National Quality Forum

Moderator: Pediatric Performance Measures
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OPERATOR: This is Conference # 24528794.

Operator: Welcome, everyone. The webcast is about to begin. Please note today's call is being recorded. Please stand by.

KateMcQueston: Good morning or afternoon, everyone. Welcome to the Pediatric Performance Measure Post Comment Call Web Meeting.

A quick reminder to those who have logged in to the webinar on the web. We'll also need you to dial in over the phone line, if possible, for the conversation.

We'll go ahead and go over the call agenda first. We'll begin with a welcome introduction and roll call. Next, we will review and discuss the comments that that we received during the comment period. Final or after that, we will discuss the measure for which consensus was not reached during our in-person meeting. This is measure number 3154, the informed coverage measure.

Following that, we will discuss request for reconsideration of two measure, the measure is number 2816 and measure number 3189. Following this, we will have an opportunity for public comment and then we'll have a review of our next step.

So just a quick overview of what happened during the in-person meeting, three measures were recommended for endorsements. These were measures related to the rate of preventable adverse events for 1,000 patient days among pediatric in-patient, measure for continuity of primary care for children with medical complexity and then antibiotic prophylaxis for among children with sickle cell anemia.

We have one measure where consensus was not reached. As stated before, this is Measure 3154, informed coverage. During this call, we will be re-voting on reliability and if it passes for reliability, we will also be voting on overall committee recommendations.

Finally, there are several measures that were not recommended during the in-person, key measures that will be reconsidered or request that have asked for reconsideration during today's call and then five other measures related to patient reported outcomes for children.

So, we'll go back now to roll call now that most of the committee is online. We will skip the co-chairs because we know that they're both on the line. So, hello, John and Jeffrey.

Male: Hello, everybody?

KateMcQueston: Hello. All right. And then we'll proceed in alphabetical order. So, do we have Lauren Agoratus?

Lauren Agoratus: Present.

KateMcQueston: Thank you. Martha Bergren?

Martha Bergren: Here.

KateMcQueston: Thank you. James Bost?

James Bost: Here.

KateMcQueston: Thank you. Tara Bristol-Rouse? Karen Dorsey? Maureen Ediger?

Maureed Ediger: Here.

KateMcQueston: Thank you. David Einzig? Deborah Fattori?

Deborah Fattori: Here.

KateMcQueston: Kerri Fei?

Kerri Fei: Here.

KateMcQueston: Jonathan Finkelstein?

Jonathan Finkelstein: Here.

KateMcQueston: Thank you. Karen Harpster?

Karen Harpster: Here.

KateMcQueston: OK. Thank you. Amy Houtrow? David Keller? Kraig Knudsen?

Kraig Knudsen: Here.

KateMcQueston: Thank you. Susan Konek? Marlene Miller? Rajiv Modak? Jill Morrow-Gorton?

Jill Morrow-Gorton: I'm here.

KateMcQueston: Thank you. Ricardo Quinonez? Jeff Schiff? Carol Stanley?

Carol Stanley: Here.

KateMcQueston: Thank you. And has anyone come on the line during the rollcall that would like to announce themselves?

David Einzig: David Einzig. I'm here.

KateMcQueston: Great. Thank you, David. Is anyone else on the line that hasn't -- that did not reply to roll call? OK. Thank you. All right. So we're going to move ahead

to review and discuss the comments that were received during the comment period.

During the comment period, we received 11 comments from four member organizations and as a reminder, our comment period for this project is open from April 11th to May 11th.

Our first theme that we identified in the comments that were received were general support for the committee's recommendation. We received five comments that supported the committee's endorsement recommendations, both for those measures that were recommended for endorsement and those that were not recommended for endorsement. We also received one general comment that supported all of the committee's recommendations.

Specifically, there are two comments that supported the committee's decision regarding measure 3166 and measure 3153. And then we had two comments that agreed with the committee's decision not to recommend measures 3220 and measure 3221.

Based on these comments, we have a very simple proposed committee response which is "Thank you for providing these comments." Now, we have an action item regarding if the committee agrees with this proposed response.

So, please let us know if there are any concerns or anything you'd like us to add to this response.

OK. Hearing none, I'm going to move forward. The next theme is related to GAPPS for future measure development. During the comment period, we received comments leading to several GAPPS that were identified where additional -- it could be just by measure concept at the clinic or to some level where further work is needed and where new measures should be considered for future development.

These measure concepts, as identified by the commenters were identification of a team to work together to plan and test improvement and eliciting parental

strengths and needs within a practice site to finding parental strengths and needs within a practice site, integrating tools such as process as well as prompts and reminders into practice flows and support, engagement (effect) and then also measure that would offer more specificity about appropriate antibiotic prophylaxis.

The proposed committee response for these comments is thank you for providing this comment. This gap will be added to the reports -- the final report's list. So, now we'll ask the committee if you agree with this response, if you have any concerns or if there's anything else you would like us to add?

OK. Great. Hearing none. We'll move forward which is not a problem. These are pretty straightforward set of comments. So, now, I'll pass it over to Suzanne to speak to the measure-specific comment.

Suzanne Theberge: Good afternoon, everyone. This is Suzanne Theberge, I'm the senior project manager on the team and I'm just going to briefly take you through the one measure that did receive some specific comments that we wanted to flag for the committee and that's on 3136 gap, the rate of preventable adverse events for 1,000 patient days among pediatric inpatients.

We did get a couple of comments from a couple of different organizations. One, with some questions and some suggested updates that they think will help clarify things, make the measure more specific and more clear and another commenter raised a more specific concerns with the trigger tool around resources and whether the tool was valid in identifying adverse events.

And the developer did provide a pretty extensive response to both of these concerns which we included in the memo that was sent out as well as the comment table. So, what we would -- next slide, please.

What we would like you to do now is just discuss whether you feel like the committee's response or the -- sorry -- the developer's responses adequately address the concerns raised by the commenters or if you have any remaining concerns and whether you think the response that the staff have drafted on your behalf is appropriate or if there's anything you'd like to add.

We thought the action item and the proposed response up here on the screen, the developer, I believe is on the line with an open mind and able to answer any questions if you want to ask any questions about their response to the comment.

