Supplemental Document No. 3

2013 SNAC Child Core Set Measure Retirement Process Summary of SNAC Scoring: Round 2 Final Scoring

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Introduction

The following document summarizes the results of the final scores submitted by 22 members of the AHRQ National Advisory Council Subcommittee on Children's Healthcare Quality Measures for Medicaid and CHIP Programs (SNAC) as of October 28, 2013. The results are provided in the following ways:

- An overall summary of final scoring results for all measures, which provides:
  - Number of scorers that provided scores for all four criteria and therefore had a total score calculated and reported.
  - Median, minimum, maximum, and 25th and 75th percentile scores per criterion (importance, scientific acceptability, feasibility, and usability).
  - Median, minimum, maximum, and 25th and 75th percentile total scores.
  - Number of “Yes,” “No,” or blank responses to whether the measure should be retired.

- Twenty measure-specific final scoring results summaries, which provide:
  - Number of scorers that provided scores for all four criteria and therefore had a total score calculated and reported.
  - Median, minimum, maximum, and 25th and 75th percentile scores per criterion.
  - Median, minimum, maximum, and 25th and 75th percentile total scores.
  - Number of “Yes,” “No,” or blank responses to whether the measure should be retired.
  - Box-and-whisker plot illustrating the minimum, maximum, median, and 25th and 75th percentiles for each criterion.
  - Histogram illustrating the distribution of total scores across SNAC members.
  - Summary of SNAC member comments for each criterion.

Responses were received from 22 SNAC members. A total score was calculated for each measure in each scoring report by creating an equally weighted average of the individual criterion scores for any SNAC member who provided a score on all four criteria. In instances where criterion-specific scoring information was missing, SNAC members were contacted to provide the missing information. Most missing information was received and included in this scoring summary; however, criterion scores from one SNAC member for Measures 13, 14, 15, and 18, and from two SNAC members for Measure 17 were not obtained. Additionally, some responses provided in the retirement column were missing. Responses that were left blank are presented as “no response” in summaries of the retirement question.

