years, and we're going to measure towards that. Maybe that's something.

But we're happy to share our process and how we work.

MEMBER LILLIE-BLANTON: So, let me just say, because I don't want us to take credit for something that we had very little to do with -- I mean, we identified a need, but basically the dental community moved it forward. Dr. Mouden has served on this body, so our Chief Dental Officer has been a part of the process.

But we have had very little to do with it, other than being a participant.

But I do think it's a model to consider, because on behavioral health, and there are other areas where I think there's some major gaps that certainly could help move the field forward.

CHAIR GESTEN: So we're going to

have to move to the last question. Marc, why don't you go?

DR. LEIB: Well first, I want to commend you on being able to take this on and solving the issues with administrative data only, so no one sitting there having to have to do chart reviews, inconveniencing everybody. So that's a great thing to do.

I understand your comment about not being able to pull information together because of different payment systems. That's different from state to state. Some states they have completely different payment systems for dentistry, others it is part of the same payment system and you can collect the data collate them.

One thing I didn't understand, so here's my question -- if you go back to the slide that had the four things with the arrows and the phase one, or phase two, and phase three -- next one, right there. There are stages.

I don't understand what your stage refers to, because I mean, you're putting the oral evaluation --

MS. ARAVAMUDHAN: That's just the stage of the meaningful use program, that's all it was.

DR. LEIB: Oh, that's where it's going to go into meaningful use --

MS. ARAVAMUDHAN: Yes, yes. So it's --

DR. LEIB: Got it, so --

MS. ARAVAMUDHAN: They didn't do all at once, they knew where they were headed. They said let's do the first two first, put it in, and then let's work on the other two.

So there's almost a four year gap between first two coming out and second two.

But at least ten years down the line, we're not saying, oh my God, we, you know, start all over again.

We had a vision and a plan and --

DR. LEIB: And your new caries

point is you want to see a decrease in that based on increase in everything else.

MS. ARAVAMUDHAN: Exactly, exactly.

CHAIR GESTEN: Okay. Last questions, again, on the phone, before we close and moved to public comment?

MS. COHEN: Yes, this is Anne, I have a question.

CHAIR GESTEN: Go ahead.

MS. COHEN: We heard this point about David in Pennsylvania talking about collecting measures for children with special health care needs, and I am curious whether the Quality Alliance has looked at that area, particularly since their dental needs are so much more complicated.

MS. ARAVAMUDHAN: So we have one measure, actually, it's funny you ask -- we are working on a measure that talks about general anaesthesia, and we want to parse it out by those who have behavioral health

problems, special needs, and things like that.

The claims database does not support that. So we're struggling with this because another thing we want to do as a dental community is we do not want Medicaid measures versus CHIP measures versus commercial sector measures.

We want a system that works for all that we can compare across all the different financing system, since a child is a child is a child.

So there are some problems like that in terms of feasibility, and this is where your local measures will come in -- if you're able to have specific files, or specific local codes, in terms of doing that.

But we're exploring that, so I don't have an answer, but that's something we're working on.

MS. COHEN: Another thing that you might want to consider when looking at that measure is I know that for many kids with

developmental disabilities, they need to have such specialized care that many of them end up getting treatment at dental, either, training schools, or actual hospitals.

So when you're looking at collecting that measure, that might be something that you need to consider.

MS. ARAVAMUDHAN: That is the GA measure. So it's a measure where you're looking at kids in the operating room.

MS. COHEN: Oh, okay.

MS. ARAVAMUDHAN: So the ED measures, the Emergency Department, follow-up of emergency care, that will be feasible for those Medicaid states that can combine their medical/dental systems, and we have good specifications on that.

The GA measure, which is looking at both general anaesthesia and operating room, is not yet fully ready because of these challenges.

MS. COHEN: Okay, thanks, thanks

for that GA.

CHAIR GESTEN: Krishna and company, in the room and otherwise, thank you so much for the presentation and for the great work.

We are going to move to public comment before we go to lunch.

Kathy, are you on the phone, operator?

THE OPERATOR: Yes, sir.

CHAIR GESTEN: Kathy, could you give folks on the phone the instructions about how they can ask a question? And also want to take this opportunity, if folks in the room have questions, to sort of queue up. We've got a microphone. But take it away, Kathy.

THE OPERATOR: At this time, if you'd like to make a comment, please press star, then the number 1 on your telephone keypad.

CHAIR GESTEN: Any questions from our distinguished and good-looking number of

folks here in the room?

Kathy, anybody who has a question?

THE OPERATOR: No, there are no comments on the phone line.

CHAIR GESTEN: Wow. WebChat. Twitter.

(Laughter.)

CHAIR GESTEN: Facebook. Instagram. SnapChat, anything.

So while folks are thinking, I'll give folks both on the phone and in the room a change to kind of gather their thoughts.

Just in summarizing what we heard this morning: we went over, really, the work of the afternoon, which we'll get to, looking at priority gap areas in measures, and we have some of the down payment on some measure discussion on oral health measures.

We heard about state experiences which really, in terms of cross-cutting issues or things that I think we'll track into the afternoon, clearly the issue of alignment with

meaningful use in eMeasure specification is one that is going to force us to do a lot of thinking about new measures and choosing measures.

We heard about specification challenges, and then last, I think, resources and data source issues, which are continuing challenges. And we got some great recommendations, both from David and from Bill around gap areas for us to consider.

We kind of re-immersed in some of the background data, health data, on cost quality in epidemiology for Medicaid and CHIP, focusing on high priority areas clearly related to costs and prevalence in mental disorders, and within that, medication use, asthma, trauma, and birth outcomes.

So our afternoon is the real work, in trying to sift through all that information and talk about, revisit, gap areas that we had landed on in our first webinar, try to prioritize some of those gap areas, and then

from those -- within those gap areas, think about what the opportunities are in terms of new measures.

So let me just, one more time, in the room? Kathy, anyone on the phone?

THE OPERATOR: No sir, there are no questions.

CHAIR GESTEN: Okay. Anything for anyone in the room? Last minute questions, comments? So five minutes early for break for lunch, yeehaw.

So we're going to meet back at 12:45, correct? 12:45? And get started.

Thanks, everyone.

(Whereupon, the meeting went off the record at 12:09 p.m. and resumed at 12:47 p.m.)

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

12:47 p.m.

CHAIR GESTEN: So the morning was fun, this is going to be more fun. Promise. This gets into the meat of the day.

So the afternoon, as we talked about, we're going to be talking about prioritizing measure gap areas, and then also talking about specific measures, and then prioritizing the measures themselves.

So let me just go over the game plan to make sure we're on the same page about how we want to approach this.

We thought that the first thing that we're going to do is taking the gap areas that have been identified by the group previously, matching them to existing NQF measures -- we're going to try to prioritize those gap areas first.

And that will help us in terms of the order in which we dig into the measures within them.

We're going to review, briefly, some of the measure selection criteria that is commonly used by NQF and others in thinking about how to select among measures, and I think we heard a number of different other criteria from the presenters this morning that we might want to consider along with that.

And then we're going to go in order of the gap areas, although we'll be starting with oral health measures, but then proceeding into the prioritized gap areas and examining and looking at the specific measures that many of you, hopefully all of you, saw, in the Excel file in the grid.

And making a collective decision about whether any of them can or should be considered to be added to the set.

We're going to, if need be, vote on those with sixty percent of our group, and we have eleven of us, so that's seven people, required to make a recommendation for consideration in the set.

And then once we've gone through that process, so we've prioritized gap areas, we've gone through and decided which measures in those gap areas we think we want to add, the last phase of this will be to actually prioritize those measures, which may or may not relate to the prioritized gap areas.

There may be other considerations that folks want to put on the table in terms of how they prioritize measures.

The driving concept here is to be able to give to CMS for consideration, amongst a potential sea of measures, some sense of what the highest priority areas are, both in terms of gaps and measures. That's what we're driving towards.

And then after we conclude all that, there will be a conversation that we'll have about some of the cross-cutting issues that were mentioned this morning about improvements overall, issues related to a measure collection -- we can take up, I think,

some of the threads of conversation that we started in the morning that relate to not specific gap areas or specific measures, but really, overriding concerns.

So before we start going through the slides, let me just make sure that folks -- that what I just said is comprehensible.

MEMBER ADIRIM: No, yes, what you are saying is comprehensible, but I was just kind of wondering for my ability to provide input, take a little bit of a step backward to kind of understand what the philosophy is behind -- philosophy may not be a good word -- but behind the measure set, its purpose.

Because one of the speakers mentioned, this morning, about really, you're trying to drive improvement, so it's really outcomes that we should be looking at as opposed to more process type measures, which, a lot of those are in the Core Set.

So I am just trying to understand, like, what the philosophy is, what our

boundaries are, with regard to that. So maybe the discussion about what's possible, kind of first, before we get into identifying priority areas.

And the other comment that I had was that it struck me that some of the discussion about what data is available almost feels like the tail wagging the dog.

You may not have that data available now, but that shouldn't -- in my opinion, shouldn't necessarily force us into certain measures just because the data is available.

Just a little bit of a discussion on that would be helpful to me.

CHAIR GESTEN: So let me just make a comment on the second part, and then I'm going to ask Marsha or Karen to talk a little bit about the first one, which I think I interpret as, what's the purpose of this? To help frame this, which I think we talked about some, but maybe can repeat it.

In terms of the second issue, I don't think that areas where there's no measures are off the table for discussion, particularly as we talk about cross-cutting issues about, not only gap areas, but like absent areas, related to development.

And we'll hear a little bit about some of the measures that are kind of in the pipeline for development, that may fill that in.

But I do think that there's a practical and pragmatic need that CMS has relative to measure selection right now for states, that doesn't mean that we can't ever have the conversation that you just described, and in fact I think it's envisioned as part of the longer conversation in 2015, but I mean that's how I see the issue about whether we're only allowed to look under the lamppost.

I think because of the accelerated timeframe in the practical application, we want to look at measures that sort of fit that

criteria that are set up for use in terms of validity and reliability in testing, and other issues' in alignment with the national quality strategy.

But I think there will be an active conversation about areas that are difficult, aspirational, where there's not much -- that's how I see the second part.

So Marsha or Karen, do you want to --

MEMBER LLANOS: Sure, and I think that's right. I would just say, I think it's just a hard conversation to have in terms of data sources.

I think when we put measures -- I mean, you heard from Dr. Kelley, I think one of the first things he said was medical chart review is really hard.

We've heard that every single time we've had a stakeholder meeting, whether it relates to our children or adult Core Sets.

MEMBER ADIRIM: It seems like some

of the measures that aren't being reported by states are available in administrative data sets, they're just not recorded. So also look at that.

MEMBER LLANOS: Yes, I mean I think it just depends on what the needs are.

So maybe talking about purpose is helpful. So, it's designed legislatively to be a Core Set of measures that states voluntarily report to CMS on an annual basis.

We want this to be a Core Set that is valuable and that resonates with the measurement needs in that state, understanding its posture set.

States are collecting more than that, or sometimes, less than the core sets. Or measures in addition to that.

So it's a starting point, it's a snapshot of a way that we can get standardized, quality measurement data into CMS, hopefully from as many states as possible, to give us a better understanding of

how states are purchasing health care and the quality of health care in their state.

So it really is designed to be a little bit of everything across the quality domain areas.

In terms of intention or purpose, we use that so we can better understand and get a glimpse of how states are performing. So we use it for very high level monitoring, but we also use it to identify areas that need improvement, or we can target quality improvement projects around that, and we would want the states to be doing the same.

CHAIR GESTEN: Does that help, Terry?

MEMBER ADIRIM: Yes.

CHAIR GESTEN: Okay. Any other questions about purpose?

Okay. Let's go to the next slide, and I think, Sarah are you going to --

MS. LASH: Yes.

CHAIR GESTEN: -- lead through

some of --

MS. LASH: Sure. So as we begin discussion of prioritizing our gap areas, wanted to remind you of the contents of the current Core Set.

Hopefully, you've had the time to review this material and absorb these a little bit. We won't spend much time on them, so you can take a minute to scan through.

And maybe we could have the next slide? This is the other half.

So, as you review, we'll want to state for the record the understanding that unless this group takes any specific action, the MAP's recommendation to CMS would likely be to continue the reporting of these measures for purposes of continuity, states continuing to gain experience, and there was a very thorough review as to measures that needed to be removed just a year or two ago.

So there's 23 total measures, as we've discussed on the web meeting, they sort

of fall out over a variety of different categories, but this is the set to which you would be adding, should you choose to do so. Next slide?

It's also worth highlighting the overlapping nature of the children's core set and the adult core sets of measures on the topic of maternal and child health.

There's some interesting, mind-bending ways to think about whether the measure applies more to the mother, to the infant, for both, and so there is a presence of maternity measures in both measure sets, but because these programs are targeted to state Medicaid agencies and they have many of the same qualities, from the state perspective, they're sort of two sides of the same coin, and they view them as -- in many cases, one large set of measures that they need to look at for their Medicaid populations.

So in particular, you heard Bill

discuss their experience with the antenatal steroids measure and elective deliveries came up. Those are not actually in the children's core set that you are reviewing, those are in the adult.

But there are a variety of other measures related to behavioral health risk assessment, chlamydia screening, prenatal care, C-sections, low birth weight, and well child visits.

Next slide? So these are the summary of the gap areas we heard you discuss at this group's web meeting: care coordination, specifically looking for measures related to home and community-based care and coordination with social services; screening for abuse and neglect; injuries and trauma, I heard that there would be potentially a relationship between those two categories; mental health, particularly access to outpatient ambulatory mental health services and wraparounds; ER use for

behavioral health as an indicator of poor access to the former; overuse measures and measures of medically unnecessary care -- CT scans were one example of a service that is potentially overused.

There was an observation that the set is rather lacking on inpatient-oriented measures. It's missing a look to durable medical equipment, and it needs potentially a greater presence of cost measures, or researched use measures in general, specifically targeting the kids who have chronic conditions and are consuming more services.

So that brings us to a shorter list, on the next slide, of a few gap areas where there are measures currently available for your review, and it's here where we want to start the discussion of the order in which you want to tackle these gap topics for the purposes of the measure-specific review.

We do plan to get through all of

them, but sometimes, discussion goes a little bit longer than we anticipate, so we want to make sure that we start with the areas this group considers highest priority.

So there's a brief count of the number of measures that we're bringing forward for your review related to each gap area.

There's most on the topic of inpatient. Some maternity stuff is in there. Three related to care coordination, five mental health, and three cost.

CHAIR GESTEN: Let me just point out, just so that we're clear. Currently available is translated to current NQF endorsed measures, correct?

Which is one of the criteria which we'll get to, I think, in the next slide, that is used -- it's not an absolute criteria, but it's an important criteria that's been used in measure selection for other task force ---- other MAP activities.

The other thing I would point out,

and this, I think, gets, Terry, to your point, is that there are measures that the group identified as priority gap areas, specifically abuse and neglect, injuries in trauma, radiation exposure, durable medical equipment, and so on -- which you do not see on this list, and you do not see on this list because currently, anyway, at least in terms of NQF measures, there's nothing that relates to those sections.

It doesn't mean it's not important, and as we'll see a little bit later, some of those areas may have measures in development.

And as we may hear, from states or from some of you around the table, you may actually be familiar with measures that are being used at your institution or at an organization in your state.

But the delimiting factor here, and what we want to focus on, are those areas which you all identified as important gap

areas for which there's currently a set of measures that have been through a process of validation, reliability testing, auditing, and a process that NQF uses to evaluate those measures.

So I just wanted to make sure folks are clear about this, and these gap areas, and how they relate to the others.

I think we're ready for the next slide, yes? Or, oh, we are going to do this now? Okay, sorry. That's right, the measure-specific stuff we do later.

So in terms of -- you know, I've been saying to Beth and Sarah that this is going to be -- there are just some challenges to prioritization, it's like trying to pick among your children which ones are most important, and we know how well that works. Although we all know that we are in fact the favorite child of our parents.

But I think one of the things -- I think we can start with some open discussion

about how people think about these four areas relative to prioritization, and before we get more formal, see whether or not we have some consensus about how we think about these.

Recognize that we're doing this in isolation from looking at the measures themselves, meaning that we might find that we prioritize a gap area, and then we look at the measures, we don't like them so much, or vice versa, there may be lower priority areas.

But again, I think our intent here is to make sure that we have a collective understanding of which areas we think are most important and most vital for CMS to consider as it thinks about gap areas and potentially changing the measure set.

So anybody want to start off with any comments about -- your thoughts about how they might go about, how they think about prioritizing these gap areas?

And let me just, I neglected to check and see -- Anne and Alvia, are you back

on the line?

MS. COHEN: This is Anne, on the line.

CHAIR GESTEN: And --

MEMBER SIDDIQI: Alvia's here.

CHAIR GESTEN: Great, thank you.

MEMBER SIDDIQI: Sure and I just -- -- I was going to make a comment about the gap error area issue of ranking as well.

I actually like the list as presented, and I think the last two, I would maybe just flip, and maybe do cost measures and those three that relate to the readmission rates before the inpatient measures, which it seems like there are many more inpatient measures that we could look at.

But in terms of inpatient measures, those that relate to readmissions certainly are important to states. A lot of them may hopefully correlate with the adult core set as well.

So states may be feeling that they

already report on those adult core set measures and maybe adding it to the pediatric population would not be an increased burden.

So that was my only recommendation, is really the same list, but just flipping the last two.