Committee members have any thoughts on whether the issues raised were adequately addressed or that do you have any new concerns about the measure that you did not previously discussed?

Jim Bost: This is Jim Bost. It looked to me like the response to the Academy of Pediatrics on each of the bullets were well thought out and I saw no issues with them.

John Brookey: I wonder if you should -- this is John. I wonder if you should show them on the webinar so people make sure that they're on the same page.

Suzanne Theberge: Sure. Let's see. Madison or Kate, can you pull up the memo and we can screen share briefly. For the folks who are looking at the memo, this section starts on page three and the developer has pulled out each of the issues raised by the American academy of pediatrics and then there's a bullet for each -- each issue and then indented paragraph with their response.

And we'll be screen sharing that although it is, of course, a little bit hard to see but you can click the enlarge button at the top of your screen and that will also help make it a little bit bigger. It's too small to read.

So basically, they've just asked for some -- some further -- some rewarding, some further explanations and further defining some of the terms used, questionnaire around the -- the pressure ulcer documentation, some other -- some other clinical questions, further clarifying the denominator.

Jeffrey Susman: Yes, this is Jeff, taking my chair hat off. It seems to me that these were thoughtful responses to the questions screenings and they're reasonable and doesn't change my initial position with the committee around endorsement.

Suzanne Theberge: OK. And on the next page, page five, there's the summary of the comment from the Armstrong Institute for patient safety and quality and then a response to those concerns raised regarding the implementation issues which the committee did discuss at the in-person meeting and then whether the tool -- whether the tool has enough validity to identify adverse events.

So, just -- we'd like to make sure the committee feels that developer adequately address these issues or are there any further concerns?

All right. Well, hearing none, I will take it that means that you are all -- you don't have any new concerns with the measure. It should remain recommended for endorsements and we did draft that response and we didn't hear any concerns about that and we will finalize that, add in a bit of a detail from today's discussion and then have a final committee response ready for these measures as well. Remember to vote.

So, I will turn it back over to Kate to talk us through Kate to talk us through the next agenda item.

KateMcQueston: Great. Thanks, Suzanne. So, next we'll be discussing Measure 3154 which is our measure where…

(Off-Mic)

KateMcQueston: I'm getting a little bit feedback. So, if you could please put the phone line on mute if you are playing the webinar from your computer also. We'd appreciate it.

So, we'll be discussing Measure 3154, the informed coverage measure. Just a quick overview of how the discussion will go. First, we -- I'll hand it over to Madison and we'll do a quick test drive of the voting to make sure it's functioning for everyone. We now have quorum on the call, so thank you everyone for joining.

After that, we'll have a quick overview of the measure and comments received the replay from the discussant or from the developer then we will pass over to

the developer to provide a brief discussion of their responses to the committees concerned and comments from the public. We will then have comments from the lead discussants, then we will have the committee discussion and vote.

John Brookey: And this is John. Would you just please read the description of the measure so we're all making sure that we're on the right measure?

Madison Jung: Yes. This is Measure 3154 informed coverage. And if you go to the memo, the discussion of this measure begins on the bottom of page six.

John Brookey: Right. And can you -- can you just raise, you know, the two-liner description of the measure, you know, on the top of the measurement?

Madison Jung: Just one moment. Is this just the measure description you -- for the brief description that…

John Brookey: Yes.

Madison Jung: OK. It's quite a -- it's a bit of a paragraph, so bear with me. So, the description is as follows. Improved measurement of the continuity of insurance coverage in the Medicaid and CHIPs population is needed to help maximize insurance continuity and coverage…

(Off-Mic)

Madison Jung: To further this goal, the AHRQ-CMS CHIPRA PQMP Center of Excellence at the Children's Hospital of Philadelphia developed the metric Informed Coverage.

The metric is designed to more accurately measure coverage among children enrolled in Medicaid or CHIP at the state level and overcome the current inability in the Medicaid Analytic eXtract dataset to determine whether a child disenrolled from Medicaid and CHIP due to loss of eligibility (such as due to parental income increase or the acquisition of employer-sponsored insurance, a “good” reason) or failure to appropriately re-enroll (a “bad” reason).

This measure can help federal and state programs develop strategies to retain children eligible for coverage and minimize gaps that can occur during the renewal process. Informed Coverage assesses the continuity of enrollment of children in publicly financed insurance programs (Medicaid and CHIP), as defined by the ratio of enrolled month to eligible months over an 18-month observation window.

Informed Coverage uses a natural experiment based on the random event of appendicitis to "inform" the estimate of coverage in a given state, bounded by two extreme assumptions regarding unknown eligibility information. The example are Coverage Presumed Eligible (PE) and Coverage Presumed Ineligible (PI).

John Brookey: Thank you. I just want to make sure everybody's -- we're all together on this. So, thank you.

KateMcQueston: Thanks, Madison.

Madison Jung: All right. So, before we begin the discussion for the measure, we'll go over our reminder of the voting process.

So, right now I'm pulling up the voting slides and we're just going to test up the voting. That will be using the links that you received from our colleagues (Sean). Those are the individual links to vote.

So the first -- the test question is do you prefer chocolate or vanilla ice cream. Option one, chocolate. Option two, vanilla.

(Shawna): And, Madison, if I may, for folks that may have logged in not using the personalized link, I've made allowances for you so you should be able to vote now. So, if we could have our voting members go ahead.

(Multiple Speakers)

Suzanne Theberge: ...clarify, committee members only.

(Shawna): I'm Sorry. That's what I -- thank you, Suzanne.

Male: All we have to do is check the box. We don't click -- there's no submit button or anything?

(Shawna): No. As soon as you click in the box next to the answer your choice, your vote is registered. If you change your mind, you may click in another box and it will remove your vote from the previous box and move it over.

Male: Thank you.

(Shawna): Thank you. And it looks like we have 17.

Kate McQueston: Great. So, and just to remind you, we'll have to read out the results for the purposes of the transcript.

(Multiple Speakers)

Male: I actually see 18.

(Shawna): Yes. We do have one more member that has just joined us, one more committee member. So, 18 is now our number.

Kate McQueston: Perfect. Thank you.

John Brookey: This is John. I didn't vote because I don't have the link so I don't know -- I'm having problems with my e-mail. So, who sent the link?