TABLE: OVERALL SUMMARY OF SNAC SCORING: ROUND 2 – FINAL SCORING

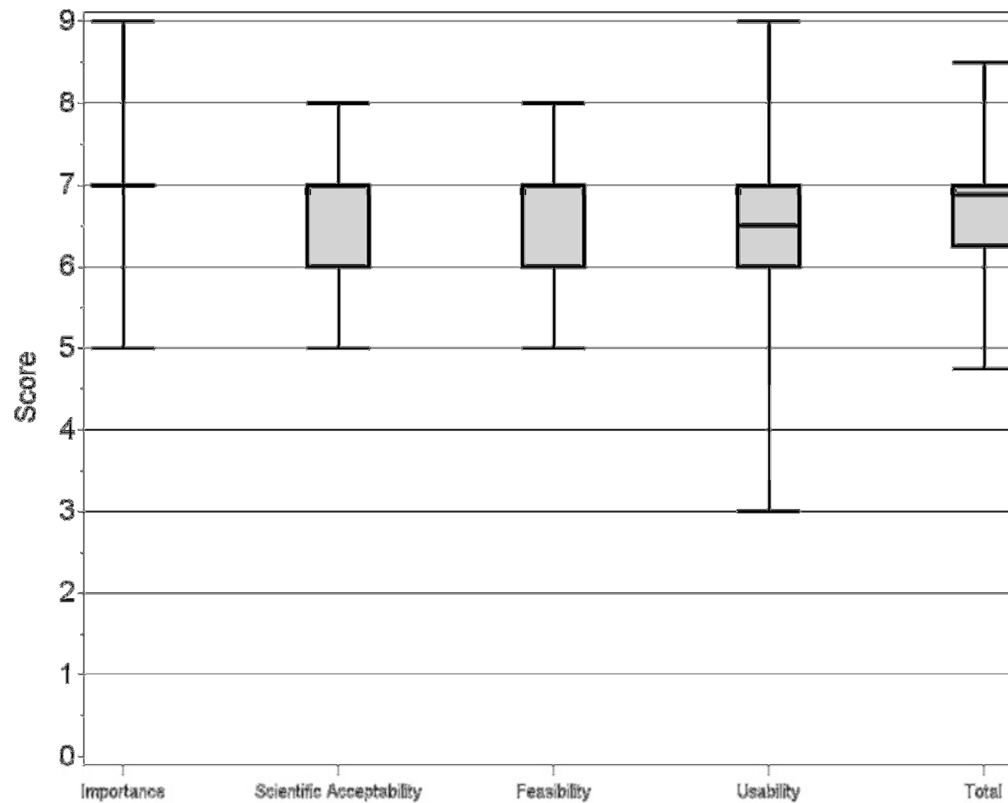
Measure Number & Brief Name (applicable ages)	Number of scorers	Measure Scores (1-9): Importance					Scientific Accept.					Feasibility					Usability					Total Score (1-9)[1]					Retire?		
		Median	Minimum	Maximum	25th Percentile	75th Percentile	Median	Minimum	Maximum	25th Percentile	75th Percentile	Median	Minimum	Maximum	25th Percentile	75th Percentile	Median	Minimum	Maximum	25th Percentile	75th Percentile	Median	Minimum	Maximum	25th Percentile	75th Percentile	Yes	No	No response
1 Timeliness of PNC	22	7	5	9	7	7	7	5	8	6	7	7	5	8	6	7	6.5	3	9	6	7	6.88	4.75	8.5	6.25	7	2	20	0
2 Freq. of PNC	22	7	1	8	6	8	6	1	8	6	7	6	4	8	5	7	6	1	8	5	7	6.25	2.75	8	5.5	7	5	17	0
3 Low Birth Weight	22	9	3	9	9	9	7	1	9	5	8	6	3	9	6	8	7	4	9	7	8	7.25	2.75	9	6.75	8	1	21	0
4 C-Section NPSV	22	7.5	3	9	7	8	6	3	9	4	7	6	3	9	5	7	6	3	9	6	7	6.5	3.25	8.75	5.5	7.5	5	17	0
5 Child Immunization Status *(2y)*	22	9	6	9	9	9	8	5	9	7	9	8	6	9	7	9	9	7	9	8	9	8.25	7	9	7.5	8.75	0	21	1
6 Adolescent Immun. Status *(13y)*	22	9	5	9	8	9	8	5	9	6	9	8	6	9	7	9	8.5	6	9	7	9	8.13	6	9	7	8.75	1	21	0
7 BMI Assess. *(3y-17y)*	22	8	1	9	7	8	7	1	9	5	7	6	1	8	5	7	6	1	9	5	7	6.5	1	8.25	6	7	4	18	0
8 Developmental Screening (1y-3y)	22	8	4	9	7	9	6	2	8	4	7	5.5	2	9	5	7	8	2	9	6	8	6.75	3.5	8.5	5.5	7.5	4	18	0
9 Chlamydia Screening *(16y-20y)*	22	7	5	9	6	7	6.5	2	9	5	7	7	2	9	6	8	7	3	9	6	7	6.5	4.25	8.5	6	7	5	17	0
10 Well-Child Care Visits *(15m)*	22	8	5	9	8	9	8	5	9	7	8	8	5	9	7	8	8	6	9	7	8	7.88	6.5	8.75	7.5	8.25	1	21	0
11 Well-Child Care Visits *(3y-6y)*	22	8	5	9	7	9	8	5	9	7	8	8	5	9	8	9	8	6	9	7	8	7.88	6	8.75	7.25	8.25	1	21	0
12 Adolescent Well-Care Visits *(12y-21y)*	22	8	4	9	6	9	7.5	2	9	6	8	8	5	9	7	8	8	4	9	6	8	7.63	4.75	8.5	6.5	8.25	3	18	1
13 Access to Primary Care *(12m-19y)*	21	6.5	3	9	5	8	5	2	9	4	7	7	2	9	5	8	5	1	9	4	6	5.75	3	7.75	5.5	6.5	16	6	0
14 Pharyngitis Test *(2y-18y)*	21	3.5	1	7	2	5	5	1	9	5	7	6	1	9	6	7	3.5	1	8	3	5	4.75	1	7	4.25	5.25	20	2	0
15 ED visits *(0y-20y)*	21	7	3	9	6	8	5	1	7	3	6	6	1	9	6	8	7	2	8	3	7	6.25	3	8	5	6.75	7	14	1
16 CLABSI – NICU	22	7	4	9	6	8	7	3	9	4	8	6	1	9	5	7	7	4	9	5	7	6.38	4.5	9	5.25	7	8	13	1
17 Asthma ED visits *(2y-20y)*	20	7	4	9	6	8	6	3	8	5.5	7	6	3	9	5	7	7	4	8	6	8	6.5	4	8	5.63	7.25	6	15	1
18 ADHD Follow-Up Care *(6y-12y)*	21	7	3	9	6	8	6	2	8	5	7	6	3	9	5	7	6	2	9	5	7	6.5	3.5	8.25	5.25	7	5	17	0

