

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

2 9:37 a.m.

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

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

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

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

22 But I appreciate those of you who

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

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

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

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

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

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

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

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

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

22 Before we go to -- go around and

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

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

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

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

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

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

22 MEMBER LILLIE-BLANTON: We now

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

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

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

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

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

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

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

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

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

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

1 before we get started?

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

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

12 CHAIRMAN GESTEN: Logistics. Beth
13 are there?

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

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

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

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

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

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

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

22 Because this is a MAP group, I

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

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

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

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

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

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

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

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

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

22 MEMBER SAKALA: Good morning,

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

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

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

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

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

1 to disclose.

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

6 MS. HAMMERSMITH: Is Alvia Siddiqi
7 on the phone?

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

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

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

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

5 Obviously you sit as individuals.
6 You're individual subject matter experts. So
7 you sit in a different position than the
8 organizational members. So we'll start with
9 Marc Leib.

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

17 MS. HAMMERSMITH: And the Chair?

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

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

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

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

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

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

1 serve under Duals Disability MAP.

2 I have no conflicts to disclose.

3 MS. HAMMERSMITH: Okay, thank you.

4 Any questions or comments from anyone based on
5 the disclosures? Anybody on the phone have
6 questions or comments?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19 As I mentioned, we have a second
20 in-depth report due to CMS by September 1,
21 2015. And I believe that work starts in
22 earnest sometime in the spring of 2015, is

1 that right? So we'll be back again.

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

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

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

1 threefold.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20 DR. GOLDEN: Yes, sure.

21 CHAIRMAN GESTEN: Hi Bill.

22 DR. GOLDEN: Hi.

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

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

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

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

22 Just a little bit of background.

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

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

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

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

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

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

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

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

22 So our EQRO actually, these are

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

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

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

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

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

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

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

1 those institutions are going to sustain that
2 activity.

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

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

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

1 our statewide immunization registry.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 The -- one other comment that I'd

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 the core set.

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

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

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

22 Then looking at cost measures.

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

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

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

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

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

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

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

1 services.

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

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

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

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

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

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

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

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

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

1 thinking, I have a couple.

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

4 Can you for the uninitiated, two
5 things. Can you briefly describe, because I
6 want people to be on the same page, what QRDA-
7 1 packaging is? Because I'm not sure everyone
8 knows what that means.

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

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

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

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

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

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

1 BMI percentile, height weight.

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

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

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

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

22 And so there is services that are

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

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

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

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

1 health.

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

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

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

15 DR. SMITH: Marsha.

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

18 DR. SMITH: The other Marsha.

19 CHAIRMAN GESTEN: The other
20 Marsha. The first Marsha.

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

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

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

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

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

22 DR. KELLEY: Let me clarify. The

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

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

9 MEMBER LACEY: Sure, sure.

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

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

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

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

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

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

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

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

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

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

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

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

7 Does that answer your question?

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

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

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

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

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

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

1 can we do with the measurement itself to
2 improve care.

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

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

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

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

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

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

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

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

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

1 slide.

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

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

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

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

1 5,000 or more patients that would be eligible
2 for shared savings. And you have to pass
3 these metrics in order to receive their shared
4 savings, or their bonus payments.

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

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

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

22 We also had other episodes of

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

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

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

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

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

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

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

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

1 again is non-standardized across states.

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

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

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

22 So a question to ask is really why

1 is the data being collected? Is it for the
2 statewide comparisons? Is it for
3 accountability? Is it for quality
4 improvement?

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

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

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

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

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

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

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

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

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

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

1 administrative data.

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

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

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

22 Prenatal care, we have issues of

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10 Questions for Bill?

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

17 DR. GOLDEN: For the medical
18 homes, yes.

19 MEMBER LACEY: Right.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20 MEMBER LACEY: So there's no
 21 quota?

22 CHAIRMAN GESTEN: No, there's no

1 quota. Cindy?

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

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

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

22 DR. GOLDEN: Yes, well one of our

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

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

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

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

22 And I don't think anybody has

1 quantitated exactly what that variation is
2 across the States.

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

8 MS. COHEN: Yes.

9 CHAIRMAN GESTEN: Go ahead.

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

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

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

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

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

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

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

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

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

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

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

1 everyone's radar.

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

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

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

22 So I guess my specific question

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

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

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

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

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

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

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

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

22 But it's certainly going to be

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

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

10 CHAIRMAN GESTEN: Thanks. David?

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

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

1 physicians. So I would start with that.

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

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

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

22 We're already building the

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

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

14 CHAIRMAN GESTEN: Thanks so much
15 David.

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

22 Because you know, you can't

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

4 CHAIRMAN GESTEN: Dr. Fleischman?

5 MEMBER FLEISCHMAN: Thank you.

6 Can we go back to the slide with all the
7 various number of States reporting and where?
8 And I hope we have a chance to go back to this
9 in the afternoon.

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

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

1 minimally.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 The States for example that we

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

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

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

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

22 But once you have to do reviews

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

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

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

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

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

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

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

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

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

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

3 Other comments?

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

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

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

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

22 Which is the issue of alignments,

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

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

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

22 DR. GOLDEN: In Arkansas, we pay

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

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

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

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

22 MEMBER LLANOS: Can I just make a

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14 DR. KELLEY: Thank you.

15 DR. GOLDEN: Thank you.

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

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

22 (Whereupon, the above-entitled

1 matter went off the record at
2 11:17 a.m. and resumed at 11:32
3 a.m.)

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

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

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

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

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

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

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

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

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

1 to.

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

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

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

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

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

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

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

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

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

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

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

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

14 75 percent of infants who go on to
15 use a NICU do so because they are premature.
16 The other 25 percent would have some type of
17 other medical problem.

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

22 And more than half of hospital

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

4 And so those discharges in
5 particular cost even more, those were close to
6 \$65,000.

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

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

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

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

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

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

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

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

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

12 And as kids grow up and reach
13 their adolescent years, they are more likely
14 to experience these conditions, so adolescents
15 13 to 18 are 25 percent of enrollees, but 45
16 percent of those using behavioral health
17 services, and the majority of expenditures as
18 well.

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

1 with diagnosed behavioral health conditions,
2 but not always.

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

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

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

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

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

1 MS. LASH: Yes.

2 MS. PELLEGRINI: Okay, thank you.

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

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

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

15 CHAIR GESTEN: I am looking --

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

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

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

1 which makes sense to me.

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

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

8 DR. GOLDEN: Foster, I offer a
9 comment.

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

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

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

22 MS. LASH: I believe that's the

1 case.

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

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

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

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

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

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

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

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

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

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

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

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

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

6 Okay. Thank you, Sarah.

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

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

1 measures.

2 So Krisha, take it away.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 When you started this conversation

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

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

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

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

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

1 understand, what are we trying to measure
2 here?

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

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

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

1 recall visit.

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

6 So 2008, CMS actually started the
7 Dental Quality Alliance. They had a survey of
8 16 states and said, okay, what do we need in
9 terms of dental health?

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

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

22 And we started in 2008, the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 together. Last slide.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 caries.

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

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

10 CHAIR GESTEN: Susan?

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

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

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

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

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

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

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

17 CHAIR GESTEN: Beth?

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

22 In trying to think about where we

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14 CHAIR GESTEN: Cindy?

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

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

1 looking longitudinally across childhood.

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

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

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

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

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

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

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

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

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

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

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

22 CHAIR GESTEN: So we're going to

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

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

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

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

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

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

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

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

11 DR. LEIB: Got it, so --

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

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

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

21 We had a vision and a plan and --

22 DR. LEIB: And your new caries

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

3 MS. ARAVAMUDHAN: Exactly,
4 exactly.

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

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

10 CHAIR GESTEN: Go ahead.

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

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

1 problems, special needs, and things like that.

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

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

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

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

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

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

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

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

11 MS. COHEN: Oh, okay.

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

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

22 MS. COHEN: Okay, thanks, thanks

1 for that GA.

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

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

8 Kathy, are you on the phone,
9 operator?

10 THE OPERATOR: Yes, sir.

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

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

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

1 folks here in the room?

2 Kathy, anybody who has a question?

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

5 CHAIR GESTEN: Wow. WebChat.
6 Twitter.

7 (Laughter.)

8 CHAIR GESTEN: Facebook.
9 Instagram. SnapChat, anything.

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

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

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

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

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

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

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

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

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

6 THE OPERATOR: No sir, there are
7 no questions.

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

12 So we're going to meet back at
13 12:45, correct? 12:45? And get started.

14 Thanks, everyone.

15 (Whereupon, the meeting went off
16 the record at 12:09 p.m. and resumed at 12:47
17 p.m.)
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19
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1	A-F-T-E-R-N-O-O-N	S-E-S-S-I-O-N
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2 | 12:47 p.m.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9 So Marsha or Karen, do you want to
10 --

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

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

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

22 MEMBER ADIRIM: It seems like some

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

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

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

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

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

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

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

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

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

14 CHAIR GESTEN: Does that help,
15 Terry?

16 MEMBER ADIRIM: Yes.

17 CHAIR GESTEN: Okay. Any other
18 questions about purpose?

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

21 MS. LASH: Yes.

22 CHAIR GESTEN: -- lead through

1 some of --

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

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

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

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

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

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

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

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

22 So in particular, you heard Bill

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

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

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

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

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

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

22 We do plan to get through all of

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

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

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

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

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

22 The other thing I would point out,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 on the line?

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

4 CHAIR GESTEN: And --

5 MEMBER SIDDIQI: Alvia's here.

6 CHAIR GESTEN: Great, thank you.

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

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

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

22 So states may be feeling that they

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

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

7 CHAIR GESTEN: Thank you. Cindy?

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

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

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

1 going to be equal to readmissions.

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

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

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

17 MS. LASH: Primarily, yes.

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

1 MS. LASH: I don't believe so.

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

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

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

20 So I think Beth, you were next.

21 MEMBER FELDPUSH: Yes, thanks.

22 Just kind of a follow-up on the readmissions

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

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

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

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

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

10 CHAIR GESTEN: Go ahead.

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

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

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

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

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

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

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

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

22 And I might think about those

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

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

9 (Laughter.)

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

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

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

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

15 Foster, Karen?

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

20 I think there's --

21 DR. GOLDEN: Can I make a comment?

22 CHAIR GESTEN: Yes.

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

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

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

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

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

22 MS. CAREY: So just to give you

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

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

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

1 additional measure would contribute to that
2 set.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10 MEMBER LLANOS: But probably not
11 endorsed yet.

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

14 CHAIR GESTEN: But not endorsed.

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

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

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

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

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

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

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

22 And in terms of kind of the topic

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

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

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

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

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

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

10 MEMBER LACEY: So are you saying
11 the Centers for Excellence program is winding
12 down, so they will not be in existence, or
13 they will not continue under the auspices of
14 --

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

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

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

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

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

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

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

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

1 relevant, I think, discussion point
2 regardless.

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

9 CHAIR GESTEN: Cindy.

10 MS. PELLEGRINI: Just for
11 clarification, did I understand right that CMS
12 has asked us to consider retiring one or both
13 of the dental measures currently in the Core
14 Set and substituting?

15 CHAIR GESTEN: That's my
16 understanding, yes.

17 MS. PELLEGRINI: Can you just
18 provide us a little bit more information about
19 why, or which -- there's also, there's two.
20 Is it both of them?

21 MEMBER LILLIE-BLANTON: It's the
22 Dental Treatment Measure. And as you heard

1 today, I mean the problem with that is that it
2 really is a utilization measure, and it's not
3 in relation to need, any measure of need, so
4 as you look at it and you're tracking it over
5 time, it's hard to evaluate whether we're
6 doing better, we're doing worse.

7 It's -- I don't want to say
8 meaningless, because it has some value to us
9 because we do want to make sure that we know
10 that children who have dental caries are being
11 treated, but it just -- it's not very useful
12 to us, it's a measure of service used.

13 And it's not very actionable. You
14 know, if you talk about a measure that you
15 want to improve, what do you want to -- is the
16 goal to just get children caries treated?
17 It's not a -- it's not a good measure that we
18 can kind of shape a quality improvement
19 project around.

20 CHAIR GESTEN: So Marsha, just to
21 be completely clear, you're talking about the
22 measure that's described as received dental

1 treatment services not in terms of retirement,
2 not the one that's -- or substitution, not the
3 only that's received preventive dental
4 services.

5 MEMBER LILLIE-BLANTON: Right.

6 No, that one you need the length, we --

7 CHAIR GESTEN: Correct.

8 MEMBER LILLIE-BLATON: There's
9 value for it, we use it. We encourage greater
10 use of preventive dental services.

11 CHAIR GESTEN: Okay. So should we
12 go back to the -- this is the list of the ones
13 that we heard about this morning from Krishna,
14 and then the other slide will give you the
15 information, a little bit more specificity on
16 the measure itself, and the spreadsheet, yes.

17 And maybe we should put that one
18 up so that people can see some of the details.
19 Krishna is still here. One of the questions
20 I had, I didn't see it in the information that
21 I had, was the way in which some of the
22 measures hinge on high risk.

1 I am just wondering, either if
2 someone at the table, or Krishna, you can come
3 up and explain to the group how high risk is
4 determined. You mentioned that this is an
5 administrative measure, so I'm guessing you
6 have some interesting administrative way of
7 determining high risk.

8 MS. ARAVAMUDHAN: So you can -- so
9 these measures are real quality measures that
10 talk about right care for the right person at
11 the right time.

12 So it was important for us to --
13 we propagate, we talk about risk-based care,
14 but what are we doing? So this measure does
15 it.

16 The risk's logic is based on past
17 history of caries, which is the strongest
18 predictor for future risk. However, as we
19 were going through this process, we now have
20 new CDT codes, which are procedure codes that
21 help classify patients at risk.

22 So low risk, moderate risk, high

1 risk. So you can pick it up that way as well.
2 Everything is simply based on claims data.

3 CHAIR GESTEN: So there are two
4 approaches -- one is looking at history of
5 caries, and the other is using the CDT codes,
6 either one is used to identify --

7 MS. ARAVAMUDHAN: Either one is
8 used, and over time we hope that you know, you
9 can drop the past history and simply go with
10 the caries codes.

11 CHAIR GESTEN: Thanks. As long as
12 you're here, does anyone have any technical
13 questions or clarifications around the
14 measures that were presented? Since we have
15 a little bit of time, and want to talk about
16 these specifically.

17 Beth, was that a hand, or --

18 MEMBER FELDPUSH: That was a hand,
19 it was a question, yes.

20 CHAIR GESTEN: Okay, yes.

21 MEMBER FELDPUSH: So on the
22 treatment -- the existing treatment measure,

1 that's measuring caries that are filled, or
2 not necessarily? It's --

3 CHAIR GESTEN: It can be treatment
4 for anything though, right? It can be
5 treatment for anything.

6 MEMBER FELDPUSH: So the five that
7 we're looking at on the list here, I mean,
8 oral evaluations, sealants, sealants, and the
9 topical fluoride, look to me as more
10 preventive services, so do you call those
11 treatments too? But they're -- that's all
12 preventive, so there's not necessarily, in
13 this group of five measures -- now there's
14 utilization of services, but there's not
15 necessarily in this list of five something --
16 a new measure, or a substitution measure, that
17 gets at treatment.

18 You are really just kind of
19 looking to solve a more general dilemma of the
20 existing measures not giving you much
21 information, so can we find other measures
22 that give more information, even if there's

1 nothing really specific about treatment on
2 this list. Got it. Thank you.

3 MEMBER LILLIE-BLANTON: We want to
4 improve the oral health of children in many
5 ways.

6 MEMBER FELDPUSH: Okay. Good goal
7 to have.

8 CHAIR GESTEN: Cindy?

9 MS. PELLEGRINI: Thanks. Showing
10 my ignorance here of dental practice, can you
11 tell us a little bit about why there are
12 separate measures for sealants for the two age
13 groups?

14 I mean, I see first molar and
15 second molar, but --

16 MS. ARAVAMUDHAN: Good question.
17 So the preventive services measure, if you
18 take a look at the codes that are there, it's
19 about, you know, did they get a cleaning,
20 which there's no evidence to support it does
21 anything in children, and then it combines
22 cleaning with fluoride with sealants.

1 And it is not about right care for
2 the right person for the right time. It says
3 any sealant, you put it on, any one fluoride
4 -- one fluoride varnish to a child does
5 nothing.

6 It's about, like vaccinations, you
7 have a periodicity schedule that you've got to
8 maintain for the child to benefit from it. So
9 you have evidence for topical fluoride saying
10 it has to be at least two or four applications
11 within a year, so the measure is looking, did
12 they get those two applications in that year?

13 With sealants, it is like you've
14 got to seal the teeth as soon as they erupt.
15 So the six to nine is looking at your first
16 molars, first permanent molars, that's the age
17 span when they come out, and say you've got to
18 seal them.

19 Because if you waited until 11,
20 12, they're already diseased. And so the cost
21 to the system also increases if you don't
22 catch it early.

1 So 10 to 14 represents a second
2 set of permanent molars, and the 6 to 9
3 represents the first set of permanent molars.

4 And when we went through our
5 validation, we found a lot of instances when
6 we were catching sealants in pre-molars,
7 primary teeth, things like that, which aren't
8 really getting you to the QI goal.

9 MS. COHEN: This is Anne, I have a
10 question.

11 CHAIR GESTEN: Go ahead.

12 MS. COHEN: So I'm just curious,
13 again this is, you know, admitting my
14 ignorance as well to dental practice, so the
15 measure 2528, the topical fluoride, I'm
16 curious in terms of rate of cavities, is there
17 any influence on communities that fluoridate
18 their water versus not? And then how that
19 particular measure might kind of have impact
20 -- the topical fluoride measure might somehow
21 be impacted in terms of the number of cavities
22 in one community versus another?

1 MS. ARAVAMUDHAN: So water
2 fluoridation is a public health kind of
3 initiative. Especially this particular
4 measure, we often get asked: why didn't you
5 throw all Medicaid in high risk? You know,
6 why isn't it a population?