CHAIR GESTEN: Thank you. Cindy?

MS. PELLEGRINI: Thanks. I am a little bit confused with the qualification of cost being related to readmissions.

And maybe I'm just not remembering the call we had correctly. To me, those are -- I mean obviously readmissions have costs, but readmissions are in and of themselves an important health outcome.

And I could be mixing up the different MAP committees, or NQF groups I've been on, but what I'm mostly remembering is cost being expressed as a concern for patients and families, and so I'm not sure I'm seeing the sort of, you know, the kind of equity here that's been given, saying cost in this case is

going to be equal to readmissions.

MS. LASH: I think you're making a great point that the gap area as identified by this group and others is broader. There's lots of components to cost, especially out of pocket.

The measures we found are on the topic of readmissions. So to be transparent about what you're going to find when we peel back that layer, those three measures are related to avoidable costs that relate to being readmitted.

MS. PELLEGRINI: Now in most cases the costs being incurred here are being incurred by insurers or providers. Less by families, is that fair?

MS. LASH: Primarily, yes.

MS. PELLEGRINI: Okay, because I am thinking about -- again, it probably was on a different call, but discussions of measures related to out of pocket spending, and I'm not sure if those are endorsed or not.

MS. LASH: I don't believe so.

CHAIR GESTEN: The challenge, or the difference might be, out of pocket costs for Medicaid, at least in our state, are almost zero.

I mean, they're particularly related to admissions and so on. So it's not that it doesn't have any salience, but it may be less important for Medicaid than it is for other populations.

But you're right. It's a great point. There are potentially other types of cost measures that might be important, but this is basically trying to fill in -- see what we have that relates to the gap areas in the existing measures, and it's not a perfect fit. And as Alvia mentioned, readmission could just as easily be considered part of an inpatient measure as well.

So I think Beth, you were next.

MEMBER FELDPUSH: Yes, thanks. Just kind of a follow-up on the readmissions

comment, and then back to sort of a more general question -- I think I struggled with looking at that as a cost issue also, and not to say that it isn't, but I wasn't sure why readmissions were singled out as specifically related to costs when other things weren't.

Because when you look at provision of care or lacking of preventive care leading to more costs later -- or then I'm thinking, well, okay, maybe it's because inpatient admissions are really expensive. Well, so are just regular admissions, much less readmissions.

So I struggled a bit with that conceptually of sort of trying to find where that boundary of cost was.

I guess, back to my sort of general question in trying to rank order these, I know we are going to talk a little bit more about specific criteria when we talk about specific measures, but I am sitting here struggling with how to rank order even these

topics, because I keep coming up with different criteria in my mind of like, well, if I looked at it this way, you know I might say care coordination is sort of the root of all good care, so maybe that's more important, but then you get to well, maybe the inpatient services are most expensive. So I am kind of just really struggling with how to even conceptually rank order the topics.

CHAIR GESTEN: Go ahead.

MS. LASH: On your first point, if I'll just respond, I think there will be a few occasions as you look at the measures where they're two-fers, and there's different ways that they relate to affordability or care coordination.

So do be flexible in your thinking as to when a measure might fit more than one of these gap areas. It's just a way for us to organize them for you.

CHAIR GESTEN: Your order question, I don't frankly have an answer to

help you with that. If you'll notice, we have not given, here's the lens through which you should look at this, and rank order it deliberately.

Because I think that we wanted to get a sense -- we wanted you to individually think about what was important to you.

But I mean, the areas are called a gap for a reason. It means that we're saying that the existing measurement set either incompletely or completely ignores a certain area.

So in my mind, one of the ways in which I think about this is, to what degree are the current measure set completely not representing what's contained in this gap area?

And there are, in my mind, two part ways of prioritizing them. One is, if there's absolutely nothing, and the other would be -- is there something better?

And I might think about those

differently. But the background information about the epidemiology, health issues, common health issues, costs, and so on, were I think partly meant to at least provide some context to think about these, but otherwise, we're asking folks to think about it from their point of view.

So I didn't help at all, did I?

(Laughter.)

MEMBER FELDPUSH: Not really, but -- and again, I am not trying to pick on the order of the conversation here, but then I'm kind of going, well, now I want to look at the individual measures and those ones that I think are the most sound, and measures that capture the gaps, well then maybe that's how I prioritize, and I go no, I know you want us to think not necessarily about just the data or just the measures that we have available, but then we're also kind of starting from this shorter list in the gap area for which measures are available.

So I'm sorry to make it even more confusing and challenging, but it's just a struggle that I'm having.

MS. LASH: Sure. If I might make a suggestion then, since it seems like there's not a strong feeling in the group as to priorities among these gap areas, we might just proceed jumping in that measure-specific discussion in the order that Alvia suggested, unless there's any objection.

And then we can reserve our discussion time for that really valuable weighing of pros and cons, and strengths and weaknesses, as it relates to those measures.

Foster, Karen?

CHAIR GESTEN: Sounds find to me, unless anybody, again, wants to make a pitch for why one of these or two of these really kind of rise to the top.

I think there's --

DR. GOLDEN: Can I make a comment?

CHAIR GESTEN: Yes.

DR. GOLDEN: Just from our perspective in Arkansas, mental health is such a dominant player in our pediatric cost and volume.

We are really the predominant pediatric mental health payer, so I'd put that with a star.

And we have been cautious with inpatient measures only because of volume differences, most via one major children's hospital, and so you get into volume issues if you don't pick your inpatient measures very carefully.

CHAIR GESTEN: Thanks, Bill. Any other comments? Any objections to proceeding in the way that Sarah just mentioned?

Okay. Why don't we go to the next slide, which I think starts to talk about the filter of thinking about measures, in a way, and again I don't know -- Beth, are you going to do it?

MS. CAREY: So just to give you

some background on the measure selection criteria, which, as Foster mentioned, these are developed to assist MAP with identifying the characteristics that are associated with an ideal measure set, either for public reporting or payment programs, so these are consistent across all of the MAP work groups and task forces.

They are not absolute rules, rather they are meant to just provide some general guidance on making the measure selection decisions, and the central focus should be on the selection of high quality measures that address the national quality strategy.

And competing priorities, as we've just been discussing -- competing priorities often need to be weighted against one another, and these measure selection criteria can be used as a reference when you're evaluating the relative strengths and weaknesses of a program measure set, and how the addition of an

additional measure would contribute to that set.

So we have here listed the measure selection criteria, starting with the NQF endorsement that shows that they have been through that evaluation process to meet importance, scientific reliability, feasibility, use and usability.

And then, I won't read all of them, but you can see them listed here. Next slide.

So MAP uses consistence decision categories, and again, these are the same across all of the work groups and task forces. The decisions are used to, again, to provide consistency, and then in addition to the decision category, there's usually a statement providing the rationale behind the decision.

For this particular review, the two categories that you would most likely use are support, which would be used in the case of measures that are ready for immediate use

and address the identified gaps, and then the conditional support category is appropriate for measures that are either still going through the NQF endorsement process and are pending endorsement, or there is something that needs to be changed or addressed by either the measure steward or working with CMS to confirm the feasibility before it would garner a full, strong support.

Okay. So again -- so again, this is our list of the gap areas that we've been talking about. Care coordination, I believe that should actually be four measures, four endorsed measures, that are -- these are the measures that are on your spreadsheet.

So there's four measures in care coordination that are all using patient-reported data or surveys. We have mental health -- five mental health measures that we've kind of bucketed into three in screening or risk assessment, one on treatment, and then one that's looking at

medication as a safety measure. We did have quite a few inpatient measures, and again, we've tried to bucket them, but you can use or not use these categories, it's just way of trying to organize them.

Some measures on premature birth or low birth weight. There's a few measures that we identified about cardiac or circulatory birth defects, and then we kind of have the Other topic.

One thing to keep in mind when we do get to looking at the specific measures in this set, several of them are at the facility level, which doesn't disqualify them, but may pose some challenges to rolling out to a state level.

And then in the cost or readmission measures that we identified, we have three of them. One is fully endorsed, looking at PICU unplanned readmissions, and this one is EHR specified. And then we have two that are going through our endorsement

process now, specifically for pediatrics, and those are coming from the Centers of Excellence. They're new measures, and they're both specified at the facility level.

Okay. So actually, we can switch to the spreadsheet. Or actually, do you want to go back to the slides for just a second?

So again, we're going to start with the oral health measures. We're starting there, it was a specific ask from CMS to start looking for a potential substitution for the treatment measure that's currently in the core set.

So we teed up this conversation this morning with Krisha's presentation, and these are the five measures that are fully NQF endorsed, and the specifications are on the spreadsheet.

And then just to have in the back of your mind -- Nadine if you could switch to the next slide, there are a few measures that we know of that are in development in this

area, but because they're not fully vetted and tested for feasibility and reliability and so forth, they're not under our consideration for this review, but we could revisit them in the future if you'd like to go back and look at them.

CHAIR GESTEN: Do you just, Beth, the check -- I wasn't sure, the check mark in that grid means -- ?

MEMBER LLANOS: But probably not endorsed yet.

MS. CAREY: It means it's been completed and delivered, but not, right --

CHAIR GESTEN: But not endorsed.

MS. CAREY: Right, exactly, if they were endorsed, they'd be on the measure list, and the two readmission measures would fall in that bucket. They are going through the endorsement process currently.

CHAIR GESTEN: Do folks needs any refresh or description of the Centers of Excellence program? We didn't -- I don't

think we covered that very much, or talked about that, I don't know how familiar folks are with what that is.

So Karen or Marsha, can you just talk a little bit about what it is?

MEMBER LLANOS: Sure. So the Centers of Excellence, it's a measurement development grant program, and it is funded by CMS, and it's managed by the Agency for Healthcare Research and Quality.

So it's a four year program, so we're wrapping up, so that's why you see some of those completion dates going through, I think, January or February, and probably a little beyond that as well.

So it really is -- so it's not your traditional kind of development contract. It is grant programs with seven Centers of Excellence who have defined themselves -- so it's mostly academic centers partnering with universities or health systems.

And in terms of kind of the topic

areas that they selected, these were areas that -- so if the Centers of Excellence started almost four years ago, then we identified the program areas probably four years ago as well.

I think they were both identified before Marsha and I started at CMS through a joint partnership with CMS and AHRQ, and there was also a public comment period as well.

So it really did take into -- it's a snapshot of kind of where we were four years ago, I would say, in terms of the needs across agencies in the pediatric measurement field, and so that was before the initial course that was implemented, so that's another thing to take in mind, so I would say probably the biggest driving force between the gap area topics were what the gap areas were in the initial Core Set, and we are now I think three years into the Core Set evolution as well.

So the measures are developed on an ongoing, rolling basis. And one of the

measures, Behavior Health Risk Assessment, is one of the Centers of Excellence measures, and we added that about two years ago.

And then I think a few other measures that have been developed by some of our NCQA -- by our NCQA Center of Excellence, have been adopted into HEDIS recently, and I think those were some of the ones that were mentioned earlier today.

MEMBER LACEY: So are you saying the Centers for Excellence program is winding down, so they will not be in existence, or they will not continue under the auspices of --

MEMBER LLANOS: It's a grant program, so it does have a --

MEMBER LACEY: So they have to continue to sustain their work themselves if they want to do it.

I guess the reason why I'm asking is because on the spreadsheet, the steward organization, a lot of those is the Centers

for Excellence, and so my question is if they are potentially going away, I think we need to think about that.

MEMBER LLANOS: It's a good point to raise. So it is a cooperative grant agreement where in some cases the Centers of Excellence are prepared to be the measure steward going on, sometimes they're not. It really depends.

So the Centers of Excellence range anywhere from an academic center to NCQA. So you could see how their ability or their interest in becoming a measure steward on an ongoing basis would be different.

There's also the potential that CMS could become a measure steward, as it has in the past. Certainly other centers than CMS have served as a measure steward role as well.

So I would say I think it's a relevant issue, we retired one of our measures last year because it was -- the measure steward was no longer taking that, so it's a

relevant, I think, discussion point regardless.

But I would say in the purposes of this discussion, almost too early to tell. I think you should flag it if it's an area ---- it's a measure of interest, and if it's not completed or not endorsed, then we'd have to revisit it anyway in next year's cycle.

CHAIR GESTEN: Cindy.

MS. PELLEGRINI: Just for clarification, did I understand right that CMS has asked us to consider retiring one or both of the dental measures currently in the Core Set and substituting?

CHAIR GESTEN: That's my understanding, yes.

MS. PELLEGRINI: Can you just provide us a little bit more information about why, or which -- there's also, there's two. Is it both of them?

MEMBER LILLIE-BLANTON: It's the Dental Treatment Measure. And as you heard

today, I mean the problem with that is that it really is a utilization measure, and it's not in relation to need, any measure of need, so as you look at it and you're tracking it over time, it's hard to evaluate whether we're doing better, we're doing worse.

It's -- I don't want to say meaningless, because it has some value to us because we do want to make sure that we know that children who have dental caries are being treated, but it just -- it's not very useful to us, it's a measure of service used.

And it's not very actionable. You know, if you talk about a measure that you want to improve, what do you want to -- is the goal to just get children caries treated? It's not a -- it's not a good measure that we can kind of shape a quality improvement project around.

CHAIR GESTEN: So Marsha, just to be completely clear, you're talking about the measure that's described as received dental

treatment services not in terms of retirement, not the one that's -- or substitution, not the only that's received preventive dental services.

MEMBER LILLIE-BLANTON: Right. No, that one you need the length, we --

CHAIR GESTEN: Correct.

MEMBER LILLIE-BLATON: There's value for it, we use it. We encourage greater use of preventive dental services.

CHAIR GESTEN: Okay. So should we go back to the -- this is the list of the ones that we heard about this morning from Krishna, and then the other slide will give you the information, a little bit more specificity on the measure itself, and the spreadsheet, yes.

And maybe we should put that one up so that people can see some of the details. Krishna is still here. One of the questions I had, I didn't see it in the information that I had, was the way in which some of the measures hinge on high risk.

I am just wondering, either if someone at the table, or Krishna, you can come up and explain to the group how high risk is determined. You mentioned that this is an administrative measure, so I'm guessing you have some interesting administrative way of determining high risk.

MS. ARAVAMUDHAN: So you can -- so these measures are real quality measures that talk about right care for the right person at the right time.

So it was important for us to -- we propagate, we talk about risk-based care, but what are we doing? So this measure does it.

The risk's logic is based on past history of caries, which is the strongest predictor for future risk. However, as we were going through this process, we now have new CDT codes, which are procedure codes that help classify patients at risk.

So low risk, moderate risk, high

risk. So you can pick it up that way as well. Everything is simply based on claims data.

CHAIR GESTEN: So there are two approaches -- one is looking at history of caries, and the other is using the CDT codes, either one is used to identify --

MS. ARAVAMUDHAN: Either one is used, and over time we hope that you know, you can drop the past history and simply go with the caries codes.

CHAIR GESTEN: Thanks. As long as you're here, does anyone have any technical questions or clarifications around the measures that were presented? Since we have a little bit of time, and want to talk about these specifically.

Beth, was that a hand, or --

MEMBER FELDPUSH: That was a hand, it was a question, yes.

CHAIR GESTEN: Okay, yes.

MEMBER FELDPUSH: So on the treatment -- the existing treatment measure,

that's measuring caries that are filled, or not necessarily? It's --

CHAIR GESTEN: It can be treatment for anything though, right? It can be treatment for anything.

MEMBER FELDPUSH: So the five that we're looking at on the list here, I mean, oral evaluations, sealants, sealants, and the topical fluoride, look to me as more preventive services, so do you call those treatments too? But they're -- that's all preventive, so there's not necessarily, in this group of five measures -- now there's utilization of services, but there's not necessarily in this list of five something -- a new measure, or a substitution measure, that gets at treatment.

You are really just kind of looking to solve a more general dilemma of the existing measures not giving you much information, so can we find other measures that give more information, even if there's

nothing really specific about treatment on this list. Got it. Thank you.

MEMBER LILLIE-BLANTON: We want to improve the oral health of children in many ways.

MEMBER FELDPUSH: Okay. Good goal to have.

CHAIR GESTEN: Cindy?

MS. PELLEGRINI: Thanks. Showing my ignorance here of dental practice, can you tell us a little bit about why there are separate measures for sealants for the two age groups?

I mean, I see first molar and second molar, but --

MS. ARAVAMUDHAN: Good question. So the preventive services measure, if you take a look at the codes that are there, it's about, you know, did they get a cleaning, which there's no evidence to support it does anything in children, and then it combines cleaning with fluoride with sealants.

And it is not about right care for the right person for the right time. It says any sealant, you put it on, any one fluoride -- one fluoride varnish to a child does nothing.

It's about, like vaccinations, you have a periodicity schedule that you've got to maintain for the child to benefit from it. So you have evidence for topical fluoride saying it has to be at least two or four applications within a year, so the measure is looking, did they get those two applications in that year?

With sealants, it is like you've got to seal the teeth as soon as they erupt. So the six to nine is looking at your first molars, first permanent molars, that's the age span when they come out, and say you've got to seal them.

Because if you waited until 11, 12, they're already diseased. And so the cost to the system also increases if you don't catch it early.

So 10 to 14 represents a second set of permanent molars, and the 6 to 9 represents the first set of permanent molars.

And when we went through our validation, we found a lot of instances when we were catching sealants in pre-molars, primary teeth, things like that, which aren't really getting you to the QI goal.

MS. COHEN: This is Anne, I have a question.