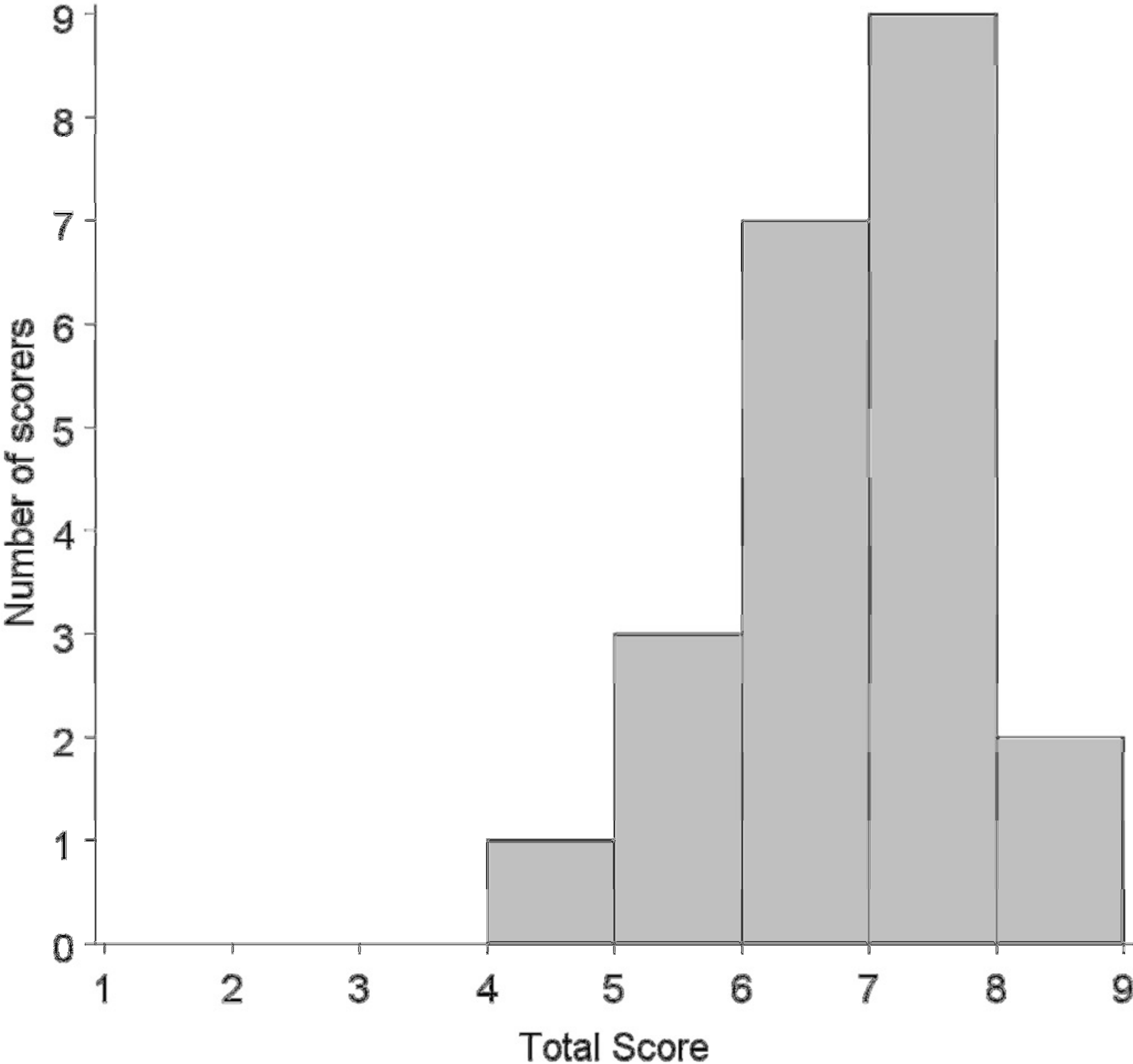
[1] For each SNAC member scoring report, the total score for a measure is a weighted average of the scores for each of the four criteria, with each criterion weighted equally.