7 If we take that tact and say
8 everyone -- and use risk as a population
9 indicator, and throw everyone in a community
10 -- you don't know whether they're getting
11 other sources of fluoride, what's happening at
12 the individual level.

13 So this measure actually addresses
14 that by saying that you've got to look at the
15 individual child's risk for caries and then
16 use prevention as necessary.

17 The other thing we like to stress
18 is we're not making a policy statement here to
19 say, you should have a benefit for this or you
20 should not have a benefit for this. You're
21 simply asking the question: are people who
22 ought to get the service getting it?

1 MS. COHEN: Thanks, that's
2 helpful.

3 CHAIR GESTEN: Marsha?

4 MEMBER LILLIE-BLANTON: I want --
5 I don't want to overly influence the group,
6 but I do want to talk about one of these
7 measures that I find particularly attractive
8 because it aligns with our oral health
9 initiative, and also with the directive that
10 came to us from Congress, which is very
11 important to us.

12 Congress asked us to track and to
13 measure sealants in six to nine year olds, but
14 they asked us to only do it, if I'm not
15 mistaken, in CHIP. Is that correct?

16 So we have begun to try to look at
17 ways of doing that, but that measure becomes
18 attractive for that reason. In addition, we
19 announced an oral health initiative about four
20 years ago and set two goals, and one of the
21 goals was to improve use of preventive
22 services, and the other was particularly to

1 improve the use of sealants in children six to
2 nine, which was also linked to what Congress
3 asked of us, and would be broader than
4 children in CHIP.

5 So I think -- you know, I really
6 do encourage you all to review all of them,
7 but I want you to know that when I learned
8 that the sealants in six to nine year olds had
9 been NQF endorsed, it, I thought, helped us to
10 address one of the challenges we had, because
11 we had not set baseline data for our six to
12 nine year old sealant goal, because we
13 continue to have problems trying to decide how
14 to measure it, because there are just many
15 challenges.

16 Because the group of children six
17 to nine continues to shift every year, and we
18 were trying to understand how we tracked it,
19 and once NQF, or at least the DQA, was able to
20 find a measure of need, it became easier for
21 us to then look at, over time, if we were
22 tracking the measure, performance, and whether

1 or not we were moving in the direction we
2 needed to move in.

3 So I just wanted to give that
4 little bit of background.

5 CHAIR GESTEN: Marsha, clarifying
6 question -- are sealants included in the
7 current measure of preventive services?

8 MEMBER LILLIE-BLANTON: Yes, it
9 is.

10 CHAIR GESTEN: So you're capturing
11 it, but you're capturing it en masse with
12 other things.

13 MEMBER LILLIE-BLANTON: Yes, we
14 are.

15 CHAIR GESTEN: So my second
16 question is since you're actually collecting
17 that measure itself, are you not able for some
18 reason to generate this measure from the data
19 that's collected currently?

20 MEMBER LILLIE-BLANTON: Only
21 because what states report to us now is for
22 any preventive service. So it could be --

1 CHAIR GESTEN: It's just a rate --

2 MEMBER LILLIE-BLANTON: Yes, it's
3 not disaggregated.

4 CHAIR GESTEN: Correct, I got it.

5 MEMBER LILLIE-BLANTON: And
6 there's a lot of evidence base that sealants
7 really can make a difference in reducing
8 caries later on.

9 So while there are other
10 preventive services that we count in that any
11 preventive services, this is a key preventive
12 service, that our understanding is can really
13 make a difference in preventing -- reducing
14 caries.

15 CHAIR GESTEN: Thank you for
16 completely biasing me on this list.

17 (Laughter.)

18 CHAIR GESTEN: Other thoughts,
19 Cindy? Go ahead, Cindy.

20 MS. PELLEGRINI: Sorry, I am
21 looking again at the two measures here of 6 to
22 9 and 10 to 14, and wondering: does it make

1 sense, really, to break them up, or to
2 consider them almost as a pair that either you
3 take both, or you take neither?

4 Or is there a reason that I'm not
5 aware of that we would -- care less is a harsh
6 way of saying it, but place less weight on the
7 care for the 10 to 14 year olds?

8 MS. ARAVAMUDHAN: Can I give an
9 opinion, and this I will just qualify, saying
10 it's just my opinion, not the DQA's, I'm
11 thinking of.

12 But I think it's all about
13 provider behavior. I think if you can change
14 provider behavior to say, this is important.
15 You've got to watch for it and do it. We're
16 going to watch you the first time.

17 I think we can be assured that it
18 will happen the next time. It's in the
19 record, you know.

20 So that's the thing about the six
21 to nine, the early age group, to see whether
22 the provider behavior component is working.

1 CHAIR GESTEN: My opinion is also
2 that there's two schools of thought about
3 this. One is, you know, if you don't measure
4 it, it doesn't -- you've heard the mantra
5 about it, if it's not measured, it doesn't
6 happen.

7 But I also believe in what Krishna
8 said, which is that it's very challenging, I
9 think, for groups to put into effect
10 improvement that would just stop at age ten,
11 and it's hard to imagine clinicians saying,
12 oh, we're not being measured on ten, so who
13 cares?

14 Again, I think measurement and
15 improvement relies on the mechanics of how
16 improvement needs to be put in, as well as
17 professionalism.

18 Was that just another way of, I
19 think, framing what you just described? Beth.

20 MEMBER FELDPUSH: So just kind of
21 as a practical question about using this
22 measure. In the measure specifications, is

1 there either an exclusion or a code for child
2 already has sealants?

3 MS. ARAVAMUDHAN: Very good
4 question. So that was something that we
5 really struggled with. The measure has
6 specified limitations that it does not exclude
7 kids who already had sealants, or a tooth had
8 not erupted.

9 We feel that if everyone measures
10 the same way, that is still going to be
11 comparable.

12 Now the e-measures I showed you in
13 the morning, they do have it, because they
14 have the capability of taking the richness of
15 the patient record to actually exclude kids.

16 So while you will get a more
17 precise score with an e-measure based off of
18 patient record, that is simply not the reality
19 today. So to have a claims-based measure that
20 is still comparable just requires reliable
21 specifications that everyone uses the same
22 way.

1 MEMBER FELDPUSH: So in practice,
2 I am just thinking if you were to start
3 collecting this measure tomorrow, a state
4 that, say, has historically already done a
5 good job in providing this care to children
6 might score lower than a state who is ramping
7 up now and doing really well, because a state
8 where more children already have sealants are
9 going to maybe look like they have a lower
10 score.

11 MS. ARAVAMUDHAN: Your reporting
12 year is one year, right? And you're having
13 kid age-in and age-out of that one year
14 bracket. So you're not really looking at
15 prevalence of sealants all throughout the age
16 ranges. You're simply -- we're looking at the
17 one year period.

18 And the great thing about these
19 measures that are only based on administrative
20 data, CMS that has data historically, like in
21 the CARTS system or the MSIS system, can run
22 the measure retrospectively and get a trend

1 line from like 2005, or whatever it is, and
2 have that basis to inform the decisions as
3 well.

4 The only thing with this measure
5 to be aware of is you're not going to target
6 100 percent as your benchmark.

7 You're going to have to see what
8 the measure score looks like across plans,
9 across states, and then pick your benchmark.

10 CHAIR GESTEN: Your question -- if
11 I may, before I get to you Marc, your question
12 raises a broader issue, which is when Terry
13 asked, you know, what's the purpose of this,
14 you notice that neither Karen nor Marsha said
15 the purpose of this is to be able to compare
16 New York to Delaware.

17 And I think you were specific in
18 not saying that. So in my mind, there's a
19 couple ways to think about this. Clearly
20 having measures that are comparable across
21 states has some value.

22 Having measures that states

1 themselves can use and look at for improvement
2 over time also has additional value as well.
3 And if in fact state-to-state comparison is
4 not at least a high level or a high priority
5 reason to have core measures in the Medicaid
6 program, then again, it's an open question
7 about its comparability from state -- whether
8 comparability from state-to-state matters in
9 picking measures or not.

10 I just throw it out there as just
11 a bit of an observation. Marc?

12 DR. LEIB: Well first, I highly
13 support the use of sealants in these age
14 populations, so you're not taking anything I
15 say as meaning that.

16 But I'm not sure that the measure
17 as constructed is going to give us useful
18 information either initially or ongoing.

19 Just take a perfect world. A
20 dentist has -- you're looking at six to nine
21 year olds, is that it, initially?

22 If a dental practice has every

1 child that he or she sees gets their sealant
2 as soon as that tooth erupts in that first
3 year, then for the next three years, they're
4 going to score zero on anyone who is seven, or
5 eight, or nine, because they got them all as
6 age six.

7 And so they're -- at best, they're
8 going to look to be, oh, 20 percent, the six
9 year olds, compared to that entire age range,
10 and they're going to stay at 20 percent, and
11 they're never going to look like they're
12 improving, whereas a dentist who didn't do
13 quite as good a job their first year, look at
14 almost 100 percent if they suddenly start
15 putting sealants on -- maybe there's extra pay
16 for that, or there's a bonus, or whatever it
17 is -- and they're going to look like they're
18 at 100 percent, and they're not going to be
19 able to tell the good dentists from the bad
20 dentists because the numbers don't measure the
21 same thing over the same time period.

22 In my mind, I'm not an expert at

1 this by any means, if you're looking for --
2 the measure should be the presence of a
3 sealant on a tooth in that age range, and it
4 wouldn't matter once they got it, it would
5 still be present the next year, and the next
6 year, and the next year, so that you'd always
7 be counting a child with a sealant over the
8 total population of that age range instead of
9 just the first year that they got it, and then
10 ignoring them the other three years.

11 MS. ARAVAMUDHAN: So we've had
12 numerous discussions about this. And again,
13 the thing is that there is limitation in the
14 claims database as to how much you can exclude
15 and how precise you can make this measure.

16 This is what it is. If you take a
17 reporting period, and one thing important to
18 remember, we're not measuring the dentist,
19 we're not measuring the provider, we're
20 measuring the plan, and we're measuring the
21 pair.

22 So you're looking at huge sample

1 sizes here and hundreds of thousands of
2 children that are included, and we have seen
3 tremendous performance gap even within the
4 four programs that we used for the NQF
5 validation testing.

6 So that tells us that, hey, the
7 existence of performance gaps and existence of
8 something that has the highest level of
9 evidence in dentistry ought to be measured.

10 So the problem about the six to
11 nine -- I can go on and on about it, but the
12 problem about the six to nine is a churn in
13 Medicaid. You are not going to -- you are
14 going to have to control, and Pennsylvania
15 does something like this, where their measure
16 goes that you only include the children who
17 are three years consecutive enrollment in
18 Medicaid program, and then you go on and
19 measure if they have a sealant.

20 Now if you put that limitation to
21 the denominator, so you'd need three years
22 continuing in enrollment, you are looking at

1 ten percent of the population.

2 And then when you start thinking
3 about the ten percent of the population, you
4 are looking at, okay, do I need a valid
5 measure or do I need a generalizable measure?

6 DR. LEIB: I was not suggesting we
7 exclude people if they are not in for three
8 years.

9 MS. ARAVAMUDHAN: But that's the
10 only way you can say -- because you will not
11 get claims. Let's say they moved out of
12 Medicaid, you're not going to get claims.

13 DR. LEIB: If the goal is to
14 increase the number of sealants on Medicaid
15 children's teeth, appropriate to the
16 appropriate age range, taking a snapshot once
17 a year by plans, by dentists, I fully
18 understand, as to how many children in that
19 age range have a sealant on the tooth, whether
20 it was placed today, yesterday, or last year,
21 shouldn't matter.

22 The sealant is in place, and

1 that's our goal, is to have sealants on teeth.

2 MS. ARAVAMUDHAN: And you will not

3 --

4 DR. LEIB: And I'm not sure this
5 measure measures sealants on teeth. It
6 measures sealants put on teeth this year, not
7 sealants on teeth in the entire
8 age-appropriate population.

9 CHAIR GESTEN: So I think you're
10 making an interesting point, and I think we
11 also need to probably get out on the table any
12 questions that people have about the measures,
13 because I think what we need to head to,
14 sooner rather than later, is sort of a head
15 count -- hand count, of measure by measure,
16 whether any of these sort of fit the criteria
17 that you have in your head that they should be
18 added to the list.

19 So healthy debate around some of
20 the limitations of the measure, some of the
21 challenges in the continuous enrollment, I
22 don't mean to shortchange that as an issue,

1 but my suggestion is that at this point if
2 there are questions about other measures that
3 people might have, that would help them be
4 able to make a decision about whether they
5 think these should be added, we should
6 probably prioritize that conversation.

7 Cindy, you have something in that
8 --

9 MS. PELLEGRINI: It's a very quick
10 dental question --

11 CHAIR GESTEN: Okay.

12 MS. PELLEGRINI: -- and I was just
13 curious, is part of the rationale here that,
14 if I am remembering my own kids' experience
15 correctly, that new molars are erupting every
16 year during that period, and so that's why the
17 kids have to keep going back?

18 Because you're never going to get,
19 I think, you're never going to have 100
20 percent of the new molars to put sealants on
21 at age six --

22 MS. ARAVAMUDHAN: You're correct,

1 we have --

2 MS. PELLEGRINI: -- or seven, or
3 eight.

4 MS. ARAVAMUDHAN: -- four molars,
5 and they all don't come up at the same time.

6 So the measure is only looking at
7 least one. So technically the child can be
8 counted multiple times during the multiple
9 years, too.

10 CHAIR GESTEN: Marc, did you have
11 another question, or is your thing just still
12 up? Don't confuse the Chair, he's very easily
13 confused.

14 (Laughter.)

15 CHAIR GESTEN: And does anybody
16 have any, I want -- does anybody have any
17 questions, clarifications about the specific
18 measures before we actually, I think, start to
19 take them one at a time, which I think makes
20 sense as an approach.

21 Okay, I guess Krishna, before you
22 go, I just want to make sure that I -- it came

1 up this morning, I want to make sure I
2 understand: the fluoride intensity measure
3 captures the delivery of fluoride only by
4 dentists, not by primary care.

5 So I'm revisiting Susan's question
6 earlier, and I heard your comment that in, at
7 least in the testing sites that you had, that
8 the primary care delivery of fluoride
9 accounted for a very small percentage.

10 MS. ARAVAMUDHAN: Okay, it's three
11 percent.

12 CHAIR GESTEN: Generally. But I
13 also heard Susan say, between sessions, that
14 in California, she thinks that that rate is
15 actually very different.

16 But I just want to make sure I
17 understand, the measure as written captures
18 topical fluoride only by dentists?

19 MS. ARAVAMUDHAN: Correct. And I
20 have to tell you this story. When we did this
21 at the DQA, we did it all three ways, dental
22 services, oral health services, dental and

1 oral health services.

2 But we had to pick to submit to
3 NQF, so what we submitted is the dental
4 services, because again, whom do you want the
5 accountability to be on? Which system do you
6 want the accountability to be on? Do you want
7 to start getting pediatricians to make sure
8 they have the child in every six months, so
9 they meet the two times a year for high risk
10 kids, you know, periodicity, or should this
11 accountability lie with the other financing
12 system?

13 CHAIR GESTEN: Thank you. Any
14 other questions?

15 So in terms of process, unless
16 somebody has a better idea, I thought that we
17 should start at the top and go down, and
18 again, I would say that in terms of voting,
19 you don't need to vote for any of them.

20 I guess what we're looking for is,
21 is there a measure in which at least 60
22 percent of us, which would be seven, including

1 two folks on the phone, assuming they're
2 hanging in there, say yes, this is a measure
3 that I think we should prioritize for
4 inclusion in the set.

5 Is that -- Sarah and Beth, do you
6 have any different idea of how to proceed?

7 Should it be six until Susan comes
8 back? Yes, because it's based on who's here,
9 right? Sandra.

10 MEMBER WHITE: Yes, now, would
11 that be prioritization for inclusion into the
12 set with modifications, or prioritization for
13 inclusion as written in the current --

14 CHAIR GESTEN: As written. There
15 will be a prioritization among measures sort
16 of at the end, but for right now, it would be
17 within this set, whether any of these measures
18 -- and again, you don't have to just vote for
19 one, but are there measures that for you
20 suggest that it should be added to the set,
21 based on what you know about it, as it's
22 written currently?

1 Okay. So why don't we start with
2 2511, Utilization of Dental Services. Just by
3 a show of hands, and I'll get to folks on the
4 phone, how many folks would vote for this to
5 be included as a measure to be added to the
6 CHIPRA Core Set?

7 2511, the one on the top, the
8 measure number. And I'm seeing no hands here.
9 Anne or Alvia?

10 MS. COHEN: I am not raising my
11 hand, this is Anne.

12 CHAIR GESTEN: Okay, not raising
13 your hand.

14 Okay. I'll tell you what, what
15 I'll do is I'll just turn to you guys, and if
16 you're raising your hand, just let us know
17 that you're in favor of it, and that'd be
18 great.

19 For 2517, Oral Evaluation? Show
20 of hands?

21 On the phone?

22 MEMBER SIDDIQI: Agree.

1 CHAIR GESTEN: I am sorry, on the
2 phone was yes?

3 MEMBER SIDDIQI: Sorry, Alvia
4 speaking --

5 CHAIR GESTEN: Okay.

6 MEMBER SIDDIQI: And I also vote
7 in favor.

8 CHAIR GESTEN: Okay. For 2508,
9 Sealants in Age 6 to 9 Years Old? Show of
10 hands?

11 On the phone? Was that yes for
12 both of you?

13 MS. COHEN: Yes.

14 MEMBER SIDDIQI: Yes.

15 CHAIR GESTEN: Thank you.

16 MS. LASH: That's nine total.

17 CHAIR GESTEN: For Measure 2509,
18 Sealants in 10 to 14 Year Olds. Show of
19 hands? And Anne or Alvia?

20 MS. COHEN: Yes.

21 MEMBER SIDDIQI: Yes.

22 CHAIR GESTEN: That was two yeses.

1 MS. LASH: Also nine.

2 CHAIR GESTEN: Also nine. And
3 then, was that the last one? No, there's one
4 more after that.

5 Topical Fluoride Intensity,
6 Measure 2528. Show of hands? Anne or Alvia?

7 MS. COHEN: Yes. This is Anne.

8 MEMBER SIDDIQI: Yes.

9 MS. LASH: That's just two.

10 CHAIR GESTEN: Two. Is there one
11 more on that list, or is that it?

12 MS. COHEN: The Annual Dental
13 Visit?

14 CHAIR GESTEN: Annual Dental
15 Visit. This is the NCQA measure? This is an
16 annual -- this is just a visit of any kind,
17 right? Having one or more dental visits with
18 a dental practitioner during the measurement
19 year, existing HEDIS measure, correct? Yes.