Madison Jung: I believe it would be coming from our colleague (Shawna) with CommPartners and I believe your e-mail is (svitori), is that correct?

(Shawna): That is correct. Is this Jonathan?

John Brookey: No, this is John Brookey. I don't have -- I've been having problems with e-mail so I don't know who sent it to me but I don't have it.

(Shawna): That's OK. John, you're logged in to the event. I've made allowances for you. You're fine to go ahead and click on the screen.

John Brookey: Click on the screen. OK. Thank you.

(Shawna): Yes. We're down to 17 again. So, let's see what we have. There we go.

Madison Jung: Great. OK. So, the results to the question, do you prefer chocolate or vanilla ice cream are 72 percent for chocolate with 13 votes, 28 percent for vanilla, with five votes.

Kate McQueston: OK.

Madison Jung: Looks like we're all set with that and then I'll turn it back over to the discussion for Measure 3154.

KateMcQueston: Great. Thank you.

All right. So, as a reminder, for this measure, the committee did not reach consensus on the criteria for reliability. It was received 1one vote for high, 11 votes for moderate, 9 votes for low and three votes for insufficient.

However, because this was criterion where consensus was not reached, we continued with voting and the measure did pass for the following criteria. However, the committee did not take a vote on the overall recommendation.

So, in response to the issue of overlap that was brought up in the in-person discussion as well as questions -- other questions for the (product) committee during the in-person meeting, the developer provided Appendix A which is included in the post comment memo, a description of responses to these questions and to the issue of overlap.

In specific regard to the issue of overlapping performance score, the developer summarized the graph that was provided with their original measure submission as follows. Twenty four of the 43 states could be distinguished for more than one half of the other state. Eleven of the states can be distinguished for more than two-thirds of other states.

And at the end of each spectrum, three of the 43 states and three of the 43 states, respectively, can be a distinguished from three fourth of the other states. And we'll let the developers speak more to that in just a moment.

Regarding this measure, we did receive one comment. The commenter stated that they agreed with the intent of the measure to more accurately capture the continuity of coverage but recommended that the measure be further validated and reevaluated for endorsement in the future.

The developer did provide a response which you can see below which indicate appreciation for the intent of the measure but also notes that along with the assumptions that the measures results were validated against the gold standard ACS. And then we'll also provide the opportunity for the developer to speak more to that comment in just a moment.

So, in moving forward with the discussion of this measure or action item is that we'll ask the committee to review the additional materials provided by the developer and as well as the comment provided by the developer and then we'll ask the primary discussants to provide their thoughts on the response. And then we will have a discussion on the new reliability information provided during the post comment.

Then we will have the committee vote on reliability and overall recommendation. And as a reminder, for our voting, more than 60 percent of the committee must vote or moderate for reliability and overall recommendation for the measure to be recommended.

So, now we'll pass it to the -- control of the call to Jeffrey Silber from Children's Hospital of Philadelphia.

Jeffrey Silber: Hi. Can you all hear me?

KateMcQueston: Yes, we can hear you.

Jeffrey Silber: Hi. Well, did you want me to talk about the clustering issue or other -- and then continue with other issues about poverty or just stop at the clustering?

Kate McQueston: I think if you want to -- yes, to speak to the clustering issue and then the other -- the other issues as addressed by the committee or commenters, that would be great.

Jeffrey Silber: Great. Thank you. I had sent a memo. I tried to summarize all the comments that were brought up at the in-person meeting. In terms of the clustering, I just tried to show that we had rank ordered all the states based on their informed coverage rates.

So, when you look at one state next to the -- to another state nearby, they were purposely similar because they were rank ordered that way and then I sent some other tables where if we rank ordered by, for example, poverty -- poverty level of states, you'd see that there was no such apparent pattern of one state always looking next, looking like its neighbor.

In terms of the states and their differences, I -- what I've tried to do is provide you a table which shows how for every state, whether they're above or below another state. So, we have the state by state differences. And then also, you can see how the states vary compared to the averages of all the state -- all the remaining states.

So, I have provided that to you and, you know, it seems to me that the results show that there are some states that look similar to others but there are many states that are different from the rest of everyone else and also different from most of their neighbors.

So, it would be useful -- we believe it would be useful information for states to have to know if they're doing a good job or not on informed coverage and on getting kids who are eligible to be participating in their health insurance.

Did you -were there any questions about table that -- the tables that I sent that tried to compare one state to the next?

Madison Jung: So, thank you for the summary, Jeffery. Do you want to speak to any of the other comments now? Otherwise, I think, we'll pass it over to John Brookey

who will moderate the comments and the discussion of the committee and they may have additional questions that they'd like you to address.

Jeffrey Silber: OK. Then, I also addressed the question of whether the -- they were different levels of poverty across states. Would that somehow influence the metric or bias the metric?

And we showed that there was no correlation between the poverty level of the states and the informed coverage so that it wasn't clear that the richer states were doing better or worse than the poor states and we gave a number of -- showed a number of figures for that, we showed a correlation table between the state informed coverage rates and the percent below with the poverty level for each state that correlation was 4.038.

There was a concern that poverty would drive this measure in a way that would affect the correct results for estimating the participation rates. And then we also redid our state by state difference table but ordered it by -- as I mentioned earlier, by poverty and you can see that now you don't get that same pattern that people were reacting to -- there doesn't look to be any neighbor affect, so to speak.

And then there was an issue about -- there was an issue about turning that -- I'm sorry, and then we also showed for poverty. We looked at the extremes, like the 10 richest states and the 10 poorest states and we showed a box plot of the 10 richest and the 10 poorest.

And if you look at the informed coverage medians, they're within the interquartile ranges of the -- the lowest poverty work within the interquartile range of the highest poverty and the P values were not significant between the 10 lowest and the 10 highest income states.

And then there was a concern about the use of the look back of four months versus five months. And so, we redid the whole analysis and I think that there was a concern, again, about income and poverty and whether the change in the -- the lookback period would change our results and the correlation in our -- the Spearman correlation was 0.986.

So, the -- if we would have gone back five months versus four months, it would not have changed our results and I think that was something that was requested during the last meeting. So, I think I'll stop there and answer any questions and -- but you'd converse about this.