CHAIR GESTEN: Go ahead.

MS. COHEN: So I'm just curious, again this is, you know, admitting my ignorance as well to dental practice, so the measure 2528, the topical fluoride, I'm curious in terms of rate of cavities, is there any influence on communities that fluoridate their water versus not? And then how that particular measure might kind of have impact -- the topical fluoride measure might somehow be impacted in terms of the number of cavities in one community versus another?

MS. ARAVAMUDHAN: So water fluoridation is a public health kind of initiative. Especially this particular measure, we often get asked: why didn't you throw all Medicaid in high risk? You know, why isn't it a population?

If we take that tact and say everyone -- and use risk as a population indicator, and throw everyone in a community -- you don't know whether they're getting other sources of fluoride, what's happening at the individual level.

So this measure actually addresses that by saying that you've got to look at the individual child's risk for caries and then use prevention as necessary.

The other thing we like to stress is we're not making a policy statement here to say, you should have a benefit for this or you should not have a benefit for this. You're simply asking the question: are people who ought to get the service getting it?

MS. COHEN: Thanks, that's helpful.

CHAIR GESTEN: Marsha?

MEMBER LILLIE-BLANTON: I want -- I don't want to overly influence the group, but I do want to talk about one of these measures that I find particularly attractive because it aligns with our oral health initiative, and also with the directive that came to us from Congress, which is very important to us.

Congress asked us to track and to measure sealants in six to nine year olds, but they asked us to only do it, if I'm not mistaken, in CHIP. Is that correct?

So we have begun to try to look at ways of doing that, but that measure becomes attractive for that reason. In addition, we announced an oral health initiative about four years ago and set two goals, and one of the goals was to improve use of preventive services, and the other was particularly to

improve the use of sealants in children six to nine, which was also linked to what Congress asked of us, and would be broader than children in CHIP.

So I think -- you know, I really do encourage you all to review all of them, but I want you to know that when I learned that the sealants in six to nine year olds had been NQF endorsed, it, I thought, helped us to address one of the challenges we had, because we had not set baseline data for our six to nine year old sealant goal, because we continue to have problems trying to decide how to measure it, because there are just many challenges.

Because the group of children six to nine continues to shift every year, and we were trying to understand how we tracked it, and once NQF, or at least the DQA, was able to find a measure of need, it became easier for us to then look at, over time, if we were tracking the measure, performance, and whether

or not we were moving in the direction we needed to move in.

So I just wanted to give that little bit of background.

CHAIR GESTEN: Marsha, clarifying question -- are sealants included in the current measure of preventive services?

MEMBER LILLIE-BLANTON: Yes, it is.

CHAIR GESTEN: So you're capturing it, but you're capturing it en masse with other things.

MEMBER LILLIE-BLANTON: Yes, we are.

CHAIR GESTEN: So my second question is since you're actually collecting that measure itself, are you not able for some reason to generate this measure from the data that's collected currently?

MEMBER LILLIE-BLANTON: Only because what states report to us now is for any preventive service. So it could be --

CHAIR GESTEN: It's just a rate --

MEMBER LILLIE-BLANTON: Yes, it's not disaggregated.

CHAIR GESTEN: Correct, I got it.

MEMBER LILLIE-BLANTON: And there's a lot of evidence base that sealants really can make a difference in reducing caries later on.

So while there are other preventive services that we count in that any preventive services, this is a key preventive service, that our understanding is can really make a difference in preventing -- reducing caries.

CHAIR GESTEN: Thank you for completely biasing me on this list.

(Laughter.)

CHAIR GESTEN: Other thoughts, Cindy? Go ahead, Cindy.

MS. PELLEGRINI: Sorry, I am looking again at the two measures here of 6 to 9 and 10 to 14, and wondering: does it make

sense, really, to break them up, or to consider them almost as a pair that either you take both, or you take neither?

Or is there a reason that I'm not aware of that we would -- care less is a harsh way of saying it, but place less weight on the care for the 10 to 14 year olds?

MS. ARAVAMUDHAN: Can I give an opinion, and this I will just qualify, saying it's just my opinion, not the DQA's, I'm thinking of.

But I think it's all about provider behavior. I think if you can change provider behavior to say, this is important. You've got to watch for it and do it. We're going to watch you the first time.

I think we can be assured that it will happen the next time. It's in the record, you know.

So that's the thing about the six to nine, the early age group, to see whether the provider behavior component is working.

CHAIR GESTEN: My opinion is also that there's two schools of thought about this. One is, you know, if you don't measure it, it doesn't -- you've heard the mantra about it, if it's not measured, it doesn't happen.

But I also believe in what Krishna said, which is that it's very challenging, I think, for groups to put into effect improvement that would just stop at age ten, and it's hard to imagine clinicians saying, oh, we're not being measured on ten, so who cares?

Again, I think measurement and improvement relies on the mechanics of how improvement needs to be put in, as well as professionalism.

Was that just another way of, I think, framing what you just described? Beth.

MEMBER FELDPUSH: So just kind of as a practical question about using this measure. In the measure specifications, is

there either an exclusion or a code for child already has sealants?

MS. ARAVAMUDHAN: Very good question. So that was something that we really struggled with. The measure has specified limitations that it does not exclude kids who already had sealants, or a tooth had not erupted.

We feel that if everyone measures the same way, that is still going to be comparable.

Now the e-measures I showed you in the morning, they do have it, because they have the capability of taking the richness of the patient record to actually exclude kids.

So while you will get a more precise score with an e-measure based off of patient record, that is simply not the reality today. So to have a claims-based measure that is still comparable just requires reliable specifications that everyone uses the same way.

MEMBER FELDPUSH: So in practice, I am just thinking if you were to start collecting this measure tomorrow, a state that, say, has historically already done a good job in providing this care to children might score lower than a state who is ramping up now and doing really well, because a state where more children already have sealants are going to maybe look like they have a lower score.

MS. ARAVAMUDHAN: Your reporting year is one year, right? And you're having kid age-in and age-out of that one year bracket. So you're not really looking at prevalence of sealants all throughout the age ranges. You're simply -- we're looking at the one year period.

And the great thing about these measures that are only based on administrative data, CMS that has data historically, like in the CARTS system or the MSIS system, can run the measure retrospectively and get a trend

line from like 2005, or whatever it is, and have that basis to inform the decisions as well.

The only thing with this measure to be aware of is you're not going to target 100 percent as your benchmark.

You're going to have to see what the measure score looks like across plans, across states, and then pick your benchmark.

CHAIR GESTEN: Your question -- if I may, before I get to you Marc, your question raises a broader issue, which is when Terry asked, you know, what's the purpose of this, you notice that neither Karen nor Marsha said the purpose of this is to be able to compare New York to Delaware.

And I think you were specific in not saying that. So in my mind, there's a couple ways to think about this. Clearly having measures that are comparable across states has some value.

Having measures that states

themselves can use and look at for improvement over time also has additional value as well. And if in fact state-to-state comparison is not at least a high level or a high priority reason to have core measures in the Medicaid program, then again, it's an open question about its comparability from state -- whether comparability from state-to-state matters in picking measures or not.

I just throw it out there as just a bit of an observation. Marc?

DR. LEIB: Well first, I highly support the use of sealants in these age populations, so you're not taking anything I say as meaning that.

But I'm not sure that the measure as constructed is going to give us useful information either initially or ongoing.

Just take a perfect world. A dentist has -- you're looking at six to nine year olds, is that it, initially?

If a dental practice has every

child that he or she sees gets their sealant as soon as that tooth erupts in that first year, then for the next three years, they're going to score zero on anyone who is seven, or eight, or nine, because they got them all as age six.

And so they're -- at best, they're going to look to be, oh, 20 percent, the six year olds, compared to that entire age range, and they're going to stay at 20 percent, and they're never going to look like they're improving, whereas a dentist who didn't do quite as good a job their first year, look at almost 100 percent if they suddenly start putting sealants on -- maybe there's extra pay for that, or there's a bonus, or whatever it is -- and they're going to look like they're at 100 percent, and they're not going to be able to tell the good dentists from the bad dentists because the numbers don't measure the same thing over the same time period.

In my mind, I'm not an expert at

this by any means, if you're looking for -- the measure should be the presence of a sealant on a tooth in that age range, and it wouldn't matter once they got it, it would still be present the next year, and the next year, and the next year, so that you'd always be counting a child with a sealant over the total population of that age range instead of just the first year that they got it, and then ignoring them the other three years.

MS. ARAVAMUDHAN: So we've had numerous discussions about this. And again, the thing is that there is limitation in the claims database as to how much you can exclude and how precise you can make this measure.

This is what it is. If you take a reporting period, and one thing important to remember, we're not measuring the dentist, we're not measuring the provider, we're measuring the plan, and we're measuring the pair.

So you're looking at huge sample

sizes here and hundreds of thousands of children that are included, and we have seen tremendous performance gap even within the four programs that we used for the NQF validation testing.

So that tells us that, hey, the existence of performance gaps and existence of something that has the highest level of evidence in dentistry ought to be measured.

So the problem about the six to nine -- I can go on and on about it, but the problem about the six to nine is a churn in Medicaid. You are not going to -- you are going to have to control, and Pennsylvania does something like this, where their measure goes that you only include the children who are three years consecutive enrollment in Medicaid program, and then you go on and measure if they have a sealant.

Now if you put that limitation to the denominator, so you'd need three years continuing in enrollment, you are looking at

ten percent of the population.

And then when you start thinking about the ten percent of the population, you are looking at, okay, do I need a valid measure or do I need a generalizable measure?

DR. LEIB: I was not suggesting we exclude people if they are not in for three years.

MS. ARAVAMUDHAN: But that's the only way you can say -- because you will not get claims. Let's say they moved out of Medicaid, you're not going to get claims.

DR. LEIB: If the goal is to increase the number of sealants on Medicaid children's teeth, appropriate to the appropriate age range, taking a snapshot once a year by plans, by dentists, I fully understand, as to how many children in that age range have a sealant on the tooth, whether it was placed today, yesterday, or last year, shouldn't matter.

The sealant is in place, and

that's our goal, is to have sealants on teeth.

MS. ARAVAMUDHAN: And you will not --

DR. LEIB: And I'm not sure this measure measures sealants on teeth. It measures sealants put on teeth this year, not sealants on teeth in the entire age-appropriate population.

CHAIR GESTEN: So I think you're making an interesting point, and I think we also need to probably get out on the table any questions that people have about the measures, because I think what we need to head to, sooner rather than later, is sort of a head count -- hand count, of measure by measure, whether any of these sort of fit the criteria that you have in your head that they should be added to the list.

So healthy debate around some of the limitations of the measure, some of the challenges in the continuous enrollment, I don't mean to shortchange that as an issue,

but my suggestion is that at this point if there are questions about other measures that people might have, that would help them be able to make a decision about whether they think these should be added, we should probably prioritize that conversation.

Cindy, you have something in that --

MS. PELLEGRINI: It's a very quick dental question --

CHAIR GESTEN: Okay.

MS. PELLEGRINI: -- and I was just curious, is part of the rationale here that, if I am remembering my own kids' experience correctly, that new molars are erupting every year during that period, and so that's why the kids have to keep going back?

Because you're never going to get, I think, you're never going to have 100 percent of the new molars to put sealants on at age six --

MS. ARAVAMUDHAN: You're correct,

we have --

MS. PELLEGRINI: -- or seven, or eight.

MS. ARAVAMUDHAN: -- four molars, and they all don't come up at the same time.

So the measure is only looking at least one. So technically the child can be counted multiple times during the multiple years, too.

CHAIR GESTEN: Marc, did you have another question, or is your thing just still up? Don't confuse the Chair, he's very easily confused.

(Laughter.)

CHAIR GESTEN: And does anybody have any, I want -- does anybody have any questions, clarifications about the specific measures before we actually, I think, start to take them one at a time, which I think makes sense as an approach.

Okay, I guess Krishna, before you go, I just want to make sure that I -- it came

up this morning, I want to make sure I understand: the fluoride intensity measure captures the delivery of fluoride only by dentists, not by primary care.

So I'm revisiting Susan's question earlier, and I heard your comment that in, at least in the testing sites that you had, that the primary care delivery of fluoride accounted for a very small percentage.

MS. ARAVAMUDHAN: Okay, it's three percent.

CHAIR GESTEN: Generally. But I also heard Susan say, between sessions, that in California, she thinks that that rate is actually very different.

But I just want to make sure I understand, the measure as written captures topical fluoride only by dentists?

MS. ARAVAMUDHAN: Correct. And I have to tell you this story. When we did this at the DQA, we did it all three ways, dental services, oral health services, dental and

oral health services.

But we had to pick to submit to NQF, so what we submitted is the dental services, because again, whom do you want the accountability to be on? Which system do you want the accountability to be on? Do you want to start getting pediatricians to make sure they have the child in every six months, so they meet the two times a year for high risk kids, you know, periodicity, or should this accountability lie with the other financing system?

CHAIR GESTEN: Thank you. Any other questions?

So in terms of process, unless somebody has a better idea, I thought that we should start at the top and go down, and again, I would say that in terms of voting, you don't need to vote for any of them.

I guess what we're looking for is, is there a measure in which at least 60 percent of us, which would be seven, including

two folks on the phone, assuming they're hanging in there, say yes, this is a measure that I think we should prioritize for inclusion in the set.

Is that -- Sarah and Beth, do you have any different idea of how to proceed?

Should it be six until Susan comes back? Yes, because it's based on who's here, right? Sandra.

MEMBER WHITE: Yes, now, would that be prioritization for inclusion into the set with modifications, or prioritization for inclusion as written in the current --

CHAIR GESTEN: As written. There will be a prioritization among measures sort of at the end, but for right now, it would be within this set, whether any of these measures -- and again, you don't have to just vote for one, but are there measures that for you suggest that it should be added to the set, based on what you know about it, as it's written currently?

Okay. So why don't we start with 2511, Utilization of Dental Services. Just by a show of hands, and I'll get to folks on the phone, how many folks would vote for this to be included as a measure to be added to the CHIPRA Core Set?

2511, the one on the top, the measure number. And I'm seeing no hands here. Anne or Alvia?

MS. COHEN: I am not raising my hand, this is Anne.

CHAIR GESTEN: Okay, not raising your hand.

Okay. I'll tell you what, what I'll do is I'll just turn to you guys, and if you're raising your hand, just let us know that you're in favor of it, and that'd be great.

For 2517, Oral Evaluation? Show of hands?

On the phone?

MEMBER SIDDIQI: Agree.

CHAIR GESTEN: I am sorry, on the phone was yes?

MEMBER SIDDIQI: Sorry, Alvia speaking --

CHAIR GESTEN: Okay.

MEMBER SIDDIQI: And I also vote in favor.

CHAIR GESTEN: Okay. For 2508, Sealants in Age 6 to 9 Years Old? Show of hands?

On the phone? Was that yes for both of you?

MS. COHEN: Yes.

MEMBER SIDDIQI: Yes.

CHAIR GESTEN: Thank you.

MS. LASH: That's nine total.

CHAIR GESTEN: For Measure 2509, Sealants in 10 to 14 Year Olds. Show of hands? And Anne or Alvia?

MS. COHEN: Yes.

MEMBER SIDDIQI: Yes.

CHAIR GESTEN: That was two yeses.

MS. LASH: Also nine.

CHAIR GESTEN: Also nine. And then, was that the last one? No, there's one more after that.

Topical Fluoride Intensity, Measure 2528. Show of hands? Anne or Alvia?

MS. COHEN: Yes. This is Anne.

MEMBER SIDDIQI: Yes.

MS. LASH: That's just two.

CHAIR GESTEN: Two. Is there one more on that list, or is that it?

MS. COHEN: The Annual Dental Visit?

CHAIR GESTEN: Annual Dental Visit. This is the NCQA measure? This is an annual -- this is just a visit of any kind, right? Having one or more dental visits with a dental practitioner during the measurement year, existing HEDIS measure, correct? Yes.

Show of hands for Annual Dental Visit? One? Anne or Alvia?

Okay. Sounds like one.

MS. LASH: That's one total.

CHAIR GESTEN: Okay. So we had two that made this -- two sealants measures, is that right, passed the test, and we'll go back and potentially prioritize those with other measures as we go through the other areas, the other gap areas. So great.

MEMBER WHITE: I wonder if we can have any comments on why the last measure failed.

CHAIR GESTEN: Anybody want to comment on why they didn't vote for it?

MEMBER FELDPUSH: It just didn't seem very specific to me, and from the presentation earlier in looking at the three measures that are currently available, I got a sense that there was a desire for more specificity, which is why I liked the sealant measures and not just the general annual visit measure.

MEMBER ADIRIM: An annual visit doesn't necessarily equal what we want for

outcomes, whereas the sealants do that.

MS. PELLEGRINI: I thought in Krishna's presentation that she said there was also a measure that had been developed that was outcome-related on caries, the presence of caries, and I just was curious why that didn't end up among our choices. Maybe it hasn't been endorsed yet, but I thought we had a list that had.

MS. ARAVAMUDHAN: Measures that are possible, feasible, for Medicaid programs, outcome measures, are not there yet. We are looking at proxy measures that we hope to submit this year to NQF. We have e-measures.

CHAIR GESTEN: And then, I mean I'd also point out in the slide set, and you saw it briefly, that there are three measures that are also in the pipeline from the Centers of Excellence as well.