19	Annual HbA1c *(5y-17y)*	22	5	2	9	3	7	4	3	9	4	7	5.5	2	9	5	7	5	2	8	3	6	5.25	2.5	7.75	4.25	5.5	19	3	0
20	Mental Hosp Follo-up *(6y-20y)*	22	8	5	9	7	8	6	1	8	5	7	7	4	9	6	8	7	3	9	6	8	6.75	3.25	8.75	6	7.75	1	21	0

Measure 1: Timeliness of Prenatal Care
Summary of 2013 SNAC member scores (N = 22)

	Importance	Scientific Acceptability	Feasibility	Usability	Total	Retire?
Minimum	5	5	5	3	4.75	Yes:2
25th percentile	7	6	6	6	6.25	No:20
Median	7	7	7	6.5	6.88	
75th percentile	7	7	7	7	7	
Maximum	9	8	8	9	8.5	





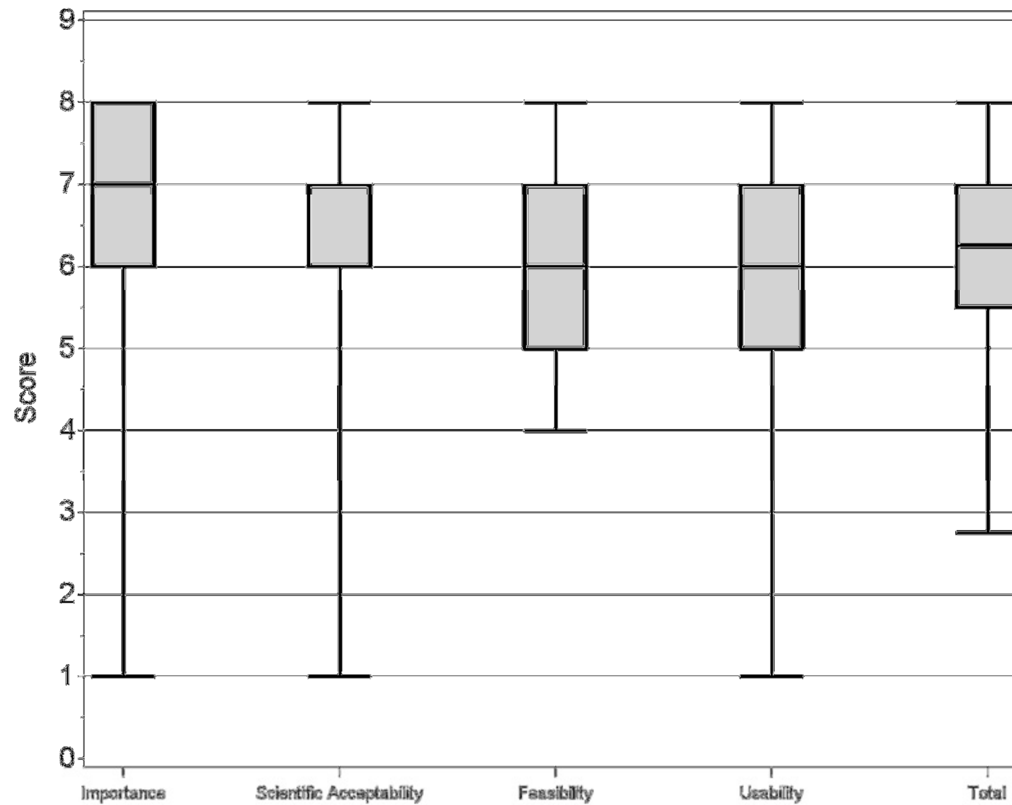
Distribution of Total Score (Measure 1)
Number of scorers
Total Score
0
1
2
3
4
5
6
7
8
9