20 Show of hands for Annual Dental
21 Visit? One? Anne or Alvia?

22 Okay. Sounds like one.

1 MS. LASH: That's one total.

2 CHAIR GESTEN: Okay. So we had
3 two that made this -- two sealants measures,
4 is that right, passed the test, and we'll go
5 back and potentially prioritize those with
6 other measures as we go through the other
7 areas, the other gap areas. So great.

8 MEMBER WHITE: I wonder if we can
9 have any comments on why the last measure
10 failed.

11 CHAIR GESTEN: Anybody want to
12 comment on why they didn't vote for it?

13 MEMBER FELDPUSH: It just didn't
14 seem very specific to me, and from the
15 presentation earlier in looking at the three
16 measures that are currently available, I got
17 a sense that there was a desire for more
18 specificity, which is why I liked the sealant
19 measures and not just the general annual visit
20 measure.

21 MEMBER ADIRIM: An annual visit
22 doesn't necessarily equal what we want for

1 outcomes, whereas the sealants do that.

2 MS. PELLEGRINI: I thought in
3 Krishna's presentation that she said there was
4 also a measure that had been developed that
5 was outcome-related on caries, the presence of
6 caries, and I just was curious why that didn't
7 end up among our choices. Maybe it hasn't
8 been endorsed yet, but I thought we had a list
9 that had.

10 MS. ARAVAMUDHAN: Measures that
11 are possible, feasible, for Medicaid programs,
12 outcome measures, are not there yet. We are
13 looking at proxy measures that we hope to
14 submit this year to NQF. We have e-measures.

15 CHAIR GESTEN: And then, I mean
16 I'd also point out in the slide set, and you
17 saw it briefly, that there are three measures
18 that are also in the pipeline from the Centers
19 of Excellence as well.

20 So again, there may be a
21 conversation next, you know, in the next
22 cycle, in which the broader scope of measures,

1 end up being more measures available to be
2 able to look at, including those as well as
3 the Centers of Excellence measures if they've
4 gone through the process and are ready for
5 prime time, or believed to be important, even
6 if they're not ready for prime time.

7 Okay, I think we're ready to move
8 onto care coordination.

9 And there was a slide, I'm not
10 sure what the number is, maybe an overall
11 slide, maybe we should do that first.

12 Yes, Helen?

13 DR. BURSTIN: Just a quick point
14 of clarification on these measures, these are
15 all measures that come out of the National
16 Survey of Children's Health, which is done by
17 HRSA every four years, is my understanding,
18 and Terry may be able to help there if I'm
19 getting that wrong from a prior life.

20 So they've not yet been adapted,
21 they are at the state level, but I don't know
22 whether Medicaid would have the capacity to do

1 that more often, it's part of -- they also
2 have the National Survey of Children with
3 Special Health Care Needs.

4 So it might be a conversation for
5 CMS to have with HRSA, HRSA's office, to see
6 if there's an opportunity there to think about
7 fielding it potentially more often, but
8 otherwise it's difficult to see how would they
9 be brought -- be useful to you, since the
10 periodicity is so infrequent.

11 CHAIR GESTEN: And you're talking
12 about the measures which we haven't put up on
13 the slide set yet, but these were suggested,
14 these are the four -- these.

15 DR. BURSTIN: These, right. So
16 they popped up and they disappeared. These,
17 yes. So these are all from that national
18 survey.

19 CHAIR GESTEN: But these, they're
20 from the national survey, they've been NQF
21 endorsed as measures.

22 DR. BURSTIN: As measures of the

1 state level, right. But again, I just want to
2 be sensitive to the fact that there's not a
3 data vehicle for CMS to do them short of
4 thinking about having a conversation with HRSA
5 about whether this could be fielded more often
6 or done in collaboration, but these are
7 specific items from within the survey that are
8 reliable and valid as indicators of quality.

9 These are some great, great
10 measures.

11 MEMBER ADIRIM: Yes, I think
12 that's a CDC survey that they get their data
13 from, right? For Children with Special Health
14 Care Needs? Yes.

15 CHAIR GESTEN: So why don't we --
16 I guess before we switch to the more detailed
17 measure description, I didn't have the same
18 kind of disconnect that other folks had about
19 costs and readmissions on the perceived as
20 safe as care coordination.

21 Sarah, you gave me a spiel. I
22 wasn't completely buying it, but can you give

1 everybody else the spiel? Maybe they'll buy
2 it.

3 MS. LASH: It's a stretch.

4 CHAIR GESTEN: Yes, go ahead.

5 MS. LASH: This -- part of this
6 gap area is characterized as connection
7 between the health system and the broader set
8 of services that children need to have
9 wellness. So, a healthy community, a safe
10 community, a safe school.

11 719 is -- actually has care
12 coordination in it, that one might not be such
13 of a stretch. Also, these transition from the
14 pediatric services system to the adult health
15 services system, might be a little more
16 squarely in the care coordination space.

17 Again, we turned over a lot of
18 rocks to try to find potential measures to
19 offer you. If they don't fit, they don't fit.
20 There's really no need to force it. But that
21 was the rationale.

22 CHAIR GESTEN: And I don't know if

1 you or somebody can comment, for the first and
2 the last one, the ones that deal more directly
3 with care coordination of individuals versus
4 coordination between health care and other
5 services. Can you comment on whether the
6 concepts that are in those are or are not
7 captured within the CAHPS, the current
8 existing CAHPS survey, whether it's the CAHPS
9 survey for chronic care needs, or general
10 CAHPS in terms of care coordination.

11 Because my understanding, without
12 having all the questions in front of me, is
13 that there are in fact questions that relate
14 to issues related to care coordination.
15 They're from a survey, from an existing
16 survey, that is part of the measure, the Core
17 Measure Set.

18 So I need a little bit of help in
19 understanding -- I understand it's a different
20 survey, maybe a different purpose, but it
21 would be helpful to understand how it may
22 differ from the existing CAHPS survey, if

1 anybody is able to do that.

2 The current CAHPS survey that is
3 part of the CHIPRA Core Measure Set.

4 MEMBER LLANOS: Yes, so we've got
5 two ---- well, so we've got the Child CAHPS
6 Survey Health Plan, and then supplemental
7 items for children with chronic conditions.

8 CHAIR GESTEN: Well I'm pretty
9 sure there are questions in there related to
10 care coordination. I guess I'm wondering, in
11 what way might they differ, or what might be
12 the added or differential value of using a
13 completely different survey to ask for the
14 same concepts?

15 DR. BURSTIN: I pulled up Child
16 Medicaid, and there is a question, for
17 example, in the last six months, did anyone
18 from your child's health plan, doctor's
19 office, or clinic help coordinate your child's
20 care? Among these different providers, so it
21 may be quite simple, yes.

22 CHAIR GESTEN: Why don't we go to

1 the next slide, I think, talks about -- this
2 is what we have, what's on the shelf, the next
3 slide talks about what's in development, is
4 that right? If I'm not mistaken.

5 MEMBER ADIRIM: So does that mean,
6 is the ADAPT going through endorsement, or it
7 says measure ready, what does measure ready
8 mean?

9 DR. BURSTIN: It's not been
10 submitted yet.

11 MEMBER ADIRIM: Oh, okay.

12 MEMBER LLANOS: I should mention,
13 so there's no requirement as part of the grant
14 program for any of the measures to be
15 developed. It was really on to the Center of
16 Excellence whether or not they budgeted for an
17 endorsement.

18 MS. COHEN: Can you -- can
19 somebody in there talk about the children with
20 disabilities algorithm? Anybody familiar with
21 that?

22 CHAIR GESTEN: Children with

1 disabilities algorithm? I am not familiar --
2 not done? I guess nobody can comment about --
3 nobody is here, Anne, that can comment on what
4 they are, unless Marsha, do you have any
5 insight?

6 MEMBER LILLIE-BLANTON: I just
7 wanted to explain, or at least mention, that
8 -- oh, yeah, I'm sorry.

9 I just wanted to mention that we
10 are setting aside some dollars to support the
11 Centers of Excellence in going through the
12 measure endorsement process.

13 So while we can't say for sure
14 that it will ultimately be endorsed, or that
15 they'll finish the process, that we are trying
16 to continue to support them.

17 And that process is still shaping
18 up.

19 MEMBER LACEY: So you're setting
20 aside some dollars for the Center of
21 Excellence to work on things, but what's your
22 timeline for winding down for the Center of

1 Excellence?

2 MEMBER LLANOS: It's supposed to
3 end in February 2015, although a Center of
4 Excellence could ask for a no-cost extension,
5 so it really would vary depending --

6 MEMBER LACEY: Oh, a no-cost
7 extension, got you.

8 MEMBER ADIRIM: So can we consider
9 some of these, if we --

10 CHAIR GESTEN: For immediate --
11 for adoption right now?

12 MEMBER ADIRIM: Well, I guess not,
13 because they're not NQF endorsed, right?

14 MS. LASH: Aside from the measure
15 designated with a check mark, which
16 unfortunately, we don't have more details to
17 offer you about, the rest of the measures are
18 not finished being tested.

19 MEMBER ADIRIM: Right, well I was
20 going to -- you know, at some point I would
21 advocate for this ADAPT measure, I mean that's
22 big in pediatrics transition -- you know, for

1 kids with special needs transitioning from
2 pediatric care to adult care, it's pretty
3 important, that's all.

4 CHAIR GESTEN: I think the
5 challenge is I don't think we have any
6 description of the measure, measure
7 specification, it hasn't gone through the
8 process.

9 So I think, right, and again, we
10 may be in a very different position in 2015
11 relative to these measures, including that
12 one, since that one actually may be further
13 developed.

14 So I think, as I said earlier,
15 there's nothing wrong with footnoting it as an
16 issue that's very important. It may, even if
17 it's not a -- it won't be part of something
18 that can be recommended right now for
19 addition, I think it sets us up for an early
20 conversation next year around high priority
21 areas.

22 I mean, I know that some of these

1 other ones -- I know that the one kept on has
2 the Center of Excellence somewhat involved in
3 it, I think it's very much in a developmental
4 phase in terms of the medication
5 reconciliation, really important area. But
6 not ready ---- close to being able to be
7 recommended as a specific measure.

8 DR. BURSTIN: I'll just point out,
9 I did get an email from the Centers of
10 Excellence folks that they would like to
11 submit ADAPT to us, when we can, they're in
12 their final testing phases.

13 MEMBER LACEY: But you do have, we
14 do have 1340 on the coordination of care,
15 children with special needs who receive
16 services needed for transition to care, but
17 it's not the ADAPT, I know it's not that
18 particular -- yes.

19 CHAIR GESTEN: So maybe what we
20 should do is go to now the more detailed --
21 Nadine, if we could go to the more detailed
22 version of the measure so that folks can see

1 a little bit more about numerators and
2 denominators and exclusions and so on, and get
3 a sense of these.

4 So I would invite, if folks have
5 any questions about what's in these surveys --
6 what's in these measures or these surveys,
7 that we can answer before we kind of go down
8 the list and vote on them, now would be -- now
9 would be the time to do that.

10 I think I asked my question about
11 the degree to which 0719 or even 1340 --- I
12 guess I'll ask it, I asked it about 0719, but
13 for 1340, for the children with chronic needs
14 survey, CAHPS survey, is there --- I'm
15 wondering, I don't know off the top of my
16 head, whether there are questions that are
17 asked at all about transition from child to
18 adult.

19 Again, this would -- I think the
20 challenge would be it applies to a broader age
21 group, the survey itself, so there would only
22 be a subpopulation who might qualify in terms

1 of a transition process. But I don't recall
2 off the top of my head whether there's any
3 questions in that CAHPS survey that
4 specifically talks about transition from child
5 health providers to adult providers.

6 MEMBER LACEY: And you said it's
7 Q4, they only do it every four years.

8 DR. BURSTIN: Yes, it's only
9 fielded every four years, which I think is the
10 biggest issue, really, is it's just not
11 feasible to collect -- Christine Bechtel, who
12 is the lead for this survey, has recently just
13 moved to Hopkins, so it might be a good
14 conversation, certainly if you haven't
15 already, to have with Christine, and see if
16 there's an opportunity to adapt it for your
17 use, because there are some wonderful
18 questions in those surveys that we've seen.

19 MS. COHEN: This is Anne. This is
20 one of the areas that I voted for, the care
21 coordination area, and I think one of the
22 challenges that we found in the Duals group is

1 that one simple question doesn't really get to
2 the answer.

3 So for instance, 1340's
4 specification talks about children 12 to 17
5 who are asked by their provider to have a
6 discussion about transitional care, but yet my
7 question would be, is there actually follow-up
8 -- whether that individual actually followed
9 up on the transitional care, or got assistance
10 in doing so, other than having a discussion.

11 So I think, Sam -- I mean, Sarah,
12 it might be helpful to talk about some of the
13 challenges with the care coordination in
14 general that we found out with the Duals
15 group.

16 CHAIR GESTEN: Anne, we're having
17 a little bit of trouble hearing you, I don't
18 know if you can get closer to the mic or turn
19 up the volume.

20 Let me make sure -- I heard, I
21 think, most of your question, but let me make
22 sure I have it.

1 I heard you saying that there are
2 challenges and limitations to asking one or
3 two questions about a broad concept, and that
4 further, beyond using survey information,
5 there's also the issue of whether, not only
6 did people perceive, perhaps, that their needs
7 were met, but whether in fact follow-up care
8 actually happened.

9 Was that the essence of what you
10 described, or did I miss it?

11 Anne? May have lost her. Beth,
12 did you have a question?

13 MS. COHEN: Are you there, hello?

14 CHAIR GESTEN: Now we can hear
15 you.

16 MS. COHEN: Hello? Okay, sorry,
17 my phone is having challenges. That's
18 correct, that was the gist of what I was -- my
19 comment. I specifically had a kind of a
20 question about 1340, as an example, where it
21 looks like this area talks about the provider
22 asking whether the individual thought about

1 transitional care and insurance coverage, but
2 the idea is, was it actually followed up upon?
3 What assistance did they get within that
4 transition?

5 And then I suggested that perhaps
6 an area for discussion, I know the Duals group
7 has talked a lot of about care coordination
8 questions, and we've struggled with how usable
9 the questions are and how meaningful they are.

10 And I thought maybe that might be
11 a good area to draw into the discussion, if
12 Sarah has any information about that, I don't
13 know if that would be helpful at all.

14 CHAIR GESTEN: I think it would
15 be. Do you have specific measures in mind
16 from that, from the Dual group, that would
17 relate to children, or -- Sarah is shaking her
18 --

19 MS. COHEN: No, yes. I think it
20 was more likely a struggle identifying
21 measures, is what I recall. Is that correct,
22 Sarah?

1 MS. LASH: Yes, I think it's a
2 similar conversation. There's a strong desire
3 for strong measures of coordination, and we've
4 hit this same wall before in that other work
5 group.

6 CHAIR GESTEN: Yes, this wall is
7 very familiar.

8 MS. COHEN: So, I think the reason
9 why I'm bringing that up is that even if the
10 CAHPS questionnaire has maybe one question, I
11 think it might be important to highlight this
12 area, even if sort of we don't have perfect
13 measures, knowing, across the MAP, we are
14 facing that same struggle.

15 CHAIR GESTEN: Thank you. Beth?

16 MEMBER FELDPUSH: So my question
17 or comment is actually more of a general one,
18 than -- I had my sign up a little earlier, and
19 probably should have just jumped in.

20 But my sentiments really echo
21 yours, Foster, in thinking that there's a
22 pretty rich pipeline here. And we don't know

1 what's going to happen to those measures, but
2 I'm a little bit hesitant, personally, to vote
3 on any of the four that are up on the
4 spreadsheet today, just because this is an
5 incredibly important area, I absolutely think
6 it's a high, high, high priority, and hope
7 that this type of activity is one that the MAP
8 will do on a yearly basis because new measures
9 come on line. But I sort of worry about being
10 faced with the dilemma of a year from now
11 saying, oops, sorry, we think there's
12 something better now than we voted on last
13 year. One, because it's kind of hard to pull
14 measures out of the set, and two, you really
15 don't want to do that, because you hope that
16 you'll collect longitudinal data once you get
17 going on something.

18 So again, sorry, just a general
19 comment now, but an incredibly important area,
20 but I'm just a little hesitant to sort of pull
21 the trigger on voting on any of these today.

22 CHAIR GESTEN: Great, thanks. Any

1 other comments before we start voting?

2 Okay. Well, why don't we take it
3 from the top. First measure is 0719, Children
4 Who Receive Effective Care Coordination of
5 Health Care Services When Needed.

6 Again, this is a survey, a survey
7 -- all of these measures are from a survey.

8 Can I have a show of hands of
9 folks who believe this should be prioritized,
10 added to the measure set?

11 One. Anyone on the phone? Okay.

12 0720, Children Who Live In
13 Communities Perceived As Safe. Can I have a
14 show of hands in the room? On the phone?

15 0721, Children Who Attend Schools
16 Perceived As Safe. Show of hands in the room?
17 On the phone?

18 And I apologize, folks on the
19 phone, no one raised their hand for 0720 or
20 0721, and we had one, I think, for 0719.

21 For 1340, Children With Special
22 Health Care Needs Receive Services for

1 Transition to Adult Health Care. Show of
2 hands in the room? One. On the phone?

3 MS. COHEN: Anne says yes.

4 CHAIR GESTEN: Two. Great. Okay.
5 Well, none of these measures passed our metric
6 for passing, but the issue absolutely is
7 coming back, as a number of folks mentioned,
8 it's a really important area.