So again, there may be a conversation next, you know, in the next cycle, in which the broader scope of measures,

end up being more measures available to be able to look at, including those as well as the Centers of Excellence measures if they've gone through the process and are ready for prime time, or believed to be important, even if they're not ready for prime time.

Okay, I think we're ready to move onto care coordination.

And there was a slide, I'm not sure what the number is, maybe an overall slide, maybe we should do that first.

Yes, Helen?

DR. BURSTIN: Just a quick point of clarification on these measures, these are all measures that come out of the National Survey of Children's Health, which is done by HRSA every four years, is my understanding, and Terry may be able to help there if I'm getting that wrong from a prior life.

So they've not yet been adapted, they are at the state level, but I don't know whether Medicaid would have the capacity to do

that more often, it's part of -- they also have the National Survey of Children with Special Health Care Needs.

So it might be a conversation for CMS to have with HRSA, HRSA's office, to see if there's an opportunity there to think about fielding it potentially more often, but otherwise it's difficult to see how would they be brought -- be useful to you, since the periodicity is so infrequent.

CHAIR GESTEN: And you're talking about the measures which we haven't put up on the slide set yet, but these were suggested, these are the four -- these.

DR. BURSTIN: These, right. So they popped up and they disappeared. These, yes. So these are all from that national survey.

CHAIR GESTEN: But these, they're from the national survey, they've been NQF endorsed as measures.

DR. BURSTIN: As measures of the

state level, right. But again, I just want to be sensitive to the fact that there's not a data vehicle for CMS to do them short of thinking about having a conversation with HRSA about whether this could be fielded more often or done in collaboration, but these are specific items from within the survey that are reliable and valid as indicators of quality.

These are some great, great measures.

MEMBER ADIRIM: Yes, I think that's a CDC survey that the get their data from, right? For Children with Special Health Care Needs? Yes.

CHAIR GESTEN: So why don't we -- I guess before we switch to the more detailed measure description, I didn't have the same kind of disconnect that other folks had about costs and readmissions on the perceived as safe as care coordination.

Sarah, you gave me a spiel. I wasn't completely buying it, but can you give

everybody else the spiel? Maybe they'll buy it.

MS. LASH: It's a stretch.

CHAIR GESTEN: Yes, go ahead.

MS. LASH: This -- part of this gap area is characterized as connection between the health system and the broader set of services that children need to have wellness. So, a healthy community, a safe community, a safe school.

719 is -- actually has care coordination in it, that one might not be such of a stretch. Also, these transition from the pediatric services system to the adult health services system, might be a little more squarely in the care coordination space.

Again, we turned over a lot of rocks to try to find potential measures to offer you. If they don't fit, they don't fit. There's really no need to force it. But that was the rationale.

CHAIR GESTEN: And I don't know if

you or somebody can comment, for the first and the last one, the ones that deal more directly with care coordination of individuals versus coordination between health care and other services. Can you comment on whether the concepts that are in those are or are not captured within the CAHPS, the current existing CAHPS survey, whether it's the CAHPS survey for chronic care needs, or general CAHPS in terms of care coordination.

Because my understanding, without having all the questions in front of me, is that there are in fact questions that relate to issues related to care coordination. They're from a survey, from an existing survey, that is part of the measure, the Core Measure Set.

So I need a little bit of help in understanding -- I understand it's a different survey, maybe a different purpose, but it would be helpful to understand how it may differ from the existing CAHPS survey, if

anybody is able to do that.

The current CAHPS survey that is part of the CHIPRA Core Measure Set.

MEMBER LLANOS: Yes, so we've got two ---- well, so we've got the Child CAHPS Survey Health Plan, and then supplemental items for children with chronic conditions.

CHAIR GESTEN: Well I'm pretty sure there are questions in there related to care coordination. I guess I'm wondering, in what way might they differ, or what might be the added or differential value of using a completely different survey to ask for the same concepts?

DR. BURSTIN: I pulled up Child Medicaid, and there is a question, for example, in the last six months, did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care? Among these different providers, so it may be quite simple, yes.

CHAIR GESTEN: Why don't we go to

the next slide, I think, talks about -- this is what we have, what's on the shelf, the next slide talks about what's in development, is that right? If I'm not mistaken.

MEMBER ADIRIM: So does that mean, is the ADAPT going through endorsement, or it says measure ready, what does measure ready mean?

DR. BURSTIN: It's not been submitted yet.

MEMBER ADIRIM: Oh, okay.

MEMBER LLANOS: I should mention, so there's no requirement as part of the grant program for any of the measures to be developed. It was really on to the Center of Excellence whether or not they budgeted for an endorsement.

MS. COHEN: Can you -- can somebody in there talk about the children with disabilities algorithm? Anybody familiar with that?

CHAIR GESTEN: Children with

disabilities algorithm? I am not familiar -- not done? I guess nobody can comment about -- nobody is here, Anne, that can comment on what they are, unless Marsha, do you have any insight?

MEMBER LILLIE-BLANTON: I just wanted to explain, or at least mention, that -- oh, yeah, I'm sorry.

I just wanted to mention that we are setting aside some dollars to support the Centers of Excellence in going through the measure endorsement process.

So while we can't say for sure that it will ultimately be endorsed, or that they'll finish the process, that we are trying to continue to support them.

And that process is still shaping up.

MEMBER LACEY: So you're setting aside some dollars for the Center of Excellence to work on things, but what's your timeline for winding down for the Center of

Excellence?

MEMBER LLANOS: It's supposed to end in February 2015, although a Center of Excellence could ask for a no-cost extension, so it really would vary depending --

MEMBER LACEY: Oh, a no-cost extension, got you.

MEMBER ADIRIM: So can we consider some of these, if we --

CHAIR GESTEN: For immediate -- for adoption right now?

MEMBER ADIRIM: Well, I guess not, because they're not NQF endorsed, right?

MS. LASH: Aside from the measure designated with a check mark, which unfortunately, we don't have more details to offer you about, the rest of the measures are not finished being tested.

MEMBER ADIRIM: Right, well I was going to -- you know, at some point I would advocate for this ADAPT measure, I mean that's big in pediatrics transition -- you know, for

kids with special needs transitioning from pediatric care to adult care, it's pretty important, that's all.

CHAIR GESTEN: I think the challenge is I don't think we have any description of the measure, measure specification, it hasn't gone through the process.

So I think, right, and again, we may be in a very different position in 2015 relative to these measures, including that one, since that one actually may be further developed.

So I think, as I said earlier, there's nothing wrong with footnoting it as an issue that's very important. It may, even if it's not a -- it won't be part of something that can be recommended right now for addition, I think it sets us up for an early conversation next year around high priority areas.

I mean, I know that same of these

other ones -- I know that the one kept on has the Center of Excellence somewhat involved in it, I think it's very much in a developmental phase in terms of the medication reconciliation, really important area. But not ready ---- close to being able to be recommended as a specific measure.

DR. BURSTIN: I'll just point out, I did get an email from the Centers of Excellence folks that they would like to submit ADAPT to us, when we can, they're in their final testing phases.

MEMBER LACEY: But you do have, we do have 1340 on the coordination of care, children with special needs who receive services needed for transition to care, but it's not the ADAPT, I know it's not that particular -- yes.

CHAIR GESTEN: So maybe what we should do is go to now the more detailed -- Nadine, if we could go to the more detailed version of the measure so that folks can see

a little bit more about numerators and denominators and exclusions and so on, and get a sense of these.

So I would invite, if folks have any questions about what's in these surveys -- what's in these measures or these surveys, that we can answer before we kind of go down the list and vote on them, now would be -- now would be the time to do that.

I think I asked my question about the degree to which 0719 or even 1340 --- I guess I'll ask it, I asked it about 0719, but for 1340, for the children with chronic needs survey, CAHPS survey, is there --- I'm wondering, I don't know off the top of my head, whether there are questions that are asked at all about transition from child to adult.

Again, this would -- I think the challenge would be it applies to a broader age group, the survey itself, so there would only be a subpopulation who might qualify in terms

of a transition process. But I don't recall off the top of my head whether there's any questions in that CAHPS survey that specifically talks about transition from child health providers to adult providers.

MEMBER LACEY: And you said it's Q4, they only do it every four years.

DR. BURSTIN: Yes, it's only fielded every four years, which I think is the biggest issue, really, is it's just not feasible to collect -- Christine Bechtel, who is the lead for this survey, has recently just moved to Hopkins, so it might be a good conversation, certainly if you haven't already, to have with Christine, and see if there's an opportunity to adapt it for your use, because there are some wonderful questions in those surveys that we've seen.

MS. COHEN: This is Anne. This is one of the areas that I voted for, the care coordination area, and I think one of the challenges that we found in the Duals group is

that one simple question doesn't really get to the answer.

So for instance, 1340's specification talks about children 12 to 17 who are asked by their provider to have a discussion about transitional care, but yet my question would be, is there actually follow-up -- whether that individual actually followed up on the transitional care, or got assistance in doing so, other than having a discussion.

So I think, Sam -- I mean, Sarah, it might be helpful to talk about some of the challenges with the care coordination in general that we found out with the Duals group.

CHAIR GESTEN: Anne, we're having a little bit of trouble hearing you, I don't know if you can get closer to the mic or turn up the volume.

Let me make sure -- I heard, I think, most of your question, but let me make sure I have it.

I heard you saying that there are challenges and limitations to asking one or two questions about a broad concept, and that further, beyond using survey information, there's also the issue of whether, not only did people perceive, perhaps, that their needs were met, but whether in fact follow-up care actually happened.

Was that the essence of what you described, or did I miss it?

Anne? May have lost her. Beth, did you have a question?

MS. COHEN: Are you there, hello?

CHAIR GESTEN: Now we can hear you.

MS. COHEN: Hello? Okay, sorry, my phone is having challenges. That's correct, that was the gist of what I was -- my comment. I specifically had a kind of a question about 1340, as an example, where it looks like this area talks about the provider asking whether the individual thought about

transitional care and insurance coverage, but the idea is, was it actually followed up upon? What assistance did they get within that transition?

And then I suggested that perhaps an area for discussion, I know the Duals group has talked a lot of about care coordination questions, and we've struggled with how usable the questions are and how meaningful they are.

And I thought maybe that might be a good area to draw into the discussion, if Sarah has any information about that, I don't know if that would be helpful at all.

CHAIR GESTEN: I think it would be. Do you have specific measures in mind from that, from the Dual group, that would relate to children, or -- Sarah is shaking her --

MS. COHEN: No, yes. I think it was more likely a struggle identifying measures, is what I recall. Is that correct, Sarah?

MS. LASH: Yes, I think it's a similar conversation. There's a strong desire for strong measures of coordination, and we've hit this same wall before in that other work group.

CHAIR GESTEN: Yes, this wall is very familiar.

MS. COHEN: So, I think the reason why I'm bringing that up is that even if the CAHPS questionnaire has maybe one question, I think it might be important to highlight this area, even if sort of we don't have perfect measures, knowing, across the MAP, we are facing that same struggle.

CHAIR GESTEN: Thank you. Beth?

MEMBER FELDPUSH: So my question or comment is actually more of a general one, than -- I had my sign up a little earlier, and probably should have just jumped in.

But my sentiments really echo yours, Foster, in thinking that there's a pretty rich pipeline here. And we don't know

what's going to happen to those measures, but I'm a little bit hesitant, personally, to vote on any of the four that are up on the spreadsheet today, just because this is an incredibly important area, I absolutely think it's a high, high, high priority, and hope that this type of activity is one that the MAP will do on a yearly basis because new measures come on line. But I sort of worry about being faced with the dilemma of a year from now saying, oops, sorry, we think there's something better now than we voted on last year. One, because it's kind of hard to pull measures out of the set, and two, you really don't want to do that, because you hope that you'll collect longitudinal data once you get going on something.

So again, sorry, just a general comment now, but an incredibly important area, but I'm just a little hesitant to sort of pull the trigger on voting on any of these today.

CHAIR GESTEN: Great, thanks. Any

other comments before we start voting?

Okay. Well, why don't we take it from the top. First measure is 0719, Children Who Receive Effective Care Coordination of Health Care Services When Needed.

Again, this is a survey, a survey -- all of these measures are from a survey.

Can I have a show of hands of folks who believe this should be prioritized, added to the measure set?

One. Anyone on the phone? Okay.

0720, Children Who Live In Communities Perceived As Safe. Can I have a show of hands in the room? On the phone?

0721, Children Who Attend Schools Perceived As Safe. Show of hands in the room? On the phone?

And I apologize, folks on the phone, no one raised their hand for 0720 or 0721, and we had one, I think, for 0719.

For 1340, Children With Special Health Care Needs Receive Services for

Transition to Adult Health Care. Show of hands in the room? One. On the phone?

MS. COHEN: Anne says yes.

CHAIR GESTEN: Two. Great. Okay. Well, none of these measures passed our metric for passing, but the issue absolutely is coming back, as a number of folks mentioned, it's a really important area.

So we have I think two more areas to go through, maybe three, depending on whether you're a lump or a splitter, or whether we can put cost together with inpatient, which I may suggest that we do.

Moving onto an area that was prioritized, you heard prioritized by the states, and we've had some conversation about this, behavioral health measures, so I don't know, Beth or Sarah, do you want to go through what it is that we have relative to the behavioral health measures?

MS. CAREY: Sure, I can give you the overview here.

So we have five measures listed here on this slide. They're a mix of -- no, I'm sorry, these are all process measures, but there's a mix of data sources and measurement levels, which we'll see when we get to the spreadsheet.

1365 and 2337 are currently going through -- are currently going through evaluation for endorsement, so if they are selected, they would need to be recommended with conditional support.

We categorized them, and again, you can do this in whatever way is useful, but we categorized them into buckets of screening and risk assessment. We have preventive care and screening for clinical depression, child and adolescent major depressive disorder, child and adolescent major depressive borders suicide risk assessment.

We have, 0004 is on initiation and engagement of alcohol and other drug dependence treatment. And then a new measure

that currently is undergoing review is 2337, which is an antipsychotic use in children under five, and that's actually going through our safety committee.

MEMBER ADIRIM: 0004 is substance use treatment, but here it says it's something -- okay, I got it. Thought it was ADD.

MS. CAREY: So Nadine, do you want to show us, quickly, the measures in the pipeline. It should be the next slide.

Right, so this was an area where there were quite a few measures coming up through the pipeline from the COEs. So CAHPS of course is ready, there is a bundle of measures on antipsychotic use which has been finished in the development phase but has not been submitted for endorsement here at NQF.

And there's a, you know, a range of other measures, Denise Dougherty at AHRQ tried to put them into the buckets as we talked about them during our web meeting.

So looking at access to outpatient

or ambulatory mental health care, and then also looking at some measures of ER use for mental and behavioral health.

So we can flag these to come back and revisit during our spring meeting.

Do we want to go to the spreadsheet?

CHAIR GESTEN: Yes. I'm sorry, let's go to the spreadsheet. I was mesmerized by the number of measures.

So we have one two three four five. What's that? Now we can see it, finally.

So they range from, as was mentioned, measures on treatment for alcohol and drug dependence, clinical depression measures, measures around assessment of suicidality and suicide risk, and then the essentially utilization measure looking at percentage of children under five who are dispensed antipsychotics. Did I miss any?

MS. COHEN: This is Anne, I have a

clarifying question. You mentioned in the measurement development area, if you can go back to that, because I missed it, there was another antipsychotic measure that's being developed, is that correct?

CHAIR GESTEN: There was actually a set of measures, that was partly why I was mesmerized.

MS. COHEN: Sorry, I missed it.

CHAIR GESTEN: No, that's fine. There are seven measures, some of which have been NCQA approved, and I believe that they relate to a number of different issues, you may have it in front of you, related to atypical antipsychotic use, polypharmacy, were there metabolic screening measures related to that?

MS. CAREY: I actually don't have the topics, but three of them are, of the seven.

MEMBER LLANOS: This is Karen, I'll add, we've actually taken one of the

antipsychotic use measures and we're in the process of e-specifying it, along with our partners at ONC, and that one should be ready soon.

Yes, paper and an e-version of one of the antipsychotic measures.

CHAIR GESTEN: Anne, did that answer your question?

MS. COHEN: Good, I was just sort of thinking about the earlier conversation about the need for antipsychotic measures as well as a suicide measure, and the desire to just kind of link them, electronically, and so I'm just kind of wondering if the existing measure has e-availability as well as the one that's in development, or?

I think it's the same challenge we just had with the care coordination questions, that it looks like there's so many in development.

CHAIR GESTEN: Right, and according to Karen, at least one of the

antipsychotic use measures is currently being developed for e-specifications, correct?

MS. CAREY: Yes, we have been working on it for over a year, so it should be relatively soon.

It's different from the PQA one, which I think is the one that -- right, so our NCQA team is e-specifying one that's a little bit different, I think we've tried to compare the two, and I think the PQA one which is on the previous slide that's been endorsed is more of a never event, if I am remembering correctly, and this one is not. This one, I think, also includes a follow-up component, if I'm not mistaken.

CHAIR GESTEN: Are we ready to go back --

MS. COHEN: Okay.

CHAIR GESTEN: Should we go back to the specifications of the measures?

Let me just invite, if folks have questions about the measures themselves, this

is the time to ask. Susan?

MEMBER LACEY: So on the status, this is on the spreadsheet, so when you look at the status, can someone give me a little bit more information about what it means? Obviously, endorsed means endorsed, but steering committee review/recommended versus recommended for endorsement by standing committee? So is -- sounds like a continuum that happens, or what's --

DR. BURSTIN: Those are pretty much the same thing. Both of those measures have gone through our committees, recommended, the last one in fact already going out for our final approval by our Consensus Standards Approval Committee, so that one's quite far along.