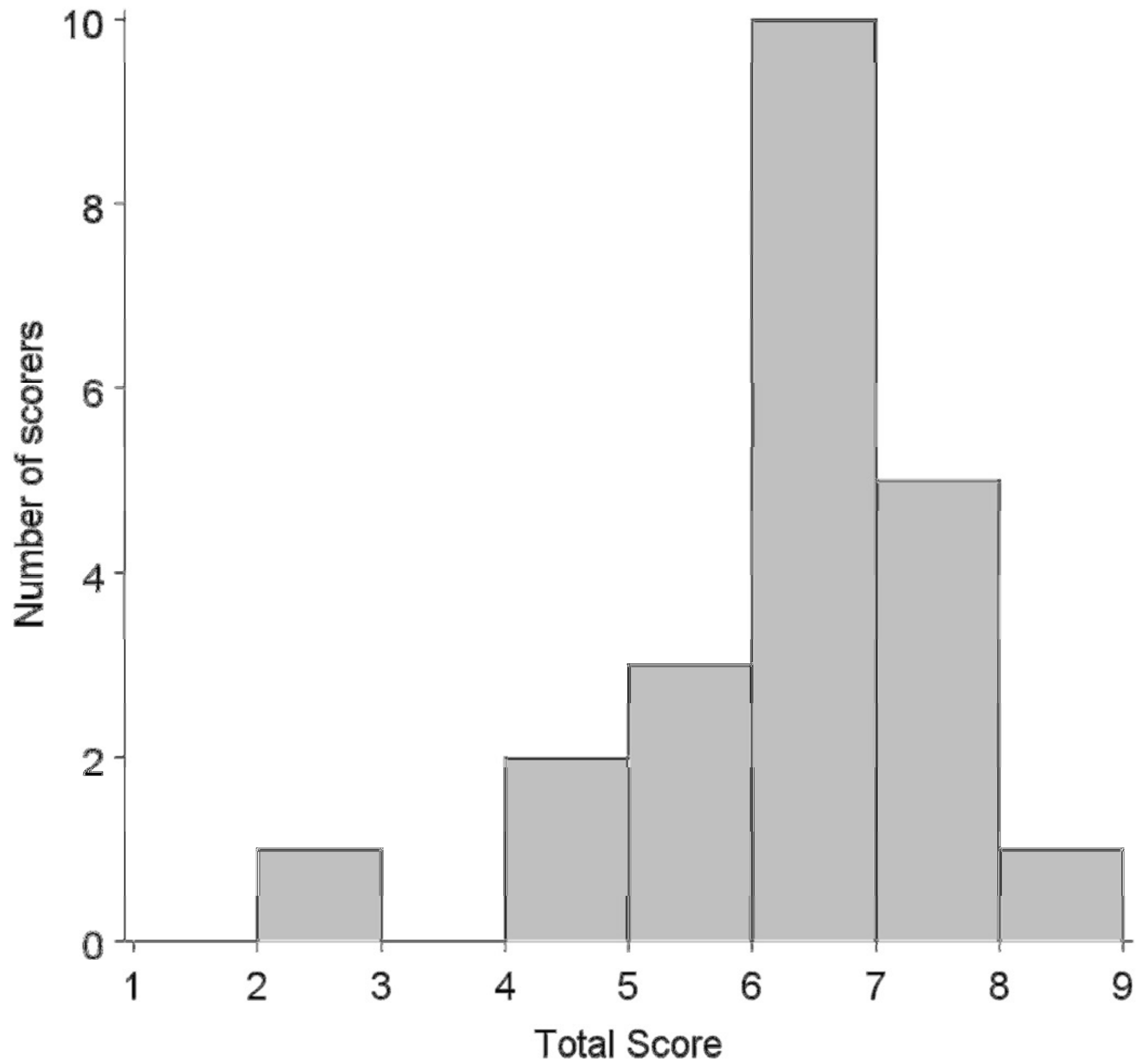
Criterion	Comment on Measure 1 : Timeliness of Prenatal Care
Importance	Important for presumptive eligibility, a systems level measure.
	Large N, and room for improvement in performance. When combined with frequency of prenatal care, seems to be a good process measure for a 'good start' for healthy kids, though content of visit seems more important to good birth outcomes than timing.
	+ performance measures.
	Evidence for focus could be better, but volume large.
	Most important for health improvement in child population overall / not just one setting.
	Prenatal care is important, how timeliness is measured is difficult.
	Greater importance with churning, exchanges.
	Barriers to insurance status.
	From discussion, appears to be important proxy for access to care, even if not good measure of quality and impact of care. Does not appear to be much evidence to support "timeliness" per se as a measure. Seems to be combined with timeliness and frequency or content of prenatal care.
	Regardless of the lack of available good studies this measure (tied to measures 2 and 3), deserves further study, and the availability of data coupled with the importance of the measure may promote better study in the future. The sizable dataset and dollars at stake identify this measure as important.
Scientific Acceptability	Ideally administrators & clinicians need a measure of timeliness that is patient-centered, not health plan-centered.
	High reliability, no data on validity.
	Mixed data.
	Excellent reliability; validity unknown.
	High reliability scores; no data on validity and concerns re: comments about what actually measuring.
	Reliability of the data is high regardless of the weakness of the reported literature.
Feasibility	States with PE [presumptive eligibility] have more timely access.
	Clear specs (HEDIS), many states used to reporting. Is costly, as requires medical record review. Measure is included on other federally-required measure lists, so states need to do this anyway.