9 So we have I think two more areas
10 to go through, maybe three, depending on
11 whether you're a lump or a splitter, or
12 whether we can put cost together with
13 inpatient, which I may suggest that we do.

14 Moving onto an area that was
15 prioritized, you heard prioritized by the
16 states, and we've had some conversation about
17 this, behavioral health measures, so I don't
18 know, Beth or Sarah, do you want to go through
19 what it is that we have relative to the
20 behavioral health measures?

21 MS. CAREY: Sure, I can give you
22 the overview here.

1 So we have five measures listed
2 here on this slide. They're a mix of -- no,
3 I'm sorry, these are all process measures, but
4 there's a mix of data sources and measurement
5 levels, which we'll see when we get to the
6 spreadsheet.

7 1365 and 2337 are currently going
8 through -- are currently going through
9 evaluation for endorsement, so if they are
10 selected, they would need to be recommended
11 with conditional support.

12 We categorized them, and again,
13 you can do this in whatever way is useful, but
14 we categorized them into buckets of screening
15 and risk assessment. We have preventive care
16 and screening for clinical depression, child
17 and adolescent major depressive disorder,
18 child and adolescent major depressive disorders
19 suicide risk assessment.

20 We have, 0004 is on initiation and
21 engagement of alcohol and other drug
22 dependence treatment. And then a new measure

1 that currently is undergoing review is 2337,
2 which is an antipsychotic use in children
3 under five, and that's actually going through
4 our safety committee.

5 MEMBER ADIRIM: 0004 is substance
6 use treatment, but here it says it's something
7 -- okay, I got it. Thought it was ADD.

8 MS. CAREY: So Nadine, do you want
9 to show us, quickly, the measures in the
10 pipeline. It should be the next slide.

11 Right, so this was an area where
12 there were quite a few measures coming up
13 through the pipeline from the COEs. So CAHPS
14 of course is ready, there is a bundle of
15 measures on antipsychotic use which has been
16 finished in the development phase but has not
17 been submitted for endorsement here at NQF.

18 And there's a, you know, a range
19 of other measures, Denise Dougherty at AHRQ
20 tried to put them into the buckets as we
21 talked about them during our web meeting.

22 So looking at access to outpatient

1 or ambulatory mental health care, and then
2 also looking at some measures of ER use for
3 mental and behavioral health.

4 So we can flag these to come back
5 and revisit during our spring meeting.

6 Do we want to go to the
7 spreadsheet?

8 CHAIR GESTEN: Yes. I'm sorry,
9 let's go to the spreadsheet. I was mesmerized
10 by the number of measures.

11 So we have one two three four
12 five. What's that? Now we can see it,
13 finally.

14 So they range from, as was
15 mentioned, measures on treatment for alcohol
16 and drug dependence, clinical depression
17 measures, measures around assessment of
18 suicidality and suicide risk, and then the
19 essentially utilization measure looking at
20 percentage of children under five who are
21 dispensed antipsychotics. Did I miss any?

22 MS. COHEN: This is Anne, I have a

1 clarifying question. You mentioned in the
2 measurement development area, if you can go
3 back to that, because I missed it, there was
4 another antipsychotic measure that's being
5 developed, is that correct?

6 CHAIR GESTEN: There was actually
7 a set of measures, that was partly why I was
8 mesmerized.

9 MS. COHEN: Sorry, I missed it.

10 CHAIR GESTEN: No, that's fine.
11 There are seven measures, some of which have
12 been NCQA approved, and I believe that they
13 relate to a number of different issues, you
14 may have it in front of you, related to
15 atypical antipsychotic use, polypharmacy, were
16 there metabolic screening measures related to
17 that?

18 MS. CAREY: I actually don't have
19 the topics, but three of them are, of the
20 seven.

21 MEMBER LLANOS: This is Karen,
22 I'll add, we've actually taken one of the

1 antipsychotic use measures and we're in the
2 process of e-specifying it, along with our
3 partners at ONC, and that one should be ready
4 soon.

5 Yes, paper and an e-version of one
6 of the antipsychotic measures.

7 CHAIR GESTEN: Anne, did that
8 answer your question?

9 MS. COHEN: Good, I was just sort
10 of thinking about the earlier conversation
11 about the need for antipsychotic measures as
12 well as a suicide measure, and the desire to
13 just kind of link them, electronically, and so
14 I'm just kind of wondering if the existing
15 measure has e-availability as well as the one
16 that's in development, or?

17 I think it's the same challenge we
18 just had with the care coordination questions,
19 that it looks like there's so many in
20 development.

21 CHAIR GESTEN: Right, and
22 according to Karen, at least one of the

1 antipsychotic use measures is currently being
2 developed for e-specifications, correct?

3 MS. CAREY: Yes, we have been
4 working on it for over a year, so it should be
5 relatively soon.

6 It's different from the PQA one,
7 which I think is the one that -- right, so our
8 NCQA team is e-specifying one that's a little
9 bit different, I think we've tried to compare
10 the two, and I think the PQA one which is on
11 the previous slide that's been endorsed is
12 more of a never event, if I am remembering
13 correctly, and this one is not. This one, I
14 think, also includes a follow-up component, if
15 I'm not mistaken.

16 CHAIR GESTEN: Are we ready to go
17 back --

18 MS. COHEN: Okay.

19 CHAIR GESTEN: Should we go back
20 to the specifications of the measures?

21 Let me just invite, if folks have
22 questions about the measures themselves, this

1 is the time to ask. Susan?

2 MEMBER LACEY: So on the status,
3 this is on the spreadsheet, so when you look
4 at the status, can someone give me a little
5 bit more information about what it means?
6 Obviously, endorsed means endorsed, but
7 steering committee review/recommended versus
8 recommended for endorsement by standing
9 committee? So is -- sounds like a continuum
10 that happens, or what's --

11 DR. BURSTIN: Those are pretty
12 much the same thing. Both of those measures
13 have gone through our committees, recommended,
14 the last one in fact already going out for our
15 final approval by our Consensus Standards
16 Approval Committee, so that one's quite far
17 along.

18 MEMBER LACEY: So both that, and
19 --

20 DR. BURSTIN: Yes, the one above
21 it as well, yes.

22 CHAIR GESTEN: So I have a couple

1 questions, I guess, taking my Chair hat off.

2 I'm wondering if anyone cares to
3 comment on -- I know that there's been a lot
4 of attention to very young children getting
5 antipsychotics, but I also know that while
6 perhaps any percentage is of concern, the
7 percentages are so low that I wonder whether
8 it's truly a measure that's useful relative to
9 quality improvement.

10 So I just wonder if anybody has a
11 view of that.

12 And then my second question is,
13 the measures on major depression -- clearly
14 major depression is a highly prevalent cause
15 of mental illness in adults. I guess I'm
16 wondering whether, of all the various mental
17 health conditions, whether major depressive
18 disorder is in fact the most common in
19 adolescents, or whether it's others, or a mix,
20 that's most common.

21 This gets at, I guess, the
22 question I have is, are we getting at the

1 right mental health condition for adolescents?

2 So I welcome if anyone has a
3 comment or thought about that.

4 MEMBER ADIRIM: So what is the
5 most common mental health condition in
6 adolescents?

7 CHAIR GESTEN: Okay, that sounds
8 clearer than what I said yes. That works for
9 me.

10 MEMBER ADIRIM: No, I'm trying to
11 understand what you're asking. Well no, I
12 would imagine it would be ADHD, depression,
13 and anxiety. I mean I could look it up, but
14 --

15 CHAIR GESTEN: Okay. So
16 depression is in the top -- you believe it's
17 in the top two.

18 MEMBER ADIRIM: I think so. I can
19 look it up, though. It's tough to consider
20 what's the most impactful, what drives costs,
21 what, you know.

22 CHAIR GESTEN: Cindy, did you have

1 a --

2 MS. PELLEGRINI: Yes, just as we
3 were looking at the list of measures under
4 development, and while I find some of these
5 measures attractive, and I think they're
6 certainly on very important issues, I think
7 I'm finding myself kind of in the place where
8 Beth was on the last one, where I am really
9 hesitant to choose from among these when
10 there's so much more coming.

11 And you know, we heard from Dr.
12 Kelley about the lag time and the ramp-up time
13 that's needed. If we put these in, are we
14 going to -- with one of these in, are we just
15 going to want to take them out in six months
16 or a year when we go through this process in
17 a more in depth way in 2015?

18 DR. BURSTIN: Comment on the PQA
19 one, because I knew that would come up.

20 So I did pull up the Pharmacy
21 Quality Alliance one that was raised. So that
22 is completely generated through prescription

1 claim data, so that might be one for
2 consideration.

3 And to Karen's point, it does look
4 at any use of antipsychotics in children under
5 five, although the developer presented pretty
6 scary data about how high that -- how rapidly
7 rising the use of antipsychotics in that age
8 group were, where there are no approved FDA
9 indications for those drugs.

10 So just to put it on there, at
11 least in terms of the burden question, I just
12 wanted to at least put that on the table.

13 MEMBER ADIRIM: I accessed
14 something, National Adolescent Health
15 Information Center, the top -- one in five
16 adolescents experience significant symptoms of
17 emotional distress, one in ten emotionally
18 impaired.

19 Most common are depression,
20 anxiety disorders, and ADHD, in substance use.

21 CHAIR GESTEN: Thanks.

22 MS. COHEN: This is Anne, I

1 actually was looking at your question about
2 the under age five children with
3 antipsychotics.

4 There's actually a number of
5 reports that have been done by Mathematica and
6 Rutgers, again, just, somebody else commented
7 about the increase in prescription
8 antipsychotics.

9 I am kind of wondering, I know
10 that another issue has been the increased
11 diagnosis of schizophrenia among children, I
12 think under age ten, and I'm interested in
13 whether that's another area that we might want
14 to consider tracking, particularly, obviously,
15 with these antipsychotics.

16 So it's just, it's not on the
17 list, I don't even know if there's a measure
18 area, but I know it's been a growing area.

19 CHAIR GESTEN: This is Foster, I
20 have seen similar, related to increased
21 diagnosis of bipolar, but I am not aware of
22 measures related to that.

1 Again, taking the Chair hat off
2 for a second and talking about measures that
3 are not on here, I am much more familiar, for
4 a variety of reasons, with the measures that
5 have just gone through NCQA recognition
6 related to antipsychotic use, and if I had to
7 pick measures not currently on the list for
8 picking, I'd certainly be much more interested
9 in those measures which I think get at many of
10 the issues, many of the important issues
11 related to inappropriate antipsychotic use in
12 kids and safety issues.

13 And it sweeps in a broader
14 percentage of kids as well, in terms of
15 measurement. So we're in this period where
16 measures have not yet gone, we don't even know
17 if they will be submitted to NQF, my guess is
18 they will, so for me it's a little bit of
19 awkward timing, because I know that there's
20 some things around the bend that aren't on
21 this list that I think I'd probably prioritize
22 over many, if not all, of these.

1 MEMBER LLANOS: Just to -- so I
2 just pulled up the in sync one related to the
3 multi -- it's multiple current antipsychotics
4 in children and adolescents, and that's the
5 one, I think, Foster, you were just
6 referencing.

7 So it's the percentage of children
8 and adults ages 1 to 20 who are on two or more
9 concurrent antipsychotics, a lower rate
10 indicates better performance.

11 So it captures a wider range, but
12 then you can report four age range
13 stratifications, 1-5, 6-11, 12-17, 18-20, and
14 then a total range, as well.

15 And that's just one of the seven
16 that were mentioned on that previous page.

17 CHAIR GESTEN: Go ahead, I'm
18 sorry, Susan?

19 MEMBER LACEY: So we have 0576,
20 Follow-Up Hospitalization for a Mental
21 Condition, and we have 0108, for ADHD
22 Follow-Up. And as reticent as we might be

1 about adding something that we may be able to
2 refine and get better a little bit later, we
3 really don't have anything all the way at the
4 back, at capturing kids who are already
5 getting in trouble.

6 Right now, what we're doing is
7 capturing data when kids are already in
8 trouble -- out of the hospital, or what have
9 you.

10 So there's nothing in there. And
11 I think what we were hearing on the call was
12 that this whole cornucopia of what mental
13 health conditions are for children, we've got
14 to start somewhere, and I would hate for us to
15 just not try to capture anything on the front
16 side with this group.

17 CHAIR GESTEN: I am not sure I am
18 following you. Can you translate it into, you
19 are advocating for -- I thought you were
20 advocating for more upstream -- a measure
21 that's not on here, which is something
22 upstream. But it sounds like you're saying --

1 MEMBER LACEY: No, what we have
2 is, you know, the endorsed, on the spreadsheet
3 -- so we have the endorsed piece around
4 Follow-Up After Hospitalization --

5 CHAIR GESTEN: In the current
6 measure set. The current Core Set has
7 Follow-Up After Hospitalization --

8 MEMBER LACEY: So those are
9 current, and that's what we have.

10 CHAIR GESTEN: -- and ADHD
11 Management.

12 MEMBER LACEY: Right. So I would
13 hate to look at this whole potential list that
14 has some, you know, screening for depression,
15 screening for suicidal tendencies and what
16 have you, and just not add anything --

17 CHAIR GESTEN: Gotcha.

18 MEMBER LACEY: -- to the mix, just
19 because we're waiting for something that
20 potentially may be better --

21 CHAIR GESTEN: Okay.

22 MEMBER LACEY: -- and that's

1 worrisome.

2 CHAIR GESTEN: Wait, there's a
3 screening measure, is there a screening
4 measure for -- there isn't a screening measure
5 in the Core Set, is there?

6 MEMBER LACEY: No. Nope.

7 CHAIR GESTEN: In the adult one.

8 MEMBER LACEY: It's all on the
9 back side.

10 CHAIR GESTEN: Okay. Sandra.

11 MEMBER WHITE: You know, I also
12 agree with the previous speaker, and I'm
13 sorry, who was speaking? Susan?

14 And this is based upon, of course,
15 what we know about our members that have a
16 behavioral health issue. If they have a
17 physical issue, the cost is 1x. A physical
18 issue with a behavioral health issue, the cost
19 is 4-5x.

20 And from the information presented
21 this morning, looking at the mental health
22 disorders that was presented earlier this

1 morning, which shows that there's a
2 disproportionate spending of Medicaid premiums
3 for behavioral health, and even though it's a
4 very small number of that population, it's
5 extremely high cost.

6 So there is 10 percent of the
7 children who are driving almost 40 percent of
8 the cost. So I, too, would agree that we do
9 need to have some upstream mental health
10 screening for this population.

11 CHAIR GESTEN: I'm sorry, I didn't
12 see who did -- Cindy? Go ahead.

13 MS. PELLEGRINI: I'll be brief, I
14 was just going to say, I agree completely
15 about the importance of all of this. The only
16 thing that gives me pause on this one is that
17 it's only for clinical depression, and that
18 it's not more holistic for mental health in
19 general.

20 CHAIR GESTEN: Terry?

21 MEMBER ADIRIM: Right, and I
22 agree, actually, with what everybody is

1 saying. However, it sounds to me, one of the
2 last things Karen just said was that it's
3 being measured in the adult Core Set, right?

4 So that, you know, if you're
5 aligning the sets, states are already
6 reporting it, this would be something that
7 would be easy to report, right?

8 CHAIR GESTEN: How many states are
9 reporting this one, for adults? Do you have
10 any idea?

11 MEMBER LLANOS: I'd have to pull
12 it up, but I don't know off-hand.

13 MEMBER ADIRIM: Yes, but
14 depression is very common in adolescents, and
15 it's something you don't want to miss because
16 it could have dire consequences.

17 CHAIR GESTEN: So I'm wondering if
18 other folks -- the two things that concern me
19 about the measure: one is that I believe the
20 task force recommendation, the U.S. Preventive
21 Task Force recommendation relative to this,
22 talks about appropriateness of screening if

1 there is in fact a system in place, and it's
2 that "if there is a system in place" part that
3 becomes problematic when you talk to
4 clinicians about whether they screen or not.

5 I have a personal view of that,
6 but in terms of the ability to use a measure
7 of screening, I don't see that as -- I'm not
8 advocating that it should be an exclusion, but
9 I don't see that in the exclusion category for
10 this measure, as it relates to, at least, U.S.
11 Preventive Task Force recommendations.

12 And then, it's very small print,
13 but I can see it, because I just had an eye
14 examination -- there's an awful lot of
15 exclusions that I wonder about the ability to
16 standardize or to implement, or
17 operationalize, these. So exclusions include
18 patients who refuse to participate; if there's
19 an urgent situation, however urgent is
20 defined; where there's motivational issues;
21 where there's a referral situation where
22 they're participating in ongoing treatment,

1 again, I'm not sure how that's defined.

2 There's a number of different
3 exclusions that make me wonder about the
4 ability to standardize this. Those exclusions
5 give me a little bit of pause.

6 But I'm wondering if anyone else
7 has any comments or concerns about those, or
8 actually, I don't have to ask --

9 MEMBER SIDDIQI: Alvia Siddiqi,
10 and Foster you pretty much took one of the
11 points that I was just about to make, and I
12 completely agree that from the USPSTF
13 standpoint, it's really challenging for
14 providers, often it's for a provider system,
15 especially for primary care, to implement
16 routine screening for clinical depression
17 unless you have appropriate referrals and
18 systems in place to be able to manage what we
19 do with a patient when they do test positive
20 on that screening.

21 And so I think this is still a
22 very challenging measure to see states report

1 on, also because a follow-up needs to be
2 documented if we're looking at 0108, and that
3 is something that you really typically can't
4 use claims data to easily be able to identify
5 follow-up that was recommended.

6 I'm thinking of this as more of a
7 hybrid-type measure where a chart you'd use
8 would probably be required as well, so I kind
9 of am more excited about the upstream of the
10 newer measures, especially the one that you
11 had mentioned about antipsychotics, as well as
12 the need for including some of those types of
13 measures that may be more helpful.

14 So I'm kind of on the -- I kind of
15 don't believe right now that this measure is
16 not going to be as effective in terms of
17 having states report on it, feel comfortable
18 operationally to be able to use it.