MEMBER LACEY: So both that, and --

DR. BURSTIN: Yes, the one above it as well, yes.

CHAIR GESTEN: So I have a couple

questions, I guess, taking my Chair hat off.

I'm wondering if anyone cares to comment on -- I know that there's been a lot of attention to very young children getting antipsychotics, but I also know that while perhaps any percentage is of concern, the percentages are so low that I wonder whether it's truly a measure that's useful relative to quality improvement.

So I just wonder if anybody has a view of that.

And then my second question is, the measures on major depression -- clearly major depression is a highly prevalent cause of mental illness in adults. I guess I'm wondering whether, of all the various mental health conditions, whether major depressive disorder is in fact the most common in adolescents, or whether it's others, or a mix, that's most common.

This gets at, I guess, the question I have is, are we getting at the

right mental health condition for adolescents?

So I welcome if anyone has a comment or thought about that.

MEMBER ADIRIM: So what is the most common mental health condition in adolescents?

CHAIR GESTEN: Okay, that sounds clearer than what I said yes. That works for me.

MEMBER ADIRIM: No, I'm trying to understand what you're asking. Well no, I would imagine it would be ADHD, depression, and anxiety. I mean I could look it up, but --

CHAIR GESTEN: Okay. So depression is in the top -- you believe it's in the top two.

MEMBER ADIRIM: I think so. I can look it up, though. It's tough to consider what's the most impactful, what drives costs, what, you know.

CHAIR GESTEN: Cindy, did you have

a --

MS. PELLEGRINI: Yes, just as we were looking at the list of measures under development, and while I find some of these measures attractive, and I think they're certainly on very important issues, I think I'm finding myself kind of in the place where Beth was on the last one, where I am really hesitant to choose from among these when there's so much more coming.

And you know, we heard from Dr. Kelley about the lag time and the ramp-up time that's needed. If we put these in, are we going to -- with one of these in, are we just going to want to take them out in six months or a year when we go through this process in a more in depth way in 2015?

DR. BURSTIN: Comment on the PQA one, because I knew that would come up.

So I did pull up the Pharmacy Quality Alliance one that was raised. So that is completely generated through prescription

claim data, so that might be one for consideration.

And to Karen's point, it does look at any use of antipsychotics in children under five, although the developer presented pretty scary data about how high that -- how rapidly rising the use of antipsychotics in that age group were, where there are no approved FDA indications for those drugs.

So just to put it on there, at least in terms of the burden question, I just wanted to at least put that on the table.

MEMBER ADIRIM: I accessed something, National Adolescent Health Information Center, the top -- one in five adolescents experience significant symptoms of emotional distress, one in ten emotionally impaired.

Most common are depression, anxiety disorders, and ADHD, in substance use.

CHAIR GESTEN: Thanks.

MS. COHEN: This is Anne, I

actually was looking at your question about the under age five children with antipsychotics.

There's actually a number of reports that have been done by Mathematica and Rutgers, again, just, somebody else commented about the increase in prescription antipsychotics.

I am kind of wondering, I know that another issue has been the increased diagnosis of schizophrenia among children, I think under age ten, and I'm interested in whether that's another area that we might want to consider tracking, particularly, obviously, with these antipsychotics.

So it's just, it's not on the list, I don't even know if there's a measure area, but I know it's been a growing area.

CHAIR GESTEN: This is Foster, I have seen similar, related to increased diagnosis of bipolar, but I am not aware of measures related to that.

Again, taking the Chair hat off for a second and talking about measures that are not on here, I am much more familiar, for a variety of reasons, with the measures that have just gone through NCQA recognition related to antipsychotic use, and if I had to pick measures not currently on the list for picking, I'd certainly be much more interested in those measures which I think get at many of the issues, many of the important issues related to inappropriate antipsychotic use in kids and safety issues.

And it sweeps in a broader percentage of kids as well, in terms of measurement. So we're in this period where measures have not yet gone, we don't even know if they will be submitted to NQF, my guess is they will, so for me it's a little bit of awkward timing, because I know that there's some things around the bend that aren't on this list that I think I'd probably prioritize over many, if not all, of these.

MEMBER LLANOS: Just to -- so I just pulled up the in sync one related to the multi -- it's multiple current antipsychotics in children and adolescents, and that's the one, I think, Foster, you were just referencing.

So it's the percentage of children and adults ages 1 to 20 who are on two or more concurrent antipsychotics, a lower rate indicates better performance.

So it captures a wider range, but then you can report four age range stratifications, 1-5, 6-11, 12-17, 18-20, and then a total range, as well.

And that's just one of the seven that were mentioned on that previous page.

CHAIR GESTEN: Go ahead, I'm sorry, Susan?

MEMBER LACEY: So we have 0576, Follow-Up Hospitalization for a Mental Condition, and we have 0108, for ADHD Follow-Up. And as reticent as we might be

about adding something that we may be able to refine and get better a little bit later, we really don't have anything all the way at the back, at capturing kids who are already getting in trouble.

Right now, what we're doing is capturing data when kids are already in trouble -- out of the hospital, or what have you.

So there's nothing in there. And I think what we were hearing on the call was that this whole cornucopia of what mental health conditions are for children, we've got to start somewhere, and I would hate for us to just not try to capture anything on the front side with this group.

CHAIR GESTEN: I am not sure I am following you. Can you translate it into, you are advocating for -- I thought you were advocating for more upstream -- a measure that's not on here, which is something upstream. But it sounds like you're saying --

MEMBER LACEY: No, what we have is, you know, the endorsed, on the spreadsheet -- so we have the endorsed piece around Follow-Up After Hospitalization --

CHAIR GESTEN: In the current measure set. The current Core Set has Follow-Up After Hospitalization --

MEMBER LACEY: So those are current, and that's what we have.

CHAIR GESTEN: -- and ADHD Management.

MEMBER LACEY: Right. So I would hate to look at this whole potential list that has some, you know, screening for depression, screening for suicidal tendencies and what have you, and just not add anything --

CHAIR GESTEN: Gotcha.

MEMBER LACEY: -- to the mix, just because we're waiting for something that potentially may be better --

CHAIR GESTEN: Okay.

MEMBER LACEY: -- and that's

worrisome.

CHAIR GESTEN: Wait, there's a screening measure, is there a screening measure for -- there isn't a screening measure in the Core Set, is there?

MEMBER LACEY: No. Nope.

CHAIR GESTEN: In the adult one.

MEMBER LACEY: It's all on the back side.

CHAIR GESTEN: Okay. Sandra.

MEMBER WHITE: You know, I also agree with the previous speaker, and I'm sorry, who was speaking? Susan?

And this is based upon, of course, what we know about our members that have a behavioral health issue. If they have a physical issue, the cost is 1x. A physical issue with a behavioral health issue, the cost is 4-5x.

And from the information presented this morning, looking at the mental health disorders that was presented earlier this

morning, which shows that there's a disproportionate spending of Medicaid premiums for behavioral health, and even though it's a very small number of that population, it's extremely high cost.

So there is 10 percent of the children who are driving almost 40 percent of the cost. So I, too, would agree that we do need to have some upstream mental health screening for this population.

CHAIR GESTEN: I'm sorry, I didn't see who did -- Cindy? Go ahead.

MS. PELLEGRINI: I'll be brief, I was just going to say, I agree completely about the importance of all of this. The only thing that gives me pause on this one is that it's only for clinical depression, and that it's not more holistic for mental health in general.

CHAIR GESTEN: Terry?

MEMBER ADIRIM: Right, and I agree, actually, with what everybody is

saying. However, it sounds to me, one of the last things Karen just said was that it's being measured in the adult Core Set, right?

So that, you know, if you're aligning the sets, states are already reporting it, this would be something that would be easy to report, right?

CHAIR GESTEN: How many states are reporting this one, for adults? Do you have any idea?

MEMBER LLANOS: I'd have to pull it up, but I don't know off-hand.

MEMBER ADIRIM: Yes, but depression is very common in adolescents, and it's something you don't want to miss because it could have dire consequences.

CHAIR GESTEN: So I'm wondering if other folks -- the two things that concern me about the measure: one is that I believe the task force recommendation, the U.S. Preventive Task Force recommendation relative to this, talks about appropriateness of screening if

there is in fact a system in place, and it's that "if there is a system in place" part that becomes problematic when you talk to clinicians about whether they screen or not.

I have a personal view of that, but in terms of the ability to use a measure of screening, I don't see that as -- I'm not advocating that it should be an exclusion, but I don't see that in the exclusion category for this measure, as it relates to, at least, U.S. Preventive Task Force recommendations.

And then, it's very small print, but I can see it, because I just had an eye examination -- there's an awful lot of exclusions that I wonder about the ability to standardize or to implement, or operationalize, these. So exclusions include patients who refuse to participate; if there's an urgent situation, however urgent is defined; where there's motivational issues; where there's a referral situation where they're participating in ongoing treatment,

again, I'm not sure how that's defined.

There's a number of different exclusions that make me wonder about the ability to standardize this. Those exclusions give me a little bit of pause.

But I'm wondering if anyone else has any comments or concerns about those, or actually, I don't have to ask --

MEMBER SIDDIQI: Alvia Siddiqi, and Foster you pretty much took one of the points that I was just about to make, and I completely agree that from the USPSTF standpoint, it's really challenging for providers, often it's for a provider system, especially for primary care, to implement routine screening for clinical depression unless you have appropriate referrals and systems in place to be able to manage what we do with a patient when they do test positive on that screening.

And so I think this is still a very challenging measure to see states report

on, also because a follow-up needs to be documented if we're looking at 0108, and that is something that you really typically can't use claims data to easily be able to identify follow-up that was recommended.

I'm thinking of this as more of a hybrid-type measure where a chart you'd use would probably be required as well, so I kind of am more excited about the upstream of the newer measures, especially the one that you had mentioned about antipsychotics, as well as the need for including some of those types of measures that may be more helpful.

So I'm kind of on the -- I kind of don't believe right now that this measure is not going to be as effective in terms of having states report on it, feel comfortable operationally to be able to use it.

CHAIR GESTEN: Okay, thanks Alvia. Terry, did you have a question? Or was that just a remnant? Susan, and then Sandra?

MEMBER LACEY: So I'm just going

to play devil's advocate with you, Foster.

So my husband works at a federally qualified clinic, he's a pediatrician. He sees women who bring in their kids all the time who had gestational diabetes, or they were very sick, or what have you. And they were screened for xyz, and the results were such that they needed intervention, but either they're undocumented or they can't get whatever they need, and they don't have the money, or what have you, and they don't get it.

And so I hesitate for us not to do something just because we don't have the perfect environment in place within a community to refer people to, because I think that's a slippery slope.

I mean, I think we have to say: this is what we need to do, and then, you know, other departments, agencies, or what have you, I think we have to coordinate in a much broader way about making sure that those

systems do get in place, and I don't know if that's our role.

CHAIR GESTEN: Sandra?

MEMBER WHITE: One of the other considerations that we can -- I am trying to read my screen at the same time.

(Laughter.)

MEMBER WHITE: One of the other considerations that we can also discuss is considering 1364 and 1365, and not incorporating 0418, because 1364 and 1365 does not have any significant exclusions.

And I do agree, it's problematic when there is not a standardized screening tool. There are lots of exclusions. But we certainly can more strongly consider the ones that do not have any exclusions.

CHAIR GESTEN: Okay. Those measures, as I understand them, 1364 and 1365, it says electronic clinical data or electronic health record as the data source, but for most folks, this is chart review. That's

currently, in the current world, right?

The -- Sarah said, in terms of the question of how many states currently -- and again, this is just really for informational purposes, not to -- just for context. There are five states that are reporting the adult version of the Screening for Clinical Depression measure, as it stands now. Five.

Was there -- did somebody on the phone, Anne or Alvia, did you want to make a comment?

MS. COHEN: This is Anne, I actually did want to make a comment.

I kind of echo what other folks were saying, that I still think we need to really do something in this category, and that while the measure is not perfect, I think it's important to look at it -- in particular with the fact that I assume, obviously, this is at the primary care level, and I think given the fact that mental health is carved out, and on top of it, many kids with EPSDT are gaining

sort of mental health services via that category or development and disability categories, it's so fragmented to capture this group that we need data from somewhere.

And we have heard how much to carve out data can be a challenge. So maybe this is an area in which we can get better quality data to the board.

MEMBER SIDDIQI: And this is Alvia, I was just going to make the comment that --

CHAIR GESTEN: Alvia, I am sorry Alvia, you are very muffled, and it's a little challenging to hear you. I don't know if there's -- if you can take us off speaker, or --

MEMBER SIDDIQI: Sure, I just did. Is that better?

CHAIR GESTEN: Much better, thank you.

MEMBER SIDDIQI: Much better, sure. So I was just going to add that

the challenge with the routine screening type measure for depression is when we look at the USPSTF screening guidelines for this, that has looked at a whole body of evidence with many scholars, obviously, looking in and trying to determine whether the evidence supports a routine screening for depression without staffs and systems in place for appropriate follow-up and referral, and that is why that recommendation through the USPSTF screening task force about depression routine screening not being implemented unless you have proper systems in place is a really important one to note.

And I just think that that's still really a challenge across the board, and I just want to echo the fact that the EHR systems would not be able to -- well, essentially you would need to cull through that data through the EHR systems rather than look at simple claims data to be able to report on even 1364 or 1365, I still find them

sort of challenging.

And really for 1364, it's essentially just -- it seems like it's looking at certain DSM-IV criteria, and then 1365 is looking at another assessment for suicide risk, so those would not be really readily, you know, operationally -- they would be very challenging to achieve, I think.

CHAIR GESTEN: Thanks. Sandra, I assume that that's a remnant, that's a vestigial card, vertical card, in front of you.

That's okay. Not a problem. Any other questions or comments?

MEMBER LLANOS: This is Karen. I just wanted to share, and I was going to -- I wasn't sure if this would be helpful context now, or during public comment, I don't know if our SAMHSA partners are on, but so they had sent us a letter in terms of measures to consider, so I'll just share it with all of you.

I think one of them has been retired, so I won't mention that one, and the other two are on this list, for what it's worth. And I think you've discussed both of them. The first one is 0418, the Screening for Clinical Depression, and the second one is the Major Depressive Disorder Suicide Risk Assessment, 1365.

So, again, just for consideration, this is from SAMHSA. 1365 and 0418, and those are the two that SAMHSA shared with us in terms of feedback.

CHAIR GESTEN: Susan.

MEMBER FLEISCHMAN: Yes, trying to understand, on 1364 and 1365 in states with mental health carve outs, is this a combined data set from the mental health community? Sometimes it's in managed care, sometimes it's county, it's not in managed care. Sometimes it's partially the accountability of the physical health plan, so mechanical question on this.

CHAIR GESTEN: So I don't think there's a -- as we heard from David, you hear from other folks, I don't think there's a simple answer to that. The reality is that there are states in which there are carve outs of numerous kinds and stripes, you know, they can include anything from behavioral health to pharmacy to you name it.

However, the ability to then put that data together is also variable, so it's not just is it carved out, but is there a mechanism to be able to splice it back together?

And again, my understanding, I think as David articulated, is it can be very variable between states that have carve outs. So mental health issues, like some other issues, may have some challenges.

I don't know if Marsha or Karen, either of you have a finer point on that as an issue.

MEMBER FLEISCHMAN: It's actually

even worse than state-by-state.

So in California, the physical health plans share -- do everything up to a certain point on serious mental illness, and then county mental health kicks in, it's not in a managed care setting. And that bar is in a different place in each county, dependent on county policy, but more importantly, county resources and capabilities.

So in a county with poor capabilities, we want the child to get care, so we push our -- we push out what we offer so that the kid doesn't fall through the cracks, and counties with better capabilities, because they're not getting paid for it, will try to push it out into the community.

So I don't have a clue, like on the diagnostic evaluation, how we would start to understand who has had a proper evaluation as far as the criteria, and who hasn't.

CHAIR GESTEN: Other comments before we get to a vote?

Okay. Let's take it from the top. First measure is 0004, The Initiation Engagement of Alcohol and Other Drug Dependence Treatment. By a show of hands, if you believe this should be added to the current Core Measure Set.

On the phone? Okay, it was a zero here.

0418 is Preventive Care and Screening, Screening for Clinical Depression and a Follow-Up Plan. By a show of hands in the room, all those who believe this should be added to the measure set?

And on the phone?

Okay, that was five, right? We need seven now, is that right? We need seven.

1364 is Child and Adolescent Major Depressive Disorder Diagnostic Evaluation. By a show of hands in the room, all those in favor of adding this, recommending to add this? One, two, three.

On the phone? Okay, three total.

For Measure 1365, Child and Adolescent Major Depressive Disorder Suicide Risk Assessment, by a show of hands, if you're in favor?

One, two, three, four, five -- six, sorry.

And on the phone?

MS. COHEN: Yes, this is Anne.

CHAIR GESTEN: Seven. And the last measure, 2337, Antipsychotic Use in Children Under Five Years Old. A show of hands?

We have three. On the phone?

MS. COHEN: Yes, this is Anne.

CHAIR GESTEN: Four. Okay, so we had one that made it, 1365.

So we have two, or if you're a lumper, I think we might try to lump the inpatient and the cost together, since as pointed out, they're kind of in the same category, to go.