Criterion	Comment on Measure 1 : Timeliness of Prenatal Care
	High percentage of utilization.
	A or H (does this mean sometimes A not possible?)
	Based on rate of state participation.
	Feasibility appears somewhat challenging but states' reporting is improving each year.
	State reporting appears to be increasing year over year suggesting improved feasibility though still disappointing.
Usability	Upward performance trend among states seems to imply the rate is impactable, though not a lot of great evidence on usability.
	Difficult to draw any conclusions.
	Documented efforts to improve, upward performance trend.
	Useful in MCO [managed care organization] contracts to drive quality improvement.
	Difficult to draw conclusions given data; some improvement over the years in data reporting and performance on the measure fairly good.
	Poor methodological studies to date but that does not diminish the importance of this measure.
General Comments	Recommend to measure steward timeliness of PNC based on gestational age (week 0 - 40 of pregnancy).
	When combined with the frequency measure, is the best available measure for process on prenatal care. Also, measure included in other federal sets. Vote not to retire until a measure that will assess content of prenatal care is available.
	States should be incentivized by CMS to make system improvements to capture claims/encounter data instead of vital statistics data in order to increase timely reporting for all prenatal care measures #1-#4.
	Drives improvement.
	In this context, the focus should be on enrolling pregnant women not timeliness among those enrolled.
	While content measures would be better--would continue this measure until new measures of content are developed.
	Should consider an improved measure but would not want to eliminate this focus.
	Retirement of any of measures 1, 2, or 3 diminishes the importance of the other two. I feel these are linked and still vitally important given the US ranking on infant mortality.

Measure 2: Frequency of Prenatal Care
Summary of 2013 SNAC member scores (N = 22)

	Importance	Scientific Acceptability	Feasibility	Usability	Total	Retire?
Minimum	1	1	4	1	2.75	Yes:5
25th percentile	6	6	5	5	5.5	No:17
Median	7	6	6	6	6.25	
75th percentile	8	7	7	7	7	
Maximum	8	8	8	8	8	