(Multiple Speakers)

John Brookey: Yes, before I open it up, do any or Kerri, Jeff, anybody else, from that team, have any other comments before the whole committee begins to ask questions or make comments?

Amy Houtrow: Sure. This is Amy. As you guys recall, we were particularly concerned about children whose families had income right on the cusp of eligibility and that those children tend to fall in and out of being eligible for coverage and then therefore aren't enrolled as consistently when they are eligible for coverage.

So in terms of from a developer standpoint, could you speak to that in particular concern that we had raised with relationship to these for us?

Jeffrey Silber: Right. Well, I didn't have the actual income of the families but what I -- what we did do is show the richest and poorest states and asked if they were differences. You know, imagine if you had states that were far richer, you might have fewer on the cusp than if you had states that were very, very poor.

What we could do is at least say that if the average income of the states was high or low, that didn't seem to be throwing off our estimates. It wasn't being driven by that.

I wouldn't have data to say that this particular patient was on the cusp but I can have data to say that the metric is stable across income levels of states.

Amy Houtrow: Great. And then with regards to the (back supply) of informed coverage on page nine, it looks like the high poverty states have not normally distributed. They're not normally distributed whereas the low poverty states are any -- anything that we should be aware of with that graph?

Jeffrey Silber: Yes. I mean, we used the Wilcoxon Test to look at the difference between those so we didn't -- so at least we can say with statistical confidence that there wasn't a difference between those two groups. I didn't explore the nonnormality. I just used a nonparametric test.

Amy Houtrow: Right. Great. Thank you.

John Brookey: Any of the lead discussants have any other questions or comments?

Kerri Fei: Hi, this is Kerri Fei, can you hear me?

John Brookey: Yes.

Kerri Fei: Great. Thank you. First of all, I just wanted to thank the developer for providing all of this additional information. It is very informative and extremely helpful and helps, I think, make it a little more clear. My only question would be -- I think my question during the meeting was probably found more into using usability as how this measure would be used.

I don't know that, you know, the differences that you see between states could be explained by many different things and if we're thinking about this from an accountability perspective. Maybe just some thoughts on some of how -- how they would envision it being used, just so that it's clear for everybody as to the test used for the measure.

Jeffrey Silber: Sure. I think there's two ways that I would envision it used. First, I could see that if a state ran these metrics and saw that they were looking very poor on this, I think that least explore and try to figure out why.

So, there is -- I think a use for this -- for the states themselves and one example is -- is Illinois was an interesting state where they instituted, and I don't have the exact year in front of me but we looked at before and after Illinois' institution of a program to get everyone who was eligible to -- there was a name for it, I'm forgetting now. But, again, everyone was eligible…

Kerri Fei: And in Illinois it's called (daycare).

Jeffrey Silber: And we show that that takes a jump up after they instituted of the program. So, you know, we leased our measure was reflecting the improvement that Illinois showed after they really made an effort to do that.

So, I think from an internal point of view, a Medicaid department could benefit from just having another view besides the two metrics that are out there. Another view that takes into consideration those patients that you might not have seen but only showed up because it did end up having an appendectomy and then looking back to see if they were covering that.

So, that's one thing that they could do. And then secondly, I think that I know there was -- when I was asked during the previous meeting, well, is this a quality measure? And I thought, well, you know, I said, well, in a sense, it's better to have higher participation that lower participation and there was this fear that once they -- who was just a little bit different than another would be harmed.

And I think -- I don't -- I think because we give the confidence intervals, I don't think that policy makes necessarily will punish states that are very, very close to each other. But if you have states that are way on one extreme and there are or on the far lower end, you know, those are ones that should be looked at more closely whether -- I'm not -- I didn't -- I asked to develop this measure to help Medicaid examine these issues and that's what we did.

Another question entirely is how it -- should it be used by -- for some penalties or things like that and then, of course, we'd have to give a lot of thought about the right penalty structure, et cetera. But that's not -- what I'm trying to do is just give the best estimate with the confidence interval and I think it does allow you, at least to see a pattern in state -- some states versus other states in terms of some that have much higher informed coverage than others.

So, internal use and also some look at how some states are doing against each other but there have to be a lot of thought about how you really would institute a penalty program which is not what I was intending to do.

Kerri Fei: OK.

(Multiple Speakers)

Jeffrey Susman: Go ahead.

Jeff Schiff: This is Jeff Schiff. I'm in the Minnesota Medicaid Program and I just think that -- I think it is a pretty interesting thing that the relationship of the measure to the lower high poverty that there's, I guess, I'd say a lack of correlation because I think this -- tell me if the developer thinks I'm wrong but I think that this measure has actually served a measure of how easy and accessible coverage is to the -- to folks not whether or not there's almost, you know, the time cost to poverty, sort of thing.

And then, so, I just had -- and I just have one other comment which is that this measure relies on presumptive eligibility which I just think we have to track with this measure if there's anything that changes federally around presumptive eligibility. The measure, I don't think they're reliable. So, if you could just comment on those two things?

Jeffrey Silber: Well, in terms of the presumptive eligibility, the fact that Medicaid paid for the appendectomy meant that they were eligible.

Jeff Schiff: Right.

Jeffrey Silber: So, now…

(Multiple Speakers)

Jeff Schiff: And that's required now but it may not continue, I guess, is…

(Multiple Speakers)

Jeffrey Silber: I will -- I would say that to the extent that -- well, if Medicaid now will not be paying for eligible children, I haven't -- my measure assumes that if Medicaid paid the bill, it meant someone had determined that they -- they were…

Jeff Schiff: No, yes. I agree.

Jeffrey Silber: So, if that changes, the measure would have to be looked at in a different way.

Jeff Schiff: Right.

Jeffrey Silber: Now, the first question was how easy is it to get -- I think what this tells me in part was -- is that, you know, I think it's a lot of policy about how hard or easy it make to family's reenroll and that it's not necessarily driven by income but it's driven by some policy.

I guess that's one way that I might look at this but I don't have -- I haven't explored the policies themselves. I just know in Illinois, they went from Mediocre to great when they instituted better policies.

Jeff Schiff: Yes.