We're at break time. My

suggestion is that we break now and come back at 3, or, if we can do a five minute break -- is that, am I pushing it by a five minute break? Is five okay?

Why don't we try to come back in five, and then we'll start by tackling that, and then we'll move on to the cross-cutting issues, or whichever comes first, if it's public comment first. No, public comment comes after the cross-cutting issues. So why don't we come back in five minutes?

(Whereupon, the above-entitled matter went off the record at 2:47 p.m. and went back on the record at 2:55 p.m.)

CHAIR GESTEN: Is there anyone that has to leave before 4:00? So we know -- because we have some voting stuff that may complicate our math a little bit, but -- okay.

Anne and Alvia, are you hanging in there okay?

MEMBER SIDDIQI: Yes. Alvia.

MS. COHEN: Yes.

CHAIR GESTEN: Thank you. Thank you so much. I know how hard it is to stay all day on a conference call, but we very much appreciate you being there. And, again, feel free if -- if you have something to say and I'm just forgetting that -- forgetting you, feel free to just jump in.

So in terms of process and where we are, we have one big lumped category that we are going to go through. We are going to put together in-patient measures along with "costs," which are the readmission measures to go through. So far we have three measures that have met the threshold, and we'll go back to those and whatever we may decide to endorse here to prioritize those before you leave. So start thinking about your favorites. Again, it is going to be another challenge to pick among them, but that's what we are here and charged to do.

And we will have time for some open comments, if there is anyone on the line

or left in the room. One brave soul. And then just kind of -- probably just revisit very briefly some of the cross-cutting issues, just to make sure that we didn't miss any, allow you to put some on the table that perhaps we didn't get to, and then we should be okay.

So I don't know if -- who wants to do this slide? Beth. This is Beth.

MS. CAREY: Perfect timing. Okay. So --

CHAIR GESTEN: And while you're getting ready, let me just -- in case I forget at the end, thank you all for -- I'm just stalling here.

MS. CAREY: Thank you.

CHAIR GESTEN: For making your trip here and contributing. You know, great comments and great questions. And I recognize that there are a number of things that we put in a parking lot, probably for next year, but we're not going to forget those. So --

DR. BURSTIN: And as long as we're stalling, I'll also mention that Mark Schuster from the Children's Hospital Boston, who is the lead for one of the centers of excellence, some of the measures we have been talking about, is on the line.

So if you have any questions for him, he is happy to answer them. They do readmission measures, and we also added, just because we had -- it recently went through our committee as well, we also added child H-CAPS to the list for your consideration as well. So that just was very favorably reviewed by our committee.

MS. CAREY: Okay.

CHAIR GESTEN: You good?

MS. CAREY: I've finished my candy.

CHAIR GESTEN: Okay.

MS. CAREY: So we're ready to go. Okay. So as Foster was saying, we do have a big bucket of measures here to go through. We

categorized two measures in premature birth or low birth weight, 0304, late sepsis or meningitis, and very low birth weight neonates; and 0477 under 1,500 grams and vent not delivered at appropriate level of care.

We have under the bucket of cardiac and circulatory birth defects 0339, a pediatric heart surgery mortality rate; 0340, a pediatric heart surgery volume, which is also in AHRQ PDI Number 7; and then a paired measure set, pediatric cardiac surgery mortality and volume.

And then under our remainder bucket of other topics we have PICU severity-adjusted length of stay; the PDI Number 2, pressure ulcer rate; a PICU standardized mortality ratio; and then a standardized mortality ratio for neonates undergoing non-cardiac surgery.

And when we get to the spreadsheet we'll see that these measures are, again, a mix of outcome and structure measures. The

ratios are mostly structural measures. Data sources are a mixed bag, and measurement levels are also a mixed bag between facilities and I believe population.

One thing to keep in mind, again, is that some of the facility level measures could be a challenge to roll up to a state.

And then on this slide we're showing the also large list of measures and development from the centers of excellence that AHRQ has provided us to look at, and you can see that, again, there are quite a few on this slide that are checkmarked as being complete, but they have not come to NQF yet for endorsement evaluation.

MEMBER ADIRIM: Do you have specifics about the sepsis ones?

MS. CAREY: This is pretty much all of the information we have. We can go back and try to get more information unless anybody else at the table knows.

Okay. Should we keep going, then,

to the readmissions? So, Nadine, if we could go to the suggested --

CHAIR GESTEN: Hang on a second. Carol, did you have a question?

MEMBER SAKALA: (Off mic comment.)

CHAIR GESTEN: That would be great. Thanks.

MS. CAREY: Okay. Very good. So here we have 0335, PICU unplanned readmission. And now that we are putting these two together it does relate to 0334, which is the severity-adjusted length of stay. They were submitted by the same measure steward. And then our two new readmissions measures, 2393, which is pediatric all condition, readmission measure; and 2414, which is a lower respiratory infection readmission measure.

Can we have the next slide, Nadine? No, we don't have any more of those, because -- right, we don't have an additional slide of the centers of excellence measures for this one, because the two are on -- they

are further along and have already come to NQF.

Any questions on this, or should we jump to our spreadsheet?

CHAIR GESTEN: So, Carol, probably now is the time to make your comment.

MEMBER SAKALA: So I think there is one more measure that would be really outstanding for this measure set that already is endorsed and could have been on that first list, and that is the exclusive breast milk feeding measure, which is the proportion of newborns exclusively fed breast milk during the hospital stay.

And it really addresses a lot of the concerns that have been raised today, for example, about volume, that over 98 percent of our children are exposed to the hospital care at the beginning of their lives. That would relate to this measure. And, by the way, 85 percent of moms, because it's a great -- you know, breastfeeding is outstanding for both of

them, and it also relates very well to other measure sets -- the in-patient quality reporting, it's an optional measure, and for meaningful use, the eligible hospitals, it's an optional measure.

And although we haven't been talking about the Joint Commission as an alignment focus, I think it's important to note that beginning this year hospitals with over 1,100 births per year are mandated to report their perinatal care measure set, which includes this one.

So I think it's a potentially good candidate, and of note is that the conditions that you discussed, Sarah, earlier -- many of the conditions, it's preventive for some of the chronic conditions that we're concerned about in this population.

CHAIR GESTEN: So we don't have the specific specifications in front of us, but I think if folks have questions about them -- does anybody object to the notion of

putting -- what's one more? Does anybody object to the notion of putting one more in front of us for us to take a look at --

MEMBER ADIRIM: No. I was just going to ask about that particular measure, what data set is used to derive that measure? I mean, I don't even --

MEMBER SAKALA: Yes. But I forgot to mention also that it is e-specified, so that it has the option of that.

MS. CAREY: I just pulled it up on QPS. It's measure 0480, PC05 exclusive breast milk feeding, and the subset measure of PC05A, exclusive breast milk feeding, considering mother's choice.

The measure description is PC05 assesses the number of newborns exclusively fed breast milk during the newborn's entire hospitalization, and a second rate PC05A, which is a subset of the first, includes those newborns whose mothers choose to exclusively feed breast milk. This measure is part of a

set of five nationally implemented measures that address perinatal care; PC01, elective delivery; PC02, Caesarean Section: PC03, antenatal steroids; PC04, health care, associated blood stream infections in newborns.

CHAIR GESTEN: Not collected currently by payer type, correct?

MS. CAREY: Let me scroll down.

CHAIR GESTEN: One of my questions would be, what is the mechanism by which states would be able to collect this from Medicaid specifically?

MS. CAREY: It is -- the data source comes from administrative claims, electronic clinical data, and paper medical records, and the level of analysis at this facility or population is a process measure.

CHAIR GESTEN: Okay. Is there a question? Yes? Okay. So we have a lot up here, and it can't all fit on one screen, so we can -- I guess we can play around with this

or maybe do these by sections. If folks have questions or thoughts about these measures, I guess this is probably the time to talk about clarifying -- ask any clarifying questions about the measures. Sandy? Sandra?

MEMBER WHITE: So are these measures -- will also be expected to be reported by the health plans, or are these measures only data collection by the state?

CHAIR GESTEN: So I'll try to answer it for CMS. Always a danger. But since you're in the room, you can answer. But given that you're not chopping at the bit to answer it, I think the existing -- I think what we heard in the two presentations this morning from the states was that the answer to that can be variable, depending on the measure and depending on the state.

So there are certainly some states who have driven, if you will, core measures through requirements in the health plans, so there is other states for some measures,

either because they collect the data set directly, have done it themselves, if it could be done through administrative data.

So I don't think that there is a simple answer to your question, but it's a good one. I don't know. Would you answer it differently, or do you --

MEMBER WHITE: This is probably a rhetorical question. And the reason that I'm asking it is because both of the state presenters this morning, they talked about the barriers of being able to collect certain types of information, and particularly collecting data from a hospital system rather than from a provider who is a part of the health plan providers network.

So I think it's -- I can probably say with certainty that it's going to be extremely challenging for health plans to get this kind of information from the various hospital systems.

MS. COHEN: This is Anne. I have

a question regarding that. And maybe this is -- and I know there is somebody else from California in the room as well, so maybe I'm way off base here, but I know -- I believe that in California there is some hospital-level data that is reported up to kind of the state and to the kind of managers or state hospitals.

And I'm just kind of curious whether there may be a different way of looking at some of these measures, since it is state-level reported. Is it possible for the hospitals to report directly? Does it necessarily have to come from the health plans? It may be from -- it's a separate agency within the state that works with the Department of Health Care Services. It is just kind of an "out of the box" idea, but I'm just trying to get that concern.

CHAIR GESTEN: No, Anne, that's a good point. And it's not clearly out of the box, because I think we've encountered this

already with existing measures. For example, CLAPSI measures are reported to the state, and I think we have had some conversations about, you know, why not just use that directly. But do you have -- I think the methodology in terms of the mechanism by which the data is presented may present some challenges as currently constructed to just kind of sweep up measures from somewhere else. But, Karen, do you want --

MEMBER LLANOS: I think you're right. I mean, I'll just give you an example. I think what everyone is raising is exactly right. Some measures are just harder to collect, and facility measures tend to be those types of measures that are harder for states to report on.

I think we have heard that challenge on both the children and adult core sets. Some states have found ways around them, but they are still challenging in terms of the data collection.

CHAIR GESTEN: Yes. Denise, why don't you just introduce yourself. We're rewarding you for being the only person in the audience for hanging in. We've made you an unofficial member of the task force.

MS. REMUS: You're in my niche now. I know this -- I know the --

CHAIR GESTEN: Go ahead.

MS. REMUS: -- world. I'm Denise Remus with All Children's Hospital in St. Petersburg, Florida. We are part of Johns Hopkins Medicine System. And I think I am the only hospital representative, perhaps, in the room.

As I was looking at these measures, I just wanted to clarify for the group that the PICU measures, as I have been reviewing them, are from the VPS system. That's a clinical registry system that hospitals participate in. So the way these are defined, you'd need to be participating in that registry system.

And I can share with you that All Children's, as advanced as we believe we are as a very high quality, freestanding children's hospital, literally just started participating in the VPS registry. So it's not quite as prevalent.

The pediatric surgery mortality measures that you are looking there are from the Society for Thoracic Surgeons' congenital heart surgery database. Again, I would guess that the majority -- almost all of the hospitals that do congenital heart surgery are in these registries, but I just wanted to clarify, the data goes into those registries.

So it's a different flow of data than what hospitals do with NHSN and others. From the state, you can grab easily from NHSN. It is not, I don't believe, going to be very easy for you to grab from these registries, and sometimes it's difficult for the hospitals to get their own data back from the registries. And some of the risk adjustment

actually occurs downstream from the hospital.

So we don't necessarily have all of that detail in a way that we could readily pass forward. So I just wanted to share that perspective.

CHAIR GESTEN: Thank you so much, Denise. Other questions? Comments? Susan?

MEMBER LACEY: Can I just get some clarification around the pressure ulcers? So that's hospital-acquired, I'm assuming, trying to maybe be in alignment with adult CAPUs. And then that's administrative data collected every four years. This is an AHRQ HCAHP. No? Or is it just --

DR. BURSTIN: Not every four years. It's -- oh, Denise knows this.

MEMBER LACEY: Oh.

MS. REMUS: Yes. The pressure ulcers, to be honest with you, this PDI, based on the administrative data, it is a valid measure based on administrative data. I can tell you that hospitals who were in Magnet,

and hospitals who really monitor this -- and I'm learning more about the pediatric world -- we don't -- we monitor this mainly because this is what leaves our door from an administrative data.

But we capture our pressure ulcers using a Magnet measure, using clinical events, because we do have a lot of pressure ulcers that occur in our population that would never be captured in this measure.

So especially in a lot -- our preemies, our babies, you know, it's -- so I'm just acknowledging that this, like many of the others, is just one of those challenges of administrative versus clinical data. We monitor and improve based on our clinical data. It's the Magnet measures, it's the nursing care sensitive measures, it's that operational definition.

This is easy to collect, and it is something certainly that you could do and monitor, just recognizing that it captures,

you know, a portion of those that occur within the hospital setting, especially, again, in this -- in your very frail babies.

CHAIR GESTEN: Cindy?

MS. PELLEGRINI: Clarification. This does say in the exclusions that it excludes neonates. So are you thinking that it would not capture most of those babies?

MS. REMUS: This measure it would. We monitor our pressure ulcers across all of our babies.

MS. PELLEGRINI: Right.

MS. REMUS: So, you know, internally we monitor everything.

MS. PELLEGRINI: But just based on what you were saying, it sounded like a high percentage of what you capture is in the neonates. So we would expect this measure not to do that.

MS. REMUS: In components that don't transfer into the ICD-9 codes that would meet this definition. That's one of the

challenges.

If you don't mind, I'd like to make a comment on the exclusive breast milk feeding, and I'm sharing this not because it's a freestanding children's hospital. We don't actually have to report this, because we don't fall under that umbrella. We don't do deliveries, but we care for these babies.

And in working with Johns Hopkins and the Children's Center that does have to report this, we have found some concerns with this, and they are working with Joint Commission on trying to clean up. And, of course, if any of those specifications are changed, they would roll into the measure that you are working with.

But there are challenges where we do need to give supplements for medical purposes that are -- that fail this measure and are not acknowledged right now currently. And some of those other components of the medical condition of the baby that are not

fully specified that we are finding as we evaluate when this measure is failed.

So it's -- I don't think it's anything to throw out the baby with the bath water, so to speak, but just know that as with many measures there is continuous effort to try to enhance and understand how that definition that looks really good when it's put out there in the real world, what some of the caveats are that we need to try to explain and modify the definition.

CHAIR GESTEN: Thanks, Denise. Why don't you stay put, because there might be other issues. We're on in-patient, and you hung in there.

Can we go down to the measure on readmissions? I had some questions about that one. It's the all condition readmission one I think that I had the question on.

I guess one of my -- one of the concerns I had about this measure -- well, first of all, as folks know, there's probably

no more measure that is a lightning rod than the readmission measure. So now -- so let's include pediatrics in this as well.

The measure does say it's case mix adjusted, which is interesting, and that addresses one of the potential issues that -- but I guess I was struck by the number of exclusions, and I -- I don't know if there's anybody here who can help or -- but I would just point out that, as I look at this and think about the fact that neonate births are excluded, and births are probably -- not probably, they are the number one cause of -- number one hospitalization in Medicaid.

Mental health -- is this the one where mental health is excluded, too? So we've excluded mental health, and we excluded births from readmissions, probably two of the most important, either based on volume, costs, whatever, admissions to the hospital for the Medicaid program.

And then there are other

exclusions related to whether the data is actually valid at the -- it says that the -- that there is an exclusion if records are not felt to be complete or valid. And I understand why that would be true, but -- I'm sorry?

DR. BURSTIN: I was going to say, if you wanted me to -- this just went through our evaluation by a standing committee, so they have looked at all of these issues. This was definitely one of the -- these were measures they did recommend pretty highly, having gone through lots of the weedy kind of issues. And I'm, you know, happy to share that information with the group if they'd like to see it.

The biggest concern that people had raised is that it doesn't exclude what may be -- you know, what may not be preventable readmissions, but that is sort of the state of the art currently in terms of readmission measures to enrollment.

CHAIR GESTEN: But can you comment on that -- on the committee's thoughts and deliberations about excluding records if -- of questionable quality and who -- how one operationalizes the issue, the exclusion issues here, that talk about excluding records of questionable quality? And what -- why wouldn't hospitals, why wouldn't states say, "All our data is of questionable quality. We're not going to include it." What's the incentive and who makes that judgment about whether the quality is --

MS. REMUS: This is Denise. I can't -- yes, I was going to say, I can't speak to that, but typically it's the demographics. If you're missing things that you need to actually find that readmission, you are missing a Social Security number or medical record number or the other -- whatever the fields are that are used to link, that is usually where your quality threshold is.

DR. BURSTIN: And, actually this

is the danger of looking at the incomplete stuff as opposed to the full stuff that the committee full reviewed, because it does exactly as Denise just pointed out. You can't do readmission rates without, for example, having the patient identifier, admission date, discharge date. It's those kinds of things as opposed to the quality of the record.

CHAIR GESTEN: So it's record by record. It's not -- it's not only none, it's a record by record evaluation.

DR. BURSTIN: Yes.

CHAIR GESTEN: And then, is there a report of what percentage of records met that criteria, so that you --

DR. BURSTIN: There should be. I don't have that in front of me.

CHAIR GESTEN: Okay. And the rationale to exclude newborns and mental health.