19 CHAIR GESTEN: Okay, thanks Alvia.
20 Terry, did you have a question? Or was that
21 just a remnant? Susan, and then Sandra?

22 MEMBER LACEY: So I'm just going

1 to play devil's advocate with you, Foster.

2 So my husband works at a federally
3 qualified clinic, he's a pediatrician. He
4 sees women who bring in their kids all the
5 time who had gestational diabetes, or they
6 were very sick, or what have you. And they
7 were screened for xyz, and the results were
8 such that they needed intervention, but either
9 they're undocumented or they can't get
10 whatever they need, and they don't have the
11 money, or what have you, and they don't get
12 it.

13 And so I hesitate for us not to do
14 something just because we don't have the
15 perfect environment in place within a
16 community to refer people to, because I think
17 that's a slippery slope.

18 I mean, I think we have to say:
19 this is what we need to do, and then, you
20 know, other departments, agencies, or what
21 have you, I think we have to coordinate in a
22 much broader way about making sure that those

1 systems do get in place, and I don't know if
2 that's our role.

3 CHAIR GESTEN: Sandra?

4 MEMBER WHITE: One of the other
5 considerations that we can -- I am trying to
6 read my screen at the same time.

7 (Laughter.)

8 MEMBER WHITE: One of the other
9 considerations that we can also discuss is
10 considering 1364 and 1365, and not
11 incorporating 0418, because 1364 and 1365 does
12 not have any significant exclusions.

13 And I do agree, it's problematic
14 when there is not a standardized screening
15 tool. There are lots of exclusions. But we
16 certainly can more strongly consider the ones
17 that do not have any exclusions.

18 CHAIR GESTEN: Okay. Those
19 measures, as I understand them, 1364 and 1365,
20 it says electronic clinical data or electronic
21 health record as the data source, but for most
22 folks, this is chart review. That's

1 currently, in the current world, right?

2 The -- Sarah said, in terms of the
3 question of how many states currently -- and
4 again, this is just really for informational
5 purposes, not to -- just for context. There
6 are five states that are reporting the adult
7 version of the Screening for Clinical
8 Depression measure, as it stands now. Five.

9 Was there -- did somebody on the
10 phone, Anne or Alvia, did you want to make a
11 comment?

12 MS. COHEN: This is Anne, I
13 actually did want to make a comment.

14 I kind of echo what other folks
15 were saying, that I still think we need to
16 really do something in this category, and that
17 while the measure is not perfect, I think it's
18 important to look at it -- in particular with
19 the fact that I assume, obviously, this is at
20 the primary care level, and I think given the
21 fact that mental health is carved out, and on
22 top of it, many kids with EPSDT are gaining

1 sort of mental health services via that
2 category or development and disability
3 categories, it's so fragmented to capture this
4 group that we need data from somewhere.

5 And we have heard how much to
6 carve out data can be a challenge. So maybe
7 this is an area in which we can get better
8 quality data to the board.

9 MEMBER SIDDIQI: And this is
10 Alvia, I was just going to make the comment
11 that --

12 CHAIR GESTEN: Alvia, I am sorry
13 Alvia, you are very muffled, and it's a little
14 challenging to hear you. I don't know if
15 there's -- if you can take us off speaker, or
16 --

17 MEMBER SIDDIQI: Sure, I just did.
18 Is that better?

19 CHAIR GESTEN: Much better, thank
20 you.

21 MEMBER SIDDIQI: Much better, sure.
22 So I was just going to add that

1 the challenge with the routine screening type
2 measure for depression is when we look at the
3 USPSTF screening guidelines for this, that has
4 looked at a whole body of evidence with many
5 scholars, obviously, looking in and trying to
6 determine whether the evidence supports a
7 routine screening for depression without
8 staffs and systems in place for appropriate
9 follow-up and referral, and that is why that
10 recommendation through the USPSTF screening
11 task force about depression routine screening
12 not being implemented unless you have proper
13 systems in place is a really important one to
14 note.

15 And I just think that that's still
16 really a challenge across the board, and I
17 just want to echo the fact that the EHR
18 systems would not be able to -- well,
19 essentially you would need to cull through
20 that data through the EHR systems rather than
21 look at simple claims data to be able to
22 report on even 1364 or 1365, I still find them

1 sort of challenging.

2 And really for 1364, it's
3 essentially just -- it seems like it's looking
4 at certain DSM-IV criteria, and then 1365 is
5 looking at another assessment for suicide
6 risk, so those would not be really readily,
7 you know, operationally -- they would be very
8 challenging to achieve, I think.

9 CHAIR GESTEN: Thanks. Sandra, I
10 assume that that's a remnant, that's a
11 vestigial card, vertical card, in front of
12 you.

13 That's okay. Not a problem. Any
14 other questions or comments?

15 MEMBER LLANOS: This is Karen. I
16 just wanted to share, and I was going to -- I
17 wasn't sure if this would be helpful context
18 now, or during public comment, I don't know if
19 our SAMHSA partners are on, but so they had
20 sent us a letter in terms of measures to
21 consider, so I'll just share it with all of
22 you.

1 I think one of them has been
2 retired, so I won't mention that one, and the
3 other two are on this list, for what it's
4 worth. And I think you've discussed both of
5 them. The first one is 0418, the Screening
6 for Clinical Depression, and the second one is
7 the Major Depressive Disorder Suicide Risk
8 Assessment, 1365.

9 So, again, just for consideration,
10 this is from SAMHSA. 1365 and 0418, and
11 those are the two that SAMHSA shared with us
12 in terms of feedback.

13 CHAIR GESTEN: Susan.

14 MEMBER FLEISCHMAN: Yes, trying to
15 understand, on 1364 and 1365 in states with
16 mental health carve outs, is this a combined
17 data set from the mental health community?
18 Sometimes it's in managed care, sometimes it's
19 county, it's not in managed care. Sometimes
20 it's partially the accountability of the
21 physical health plan, so mechanical question
22 on this.

1 CHAIR GESTEN: So I don't think
2 there's a -- as we heard from David, you hear
3 from other folks, I don't think there's a
4 simple answer to that. The reality is that
5 there are states in which there are carve outs
6 of numerous kinds and stripes, you know, they
7 can include anything from behavioral health to
8 pharmacy to you name it.

9 However, the ability to then put
10 that data together is also variable, so it's
11 not just is it carved out, but is there a
12 mechanism to be able to splice it back
13 together?

14 And again, my understanding, I
15 think as David articulated, is it can be very
16 variable between states that have carve outs.
17 So mental health issues, like some other
18 issues, may have some challenges.

19 I don't know if Marsha or Karen,
20 either of you have a finer point on that as an
21 issue.

22 MEMBER FLEISCHMAN: It's actually

1 even worse than state-by-state.

2 So in California, the physical
3 health plans share -- do everything up to a
4 certain point on serious mental illness, and
5 then county mental health kicks in, it's not
6 in a managed care setting. And that bar is in
7 a different place in each county, dependent on
8 county policy, but more importantly, county
9 resources and capabilities.

10 So in a county with poor
11 capabilities, we want the child to get care,
12 so we push our -- we push out what we offer so
13 that the kid doesn't fall through the cracks,
14 and counties with better capabilities, because
15 they're not getting paid for it, will try to
16 push it out into the community.

17 So I don't have a clue, like on
18 the diagnostic evaluation, how we would start
19 to understand who has had a proper evaluation
20 as far as the criteria, and who hasn't.

21 CHAIR GESTEN: Other comments
22 before we get to a vote?

1 Okay. Let's take it from the top.
2 First measure is 0004, The Initiation
3 Engagement of Alcohol and Other Drug
4 Dependence Treatment. By a show of hands, if
5 you believe this should be added to the
6 current Core Measure Set.

7 On the phone? Okay, it was a zero
8 here.

9 0418 is Preventive Care and
10 Screening, Screening for Clinical Depression
11 and a Follow-Up Plan. By a show of hands in
12 the room, all those who believe this should be
13 added to the measure set?

14 And on the phone?

15 Okay, that was five, right? We
16 need seven now, is that right? We need seven.

17 1364 is Child and Adolescent Major
18 Depressive Disorder Diagnostic Evaluation. By
19 a show of hands in the room, all those in
20 favor of adding this, recommending to add
21 this? One, two, three.

22 On the phone? Okay, three total.

1 For Measure 1365, Child and
2 Adolescent Major Depressive Disorder Suicide
3 Risk Assessment, by a show of hands, if you're
4 in favor?

5 One, two, three, four, five --
6 six, sorry.

7 And on the phone?

8 MS. COHEN: Yes, this is Anne.

9 CHAIR GESTEN: Seven. And the
10 last measure, 2337, Antipsychotic Use in
11 Children Under Five Years Old. A show of
12 hands?

13 We have three. On the phone?

14 MS. COHEN: Yes, this is Anne.

15 CHAIR GESTEN: Four. Okay, so we
16 had one that made it, 1365.

17 So we have two, or if you're a
18 lumper, I think we might try to lump the
19 inpatient and the cost together, since as
20 pointed out, they're kind of in the same
21 category, to go.

22 We're at break time. My

1 suggestion is that we break now and come back
2 at 3, or, if we can do a five minute break --
3 is that, am I pushing it by a five minute
4 break? Is five okay?

5 Why don't we try to come back in
6 five, and then we'll start by tackling that,
7 and then we'll move on to the cross-cutting
8 issues, or whichever comes first, if it's
9 public comment first. No, public comment
10 comes after the cross-cutting issues. So why
11 don't we come back in five minutes?

12 (Whereupon, the above-entitled
13 matter went off the record at 2:47 p.m. and
14 went back on the record at 2:55 p.m.)

15 CHAIR GESTEN: Is there anyone
16 that has to leave before 4:00? So we know --
17 because we have some voting stuff that may
18 complicate our math a little bit, but -- okay.

19 Anne and Alvia, are you hanging in
20 there okay?

21 MEMBER SIDDIQI: Yes. Alvia.

22 MS. COHEN: Yes.

1 CHAIR GESTEN: Thank you. Thank
2 you so much. I know how hard it is to stay
3 all day on a conference call, but we very much
4 appreciate you being there. And, again, feel
5 free if -- if you have something to say and
6 I'm just forgetting that -- forgetting you,
7 feel free to just jump in.

8 So in terms of process and where
9 we are, we have one big lumped category that
10 we are going to go through. We are going to
11 put together in-patient measures along with
12 "costs," which are the readmission measures to
13 go through. So far we have three measures
14 that have met the threshold, and we'll go back
15 to those and whatever we may decide to endorse
16 here to prioritize those before you leave. So
17 start thinking about your favorites. Again,
18 it is going to be another challenge to pick
19 among them, but that's what we are here and
20 charged to do.

21 And we will have time for some
22 open comments, if there is anyone on the line

1 or left in the room. One brave soul. And
2 then just kind of -- probably just revisit
3 very briefly some of the cross-cutting issues,
4 just to make sure that we didn't miss any,
5 allow you to put some on the table that
6 perhaps we didn't get to, and then we should
7 be okay.

8 So I don't know if -- who wants to
9 do this slide? Beth. This is Beth.

10 MS. CAREY: Perfect timing. Okay.

11 So --

12 CHAIR GESTEN: And while you're
13 getting ready, let me just -- in case I forget
14 at the end, thank you all for -- I'm just
15 stalling here.

16 MS. CAREY: Thank you.

17 CHAIR GESTEN: For making your
18 trip here and contributing. You know, great
19 comments and great questions. And I recognize
20 that there are a number of things that we put
21 in a parking lot, probably for next year, but
22 we're not going to forget those. So --

1 DR. BURSTIN: And as long as we're
2 stalling, I'll also mention that Mark Schuster
3 from the Children's Hospital Boston, who is
4 the lead for one of the centers of excellence,
5 some of the measures we have been talking
6 about, is on the line.

7 So if you have any questions for
8 him, he is happy to answer them. They do
9 readmission measures, and we also added, just
10 because we had -- it recently went through our
11 committee as well, we also added child H-CAPS
12 to the list for your consideration as well.
13 So that just was very favorably reviewed by
14 our committee.

15 MS. CAREY: Okay.

16 CHAIR GESTEN: You good?

17 MS. CAREY: I've finished my
18 candy.

19 CHAIR GESTEN: Okay.

20 MS. CAREY: So we're ready to go.
21 Okay. So as Foster was saying, we do have a
22 big bucket of measures here to go through. We

1 categorized two measures in premature birth or
2 low birth weight, 0304, late sepsis or
3 meningitis, and very low birth weight
4 neonates; and 0477 under 1,500 grams and vent
5 not delivered at appropriate level of care.

6 We have under the bucket of
7 cardiac and circulatory birth defects 0339, a
8 pediatric heart surgery mortality rate; 0340,
9 a pediatric heart surgery volume, which is
10 also in AHRQ PDI Number 7; and then a paired
11 measure set, pediatric cardiac surgery
12 mortality and volume.

13 And then under our remainder
14 bucket of other topics we have PICU
15 severity-adjusted length of stay; the PDI
16 Number 2, pressure ulcer rate; a PICU
17 standardized mortality ratio; and then a
18 standardized mortality ratio for neonates
19 undergoing non-cardiac surgery.

20 And when we get to the spreadsheet
21 we'll see that these measures are, again, a
22 mix of outcome and structure measures. The

1 ratios are mostly structural measures. Data
2 sources are a mixed bag, and measurement
3 levels are also a mixed bag between facilities
4 and I believe population.

5 One thing to keep in mind, again,
6 is that some of the facility level measures
7 could be a challenge to roll up to a state.

8 And then on this slide we're
9 showing the also large list of measures and
10 development from the centers of excellence
11 that AHRQ has provided us to look at, and you
12 can see that, again, there are quite a few on
13 this slide that are checkmarked as being
14 complete, but they have not come to NQF yet
15 for endorsement evaluation.

16 MEMBER ADIRIM: Do you have
17 specifics about the sepsis ones?

18 MS. CAREY: This is pretty much
19 all of the information we have. We can go
20 back and try to get more information unless
21 anybody else at the table knows.

22 Okay. Should we keep going, then,

1 to the readmissions? So, Nadine, if we could
2 go to the suggested --

3 CHAIR GESTEN: Hang on a second.
4 Carol, did you have a question?

5 MEMBER SAKALA: (Off mic comment.)

6 CHAIR GESTEN: That would be
7 great. Thanks.

8 MS. CAREY: Okay. Very good. So
9 here we have 0335, PICU unplanned readmission.
10 And now that we are putting these two together
11 it does relate to 0334, which is the
12 severity-adjusted length of stay. They were
13 submitted by the same measure steward. And
14 then our two new readmissions measures, 2393,
15 which is pediatric all condition, readmission
16 measure; and 2414, which is a lower
17 respiratory infection readmission measure.

18 Can we have the next slide,
19 Nadine? No, we don't have any more of those,
20 because -- right, we don't have an additional
21 slide of the centers of excellence measures
22 for this one, because the two are on -- they

1 are further along and have already come to
2 NQF.

3 Any questions on this, or should
4 we jump to our spreadsheet?

5 CHAIR GESTEN: So, Carol, probably
6 now is the time to make your comment.

7 MEMBER SAKALA: So I think there
8 is one more measure that would be really
9 outstanding for this measure set that already
10 is endorsed and could have been on that first
11 list, and that is the exclusive breast milk
12 feeding measure, which is the proportion of
13 newborns exclusively fed breast milk during
14 the hospital stay.

15 And it really addresses a lot of
16 the concerns that have been raised today, for
17 example, about volume, that over 98 percent of
18 our children are exposed to the hospital care
19 at the beginning of their lives. That would
20 relate to this measure. And, by the way, 85
21 percent of moms, because it's a great -- you
22 know, breastfeeding is outstanding for both of

1 them, and it also relates very well to other
2 measure sets -- the in-patient quality
3 reporting, it's an optional measure, and for
4 meaningful use, the eligible hospitals, it's
5 an optional measure.

6 And although we haven't been
7 talking about the Joint Commission as an
8 alignment focus, I think it's important to
9 note that beginning this year hospitals with
10 over 1,100 births per year are mandated to
11 report their perinatal care measure set, which
12 includes this one.

13 So I think it's a potentially good
14 candidate, and of note is that the conditions
15 that you discussed, Sarah, earlier -- many of
16 the conditions, it's preventive for some of
17 the chronic conditions that we're concerned
18 about in this population.

19 CHAIR GESTEN: So we don't have
20 the specific specifications in front of us,
21 but I think if folks have questions about them
22 -- does anybody object to the notion of

1 putting -- what's one more? Does anybody
2 object to the notion of putting one more in
3 front of us for us to take a look at --

4 MEMBER ADIRIM: No. I was just
5 going to ask about that particular measure,
6 what data set is used to derive that measure?
7 I mean, I don't even --

8 MEMBER SAKALA: Yes. But I forgot
9 to mention also that it is e-specified, so
10 that it has the option of that.

11 MS. CAREY: I just pulled it up on
12 QPS. It's measure 0480, PC05 exclusive breast
13 milk feeding, and the subset measure of PC05A,
14 exclusive breast milk feeding, considering
15 mother's choice.

16 The measure description is PC05
17 assesses the number of newborns exclusively
18 fed breast milk during the newborn's entire
19 hospitalization, and a second rate PC05A,
20 which is a subset of the first, includes those
21 newborns whose mothers choose to exclusively
22 feed breast milk. This measure is part of a

1 set of five nationally implemented measures
2 that address perinatal care; PC01, elective
3 delivery; PC02, Caesarean Section; PC03,
4 antenatal steroids; PC04, health care,
5 associated blood stream infections in
6 newborns.

7 CHAIR GESTEN: Not collected
8 currently by payer type, correct?

9 MS. CAREY: Let me scroll down.

10 CHAIR GESTEN: One of my questions
11 would be, what is the mechanism by which
12 states would be able to collect this from
13 Medicaid specifically?

14 MS. CAREY: It is -- the data
15 source comes from administrative claims,
16 electronic clinical data, and paper medical
17 records, and the level of analysis at this
18 facility or population is a process measure.