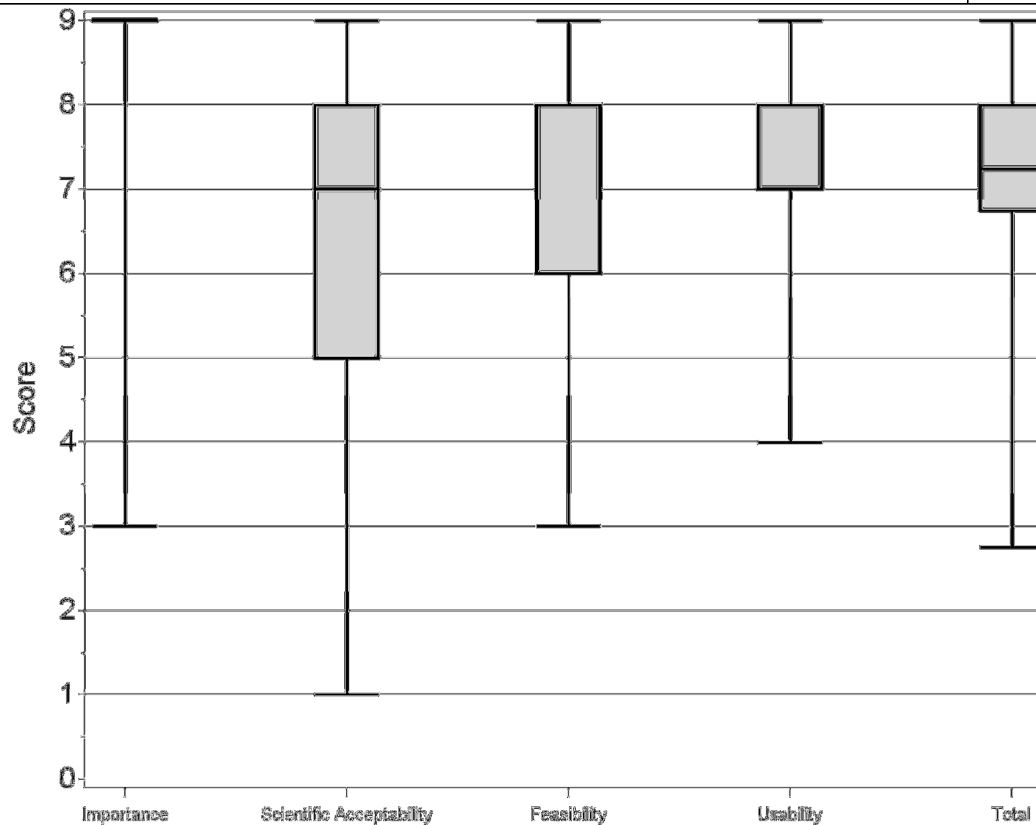

Distribution of Total Score (Measure 2)
Number of scorers
10
8
6
4
2
0
1
2
3
4
5
6
7
8
9
Total Score