John Brookey: Jeff Susman, you had a comment?

Jeffrey Susman: I think that's it.

John Brookey: OK. Any other that are lead discussants that are on the line in here -- any other comments from you before I move to the rest of the committee? So, committee members, comments or questions?

Do we feel like we have enough visual information to vote?

Male: Yes.

John Brookey: Any objection? OK.

Madison Jung: OK. This is Madison and I'm pulling up the voting slides for…

(Off-Mic)

Madison Jung: OK. So, this is for Measure 3154 informed coverage and this is voting on the reliability. Option one, high; option two, moderate; option three, low; and option four, insufficient. And the voting is now open.

So, we have 19 votes in and, John, are we at 19 now?

Female: No, we aren't and I am cross-checking that. We did have a message from a participant and I've checked and the votes are tracked with names on them and I don't see one with that participant's name on it.

Let's see.

Madison Jung: Great. Thank you.

Male: Vote early, vote often.

Male: It looks like we just dropped to 18 now.

Female: There we go. Sometimes it takes a second if you've changed your vote for it to settle down. So, yes, we are at 18.

Madison Jung: Great. So. the results to Measure 3154 for reliability are 6 percent for high with one vote, 78 percent for moderate with 14 votes, 17 percent for low with three votes and 0 percent with zero votes for insufficient. And with that, the measure passes for reliability.

Female: OK.

Madison Jung: The next option for voting is overall suitability for endorsement and I guess this is a question for the co-chair. I think we want to have overall discussion or did we want to go right into voting for endorsement?

John Brookey: Is there any other discussion?

Jeffrey Susman: I would like to raise -- this is Jeff Susman -- without my chair hat on. The potential unintended consequences particularly if this is used by CMS for rewards and/or potential cutbacks or penalties. Since there's such substantial

overlap, I'm concerned that there could be actions that aren't really supported by the level of reliability of the measure, if that makes sense.

John Brookey: Yes. I think, Jeff, that was our discussion that of the unintended consequences of how CMS may choose to use this. I think -- as the discussion went, I think -- to me that what I heard was that this could be useful information or safe to look at their own data to perhaps evaluate their current status.

On the other hand, on the flip side of that, if it used as an accountability measure which we don't really -- from what I heard in the discussion, folks aren't too comfortable about this thing in accountability measure, there could be unintended consequences.

So, I think that's what the committee members need to weigh when we're -- when they're considering overall suitability. Does that sound right?

Jeffrey Susman: It sounds really, to me, you know, I think this measure could be very useful and as the example given by the developer, might lead to changes and policy and procedures. I worry, though, when it might be used for accountability that's tied to other actions that they might not be supported by (rate applied).

David Keller: Yes. This is David Keller, though. I mean, I hear you and I hear the previous discussion. But isn't that true for just about every measure we've ever approved? I mean, the -- especially when you take measures that have been developed that have error bars attached to them and they get used in any kind of payment scheme.

Generally, that means they're associated with the benchmark which means they're associated with an absolute cutoff rather than a relative cutoff and that's true whether we're talking about this measure or we're talking about, you know, the rate of positive -- rate abusing a culture for strep throat which I lost money on because I was 0.2 percent below the median.

So, I just -- you know, I hear the concern but I think it's a general concern with measuring when we're using tools that have error intrinsic to them. I think the important thing is for us acknowledge that the error is there to make

sure that error is clearly defined which the developer has done for us. And then it becomes a discussion between, you know, essentially the payer and the payee as the fairness abusing that measure for that purpose.

John Brookey: Yes. I think you're absolutely correct. I think as we vote, we need to consider whether or not we think this is different than other measures that have been used for accountability and people may have, more or less, confidence in this particular measure showing real differences between states. Are there any other comments or concerns, questions, before we vote? OK.

Carol Stanley: This is Carol Stanley and I'm recalling that when we met back in March that there was a discussion on the comparison between Medicaid fee-for-service and managed care and I'm trying to recall what that discussion was because I think it had contributed to our perception of reliability. If there's any difference accounted for with regards to states that are heavy, managed care concentration with Medicaid versus fee-for-service?

John Brookey: Is that a question for the developer?

Carol Stanley: Yes.

Jeffrey Silber: Well, when we developed a measure and I think you have it there, we created a filter to make sure that data reflected -- that the states were -- their managed care patients did get bills were included and we had a formal test for that and that filter is a program that we would furnish the states to use.

So, we do account for it and I didn't recall that there was request made about any further analysis on those except that we would -- would make sure that the states who used and whenever this measure is used that they look to make sure that the managed care bills are being reflected and that vary state by state and that's why we have the filter built in.

Carol Stanley: OK. Thank you.

John Brookey: Any other questions, comments? OK. Ready to vote.

Madison Jung: OK. Voting for overall suitability for endorsement for Measure 3154, informed coverage is now open. Option one, yes; option two, no. Looks like we're looking for one more vote.

(Shawna): Yes. If any of our voting members are having difficulty or having an issue with their connection, they can refresh their session by pressing F5 on their keyboard in case you've lost the boxes. We're still waiting for one more vote.

John Brookey: And you know who it is but you can't say who it is. He may have stepped off from the meeting. We lost a vote.

(Off-Mic)

Madison Jung: We still have quorum with 16 votes. Would we -- no, going back. Sean, is everybody -- does it look like we still have 18 people on the line or did somebody step away?

(Shawna): No, we still have 18 online.

John Brookey: We would still have threshold even with 17, though. Even if that person voted no, right?

Madison Jung: Correct. I was just going to say that. Are we OK to close the vote then?

Female: Yes. We need to close the vote.

Madison Jung: OK. Great.

Female: They might have stepped away from their desk.

Madison Jung: OK. We have 17 votes right now and we're closing the votes for Measure 3154 informed coverage for the overall suitability for endorsement vote. We have 76 percent with 13 votes for yes and 24 percent with four votes for no and with that 76 percent, it meets the 60 percent threshold and it is recommended for endorsement.

KateMcQueston: Great. And now we'll toss it over to Suzanne to introduce their request for reconsideration.