19 CHAIR GESTEN: Okay. Is there a
20 question? Yes? Okay. So we have a lot up
21 here, and it can't all fit on one screen, so
22 we can -- I guess we can play around with this

1 or maybe do these by sections. If folks have
2 questions or thoughts about these measures, I
3 guess this is probably the time to talk about
4 clarifying -- ask any clarifying questions
5 about the measures. Sandy? Sandra?

6 MEMBER WHITE: So are these
7 measures -- will also be expected to be
8 reported by the health plans, or are these
9 measures only data collection by the state?

10 CHAIR GESTEN: So I'll try to
11 answer it for CMS. Always a danger. But
12 since you're in the room, you can answer. But
13 given that you're not chopping at the bit to
14 answer it, I think the existing -- I think
15 what we heard in the two presentations this
16 morning from the states was that the answer to
17 that can be variable, depending on the measure
18 and depending on the state.

19 So there are certainly some states
20 who have driven, if you will, core measures
21 through requirements in the health plans, so
22 there is other states for some measures,

1 either because they collect the data set
2 directly, have done it themselves, if it could
3 be done through administrative data.

4 So I don't think that there is a
5 simple answer to your question, but it's a
6 good one. I don't know. Would you answer it
7 differently, or do you --

8 MEMBER WHITE: This is probably a
9 rhetorical question. And the reason that I'm
10 asking it is because both of the state
11 presenters this morning, they talked about the
12 barriers of being able to collect certain
13 types of information, and particularly
14 collecting data from a hospital system rather
15 than from a provider who is a part of the
16 health plan providers network.

17 So I think it's -- I can probably
18 say with certainty that it's going to be
19 extremely challenging for health plans to get
20 this kind of information from the various
21 hospital systems.

22 MS. COHEN: This is Anne. I have

1 a question regarding that. And maybe this is
2 -- and I know there is somebody else from
3 California in the room as well, so maybe I'm
4 way off base here, but I know -- I believe
5 that in California there is some
6 hospital-level data that is reported up to
7 kind of the state and to the kind of managers
8 or state hospitals.

9 And I'm just kind of curious
10 whether there may be a different way of
11 looking at some of these measures, since it is
12 state-level reported. Is it possible for the
13 hospitals to report directly? Does it
14 necessarily have to come from the health
15 plans? It may be from -- it's a separate
16 agency within the state that works with the
17 Department of Health Care Services. It is
18 just kind of an "out of the box" idea, but I'm
19 just trying to get that concern.

20 CHAIR GESTEN: No, Anne, that's a
21 good point. And it's not clearly out of the
22 box, because I think we've encountered this

1 already with existing measures. For example,
2 CLAPSI measures are reported to the state, and
3 I think we have had some conversations about,
4 you know, why not just use that directly. But
5 do you have -- I think the methodology in
6 terms of the mechanism by which the data is
7 presented may present some challenges as
8 currently constructed to just kind of sweep up
9 measures from somewhere else. But, Karen, do
10 you want --

11 MEMBER LLANOS: I think you're
12 right. I mean, I'll just give you an example.
13 I think what everyone is raising is exactly
14 right. Some measures are just harder to
15 collect, and facility measures tend to be
16 those types of measures that are harder for
17 states to report on.

18 I think we have heard that
19 challenge on both the children and adult core
20 sets. Some states have found ways around
21 them, but they are still challenging in terms
22 of the data collection.

1 CHAIR GESTEN: Yes. Denise, why
2 don't you just introduce yourself. We're
3 rewarding you for being the only person in the
4 audience for hanging in. We've made you an
5 unofficial member of the task force.

6 MS. REMUS: You're in my niche
7 now. I know this -- I know the --

8 CHAIR GESTEN: Go ahead.

9 MS. REMUS: -- world. I'm Denise
10 Remus with All Children's Hospital in St.
11 Petersburg, Florida. We are part of Johns
12 Hopkins Medicine System. And I think I am the
13 only hospital representative, perhaps, in the
14 room.

15 As I was looking at these
16 measures, I just wanted to clarify for the
17 group that the PICU measures, as I have been
18 reviewing them, are from the VPS system.
19 That's a clinical registry system that
20 hospitals participate in. So the way these
21 are defined, you'd need to be participating in
22 that registry system.

1 And I can share with you that All
2 Children's, as advanced as we believe we are
3 as a very high quality, freestanding
4 children's hospital, literally just started
5 participating in the VPS registry. So it's
6 not quite as prevalent.

7 The pediatric surgery mortality
8 measures that you are looking there are from
9 the Society for Thoracic Surgeons' congenital
10 heart surgery database. Again, I would guess
11 that the majority -- almost all of the
12 hospitals that do congenital heart surgery are
13 in these registries, but I just wanted to
14 clarify, the data goes into those registries.

15 So it's a different flow of data
16 than what hospitals do with NHSN and others.
17 From the state, you can grab easily from NHSN.
18 It is not, I don't believe, going to be very
19 easy for you to grab from these registries,
20 and sometimes it's difficult for the hospitals
21 to get their own data back from the
22 registries. And some of the risk adjustment

1 actually occurs downstream from the hospital.

2 So we don't necessarily have all
3 of that detail in a way that we could readily
4 pass forward. So I just wanted to share that
5 perspective.

6 CHAIR GESTEN: Thank you so much,
7 Denise. Other questions? Comments? Susan?

8 MEMBER LACEY: Can I just get some
9 clarification around the pressure ulcers? So
10 that's hospital-acquired, I'm assuming, trying
11 to maybe be in alignment with adult CAPUs.
12 And then that's administrative data collected
13 every four years. This is an AHRQ HCAHP. No?
14 Or is it just --

15 DR. BURSTIN: Not every four
16 years. It's -- oh, Denise knows this.

17 MEMBER LACEY: Oh.

18 MS. REMUS: Yes. The pressure
19 ulcers, to be honest with you, this PDI, based
20 on the administrative data, it is a valid
21 measure based on administrative data. I can
22 tell you that hospitals who were in Magnet,

1 and hospitals who really monitor this -- and
2 I'm learning more about the pediatric world --
3 we don't -- we monitor this mainly because
4 this is what leaves our door from an
5 administrative data.

6 But we capture our pressure ulcers
7 using a Magnet measure, using clinical events,
8 because we do have a lot of pressure ulcers
9 that occur in our population that would never
10 be captured in this measure.

11 So especially in a lot -- our
12 preemies, our babies, you know, it's -- so I'm
13 just acknowledging that this, like many of the
14 others, is just one of those challenges of
15 administrative versus clinical data. We
16 monitor and improve based on our clinical
17 data. It's the Magnet measures, it's the
18 nursing care sensitive measures, it's that
19 operational definition.

20 This is easy to collect, and it is
21 something certainly that you could do and
22 monitor, just recognizing that it captures,

1 you know, a portion of those that occur within
2 the hospital setting, especially, again, in
3 this -- in your very frail babies.

4 CHAIR GESTEN: Cindy?

5 MS. PELLEGRINI: Clarification.

6 This does say in the exclusions that it
7 excludes neonates. So are you thinking that
8 it would not capture most of those babies?

9 MS. REMUS: This measure it would.
10 We monitor our pressure ulcers across all of
11 our babies.

12 MS. PELLEGRINI: Right.

13 MS. REMUS: So, you know,
14 internally we monitor everything.

15 MS. PELLEGRINI: But just based on
16 what you were saying, it sounded like a high
17 percentage of what you capture is in the
18 neonates. So we would expect this measure not
19 to do that.

20 MS. REMUS: In components that
21 don't transfer into the ICD-9 codes that would
22 meet this definition. That's one of the

1 challenges.

2 If you don't mind, I'd like to
3 make a comment on the exclusive breast milk
4 feeding, and I'm sharing this not because it's
5 a freestanding children's hospital. We don't
6 actually have to report this, because we don't
7 fall under that umbrella. We don't do
8 deliveries, but we care for these babies.

9 And in working with Johns Hopkins
10 and the Children's Center that does have to
11 report this, we have found some concerns with
12 this, and they are working with Joint
13 Commission on trying to clean up. And, of
14 course, if any of those specifications are
15 changed, they would roll into the measure that
16 you are working with.

17 But there are challenges where we
18 do need to give supplements for medical
19 purposes that are -- that fail this measure
20 and are not acknowledged right now currently.
21 And some of those other components of the
22 medical condition of the baby that are not

1 fully specified that we are finding as we
2 evaluate when this measure is failed.

3 So it's -- I don't think it's
4 anything to throw out the baby with the bath
5 water, so to speak, but just know that as with
6 many measures there is continuous effort to
7 try to enhance and understand how that
8 definition that looks really good when it's
9 put out there in the real world, what some of
10 the caveats are that we need to try to explain
11 and modify the definition.

12 CHAIR GESTEN: Thanks, Denise.
13 Why don't you stay put, because there might be
14 other issues. We're on in-patient, and you
15 hung in there.

16 Can we go down to the measure on
17 readmissions? I had some questions about that
18 one. It's the all condition readmission one
19 I think that I had the question on.

20 I guess one of my -- one of the
21 concerns I had about this measure -- well,
22 first of all, as folks know, there's probably

1 no more measure that is a lightning rod than
2 the readmission measure. So now -- so let's
3 include pediatrics in this as well.

4 The measure does say it's case mix
5 adjusted, which is interesting, and that
6 addresses one of the potential issues that --
7 but I guess I was struck by the number of
8 exclusions, and I -- I don't know if there's
9 anybody here who can help or -- but I would
10 just point out that, as I look at this and
11 think about the fact that neonate births are
12 excluded, and births are probably -- not
13 probably, they are the number one cause of --
14 number one hospitalization in Medicaid.

15 Mental health -- is this the one
16 where mental health is excluded, too? So
17 we've excluded mental health, and we excluded
18 births from readmissions, probably two of the
19 most important, either based on volume, costs,
20 whatever, admissions to the hospital for the
21 Medicaid program.

22 And then there are other

1 exclusions related to whether the data is
2 actually valid at the -- it says that the --
3 that there is an exclusion if records are not
4 felt to be complete or valid. And I
5 understand why that would be true, but -- I'm
6 sorry?

7 DR. BURSTIN: I was going to say,
8 if you wanted me to -- this just went through
9 our evaluation by a standing committee, so
10 they have looked at all of these issues. This
11 was definitely one of the -- these were
12 measures they did recommend pretty highly,
13 having gone through lots of the weedy kind of
14 issues. And I'm, you know, happy to share
15 that information with the group if they'd like
16 to see it.

17 The biggest concern that people
18 had raised is that it doesn't exclude what may
19 be -- you know, what may not be preventable
20 readmissions, but that is sort of the state of
21 the art currently in terms of readmission
22 measures to enrollment.

1 CHAIR GESTEN: But can you comment
2 on that -- on the committee's thoughts and
3 deliberations about excluding records if -- of
4 questionable quality and who -- how one
5 operationalizes the issue, the exclusion
6 issues here, that talk about excluding records
7 of questionable quality? And what -- why
8 wouldn't hospitals, why wouldn't states say,
9 "All our data is of questionable quality.
10 We're not going to include it." What's the
11 incentive and who makes that judgment about
12 whether the quality is --

13 MS. REMUS: This is Denise. I
14 can't -- yes, I was going to say, I can't
15 speak to that, but typically it's the
16 demographics. If you're missing things that
17 you need to actually find that readmission,
18 you are missing a Social Security number or
19 medical record number or the other -- whatever
20 the fields are that are used to link, that is
21 usually where your quality threshold is.

22 DR. BURSTIN: And, actually this

1 is the danger of looking at the incomplete
2 stuff as opposed to the full stuff that the
3 committee full reviewed, because it does
4 exactly as Denise just pointed out. You can't
5 do readmission rates without, for example,
6 having the patient identifier, admission date,
7 discharge date. It's those kinds of things as
8 opposed to the quality of the record.

9 CHAIR GESTEN: So it's record by
10 record. It's not -- it's not only none, it's
11 a record by record evaluation.

12 DR. BURSTIN: Yes.

13 CHAIR GESTEN: And then, is there
14 a report of what percentage of records met
15 that criteria, so that you --

16 DR. BURSTIN: There should be. I
17 don't have that in front of me.

18 CHAIR GESTEN: Okay. And the
19 rationale to exclude newborns and mental
20 health.

21 MS. REMUS: have mixed feelings
22 about this, and I truly know the adult world

1 extremely well with readmissions. I have been
2 focused on that for many years.

3 Having drilled into the pediatric
4 data, I have some concerns about -- one I know
5 -- mental health is challenging. And mental
6 health, if you're -- if this is a provider
7 level -- and, again, I guess that's -- most of
8 these are provider level. We at our facility
9 have probably two patients a day Baker Act'd
10 in our EC. We have no in-patient beds. We do
11 not provide behavioral health/mental health
12 services.

13 So those patients are EC visits,
14 are not admitted, so they wouldn't actually
15 fall into this metric, but that's just
16 reflective of the challenge that we have in
17 finding beds to take care of adolescent
18 patients.

19 They are not treated routinely in
20 hospitals in our community. We hold them
21 until they can go to a residential facility,
22 so they are typically up on our floor, then a

1 medical clearance, and then they'll move out
2 with the mental health. Those are patients
3 that we have to coordinate with the community,
4 we can't handle independently, and they are
5 really a challenge.

6 The other -- I have actually just
7 finished looking at a year of our readmission
8 data, all-cause, 30-day. And our big concern
9 is we have a huge Hem/Onc population. And we
10 have some patients who are coming in every
11 month for their treatments, and they're not
12 excluded in an all-cause readmission measure.
13 And it doesn't look to some of those therapies
14 where it truly is not safe for these Medicaid
15 children to be treated and receive their
16 therapies in the community.

17 I just -- this measure hasn't been
18 -- it hasn't been --

19 DR. BURSTIN: This measure has a
20 lot of those bells and whistles, so we
21 probably shouldn't get into the details.

22 MS. REMUS: Okay. Okay, good. So

1 that's good. So that's not clear from looking
2 at it, that that's one of the nuances that we
3 are concerned with is how we implement that.

4 So are those excluded, your
5 Hem/Onc?

6 DR. BURSTIN: No. Planned
7 readmissions are --

8 MS. REMUS: Oh, okay. Okay.

9 CHAIR GESTEN: If they're planned.
10 Planned is another category.

11 So I guess one of the challenges I
12 think of taking some of the measures, and this
13 isn't just for this measure or these
14 categories is whether the way in which certain
15 measures are crafted, when they are going to
16 be used relative to particular public
17 reporting or payment programs for CMS to
18 providers, whether those limitations, all of
19 which you describe which have been around
20 those issues a lot as well, whether they are
21 as germane when the accountable unit is a
22 state and state Medicaid program, where one

1 could argue that, well, you as one facility or
2 hospitals may have concerns about what it is
3 that they can or cannot deliver on or
4 differences between them in terms of their
5 case mix.

6 In looking across a state in terms
7 of the development of a system for treatment
8 of mental health, it may not be irrational to
9 hold a state accountable for that. So I'd
10 just throw it out there as a -- one of the
11 challenges of trying to interpret measures
12 that reasonably develop for the provider level
13 to thinking about it from a programmatic or
14 statewide point of view.

15 DR. BURSTIN: And Mark Schuster
16 from Children's is on if you want to ask the
17 questions about mental health and newborns.
18 And, as we said, PIMU is excluded, so just to
19 --

20 CHAIR GESTEN: Well, for time
21 reasons, I probably won't, if that's okay, and
22 let other folks -- Mark, you had your --

1 DR. LEIB: This is measured at the
2 plan level, not at the hospital level. So if
3 they get admitted to a different hospital 10
4 days later, it gets picked up and captured,
5 because it says --

6 CHAIR GESTEN: Yes. This measure
7 I specified is -- I think is at the hospital
8 level, so your question raises the issue of,
9 if this was one that was put forward, what
10 does it mean in the context of state Medicaid
11 programs? Is it simply a collection of the
12 hospital measures, or is it reported, getting
13 to Sandra's point, is it reported somehow on
14 a plan level, or does the state do the
15 reporting, and so on, right.

16 DR. LEIB: You know, there is -- I
17 do -- I have heard rumors of hospitals doing
18 -- I know on this one we had to do that, but
19 that some hospitals who admit their return
20 patients to a sister hospital, just to avoid
21 the identification of a readmission.

22 And especially with surgical

1 complications, things like that, that they
2 never come back to the primary hospital. They
3 go to a sister hospital. Again, I'm not
4 saying here you do that, but it does occur
5 where if you do capture the data at the plan
6 level, you pick those things up and you have
7 a benefit.

8 CHAIR GESTEN: Not to mention the
9 issues of observation stays, but we won't go
10 there. Did you have another -- was that your
11 comment?

12 Okay. Beth.

13 MEMBER FELDPUSH: Thank you. Is
14 it for the purpose of the Medicare measures?
15 The initial hospital is the one to which the
16 readmission is attributed to no matter where
17 they go, so --

18 DR. LEIB: Correct.

19 MEMBER FELDPUSH: Right. But just
20 on these measures, I just want to make sure we
21 have -- I have clarity that the Steering
22 Committee has recommended that these move

1 forward, but they have not gotten all the way
2 through the NQF process, correct?

3 DR. BURSTIN: That is correct.
4 Most of our readmission -- actually, all of
5 our readmission measures are -- did not move
6 forward through membership vote, so we are
7 doing some additional consensus-building. It
8 will go through our CESAC and Board. But at
9 this point these were recommended by the
10 Steering Committee, yes.

11 MEMBER FELDPUSH: But because the
12 process isn't completed yet, it would be
13 somewhat of an assumption or kind of
14 conditional support. But then also, Helen,
15 given the intensity of the work that NQF is
16 doing around readmissions, I wondered if you
17 could just share briefly with us some of the
18 pilot testing around the SES factors and
19 whether any of that is planned or can play
20 into these measures as well.

21 DR. BURSTIN: Yes. So the
22 Admission/Readmission Committee was operating

1 under our policy prior to the SES report, so
2 they were not allowed to consider issues of
3 SES. I know this was something that I believe
4 his team -- and Marc can speak to that if he'd
5 like -- was interested in including and they
6 were excluded.