MS. REMUS: have mixed feelings about this, and I truly know the adult world

extremely well with readmissions. I have been focused on that for many years.

Having drilled into the pediatric data, I have some concerns about -- one I know -- mental health is challenging. And mental health, if you're -- if this is a provider level -- and, again, I guess that's -- most of these are provider level. We at our facility have probably two patients a day Baker Act'd in our EC. We have no in-patient beds. We do not provide behavioral health/mental health services.

So those patients are EC visits, are not admitted, so they wouldn't actually fall into this metric, but that's just reflective of the challenge that we have in finding beds to take care of adolescent patients.

They are not treated routinely in hospitals in our community. We hold them until they can go to a residential facility, so they are typically up on our floor, then a

medical clearance, and then they'll move out with the mental health. Those are patients that we have to coordinate with the community, we can't handle independently, and they are really a challenge.

The other -- I have actually just finished looking at a year of our readmission data, all-cause, 30-day. And our big concern is we have a huge Hem/Onc population. And we have some patients who are coming in every month for their treatments, and they're not excluded in an all-cause readmission measure. And it doesn't look to some of those therapies where it truly is not safe for these Medicaid children to be treated and receive their therapies in the community.

I just -- this measure hasn't been -- it hasn't been --

DR. BURSTIN: This measure has a lot of those bells and whistles, so we probably shouldn't get into the details.

MS. REMUS: Okay. Okay, good. So

that's good. So that's not clear from looking at it, that that's one of the nuances that we are concerned with is how we implement that.

So are those excluded, your Hem/Onc?

DR. BURSTIN: No. Planned readmissions are --

MS. REMUS: Oh, okay. Okay.

CHAIR GESTEN: If they're planned. Planned is another category.

So I guess one of the challenges I think of taking some of the measures, and this isn't just for this measure or these categories is whether the way in which certain measures are crafted, when they are going to be used relative to particular public reporting or payment programs for CMS to providers, whether those limitations, all of which you describe which have been around those issues a lot as well, whether they are as germane when the accountable unit is a state and state Medicaid program, where one

could argue that, well, you as one facility or hospitals may have concerns about what it is that they can or cannot deliver on or differences between them in terms of their case mix.

In looking across a state in terms of the development of a system for treatment of mental health, it may not be irrational to hold a state accountable for that. So I'd just throw it out there as a -- one of the challenges of trying to interpret measures that reasonably develop for the provider level to thinking about it from a programmatic or statewide point of view.

DR. BURSTIN: And Mark Schuster from Children's is on if you want to ask the questions about mental health and newborns. And, as we said, PIMU is excluded, so just to --

CHAIR GESTEN: Well, for time reasons, I probably won't, if that's okay, and let other folks -- Mark, you had your --

DR. LEIB: This is measured at the plan level, not at the hospital level. So if they get admitted to a different hospital 10 days later, it gets picked up and captured, because it says --

CHAIR GESTEN: Yes. This measure I specified is -- I think is at the hospital level, so your question raises the issue of, if this was one that was put forward, what does it mean in the context of state Medicaid programs? Is it simply a collection of the hospital measures, or is it reported, getting to Sandra's point, is it reported somehow on a plan level, or does the state do the reporting, and so on, right.

DR. LEIB: You know, there is -- I do -- I have heard rumors of hospitals doing -- I know on this one we had to do that, but that some hospitals who admit their return patients to a sister hospital, just to avoid the identification of a readmission.

And especially with surgical

complications, things like that, that they never come back to the primary hospital. They go to a sister hospital. Again, I'm not saying here you do that, but it does occur where if you do capture the data at the plan level, you pick those things up and you have a benefit.

CHAIR GESTEN: Not to mention the issues of observation stays, but we won't go there. Did you have another -- was that your comment?

Okay. Beth.

MEMBER FELDPUSH: Thank you. Is it for the purpose of the Medicare measures? The initial hospital is the one to which the readmission is attributed to no matter where they go, so --

DR. LEIB: Correct.

MEMBER FELDPUSH: Right. But just on these measures, I just want to make sure we have -- I have clarity that the Steering Committee has recommended that these move

forward, but they have not gotten all the way through the NQF process, correct?

DR. BURSTIN: That is correct. Most of our readmission -- actually, all of our readmission measures are -- did not move forward through membership vote, so we are doing some additional consensus-building. It will go through our CESAC and Board. But at this point these were recommended by the Steering Committee, yes.

MEMBER FELDPUSH: But because the process isn't completed yet, it would be somewhat of an assumption or kind of conditional support. But then also, Helen, given the intensity of the work that NQF is doing around readmissions, I wondered if you could just share briefly with us some of the pilot testing around the SES factors and whether any of that is planned or can play into these measures as well.

DR. BURSTIN: Yes. So the Admission/Readmission Committee was operating

under our policy prior to the SES report, so they were not allowed to consider issues of SES. I know this was something that I believe his team -- and Marc can speak to that if he'd like -- was interested in including and they were excluded.

So it is something I think they could address going forward. But we will be watching our trial period when measures can be submitted that, with SES adjustment, we also expect multiple measures will likely be pulled into the trial period that are already endorsed for looking at the SES adjustment and whether it's appropriate.

CHAIR GESTEN: Remember, we're talking -- so it's relevant -- or what's interesting is that, remember, we're talking about statewide measures of the Medicaid program and whether SES adjustment is as relevant in that analysis is an open question. But it's what it is in my mind, a question.

Susan?

MEMBER FLEISCHMAN: Just a question around intent on this measure a little bit. I mean, are you looking at whether hospitals are discharging early or with inadequate plans? Are you measuring health plan, you know, care management capabilities after discharge? So, again, depending on whether you're in a managed care state or in a fee for service state, you kind of -- it's not clear what your measure -- you know, what the focus is.

DR. BURSTIN: Again, it's a hospital level measure.

MEMBER FLEISCHMAN: Right.

DR. BURSTIN: So inherently it's -- the thought is some of this is reflective of the hospital's performance as well as others involved in coordination of care. I don't think there's anything explicit to the health plan, although they certainly are part of the broader improvement efforts.

MEMBER FLEISCHMAN: Okay.

MEMBER SIDDIQI: This is Alvia as well on the phone.

CHAIR GESTEN: Okay. I'll get right to you after Carol.

MEMBER SIDDIQI: Sure.

MEMBER SAKALA: Thanks. A similar question, Helen. You said HCAHPS, the child version, was very well received. How far along in the process is that right now?

DR. BURSTIN: That's a little bit earlier. It's been approved by our Standing Committee, and I believe -- goodness gracious, I should know this. I believe it has gone through its post-comment call, and it is pretty close, but it's similar. It's not all the way through our process yet, but, you know, big hurdles getting through the Standing Committee, and it did very well in our Standing Committee.

CHAIR GESTEN: Alvia?

MEMBER SIDDIQI: I was just going to make two quick comments. I think in terms

of breastfeeding measure, I was surprised to see that there weren't some exclusions there for, for example, when formula would be needed, for example, for an HIV patient or a mom who would deliver her baby.

And I know that we had these same concerns in our state chapter, the American Academy of Pediatrics meetings, about babies being in hospitals that don't carry formula and just the need for formula sometimes in these special cases. So I do think that that measure still probably needs to work out better exclusions and exclusion criteria.

And then the second comment I was just going to make, for the readmission measures, I think the one that actually seems to be the one that I like the most is really that PICU one, the PICU unplanned readmission rate. And it seems to be a pretty simple, straightforward measure. There really aren't any exclusions that are noted, but it would be helpful because I think hospitals are tracking

this in terms of PICU readmission rates, and it's something that they could work on with trying to report to the states.

But, again, any facility reporting is obviously going to be a challenge, but I still just kind of like that one the best out of the three cost measures for readmission.

CHAIR GESTEN: Okay. Thanks. Do we need to say two words about HCAHPS at all, since that was sort of on the list and people didn't have a chance to prereview it, and I just want to make sure that everybody knows what that is. This is the Hospital Consumer Assessment of Health Care Experience of Care Survey, which has been validated and it's -- I assume since it's on the list it has been -- it is NQF-endorsed, is that right?

DR. BURSTIN: It's the one I was just answering the question from Carol. It has already been through our Standing Committee. It's not all the way through the process, but it's -- you know, part of that

CAHPS family of measures developed collaboratively. It is supposed to be the companion measure to HCAHPS for kids.

CHAIR GESTEN: So, presumably, in terms of state Medicaid programs, this would be segmented, would be done specifically for Medicaid, and it would be reported by the hospitals either to health plans or to the state, right? That's how we've envisioned that it would be implemented?

I mean, currently HCAHPS is reported -- okay. Let me -- Mark, are you on? If you're on the call, do you want to weigh in here about HCAHPS? Mark Schuster? Take yourself off mute.

MS. LASH: The operator might need to open his line if he's logged in as a member of the public.

CHAIR GESTEN: Oh, I see.

OPERATOR: I don't see Mark online.

CHAIR GESTEN: Okay. Go ahead,

Denise.

MS. REMUS: This is -- we have -- All Children's participated in the pilot for HCAHPS, the children's version. We are very supportive of it. We do need standardized surveys for care of children.

The payer is one of the fields that is submitted to the vendor, so you can certainly stratify the data by payer. The question that I'd have that hopefully would be clarified would be the sample size. You know, Medicare, with the HCAHPS does have a sample size requirement. You would want the same thing, I would think, if you want to understand the real picture of services.

CHAIR GESTEN: So while we're seeing if we can unmute Mark, is there -- does anyone want to make any other comments, pro or con, related to any of the measures, any of the other measures? Maybe we should go up the list off of these, make any comments about -- want to advocate for or against.

While you're thinking about that, I mean, I have some concerns about the heart surgery, thinking about the number of states that currently have their own methodology for reporting this, and the challenges and thinking about having a coexisting one, even if it's from a national registry. I think the issues around national registries and access to that data and participation have been articulated.

But I guess I have some concerns about how this would play or relate to what we have existing currently, which is an all-payer model, provider-specific, looking at pediatric heart surgery mortality, which is publicly reported. And I've been doing that for a while. I don't think we're the only state that has that. I know Pennsylvania, I think Massachusetts, and a number of others do as well.

Mark, are you able to comment now? Did we unmute him? Yes?

DR. SCHUSTER: Foster, can you hear me?

CHAIR GESTEN: Yes. Thank you, Mark.

DR. SCHUSTER: Oh, you can. That's fantastic. Okay. So just to give the context again. Child HCAHPS is a family experience of care measure. It is completely harmonized with the adult measure and already accepted as a part of the CAHPS family.

As you know, most hospitals around the country already collect this kind of data. It's just they have each used their own proprietary measures that vendors provide. And this is the first that will be available broadly that can be used by everybody and is in the public domain. And it is case mix adjusted. We did a national field test with 69 hospitals and 17,000 surveys, and so I'm happy to answer questions.

DR. BURSTIN: I think the main question, Mark -- this is Helen -- is whether

or not you have the data to be able to stratify by Medicaid. So that could be aggregated up to a state level.

DR. SCHUSTER: Yes. So vendors -- so the data are collected by vendors who send out surveys or call and interview people. And absolutely, because the administrative data that come in from the hospitals can, and usually do, include insurance type. So it definitely can be stratified by Medicaid or public insurance versus not public insurance.

CHAIR GESTEN: And does anybody recall where the health plan CAHPS -- health plan CAHPS is one of -- is on the current core list, right? Acquired for CHIP, that states do it for CHIP?

MEMBER LLANOS: Yes. So we have CAHPS child, health plan version, and the supplemental items one. It's only -- it's part of our core set. There is a broad requirement that CHIP programs report CAHPS site surveys, so using that CAHPS survey to

CMS.

CHAIR GESTEN: Do we know how many states are reporting it from Medicaid?

MEMBER LLANOS: I don't have that number offhand.

CHAIR GESTEN: Okay. Would it be wrong to say it's not at the top of the list?

MEMBER LLANOS: It's not at the top. It's --

CHAIR GESTEN: In the middle.

MEMBER LLANOS: -- a tough one. Yes. I mean, I think we've gotten different kinds of cost estimates in terms of how much it costs the state to do it.

CHAIR GESTEN: Okay.

MEMBER LLANOS: Particularly if you've got a separate CHIP program, because that's an additional cost.

CHAIR GESTEN: Right.

MEMBER LLANOS: And I think the other piece is sometimes you stagger it, one year yes, one year no, in order to stretch out

the funding.

CHAIR GESTEN: Marsha? And then I'm going to get down to a voting strategy.

MEMBER LILLIE-BLANTON: When the vendor administers the survey, who pays the vendor? Who contracts with the vendor?

DR. SCHUSTER: The individual hospitals already do this. They already have relationships with vendors and are paying them to administer surveys, and this would just be a survey that all vendors would be able to switch to and start using. It will be going up on the AHRQ website soon. It's just in the queue to get onto the website, so it is a completed survey and ready for use.

CHAIR GESTEN: So here is what I'd propose in terms of how we go through these measures. Rather than going through them one at a time, in this case, what I would suggest is any member can nominate one of the measures, good enough, and then we'll take a vote on it. And so we won't vote on measures

that don't get nominated by somebody that is on the group here, and we will assume that those are not going to -- if it's not nominated, folks aren't going to vote for it.

So why don't we do that, and open to anybody wanting to nominate any measure.

MEMBER SIDDIQI: Foster, this is Alvia. Just a quick question. None of these measures have gone through the NQF endorsement process, or at least not in the complete stage, is that correct?

DR. BURSTIN: Only the ones that are blue.

CHAIR GESTEN: So all the ones that are not blue are -- have been through, are fully endorsed measures.

MEMBER SIDDIQI: Okay.

CHAIR GESTEN: So this is the time to nominate a measure. Everybody clear here? There's a lot of measures here. Carol? Thank you.

MEMBER SAKALA: Child HCAHPS.

CHAIR GESTEN: Okay. So Carol has nominated that we vote for child -- the child version of HCAHPS. That's measure 2548, right? And we just had a lively conversation about that and the implementation issues.

So, again, for folks in the room, let's take a vote of -- raise your hand if you vote to suggest that this be added to the core set. Seven in the room. And on the phone?

MS. COHEN: What's the number in the room of voters?

CHAIR GESTEN: Seven.

MS. COHEN: This is Anne. I have to vote yes then.

MEMBER SIDDIQI: And Alvia is voting yes as well.

CHAIR GESTEN: Okay. And, Anne, you voted yes, too?

MS. COHEN: Yes.

CHAIR GESTEN: Okay. Is that a yes?

MS. LASH: Either way it passes.

CHAIR GESTEN: I know it passes. Okay.

Sandra, did you have a question?

MEMBER WHITE: Yes. My question is, was 2548 recently added? Because that was not on my list --

CHAIR GESTEN: Correct.

MEMBER WHITE: -- of measures. Oh, okay. Well --

CHAIR GESTEN: Any other nominations? Susan?

MEMBER LACEY: Hospital-acquired pressure ulcers.

CHAIR GESTEN: Okay. Hospital-acquired pressure ulcers, which is number -- it is 0337.

MS. CAREY: Right. And it's shaded blue, because it's going to be coming through review again next year. But it is fully endorsed now.

CHAIR GESTEN: So 0337, pressure ulcer rate. All those in favor of

recommending this to be added to the set raise your hand. And one on the phone. Okay. One.

Any other nominations of measures? Cindy?

MS. PELLEGRINI: I don't think we have talked about this one at all, but I will throw out there 477, under 1,500 gram infant not delivered at appropriate level of care. There is a substantial body of evidence showing that babies who are delivered at the facilities best able to take care of them do -- have far, far better outcomes than those who are born at lower level NICUs that aren't prepared to care for them, and that there is a substantial amount of room for improvement in the current state of affairs.

CHAIR GESTEN: Okay. Thanks, Cindy. So this is 0477, under 1,500 gram infants not delivered at the appropriate level of care. Susan, did you have a question before we --

MEMBER SAKALA: Clarifying

question. Sometimes it just happens.

MS. PELLEGRINI: Sometimes it does, but there are far, far more cases. For example, there are a lot of cases of high-risk women who are not being counseled at all about the proper hospital where they ought to be delivering, where there is a Level 3 or a Level 4 NICU. We have talked to -- the March of Dimes has talked to, let's say, like hospital systems where they have multiple hospitals within a system. And they had one with the highest level NICU, and I've had NICU directors say to me, "I can't get our sister hospitals to send our high-risk babies here because they are keeping them and then they'll transfer them after they're born." And there are some really perverse payment incentives in there.

MEMBER SAKALA: That's horrible.

CHAIR GESTEN: Beth, did you have a question about this before we --

PARTICIPANT: There was no

exclusion criteria here.

MEMBER FELDPUSH: Just to find out a little bit more about this area, because it is just not what I know, so, Cindy, if you're the one that has the most knowledge, or anybody, on this measure. To what extent is this tied to access to prenatal care? I'm just kind of thinking this is an outcome measure, but why is it happening?

MS. PELLEGRINI: I think it has to do more with the quality of care delivered to women who are known to be high-risk. So there's a pretty substantial cadre of women out there who are documented to be at high risk, either because they've had a previous preterm birth or they have a condition like high blood pressure or obesity or gestational diabetes or things like that.

Over 80 percent, if I'm getting -- I think I'm getting my numbers right here -- well over 80 percent of women are getting at least some prenatal care. It varies a little

bit by community and location and demographic, but the numbers of people getting at least some prenatal care is pretty darn high. The people who are getting no prenatal care, or little or none, are a fairly modest percentage.