Suzanne Theberge: OK. Thanks, Kate. Next slide, please. So, as we mentioned earlier, we have two request for reconsideration. These are two similar measures from the same developer but we are going to split out the discussions. So the first discussion is going to focus on 3189, rate of emergency department visit used for children managed for identifiable asthma, visits per 100 child-years.

And as you may recall, this measure passed evidence and gap but was insufficient for reliability at the in-person meeting. So, it did stop there.

The developer did -- it didn't move forward because it was not recommended. So, the developer did provide some additional data and information addressing the committee's concerns which were provided in the memo that we sent you in Appendix B and we also included the original submission of the measure in Appendix C.

So what we would like you to do now, we're going to give the develop just a couple of minutes to briefly introduce what additional information they provided, just a two-minute overview and then we'd like the committee to, first, vote yes or no on whether you would like to consider this request for reconsideration. So, that will be a yes/no vote. The measure -- greater than 60 percent of the committee must vote yes in order to reconsider the measure.

And if you do vote to reconsider, we'll then proceed through discussing and voting on reliability then validity, feasibility, usability, and use -- and overall recommendation for endorsement. So, next slide, just to pull up the -- this slide here, just to remind you that the testing information was insufficient. Basically, with the -- with the big issue.

Our lead discussants for this measure are Karen Dorsey, Jonathan Finkelstein, Carol Stanley and Ricardo Quinonez. So, we'll ask you to kick off the discussion once we get going. We did not receive any comments about this measure and the next slide displays the action item so we can just hold it on this next slide and we will turn the call over to (Larry Feinman), the measure developer, to very briefly provide us some information about the additional information you provided.

(Larry Feinman): Thank you, Suzanne, and thanks for the committee for the opportunity to bring this for you -- for you for reconsideration.

What we've provided you for the reliability data are results from regression analysis demonstrating, using two specific counties in New York State, one New York City which is really a five-county area but is considered a county for state analysis, analytical purposes.

And Westchester County since New York City is somewhat exception as a County. As the index -- and showing that you get -- after adjusting for age which we do want this to be -- to look that with age considerations, that you have a very nice confidence intervals.

It generates differences between counties and between health plans for the other analysis, we did a number of health as we sent you. One, it is typical but there are -- they are -- it's what they look like some plans differ, other plans don't and we used -- we did this -- we present a plus on model.

We also did zero inflated poison and did it as a -- and found very similar results. For simplicity's sake, we just included one piece of data.

I would tell you that the tables are accurate. The graph are accurate in their point estimates but for some reason, I'm seeing now and I apologize that I didn't see this before, it seemed to use the index plan or the index county for generating standard errors for all the others.

So, those error bars are not as accurate but they are given to you in -- as the standard error or the confidence limits are given in the tables that we provide to show you that. It's just a graph of a representation of them that's not accurate.

We had issues regarding exclusion and inclusion criteria -- or an inclusion criteria. We found exclusions are infrequent COPD, 221; acute respiratory failure, 139; emphysema, 482. These were not going to change in profound ways, the measure by virtue of them being in or being out.

Leukotriene inhibitors as an -- were not a part of the inclusion criteria. Taking all the maximum bad assumptions for them, hurting the measure, they would lead to a misclassification with a denominator of 0.6 percent, 795 out of a 125,000 plus children, their only medication criteria would have leukotriene inhibitors.

Some of them would have been qualified already for other things and some of them clearly would not have asthma. So that maximum estimate really is an overestimate by design.

We described in our response why short-acting beta agonists were not included as inclusion criteria. There was careful discussion by our expert panel and I think it's the right decision and it's borne out in the fact that we find that they heat a persistent asthma measure, would have included 3.1 percent of kids. The national survey of children tells -- shows an excess of 15 percent of the kids that's having asthma in Medicaid and New York state and we got 8.6 percent.

So we were looking to be in the middle of those two. We were, I think, that is a -- that's an important indicator that we had faced validity and we achieved our goal of filtering out the kids who didn't really have serious asthma but not being so restrictive as the intentionally restrictive HEDIS measure.

We were asked about the completeness of raise data. We have no notes that it was missing from this analysis but we've recently done another analysis using kids with mental health diagnosis or mental health medication and it was completed in that study and we presented you the numbers there but it was hundreds of thousands without any missing data, except in the New York State (it only manages).

We sent you a data element validity payable and I hope that was two minutes and I'm happy to answer any questions.

Suzanne Theberge: All right. Thank you, (Larry). I will now turn it over to Jeff to facilitate the committee's discussion of the call -- of the measure.

Jeffrey Susman: OK. Thank you very much. Thank you to the developer. We have the primary discussants who I'll allow to talk about the request for reconsideration just to framework decision. We're going to take, openly, a yes/no vote and look for greater than 60 percent of the committee voting yes for reconsideration. If it fails, that we stop there.

So, Karen? Would you like to start out?

Suzanne Theberge: Karen is actually not on this call.

Jeffrey Susman: OK. How about Jonathan?

Jonathan Finkelstein: So, I'll just -- I'll just say a couple of things and thanks to the developer for kind of providing us all of that -- that data. I think the initial discussion fell into two areas and one was the reliability testing issues and I thought the -- the testing that was submitted now in the reconsideration piece was very adequate from my perspective.

I can't claim to understand all the statistical nuances to bring between zero-inflated poisson and the other methods used but for claims based measure according to my understand what NQF requires, I think it met those criteria.

I think the other set of things we brought up were both the -- the denominator -- the denominator is quite complicated. I understand how -- how they got there. It was -- it was an expert panel who got to this -- this particular criteria that other people could quibble with or not -- or not quibble with and I think those -- we don’t have a lot -- so I appreciate that lack of presence or lack of medication data would change things very much the presence or absence of any individual medication included or excluded wouldn't change things that -- that much.

And so, those are somewhat reassuring but I think the committee still has to grapple with the set of criteria -- criteria that make sense. So, I'll leave it there.

Jeffrey Susman: Great. Thank you very much. Carol, would you like to add anything?

Carol Stanley: Yes. So one of the things I think was an issue was these three -- at the end of the day, this measure is set up to hold the health plans accountable if I'm not mistaken and to only require three months as continuous enrollment really put the health plan at a disadvantage when you take into account would have to happen during those three months.