7 So it is something I think they
8 could address going forward. But we will be
9 watching our trial period when measures can be
10 submitted that, with SES adjustment, we also
11 expect multiple measures will likely be pulled
12 into the trial period that are already
13 endorsed for looking at the SES adjustment and
14 whether it's appropriate.

15 CHAIR GESTEN: Remember, we're
16 talking -- so it's relevant -- or what's
17 interesting is that, remember, we're talking
18 about statewide measures of the Medicaid
19 program and whether SES adjustment is as
20 relevant in that analysis is an open question.
21 But it's what it is in my mind, a question.

22 Susan?

1 MEMBER FLEISCHMAN: Just a
2 question around intent on this measure a
3 little bit. I mean, are you looking at
4 whether hospitals are discharging early or
5 with inadequate plans? Are you measuring
6 health plan, you know, care management
7 capabilities after discharge? So, again,
8 depending on whether you're in a managed care
9 state or in a fee for service state, you kind
10 of -- it's not clear what your measure -- you
11 know, what the focus is.

12 DR. BURSTIN: Again, it's a
13 hospital level measure.

14 MEMBER FLEISCHMAN: Right.

15 DR. BURSTIN: So inherently it's
16 -- the thought is some of this is reflective
17 of the hospital's performance as well as
18 others involved in coordination of care. I
19 don't think there's anything explicit to the
20 health plan, although they certainly are part
21 of the broader improvement efforts.

22 MEMBER FLEISCHMAN: Okay.

1 MEMBER SIDDIQI: This is Alvia as
2 well on the phone.

3 CHAIR GESTEN: Okay. I'll get
4 right to you after Carol.

5 MEMBER SIDDIQI: Sure.

6 MEMBER SAKALA: Thanks. A similar
7 question, Helen. You said HCAHPS, the child
8 version, was very well received. How far
9 along in the process is that right now?

10 DR. BURSTIN: That's a little bit
11 earlier. It's been approved by our Standing
12 Committee, and I believe -- goodness gracious,
13 I should know this. I believe it has gone
14 through its post-comment call, and it is
15 pretty close, but it's similar. It's not all
16 the way through our process yet, but, you
17 know, big hurdles getting through the Standing
18 Committee, and it did very well in our
19 Standing Committee.

20 CHAIR GESTEN: Alvia?

21 MEMBER SIDDIQI: I was just going
22 to make two quick comments. I think in terms

1 of breastfeeding measure, I was surprised to
2 see that there weren't some exclusions there
3 for, for example, when formula would be
4 needed, for example, for an HIV patient or a
5 mom who would deliver her baby.

6 And I know that we had these same
7 concerns in our state chapter, the American
8 Academy of Pediatrics meetings, about babies
9 being in hospitals that don't carry formula
10 and just the need for formula sometimes in
11 these special cases. So I do think that that
12 measure still probably needs to work out
13 better exclusions and exclusion criteria.

14 And then the second comment I was
15 just going to make, for the readmission
16 measures, I think the one that actually seems
17 to be the one that I like the most is really
18 that PICU one, the PICU unplanned readmission
19 rate. And it seems to be a pretty simple,
20 straightforward measure. There really aren't
21 any exclusions that are noted, but it would be
22 helpful because I think hospitals are tracking

1 this in terms of PICU readmission rates, and
2 it's something that they could work on with
3 trying to report to the states.

4 But, again, any facility reporting
5 is obviously going to be a challenge, but I
6 still just kind of like that one the best out
7 of the three cost measures for readmission.

8 CHAIR GESTEN: Okay. Thanks. Do
9 we need to say two words about HCAHPS at all,
10 since that was sort of on the list and people
11 didn't have a chance to prereview it, and I
12 just want to make sure that everybody knows
13 what that is. This is the Hospital Consumer
14 Assessment of Health Care Experience of Care
15 Survey, which has been validated and it's --
16 I assume since it's on the list it has been --
17 it is NQF-endorsed, is that right?

18 DR. BURSTIN: It's the one I was
19 just answering the question from Carol. It
20 has already been through our Standing
21 Committee. It's not all the way through the
22 process, but it's -- you know, part of that

1 CAHPS family of measures developed
2 collaboratively. It is supposed to be the
3 companion measure to HCAHPS for kids.

4 CHAIR GESTEN: So, presumably, in
5 terms of state Medicaid programs, this would
6 be segmented, would be done specifically for
7 Medicaid, and it would be reported by the
8 hospitals either to health plans or to the
9 state, right? That's how we've envisioned
10 that it would be implemented?

11 I mean, currently HCAHPS is
12 reported -- okay. Let me -- Mark, are you on?
13 If you're on the call, do you want to weigh in
14 here about HCAHPS? Mark Schuster? Take
15 yourself off mute.

16 MS. LASH: The operator might need
17 to open his line if he's logged in as a member
18 of the public.

19 CHAIR GESTEN: Oh, I see.

20 OPERATOR: I don't see Mark
21 online.

22 CHAIR GESTEN: Okay. Go ahead,

1 Denise.

2 MS. REMUS: This is -- we have --
3 All Children's participated in the pilot for
4 HCAHPS, the children's version. We are very
5 supportive of it. We do need standardized
6 surveys for care of children.

7 The payer is one of the fields
8 that is submitted to the vendor, so you can
9 certainly stratify the data by payer. The
10 question that I'd have that hopefully would be
11 clarified would be the sample size. You know,
12 Medicare, with the HCAHPS does have a sample
13 size requirement. You would want the same
14 thing, I would think, if you want to
15 understand the real picture of services.

16 CHAIR GESTEN: So while we're
17 seeing if we can unmute Mark, is there -- does
18 anyone want to make any other comments, pro or
19 con, related to any of the measures, any of
20 the other measures? Maybe we should go up the
21 list off of these, make any comments about --
22 want to advocate for or against.

1 While you're thinking about that,
2 I mean, I have some concerns about the heart
3 surgery, thinking about the number of states
4 that currently have their own methodology for
5 reporting this, and the challenges and
6 thinking about having a coexisting one, even
7 if it's from a national registry. I think the
8 issues around national registries and access
9 to that data and participation have been
10 articulated.

11 But I guess I have some concerns
12 about how this would play or relate to what we
13 have existing currently, which is an all-payer
14 model, provider-specific, looking at pediatric
15 heart surgery mortality, which is publicly
16 reported. And I've been doing that for a
17 while. I don't think we're the only state
18 that has that. I know Pennsylvania, I think
19 Massachusetts, and a number of others do as
20 well.

21 Mark, are you able to comment now?
22 Did we unmute him? Yes?

1 DR. SCHUSTER: Foster, can you
2 hear me?

3 CHAIR GESTEN: Yes. Thank you,
4 Mark.

5 DR. SCHUSTER: Oh, you can.
6 That's fantastic. Okay. So just to give the
7 context again. Child HCAHPS is a family
8 experience of care measure. It is completely
9 harmonized with the adult measure and already
10 accepted as a part of the CAHPS family.

11 As you know, most hospitals around
12 the country already collect this kind of data.
13 It's just they have each used their own
14 proprietary measures that vendors provide.
15 And this is the first that will be available
16 broadly that can be used by everybody and is
17 in the public domain. And it is case mix
18 adjusted. We did a national field test with
19 69 hospitals and 17,000 surveys, and so I'm
20 happy to answer questions.

21 DR. BURSTIN: I think the main
22 question, Mark -- this is Helen -- is whether

1 or not you have the data to be able to
2 stratify by Medicaid. So that could be
3 aggregated up to a state level.

4 DR. SCHUSTER: Yes. So vendors --
5 so the data are collected by vendors who send
6 out surveys or call and interview people. And
7 absolutely, because the administrative data
8 that come in from the hospitals can, and
9 usually do, include insurance type. So it
10 definitely can be stratified by Medicaid or
11 public insurance versus not public insurance.

12 CHAIR GESTEN: And does anybody
13 recall where the health plan CAHPS -- health
14 plan CAHPS is one of -- is on the current core
15 list, right? Acquired for CHIP, that states
16 do it for CHIP?

17 MEMBER LLANOS: Yes. So we have
18 CAHPS child, health plan version, and the
19 supplemental items one. It's only -- it's
20 part of our core set. There is a broad
21 requirement that CHIP programs report CAHPS
22 site surveys, so using that CAHPS survey to

1 CMS.

2 CHAIR GESTEN: Do we know how many
3 states are reporting it from Medicaid?

4 MEMBER LLANOS: I don't have that
5 number offhand.

6 CHAIR GESTEN: Okay. Would it be
7 wrong to say it's not at the top of the list?

8 MEMBER LLANOS: It's not at the
9 top. It's --

10 CHAIR GESTEN: In the middle.

11 MEMBER LLANOS: -- a tough one.
12 Yes. I mean, I think we've gotten different
13 kinds of cost estimates in terms of how much
14 it costs the state to do it.

15 CHAIR GESTEN: Okay.

16 MEMBER LLANOS: Particularly if
17 you've got a separate CHIP program, because
18 that's an additional cost.

19 CHAIR GESTEN: Right.

20 MEMBER LLANOS: And I think the
21 other piece is sometimes you stagger it, one
22 year yes, one year no, in order to stretch out

1 the funding.

2 CHAIR GESTEN: Marsha? And then
3 I'm going to get down to a voting strategy.

4 MEMBER LILLIE-BLANTON: When the
5 vendor administers the survey, who pays the
6 vendor? Who contracts with the vendor?

7 DR. SCHUSTER: The individual
8 hospitals already do this. They already have
9 relationships with vendors and are paying them
10 to administer surveys, and this would just be
11 a survey that all vendors would be able to
12 switch to and start using. It will be going
13 up on the AHRQ website soon. It's just in the
14 queue to get onto the website, so it is a
15 completed survey and ready for use.

16 CHAIR GESTEN: So here is what I'd
17 propose in terms of how we go through these
18 measures. Rather than going through them one
19 at a time, in this case, what I would suggest
20 is any member can nominate one of the
21 measures, good enough, and then we'll take a
22 vote on it. And so we won't vote on measures

1 that don't get nominated by somebody that is
2 on the group here, and we will assume that
3 those are not going to -- if it's not
4 nominated, folks aren't going to vote for it.

5 So why don't we do that, and open
6 to anybody wanting to nominate any measure.

7 MEMBER SIDDIQI: Foster, this is
8 Alvia. Just a quick question. None of these
9 measures have gone through the NQF endorsement
10 process, or at least not in the complete
11 stage, is that correct?

12 DR. BURSTIN: Only the ones that
13 are blue.

14 CHAIR GESTEN: So all the ones
15 that are not blue are -- have been through,
16 are fully endorsed measures.

17 MEMBER SIDDIQI: Okay.

18 CHAIR GESTEN: So this is the time
19 to nominate a measure. Everybody clear here?
20 There's a lot of measures here. Carol? Thank
21 you.

22 MEMBER SAKALA: Child HCAHPS.

1 CHAIR GESTEN: Okay. So Carol has
2 nominated that we vote for child -- the child
3 version of HCAHPS. That's measure 2548,
4 right? And we just had a lively conversation
5 about that and the implementation issues.

6 So, again, for folks in the room,
7 let's take a vote of -- raise your hand if you
8 vote to suggest that this be added to the core
9 set. Seven in the room. And on the phone?

10 MS. COHEN: What's the number in
11 the room of voters?

12 CHAIR GESTEN: Seven.

13 MS. COHEN: This is Anne. I have
14 to vote yes then.

15 MEMBER SIDDIQI: And Alvia is
16 voting yes as well.

17 CHAIR GESTEN: Okay. And, Anne,
18 you voted yes, too?

19 MS. COHEN: Yes.

20 CHAIR GESTEN: Okay. Is that a
21 yes?

22 MS. LASH: Either way it passes.

1 CHAIR GESTEN: I know it passes.

2 Okay.

3 Sandra, did you have a question?

4 MEMBER WHITE: Yes. My question
5 is, was 2548 recently added? Because that was
6 not on my list --

7 CHAIR GESTEN: Correct.

8 MEMBER WHITE: -- of measures.

9 Oh, okay. Well --

10 CHAIR GESTEN: Any other
11 nominations? Susan?

12 MEMBER LACEY: Hospital-acquired
13 pressure ulcers.

14 CHAIR GESTEN: Okay.
15 Hospital-acquired pressure ulcers, which is
16 number -- it is 0337.

17 MS. CAREY: Right. And it's
18 shaded blue, because it's going to be coming
19 through review again next year. But it is
20 fully endorsed now.

21 CHAIR GESTEN: So 0337, pressure
22 ulcer rate. All those in favor of

1 recommending this to be added to the set raise
2 your hand. And one on the phone. Okay. One.

3 Any other nominations of measures?
4 Cindy?

5 MS. PELLEGRINI: I don't think we
6 have talked about this one at all, but I will
7 throw out there 477, under 1,500 gram infant
8 not delivered at appropriate level of care.
9 There is a substantial body of evidence
10 showing that babies who are delivered at the
11 facilities best able to take care of them do
12 -- have far, far better outcomes than those
13 who are born at lower level NICUs that aren't
14 prepared to care for them, and that there is
15 a substantial amount of room for improvement
16 in the current state of affairs.

17 CHAIR GESTEN: Okay. Thanks,
18 Cindy. So this is 0477, under 1,500 gram
19 infants not delivered at the appropriate level
20 of care. Susan, did you have a question
21 before we --

22 MEMBER SAKALA: Clarifying

1 question. Sometimes it just happens.

2 MS. PELLEGRINI: Sometimes it
3 does, but there are far, far more cases. For
4 example, there are a lot of cases of high-risk
5 women who are not being counseled at all about
6 the proper hospital where they ought to be
7 delivering, where there is a Level 3 or a
8 Level 4 NICU. We have talked to -- the March
9 of Dimes has talked to, let's say, like
10 hospital systems where they have multiple
11 hospitals within a system. And they had one
12 with the highest level NICU, and I've had NICU
13 directors say to me, "I can't get our sister
14 hospitals to send our high-risk babies here
15 because they are keeping them and then they'll
16 transfer them after they're born." And there
17 are some really perverse payment incentives in
18 there.

19 MEMBER SAKALA: That's horrible.

20 CHAIR GESTEN: Beth, did you have
21 a question about this before we --

22 PARTICIPANT: There was no

1 exclusion criteria here.

2 MEMBER FELDPUSH: Just to find out
3 a little bit more about this area, because it
4 is just not what I know, so, Cindy, if you're
5 the one that has the most knowledge, or
6 anybody, on this measure. To what extent is
7 this tied to access to prenatal care? I'm
8 just kind of thinking this is an outcome
9 measure, but why is it happening?

10 MS. PELLEGRINI: I think it has to
11 do more with the quality of care delivered to
12 women who are known to be high-risk. So
13 there's a pretty substantial cadre of women
14 out there who are documented to be at high
15 risk, either because they've had a previous
16 preterm birth or they have a condition like
17 high blood pressure or obesity or gestational
18 diabetes or things like that.

19 Over 80 percent, if I'm getting --
20 I think I'm getting my numbers right here --
21 well over 80 percent of women are getting at
22 least some prenatal care. It varies a little

1 bit by community and location and demographic,
2 but the numbers of people getting at least
3 some prenatal care is pretty darn high. The
4 people who are getting no prenatal care, or
5 little or none, are a fairly modest
6 percentage.

7 So I think what we have here is
8 really a case of missed opportunities, far
9 more than -- but, you know, based on the data
10 we have seen.

11 MEMBER FELDPUSH: So from a state
12 level, if this were then to be a state level
13 measure, what would be the actionability of
14 this measure? What could states do to improve
15 on this from the state level?

16 MS. PELLEGRINI: Right. Okay. So
17 that would be a really long conversation, but
18 I think there is a substantial list. What
19 this really gets to -- is the idea of some
20 degree, whether it's formal or informal, of
21 regionalization of care, having a standardized
22 -- or I shouldn't say having --- adopting,

1 let's say, the AAP perinatal levels of care
2 designations, and actually certifying or
3 verifying those in some ways, because in a lot
4 of -- in some states right now you can say,
5 "We're a Level 4 NICU," and nobody ever comes
6 in and says, "Well, actually, do you meet all
7 of the standards for being a Level 4 NICU?"
8 They just say they are. Or a Level 3 or a
9 Level 2, or whatever the case is.

10 So there is a lot of different
11 issues tied up in this, but it means that
12 there is a great deal of room for improvement
13 and a lot of things that can be done.

14 CHAIR GESTEN: So I'm going to
15 have to abbreviate this. Great questions.
16 Carol, and then we're going to vote on this.

17 MEMBER SAKALA: Yes. I just
18 wanted to reinforce what Cindy is saying, that
19 the developer has found that rural hospitals,
20 for example, are appropriately making those
21 arrangements in advance, and it's a lot of
22 urban hospitals that think, "Well, we'll just

1 keep them for the perverse incentives, and
2 then transfer later." So it's really
3 inappropriate practices that can be addressed.

4 CHAIR GESTEN: Okay. Unless there
5 is any other clarifying questions, I would
6 suggest that we take a vote. So all those in
7 favor of adding measure 0477, under 1,500 gram
8 infant not delivered appropriate level of care
9 to recommendations to CMS, raise your hand.

10 And on the phone? We have five in
11 the room.

12 MEMBER SIDDIQI: Yes. Alvia
13 speaking.

14 CHAIR GESTEN: Alvia is seven.
15 Anne?

16 MS. COHEN: Yes.

17 CHAIR GESTEN: Eight. Okay. Any
18 other measures nominated? Carol?

19 MEMBER SAKALA: I have to nominate
20 exclusive breast milk feeding, and to comment
21 that there is no expectation of 100 percent
22 and there are already exclusions, and those

1 exclusions really are amounting for a very
2 small percentage of the population. And the
3 improvability is huge, as all the CDC programs
4 will attest to.

5 CHAIR GESTEN: Okay. Great
6 last-minute lobbying. And we have talked
7 about this one, so the measure now is measure
8 04880, exclusive breast milk feeding. This is
9 a new one, for those of you who are surprised
10 by this, like the HCAHPS one was just added
11 today. All those in favor of recommending
12 this to be added to the set, please raise your
13 hand. One, two, we have six -- six in the
14 room. And on the phone?