So I think what we have here is really a case of missed opportunities, far more than -- but, you know, based on the data we have seen.

MEMBER FELDPUSH: So from a state level, if this were then to be a state level measure, what would be the actionability of this measure? What could states do to improve on this from the state level?

MS. PELLEGRINI: Right. Okay. So that would be a really long conversation, but I think there is a substantial list. What this really gets to -- is the idea of some degree, whether it's formal or informal, of regionalization of care, having a standardized -- or I shouldn't say having --- adopting,

let's say, the AAP perinatal levels of care designations, and actually certifying or verifying those in some ways, because in a lot of -- in some states right now you can say, "We're a Level 4 NICU," and nobody ever comes in and says, "Well, actually, do you meet all of the standards for being a Level 4 NICU?" They just say they are. Or a Level 3 or a Level 2, or whatever the case is.

So there is a lot of different issues tied up in this, but it means that there is a great deal of room for improvement and a lot of things that can be done.

CHAIR GESTEN: So I'm going to have to abbreviate this. Great questions. Carol, and then we're going to vote on this.

MEMBER SAKALA: Yes. I just wanted to reinforce what Cindy is saying, that the developer has found that rural hospitals, for example, are appropriately making those arrangements in advance, and it's a lot of urban hospitals that think, "Well, we'll just

keep them for the perverse incentives, and then transfer later." So it's really inappropriate practices that can be addressed.

CHAIR GESTEN: Okay. Unless there is any other clarifying questions, I would suggest that we take a vote. So all those in favor of adding measure 0477, under 1,500 gram infant not delivered appropriate level of care to recommendations to CMS, raise your hand.

And on the phone? We have five in the room.

MEMBER SIDDIQI: Yes. Alvia speaking.

CHAIR GESTEN: Alvia is seven. Anne?

MS. COHEN: Yes.

CHAIR GESTEN: Eight. Okay. Any other measures nominated? Carol?

MEMBER SAKALA: I have to nominate exclusive breast milk feeding, and to comment that there is no expectation of 100 percent and there are already exclusions, and those

exclusions really are amounting for a very small percentage of the population. And the improvability is huge, as all the CDC programs will attest to.

CHAIR GESTEN: Okay. Great last-minute lobbying. And we have talked about this one, so the measure now is measure 04880, exclusive breast milk feeding. This is a new one, for those of you who are surprised by this, like the HCAHPS one was just added today. All those in favor of recommending this to be added to the set, please raise your hand. One, two, we have six -- six in the room. And on the phone?

MS. COHEN: This is Anne. Yes.

CHAIR GESTEN: Seven. Okay. So before we close out, any last minute? Any other nominations before we move to looking at the entire -- go ahead.

MS. COHEN: This is Anne. I have a -- I have some concerns with it, so maybe it would be -- I'm sorry, I have my 16-month-old

baby on my lap, so forgive me if you hear noise in the background.

The late sepsis measure, I'm concerned because it's only related to low birth weight infants. But I think the measure related to infection might be an important area to look at, if not this time maybe for next time.

CHAIR GESTEN: Okay. I know we started to put measures up there. Maybe we should add your running slide. So we're running late. I'm sorry. Go ahead.

MS. COHEN: No. I was just going to say I'm not sure if it's worth voting on, because I have major concerns about it being so narrow.

CHAIR GESTEN: Your call. Do you want -- now is the time if you want to call a vote on it.

MS. COHEN: Maybe just add it to the list of concerns for next time.

CHAIR GESTEN: Okay. We'll do

that. Sold.

So our next task, I was going to say, should you decide to take it, but you've already decided, you're here, is to rank order the measures that received enough votes to be recommended. And, again, the context of this is a working presumption that CMS is likely, at least not now, although we don't know, in a position to accept all of these recommendations. So they certainly want the information that helps them to be able to prioritize this.

So we have -- Sarah is madly writing on the board, and you have a -- I think we're going to have a measure, a slide as well that is going to show you what we have -- which measures made it. And is that all of them? One, two, three, four, five, six, seven? One, two, three -- so we have one, two, three, four, five, six. Six measures.

So there is a slide that's up right now, 2508, dental sealants. There's two

of them, one is for age six to nine, the second is 10 to 14, 2509. There is child and adolescent major depressive disorder, suicide risk assessment, 1365; HCAHPS, 2548; 0477, which we just voted on, under 1,500 grams, infants not delivered at appropriate level of care; and 0480, which is exclusive breast milk feeding.

So I think the way to do this is you -- let's see, should we vote on folks -- on who is -- on number ones, which one of these is folks' number one, is that the way we are going to do this? This is going to be -- I guess I don't have another --

We can just raise hands on which one is -- that would probably be easier, right? Raise hands if 2508 is number one, and then go back, but that presumes that people have had a chance to think about this.

So I think we need to -- what's that? Three picks? Okay.

MEMBER FELDPUSH: I was going to

say, maybe this is a question for the CMS folks. Knowing that we went from a list of a lot to six, do we need to prioritize further down from six? Yes?

MEMBER LLANOS: I think getting a more general sense of if we only had to pick through those which ones would be the ones that would be the most helpful.

MEMBER WHITE: I would also recommend considering 2508 and 2509 as one, and then the others.

CHAIR GESTEN: Okay. So the recommendation is to consider those as -- lump them together. It's less to have to prioritize, right?

MS. COHEN: This is Anne. I think we're missing one. Didn't we have antipsychotics as well under the mental health? Am I wrong? That was upstream.

CHAIR GESTEN: It missed. I think it was close, but it missed.

MS. COHEN: Okay.

CHAIR GESTEN: Does anybody object to putting 2508 and 2509 together?

DR. LEIB: I think CMS may have a different way of looking at it, not speaking for them, but the six to nine year old is a legislative mandate. The 10 to 14 year old is maybe a nice thing to do, but not a mandate. And so they may view those differently. Just a thought.

CHAIR GESTEN: That's correct. Well, I think we're talking about -- that's true. If it's the top three, that's right. Like I said, picking your children.

So maybe the way to do this is we'll go around, and obviously the last person will have a little bit more time to think about this. And at least we'll get your thoughts about how you would go about -- how you would prioritize these in terms of one, two, three, and then maybe say something about the rest. That may be a way to --

MEMBER WHITE: Okay. The way how

I -- this is Sandra White. The way how I would prioritize them is I would lump 2508/2509 as one, 1365 as two, and 2548, HCAHPS, as three.

CHAIR GESTEN: Great. Susan?

MEMBER FLEISCHMAN: Yes. I would lump 2508 and 2509 as one of my -- one of my three, HCAHPS as one, and either breast milk or infant not delivered -- I'll go with exclusive breast milk.

CHAIR GESTEN: I'm sorry. You had a question, Cindy?

MS. PELLEGRINI: Well, the way I've seen NQF do this sometimes is that they just give out a couple markers and everybody goes and votes for their three, and then at least you see where the clusters are. Would you mind if we all ran up with that or --- just thinking, like I'm having trouble following people's rankings.

CHAIR GESTEN: I would separate them. I think you get one vote for each. So

you're putting three marks down?

You've got more than one marker, right? So do you want to give them out?

MS. CAREY: Anne and Alvia, could you please give us your top three, so we can add dots for you.

MS. COHEN: Yes. This is Anne. 2508 is one; 2509, two; and 1365 is three. And I'm not lumping together, assuming CMS will reject the idea.

MS. CAREY: Okay. Thank you. Alvia?

MEMBER SIDDIQI: Yes. Alvia. So 2508, one; 2509, two; and 0477, three.

MS. CAREY: Okay.

CHAIR GESTEN: Is there anyone who didn't --- you got Anne and Alvia?

MS. CAREY: Yes.

CHAIR GESTEN: All right. So this one is one, two, three, four, five, six, seven, eight, nine, 10.

MS. CAREY: So we're counting 10

for 2508.

CHAIR GESTEN: And 2509, one, two, three, four, five.

MS. CAREY: Five for 2509.

CHAIR GESTEN: Four.

MS. CAREY: Four for 1365.

CHAIR GESTEN: Seven.

MS. CAREY: Seven for 2548.

CHAIR GESTEN: Four.

MS. CAREY: Four for 0477.

CHAIR GESTEN: Three.

MS. CAREY: And three for 0480.

MEMBER ADIRIM: I'm just surprised, because I remember on the call mental health -- pretty uniformly people wanted to have a measure around that or a better measure around that. So I'm just surprised that the mouth won out over the head. So it's --

CHAIR GESTEN: Well, I think -- and my interpretation of that could be wrong -- is that the number of mental health

measures that are on the horizon may have influenced -- I'm going to be honest, it influenced my voting related to those measures. But comments about how this turned out? Go ahead.

MEMBER SIDDIQI: Mine as well. I just wanted -- I can't see the -- oh, I can see it on the -- okay.

CHAIR GESTEN: Alvia, you are kind of like you are underwater again. I don't know. Top three? The first one is -- with 10 votes was sealants, six to nine; the second was HCAHPS, child HCAHPS; and the third at five votes was sealants for 10 to -- looks like 10 to 14 -- 10 to 14.

And then suicide risk assessment and delivery at appropriate care level both received four votes. And then exclusive breastfeeding received three.

Okay. So are we done with rank ordering?

MS. LASH: We are. I want to make

one more comment for the record, and the good of the order. It has been MAP's practice to conditionally support measures that were still undergoing endorsement review, that CMS would add them after that process is complete and endorsement is awarded.

Is the task force comfortable with following that practice, or do you want to give full support to the HCAHPS measure at this time?

CHAIR GESTEN: Nodding for full support or nodding for conditional? What's that?

PARTICIPANT: For the HCAHP measure?

CHAIR GESTEN: Yes.

PARTICIPANT: I'm going for full support.

MEMBER FELDPUSH: I would speak up to conditional support if that has been the practice of the MAP. I wouldn't want to set precedent here today.

DR. BURSTIN: I think it's going through. It's just purely a formality.

MS. COHEN: This is Anne. The only thing that I would say is I -- knowing that lens, I wish we would have gone back and looked at the antipsychotic measure that was almost approved, too, because it would have been nice to have that with the mental health measure.

MEMBER WHITE: And let me just clarify. I think I misspoke. I was going for full support of the measure, not that NCQF had to have already provided full support. So I withdraw my vote on that one.

CHAIR GESTEN: Okay.

MEMBER WHITE: Okay. Great.

CHAIR GESTEN: So I think time prevents us from going back, Anne, and revisiting measures. Again, I would say that the issue about mental health measures and antipsychotics, and so on, I mean, I think it's going to come up again very soon as some

of these measures go through and are put forward for support.

I want to go to some of the last slides about cross-cutting issues. Let's keep going. And these are some of the issues that you saw in advance in terms of strategic issues that confront us as we think about creating a measure.

There's the -- you know, the lack of an overarching data infrastructure to facilitate reporting, and, in my mind, that includes the issues about differences between e-measures and chart review, and so on, the challenges of getting measures from hospitals, the challenges of connecting, for some measures, data to existing registries, and so on, being able to put data sets together that might be relevant for reporting.

So I think we've talked about that in the context of many of the specific measures. It clearly is a challenge. It's not a specific challenge, I don't think, for

child measures, but certainly, you know, we have seen it here.

The alignment issue between maternal and child health measures, actually, I think the -- as you saw in the slide and in our conversations, there is a fair amount of alignment and thought about which ones belong in which set, but it's an ongoing issue to make sure that there is connectivity between the maternal and adult core measures and the child health measures, and there's not any gap areas.

You know, exactly what Medicaid's role is relative to social and environmental determinants of health, I think that this tracks into some of the conversations that we were having about readmissions and other issues, and then how we take measures that may have been constructed for providers or health plans or for regions and translate those into a state level are some system level issues I think that we have.

The other ones that I heard from this morning that are not on this list was the issues around alignment, and specifically around trying to align measures with meaningful use and with the directionality of electronic health measures. I think we also heard about alignment with HEDIS measures as well.

And I think there were some other -- I want to take this opportunity to make sure that in terms of overarching issues that we have --- and we want to note these for the report going forward, that we might have missed.

Susan, did you have -- did you want to add something?

MEMBER FLEISCHMAN: No. I was going to make a comment on -- we have a great interest in that third bullet and would appreciate a conversation around that in the future. And we also have an interest in -- I'm late to the group, I know -- in Medicaid's

role in childhood obesity, which I know we have the BMI measure. But we think there's -- as the payer for, you know, 50 or more percent of children in some states, we think that Medicaid agency could be a bigger lever in the childhood obesity epidemic. So if we could add that.

CHAIR GESTEN: Thanks. Are there any other strategic issues? I mean, there are some nuts and bolts issues around measure, measure stewardship, and so on, which I don't know if they're strategic. I guess they're kind of nitty-gritty real-life issues that need to be reconciled and dealt with. But anything that falls under this category that we want to put forward? Cindy?

MS. PELLEGRINI: Just briefly. I think as we move forward, and as the science develops, we are going to want to look at things, particularly in the maternal and child health space, where we can develop sets of measures that capture the mother-child dyad,

and that kind of crosswalk up and back and track those -- or reflect those, for instance, impacts of maternal care upon infant health.

So, for instance, did Mom get a TDAP immunization? Did that infant later develop pertussis? Just making one up off the top of my head.

The second thing that I would say is I'd love to see -- I don't know who, but someone -- CMS, NQF, somebody else -- take a more systematic look at where the opportunities are for measures -- and this is even beyond the centers of excellence. What are the sources of the information and the ideas that we ought to be fostering the development of measures from?

So is it something like the "Choose Wisely" campaign? Is it all of this work PCORI is doing? You know, PCORI is going to churn out of all of this information about which of the comparative effect -- which is comparatively more effective among treatments?

Should we not be, then, systematically taking some of that and converting it into measures?

CHAIR GESTEN: Great. Anybody else have any other overarching issues? I think -- can we go to the next slide? I think, at least the slides that I have, clearly one of the issues -- and I don't think we need to resolve this today, but we might actually want to poll the group around measures in the developmental pipeline that folks are most interested in hearing about.

I think we heard specifically some interest in sepsis, for example. We heard -- I think we have ongoing interest in the behavioral health measures, particularly related to antipsychotics, but others. Is there anything else that folks want to footnote right now that they saw on the developing list that they have particular interest in?

MS. COHEN: This is Anne. The care coordination for child care needs, the

care transition.

CHAIR GESTEN: Yes, the care transitions, right. Was that adapt? What was -- adapt, yes. Anything else that we want to note? This isn't the only opportunity, obviously, to emphasize this, but if there's something --

MS. COHEN: Oh. Abuse and neglect.

CHAIR GESTEN: Okay. Although I didn't see any of those in the pipeline, but it's an area that needs a pipe. Yes?

MS. PELLEGRINI: Perinatal and -- or, excuse me, pre-conception and interconception health, although CDC has under-development almost finished, almost ready, right, a great contraception measure that we hope will be considered for the Medicaid core set for I think both adults and adolescents. CDC -- there is a webinar, is it just next week? Two weeks?

MEMBER LILLIE-BLANTON: Webinar is

November 5th, and we are considering it a developmental measure, but they will be submitting it to you.

CHAIR GESTEN: So I apologize for going over in terms of the public comment. I think we have managed to clear the room here. But, Cathy, if there's anybody on the phone from the public who wants to make a comment, if you can just go over the instructions again right now, we'll give them the opportunity to do that.

OPERATOR: Yes, sir. At this time, if you'd like to make a public comment, please press star, then the number one.

Okay. At this time, there are no public comments.

CHAIR GESTEN: Thank you, Cathy.

There is a slide on next steps, and maybe either Beth or Sarah will just go over what happens next.

MS. CAREY: Sure. Absolutely. So we will be very busy writing this up into a

draft report next week, and we will post it for public comments on Monday, October 27th, for a two-week period, which means it will close on Friday, November 4th. We will take the draft report and a quick preliminary analysis to the MAP Coordinating Committee on November 10th. That's the next time they meet. And they are typically aligned with our timeline.

And then, the final report is due to CMS on November 14th. Then, we'll go on a brief hiatus until we reconvene. We will recover from the expedited review and we will reconvene in the spring for the annual cycle.

CHAIR GESTEN: Great. Any questions about the timeline or next steps? And who says we don't have the patient voice here? Do you hear the baby on the phone? It's our way of incorporating patient perspective.

Anything else for the good of the order?

MEMBER LLANOS: So I'll just add for folks that are interested, CMS is required to release our annual updates on both our children and adult core sets, which we usually do together, through an informational bulletin by January 1st of this coming year.

CHAIR GESTEN: Great. Thank you.

DR. BURSTIN: Also, I'll add my thanks to Foster for some pretty impressive facilitation today through a very big agenda.

CHAIR GESTEN: Thank you. Well, thank you, all. It was a great -- great team. Look forward to doing this again in the spring. And, again, I'd encourage you to carefully look at the draft report and make sure that we captured your thoughts and deliberations here.

Thanks to Sarah and Beth for -- and Nadine for, you know, making this happen.

So safe travels home, and see you again in the spring. Thank you all very much. Thank you, folks on the phone, Anne and Alvia,

and other folks who listened in. Thank you.

(Whereupon, the above-entitled matter went off the record at 4:09 p.m.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: MAP Medicaid Child Task Force In-Person Meeting

Before: NQF

Date: 10-17-14

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R. Gross

Court Reporter