So, I think one of the issues was does it really make sense to hold the health plans accountable for three months of enrolment for a child with a chronic condition and I think another issue as well was really getting into the nitty gritty connecting the dots from things such as how the age categories were determined through the expert panel versus being able to link them to strong evidence where in the clinical guidelines.

So, I think these were kind of my two areas and I think even though there was a 12-month look-back period it's not really clear how reliable that dataset is when it's coming from I believe a data hub of some sort.

Jeffrey Susman: OK. Thank you. Let's then go to Ricardo if you're on.

Suzanne Theberge: Ricardo is not on the line either. So, Karen and Ricardo is on vacation. Sorry.

Jeffrey Susman: OK.

(Off-Mic)

Suzanne Theberge: …for coming prepared.

Jeffrey Susman: Well, I appreciate the primary discussions. Now thoughts from the committee before we consider the request for reconsideration. Any committee questions for the developer or questions to our primary consultants or other potential thoughts?

Jonathan Finkelstein: I have one quick question for the developer that I was trying to remember from last time. If we could understand, there's this issue if I remember right

now reviewing that the look-back period for someone is the year prior -- that account to year prior plus the months before the measurement month.

So if somebody has a measurement month in January, they have a 12-month look-back period. But if they have a measurement month in July, they have an 18-month look-back period. If they have it in November, they have a 23-month look-back period.

It's -- first of all, do I have that right and remind us what the response to that issue was.

(Larry Feinman): Sure. Thank you, John. And so that is correct and the rationale is several folds. One, longer look-back periods are more reliable for identifying children with asthma.

That said, we -- and this relates to the three-month comment that Carol made as well, we did not feel it was appropriate to hold plans accountable for children whom they might not have sufficient information that they should be aware that the child has asthma. That's why these criteria had to be satisfied within the period when the child was enrolled.

So if you have a child who is enrolled for three months and has three visits for asthma beforehand, we figure or visits plus -- two visits and medication use, we feel like the plan ought to know that that kid has asthma and be doing something to manage them.

So that was the balance we thought. Then finally from a measurement point to you, historically, measures have been presented as a risk or a pseudorisk where the denominator is the number of children and the numerator is the number of children with events.

This measure is actually a rate which is by definition over a unit time and we are able to do the unit time as months in order to create it as a hundred child years for the ultimate. But it gives us more precision and increases the signal to noise ratio by doing that and it also treats differently a child who has five

ER visits or hospitalizations from one who has one. And so it's a more quantitative and a more finely tuned approach.

And -- OK. I'll leave it at that.

Jeffrey Susman: OK. Thank you. Thank you for the question and comments. Any other questions? If not, we're going to go ahead and vote. This is the yes/no vote on reconsideration of this measure.

Kate McQueston: OK. The voting for…

Jeffrey Susman: The NQF are going to do the magic.

Kate McQueston: The voting for Measure 3189: Rate of Emergency Department Visit for Use -- Visit Use for Children Managed for Identifiable Asthma: Visits per 100 Child-years request for reconsideration is now open. Option one, yes; option two, no.

Madison Jung: And just so folks know, someone had to leave to catch a flight. So we're down to 17 committee members now. We need one more vote. All right. We are at 17.

Kate McQueston: OK.

Madison Jung: And go ahead...

Kate McQueston: Go ahead.

Madison Jung: Thank you. OK. So the vote is 53 percent or nine votes for yes and 47 percent or eight votes for no. Because a request for reconsideration needs to achieve greater than 60 percent to go forward, this measure will not go forward. It will remain not recommended.

(Larry Feinman): Thank you.

Suzanne Theberge: OK. So we will now move on to the second request for reconsideration, 2816, Rate of Emergency Department Visits for Children Managed for Identifiable Asthma: Visits for 100 Child- years.

At the meeting, the Committee did not reach consensus on evidence. The measure did pass GAPPS and did not pass reliability. So, next slide.

The Committee -- just to note, sorry, it did not pass validity. The measure used the data element validity testing which is acceptable for out testing purposes. So…

(Larry Feinman): So, I'm sorry. I think the title of the measure is wrong. The number is right, 2816, but we're talking about the appropriateness measure now, not the rate measure.

Suzanne Theberge: You are correct. I'm sorry about that. There is a mistake on our slides. So the measure we are now discussing is 2816: Appropriateness of Emergency Department Visits for Children and Adolescents with Identifiable Asthma. Thank you for that correction and our apologies.

So the next slide, the Committee had a number of concerns with this measure. The construction and testing of the measure, the appropriateness criteria. There was some concerns with the testing having been done only in one hospital which made it difficult to discern meaningful differences.

Not all critical data elements are tested. There were some variation in the specifications as of the data is available. We did receive one comment on this measure. The pulmo -- as you may recall, the pulmonary committee had previously reviewed this measure and they had had some concerns about the lack of risk adjustment.

This Committee actually didn't discuss that topic since we did not proceed that far in the voting and discussion. So again we will turn this over to the developer and next slide for the action item.

We'll turn this over to the developer to give us two-minute introduction to -- as to the new information that's been provided and the rationale for the request and then we will turn it over to the Committee to discuss and then vote

on a yes/no for reconsideration. And then if it passes that, we'll continue through the criteria. So, (Larry)?

(Larry Feinman): Yes. Thank you, Suzanne. So for this, a lot of the materials that we provided actually relates to some of the things that were provided for the measure before that relate to data element reliability and we also -- we spent a little bit of time responding to the comment to basically suggest that the NHLBI guideline which drives the work is quite specific that outcome should be blind to any number of risk adjusters, including clinical risk adjusters recognizing that they're all with outliers.

But that in the population for whom the measure needs to account for, we shouldn't be -- we disease provide an opportunity to stratify by -- we ask it to be stratified by age. We provide an opportunity to be stratified by race and by some of the social factors such as poverty and urbanicity, morality.

The measures -- the data elements in the numerator were validated with (CAPAs) against the gold standard of the measure developers' review of the chart. We're one of the measure developers' review of the chart.

And we recognized that asthma -- appropriateness is a new construct. So there really is no -- there's no existing data to take us further. We wish that they were and can't get past the limitation at the moment that this was done in one hospital but we can at least demonstrate that the evaluation in that institution was broad and our capacity to identify eligible cases now with hospitalizations that are or rather, I'm sorry, emergency visits we demonstrated through the work in the other measure.