15 MS. COHEN: This is Anne. Yes.

16 CHAIR GESTEN: Seven. Okay. So
17 before we close out, any last minute? Any
18 other nominations before we move to looking at
19 the entire -- go ahead.

20 MS. COHEN: This is Anne. I have
21 a -- I have some concerns with it, so maybe it
22 would be -- I'm sorry, I have my 16-month-old

1 baby on my lap, so forgive me if you hear
2 noise in the background.

3 The late sepsis measure, I'm
4 concerned because it's only related to low
5 birth weight infants. But I think the measure
6 related to infection might be an important
7 area to look at, if not this time maybe for
8 next time.

9 CHAIR GESTEN: Okay. I know we
10 started to put measures up there. Maybe we
11 should add your running slide. So we're
12 running late. I'm sorry. Go ahead.

13 MS. COHEN: No. I was just going
14 to say I'm not sure if it's worth voting on,
15 because I have major concerns about it being
16 so narrow.

17 CHAIR GESTEN: Your call. Do you
18 want -- now is the time if you want to call a
19 vote on it.

20 MS. COHEN: Maybe just add it to
21 the list of concerns for next time.

22 CHAIR GESTEN: Okay. We'll do

1 that. Sold.

2 So our next task, I was going to
3 say, should you decide to take it, but you've
4 already decided, you're here, is to rank order
5 the measures that received enough votes to be
6 recommended. And, again, the context of this
7 is a working presumption that CMS is likely,
8 at least not now, although we don't know, in
9 a position to accept all of these
10 recommendations. So they certainly want the
11 information that helps them to be able to
12 prioritize this.

13 So we have -- Sarah is madly
14 writing on the board, and you have a -- I
15 think we're going to have a measure, a slide
16 as well that is going to show you what we have
17 -- which measures made it. And is that all of
18 them? One, two, three, four, five, six,
19 seven? One, two, three -- so we have one,
20 two, three, four, five, six. Six measures.

21 So there is a slide that's up
22 right now, 2508, dental sealants. There's two

1 of them, one is for age six to nine, the
2 second is 10 to 14, 2509. There is child and
3 adolescent major depressive disorder, suicide
4 risk assessment, 1365; HCAHPS, 2548; 0477,
5 which we just voted on, under 1,500 grams,
6 infants not delivered at appropriate level of
7 care; and 0480, which is exclusive breast milk
8 feeding.

9 So I think the way to do this is
10 you -- let's see, should we vote on folks --
11 on who is -- on number ones, which one of
12 these is folks' number one, is that the way we
13 are going to do this? This is going to be --
14 I guess I don't have another --

15 We can just raise hands on which
16 one is -- that would probably be easier,
17 right? Raise hands if 2508 is number one, and
18 then go back, but that presumes that people
19 have had a chance to think about this.

20 So I think we need to -- what's
21 that? Three picks? Okay.

22 MEMBER FELDPUSH: I was going to

1 say, maybe this is a question for the CMS
2 folks. Knowing that we went from a list of a
3 lot to six, do we need to prioritize further
4 down from six? Yes?

5 MEMBER LLANOS: I think getting a
6 more general sense of if we only had to pick
7 through those which ones would be the ones
8 that would be the most helpful.

9 MEMBER WHITE: I would also
10 recommend considering 2508 and 2509 as one,
11 and then the others.

12 CHAIR GESTEN: Okay. So the
13 recommendation is to consider those as -- lump
14 them together. It's less to have to
15 prioritize, right?

16 MS. COHEN: This is Anne. I think
17 we're missing one. Didn't we have
18 antipsychotics as well under the mental
19 health? Am I wrong? That was upstream.

20 CHAIR GESTEN: It missed. I think
21 it was close, but it missed.

22 MS. COHEN: Okay.

1 CHAIR GESTEN: Does anybody object
2 to putting 2508 and 2509 together?

3 DR. LEIB: I think CMS may have a
4 different way of looking at it, not speaking
5 for them, but the six to nine year old is a
6 legislative mandate. The 10 to 14 year old is
7 maybe a nice thing to do, but not a mandate.
8 And so they may view those differently. Just
9 a thought.

10 CHAIR GESTEN: That's correct.
11 Well, I think we're talking about -- that's
12 true. If it's the top three, that's right.
13 Like I said, picking your children.

14 So maybe the way to do this is
15 we'll go around, and obviously the last person
16 will have a little bit more time to think
17 about this. And at least we'll get your
18 thoughts about how you would go about -- how
19 you would prioritize these in terms of one,
20 two, three, and then maybe say something about
21 the rest. That may be a way to --

22 MEMBER WHITE: Okay. The way how

1 I -- this is Sandra White. The way how I
2 would prioritize them is I would lump
3 2508/2509 as one, 1365 as two, and 2548,
4 HCAHPS, as three.

5 CHAIR GESTEN: Great. Susan?

6 MEMBER FLEISCHMAN: Yes. I would
7 lump 2508 and 2509 as one of my -- one of my
8 three, HCAHPS as one, and either breast milk
9 or infant not delivered -- I'll go with
10 exclusive breast milk.

11 CHAIR GESTEN: I'm sorry. You had
12 a question, Cindy?

13 MS. PELLEGRINI: Well, the way
14 I've seen NQF do this sometimes is that they
15 just give out a couple markers and everybody
16 goes and votes for their three, and then at
17 least you see where the clusters are. Would
18 you mind if we all ran up with that or ---
19 just thinking, like I'm having trouble
20 following people's rankings.

21 CHAIR GESTEN: I would separate
22 them. I think you get one vote for each. So

1 you're putting three marks down?

2 You've got more than one marker,
3 right? So do you want to give them out?

4 MS. CAREY: Anne and Alvia, could
5 you please give us your top three, so we can
6 add dots for you.

7 MS. COHEN: Yes. This is Anne.
8 2508 is one; 2509, two; and 1365 is three.
9 And I'm not lumping together, assuming CMS
10 will reject the idea.

11 MS. CAREY: Okay. Thank you.
12 Alvia?

13 MEMBER SIDDIQI: Yes. Alvia. So
14 2508, one; 2509, two; and 0477, three.

15 MS. CAREY: Okay.

16 CHAIR GESTEN: Is there anyone who
17 didn't --- you got Anne and Alvia?

18 MS. CAREY: Yes.

19 CHAIR GESTEN: All right. So this
20 one is one, two, three, four, five, six,
21 seven, eight, nine, 10.

22 MS. CAREY: So we're counting 10

1 for 2508.

2 CHAIR GESTEN: And 2509, one, two,
3 three, four, five.

4 MS. CAREY: Five for 2509.

5 CHAIR GESTEN: Four.

6 MS. CAREY: Four for 1365.

7 CHAIR GESTEN: Seven.

8 MS. CAREY: Seven for 2548.

9 CHAIR GESTEN: Four.

10 MS. CAREY: Four for 0477.

11 CHAIR GESTEN: Three.

12 MS. CAREY: And three for 0480.

13 MEMBER ADIRIM: I'm just
14 surprised, because I remember on the call
15 mental health -- pretty uniformly people
16 wanted to have a measure around that or a
17 better measure around that. So I'm just
18 surprised that the mouth won out over the
19 head. So it's --

20 CHAIR GESTEN: Well, I think --
21 and my interpretation of that could be wrong
22 -- is that the number of mental health

1 measures that are on the horizon may have
2 influenced -- I'm going to be honest, it
3 influenced my voting related to those
4 measures. But comments about how this turned
5 out? Go ahead.

6 MEMBER SIDDIQI: Mine as well. I
7 just wanted -- I can't see the -- oh, I can
8 see it on the -- okay.

9 CHAIR GESTEN: Alvia, you are kind
10 of like you are underwater again. I don't
11 know. Top three? The first one is -- with 10
12 votes was sealants, six to nine; the second
13 was HCAHPS, child HCAHPS; and the third at
14 five votes was sealants for 10 to -- looks
15 like 10 to 14 -- 10 to 14.

16 And then suicide risk assessment
17 and delivery at appropriate care level both
18 received four votes. And then exclusive
19 breastfeeding received three.

20 Okay. So are we done with rank
21 ordering?

22 MS. LASH: We are. I want to make

1 one more comment for the record, and the good
2 of the order. It has been MAP's practice to
3 conditionally support measures that were still
4 undergoing endorsement review, that CMS would
5 add them after that process is complete and
6 endorsement is awarded.

7 Is the task force comfortable with
8 following that practice, or do you want to
9 give full support to the HCAHPS measure at
10 this time?

11 CHAIR GESTEN: Nodding for full
12 support or nodding for conditional? What's
13 that?

14 PARTICIPANT: For the HCAHP
15 measure?

16 CHAIR GESTEN: Yes.

17 PARTICIPANT: I'm going for full
18 support.

19 MEMBER FELDPUSH: I would speak up
20 to conditional support if that has been the
21 practice of the MAP. I wouldn't want to set
22 precedent here today.

1 DR. BURSTIN: I think it's going
2 through. It's just purely a formality.

3 MS. COHEN: This is Anne. The
4 only thing that I would say is I -- knowing
5 that lens, I wish we would have gone back and
6 looked at the antipsychotic measure that was
7 almost approved, too, because it would have
8 been nice to have that with the mental health
9 measure.

10 MEMBER WHITE: And let me just
11 clarify. I think I misspoke. I was going for
12 full support of the measure, not that NCQF had
13 to have already provided full support. So I
14 withdraw my vote on that one.

15 CHAIR GESTEN: Okay.

16 MEMBER WHITE: Okay. Great.

17 CHAIR GESTEN: So I think time
18 prevents us from going back, Anne, and
19 revisiting measures. Again, I would say that
20 the issue about mental health measures and
21 antipsychotics, and so on, I mean, I think
22 it's going to come up again very soon as some

1 of these measures go through and are put
2 forward for support.

3 I want to go to some of the last
4 slides about cross-cutting issues. Let's keep
5 going. And these are some of the issues that
6 you saw in advance in terms of strategic
7 issues that confront us as we think about
8 creating a measure.

9 There's the -- you know, the lack
10 of an overarching data infrastructure to
11 facilitate reporting, and, in my mind, that
12 includes the issues about differences between
13 e-measures and chart review, and so on, the
14 challenges of getting measures from hospitals,
15 the challenges of connecting, for some
16 measures, data to existing registries, and so
17 on, being able to put data sets together that
18 might be relevant for reporting.

19 So I think we've talked about that
20 in the context of many of the specific
21 measures. It clearly is a challenge. It's
22 not a specific challenge, I don't think, for

1 child measures, but certainly, you know, we
2 have seen it here.

3 The alignment issue between
4 maternal and child health measures, actually,
5 I think the -- as you saw in the slide and in
6 our conversations, there is a fair amount of
7 alignment and thought about which ones belong
8 in which set, but it's an ongoing issue to
9 make sure that there is connectivity between
10 the maternal and adult core measures and the
11 child health measures, and there's not any gap
12 areas.

13 You know, exactly what Medicaid's
14 role is relative to social and environmental
15 determinants of health, I think that this
16 tracks into some of the conversations that we
17 were having about readmissions and other
18 issues, and then how we take measures that may
19 have been constructed for providers or health
20 plans or for regions and translate those into
21 a state level are some system level issues I
22 think that we have.

1 The other ones that I heard from
2 this morning that are not on this list was the
3 issues around alignment, and specifically
4 around trying to align measures with
5 meaningful use and with the directionality of
6 electronic health measures. I think we also
7 heard about alignment with HEDIS measures as
8 well.

9 And I think there were some other
10 -- I want to take this opportunity to make
11 sure that in terms of overarching issues that
12 we have --- and we want to note these for the
13 report going forward, that we might have
14 missed.

15 Susan, did you have -- did you
16 want to add something?

17 MEMBER FLEISCHMAN: No. I was
18 going to make a comment on -- we have a great
19 interest in that third bullet and would
20 appreciate a conversation around that in the
21 future. And we also have an interest in --
22 I'm late to the group, I know -- in Medicaid's

1 role in childhood obesity, which I know we
2 have the BMI measure. But we think there's --
3 as the payer for, you know, 50 or more percent
4 of children in some states, we think that
5 Medicaid agency could be a bigger lever in the
6 childhood obesity epidemic. So if we could
7 add that.

8 CHAIR GESTEN: Thanks. Are there
9 any other strategic issues? I mean, there are
10 some nuts and bolts issues around measure,
11 measure stewardship, and so on, which I don't
12 know if they're strategic. I guess they're
13 kind of nitty-gritty real-life issues that
14 need to be reconciled and dealt with. But
15 anything that falls under this category that
16 we want to put forward? Cindy?

17 MS. PELLEGRINI: Just briefly. I
18 think as we move forward, and as the science
19 develops, we are going to want to look at
20 things, particularly in the maternal and child
21 health space, where we can develop sets of
22 measures that capture the mother-child dyad,

1 and that kind of crosswalk up and back and
2 track those -- or reflect those, for instance,
3 impacts of maternal care upon infant health.

4 So, for instance, did Mom get a
5 TDAP immunization? Did that infant later
6 develop pertussis? Just making one up off the
7 top of my head.

8 The second thing that I would say
9 is I'd love to see -- I don't know who, but
10 someone -- CMS, NQF, somebody else -- take a
11 more systematic look at where the
12 opportunities are for measures -- and this is
13 even beyond the centers of excellence. What
14 are the sources of the information and the
15 ideas that we ought to be fostering the
16 development of measures from?

17 So is it something like the
18 "Choose Wisely" campaign? Is it all of this
19 work PCORI is doing? You know, PCORI is going
20 to churn out of all of this information about
21 which of the comparative effect -- which is
22 comparatively more effective among treatments?

1 Should we not be, then, systematically taking
2 some of that and converting it into measures?

3 CHAIR GESTEN: Great. Anybody
4 else have any other overarching issues? I
5 think -- can we go to the next slide? I
6 think, at least the slides that I have,
7 clearly one of the issues -- and I don't think
8 we need to resolve this today, but we might
9 actually want to poll the group around
10 measures in the developmental pipeline that
11 folks are most interested in hearing about.

12 I think we heard specifically some
13 interest in sepsis, for example. We heard --
14 I think we have ongoing interest in the
15 behavioral health measures, particularly
16 related to antipsychotics, but others. Is
17 there anything else that folks want to
18 footnote right now that they saw on the
19 developing list that they have particular
20 interest in?

21 MS. COHEN: This is Anne. The
22 care coordination for child care needs, the

1 care transition.

2 CHAIR GESTEN: Yes, the care
3 transitions, right. Was that adapt? What was
4 -- adapt, yes. Anything else that we want to
5 note? This isn't the only opportunity,
6 obviously, to emphasize this, but if there's
7 something --

8 MS. COHEN: Oh. Abuse and
9 neglect.

10 CHAIR GESTEN: Okay. Although I
11 didn't see any of those in the pipeline, but
12 it's an area that needs a pipe. Yes?

13 MS. PELLEGRINI: Perinatal and --
14 or, excuse me, pre-conception and
15 interconception health, although CDC has
16 under-development almost finished, almost
17 ready, right, a great contraception measure
18 that we hope will be considered for the
19 Medicaid core set for I think both adults and
20 adolescents. CDC -- there is a webinar, is it
21 just next week? Two weeks?

22 MEMBER LILLIE-BLANTON: Webinar is

1 November 5th, and we are considering it a
2 developmental measure, but they will be
3 submitting it to you.

4 CHAIR GESTEN: So I apologize for
5 going over in terms of the public comment. I
6 think we have managed to clear the room here.
7 But, Cathy, if there's anybody on the phone
8 from the public who wants to make a comment,
9 if you can just go over the instructions again
10 right now, we'll give them the opportunity to
11 do that.

12 OPERATOR: Yes, sir. At this
13 time, if you'd like to make a public comment,
14 please press star, then the number one.

15 Okay. At this time, there are no
16 public comments.

17 CHAIR GESTEN: Thank you, Cathy.
18 There is a slide on next steps,
19 and maybe either Beth or Sarah will just go
20 over what happens next.

21 MS. CAREY: Sure. Absolutely. So
22 we will be very busy writing this up into a

1 draft report next week, and we will post it
2 for public comments on Monday, October 27th,
3 for a two-week period, which means it will
4 close on Friday, November 4th. We will take
5 the draft report and a quick preliminary
6 analysis to the MAP Coordinating Committee on
7 November 10th. That's the next time they
8 meet. And they are typically aligned with our
9 timeline.

10 And then, the final report is due
11 to CMS on November 14th. Then, we'll go on a
12 brief hiatus until we reconvene. We will
13 recover from the expedited review and we will
14 reconvene in the spring for the annual cycle.

15 CHAIR GESTEN: Great. Any
16 questions about the timeline or next steps?
17 And who says we don't have the patient voice
18 here? Do you hear the baby on the phone?
19 It's our way of incorporating patient
20 perspective.

21 Anything else for the good of the
22 order?

1 MEMBER LLANOS: So I'll just add
2 for folks that are interested, CMS is required
3 to release our annual updates on both our
4 children and adult core sets, which we usually
5 do together, through an informational bulletin
6 by January 1st of this coming year.

7 CHAIR GESTEN: Great. Thank you.

8 DR. BURSTIN: Also, I'll add my
9 thanks to Foster for some pretty impressive
10 facilitation today through a very big agenda.

11 CHAIR GESTEN: Thank you. Well,
12 thank you, all. It was a great -- great team.
13 Look forward to doing this again in the
14 spring. And, again, I'd encourage you to
15 carefully look at the draft report and make
16 sure that we captured your thoughts and
17 deliberations here.

18 Thanks to Sarah and Beth for --
19 and Nadine for, you know, making this happen.

20 So safe travels home, and see you
21 again in the spring. Thank you all very much.
22 Thank you, folks on the phone, Anne and Alvia,

1 and other folks who listened in. Thank you.

2 (Whereupon, the above-entitled
3 matter went off the record at 4:09 p.m.)

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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
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Court Reporter

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