So we again appreciate the opportunity to present this. I would appreciate your support and endorsement of the measure and keeping with Suzanne's request, I'll keep it very short but I'm happy to answer specific questions that could be helpful.

Jeff Susman: OK. This is Jeff. So, thank you very much for another succinct and relevant summary. Ricardo is somewhere enjoying himself. Marlene, are you on the line? Marlene, if you are there?

Operator: We do not have Marlene on the call.

Jeff Susman: OK. Well, I'll let James have a stab at it before I weigh in.

James Duncan: Sure. Thanks for your additional comments. I think that unfortunately the information provided did not add any additional information associated with validity of the numerator construct. As (Larry) said, it was still done with one institution. It did not actually use the -- all of the assessment criteria and we would have certainly like to seeing some additional validity associated with the numerator.

I'm not sure that specific additional information was provided for the evidence component either. I do appreciate the thoughtful discussion on the stratification and just to make it clear, it was not that this measure should undergo risk adjustment in terms of statistical modeling but more that it gives folks the option to provide the measure for different combinations of subgroups.

Always a caution when you make something like that optional that if comparisons are done across entities that they need to make sure that it's done comparing the appropriate subgroups. And that's it.

Jeff Susman: OK. Thanks very much, James. I have much the same sense that we haven't received significant new information for this particular measure and that my concerns about the evidence and support of this as well as of the potential contenders around appropriateness and whether a child even gets to the emergency room or not is still present.

And with that, I'll -- let us turn the voting and other questions on the Committee. So does the committee membership at large have any further questions for the developer or comments? Go ahead.

Hearing none, we'll move to a request for reconsideration yes/no vote and again more than 60 percent. Is that correct?

Suzanne Theberge: That is right.

Jeff Susman: OK.

Suzanne Theberge: We have the correct title up here. So the voting for -- apologies about that. So the voting for measure 2816: Appropriateness of Emergency Department Visits for Children and Adolescents with Identifiable Asthma request for reconsideration is now open. Option one, yes; option two, no.

Jeff Susman: I think we've got it.

(Multiple Speakers)

Jeff Susman: Just kidding.

Suzanne Theberge: We have all the votes in with 100 percent or 17 votes for no.

Jeff Susman: I just like to take liberty as the co-chair to say that I think this topic is very important and the line of investigation that you all are doing is what we're continuing to pursue. So, I hope that you won't take our decisions with more force (than it really meant) to convey. Thank you very much.

(Larry Feinman): I appreciate that. Can I -- would it be OK to take the liberty to ask the Committee one question about the former measure, the rate measure? And that would be if there's any direction since I don't know how to conceptually address a failure to reconsider with a majority of favor in favor.

Should I think that if we've been able to get this sooner it might have gone forward or are there specific GAPPS that the Committee could point us to either now or at some point in the future. It certainly would be very helpful.

Jeff Susman: We can certainly work with NQF to ask to provide the feedback from the comments and summarize that I think. As you heard, there was significant difference of opinions even on that measure and with the appropriate measure less appetite for reconsideration.

(Larry Feinman): Thank you very much and I appreciate your time and your thoughtfulness.

Jeff Susman: Thank you very much.

Carol Stanley: And can I say something about that measure as well? This is Carol. Basically, a few years ago when I was in Virginia Medicaid, we used a measure that has been developed out of Alabama, I think it was Alabama Medicaid, and it was measuring (ADUs) and that measure and I'm sure you're aware of this already was eventually dropped.

Jeff Susman: Yes.

Carol Stanley: Because there's some flaws uncovered. However, we found that useful. I'm using it sort of as a soft measure of ED utilities and we're able to stratify it by ZIP code and region and health plan. And so it's definitely a high-need measure. So, I hope you'll continue to work on that.

(Larry Feinman): Thank you. And, yes, I appreciate you bringing up that measure. That was the measure that CMS and ARC asked us to improve upon. So that -- because of some of it there were flaws, there were definitional flaws or a number of things and this was -- this approach was the result to try and to create greater meaning in that similar construct.

So that's -- we're struggling with it and we struggle with churning as a means of potentially rewarding difficult enrollment. If kids are on and off, you never reach continuous enrollment.

Carol Stanley: Yes.

(Larry Feinman): So that, we came up with a three-month -- it's actually New York Medicaid who suggested the three-month period as efficient. So anyway, we'll keep working on it. So thank you.

Carol Stanley: Yes. OK. Thanks.

Jeff Susman: All right. I guess we'll turn it back to Steph.

(Stephanie): Thank you. So the next section of our agenda is public comment. So we'll ask the operator to please open the line for any public comment.

Operator: OK. For some, if you would like to make a public comment, please press star then the number one. At this time, there are no public comments.

(Stephanie): OK. Thank you. The next, I'll pass it to Madison to discuss our next steps and timeline.

Madison Jung: great. Thank you. So following this, we'll update the memo and put out a memo summarizing the results of this phone call and the conversations.

And following that, we will be opening for a member vote. The dates for that are June 12th through June 26th. And then following that, we will have the CSAC review where they will make the final endorsement -- vote for endorsement and that will be taking place in July 11th to July 12th.

And following that is any appeals. It will be open for appeals period and those dates are July 17th through August 15th.

Next is just our project information. I'm sure as many of you know by the now, our e-mail address also here in the link to the project page and SharePoint site for the committee members in addition to our phone number.

And if there's nothing else, anything else from the co-chairs?

Jeff Susman: No. I just want to thank everybody. To staff as usual who's done a great job of organizing things and the developers and members of the committee have been wonderful. Thank you.

John Brookey: Yes. I just want to say thanks again and also for this -- the key discussants for doing a good job preparing for the meeting. So, thank you everybody, and to Jeff as well.

Male: Thank you.

Madison Jung: Great. And with that, I think we will end the call. And so thank you very much for all of your participation today, everyone.

Female: Thank you.

Female: Great. Thank you.

Male: Thank you.

Female: Thank you.

Male: Thank you.

Male: Take care, everyone.

Female: Thanks, everybody.

Male: Thank you.

Female: Thank you.

END