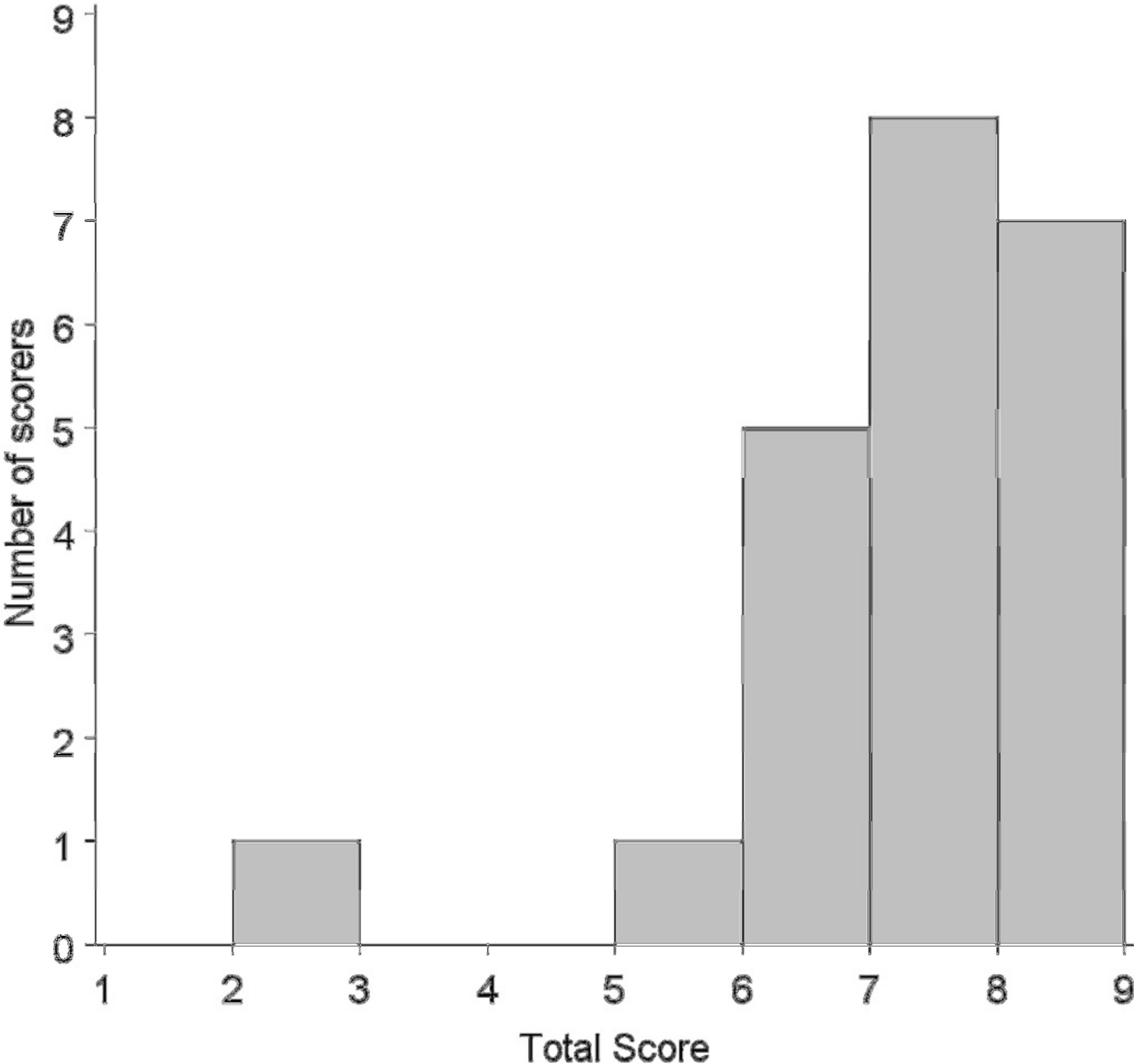
Criterion	Comment on Measure 2 : Frequency of Prenatal Care
Importance	Frequency is a measure of utilization, appropriate or not. It is connected to pregnancy outcomes.
	Large N, and room for improvement in performance. When combined with frequency of prenatal care, seems to be a good process measure for a 'good start' for healthy kids, though content of visit seems more important to good birth outcomes than timing.
	+ performance measures
	Evidence for focus could be better, but volume large.
	Perhaps not as important as measure #1, but potential remains to drive improvement related to Low Birth Weight/C-Section rates.
	Greater frequency may be driven by population risk.
	Behavior change/coaching more important.
	Among states reporting mean rate only 58.7%--still large problem (and significant spread between 25th and 75th percentile).
	Similar to above re: comments re: frequency, that is, appears to be important proxy for access to care, even if not good measure of quality and impact of care. Seems to be combined with timeliness and frequency or content of prenatal care.
	Data is highly reliable within percentile categories, has an acceptable measure scientific grade and provides a very good reliability for percentile distributions. This data measure is simply waiting for the right group to study and correlate outcomes using appropriate methodology.
Scientific Acceptability	High reliability, no data on validity.
	Lack of validity data.
	Excellent reliability; validity unknown.
	Not clear tied to outcomes.
	Reliability good but no data on validity - same concern as timeliness re: what measuring.
	Very high reliability of the measure across the categories.
Feasibility	Clear specs (HEDIS), many states used to reporting. Is costly, as requires medical record review. Measure is included on other federally-required measure lists, so states need to do this anyway.
	Low percentage reporting.
	A or H.

Criterion	Comment on Measure 2 : Frequency of Prenatal Care
	Careful for states where global billing practices are common.
	Often requires chart review in Medicaid programs that bundle OB [obstetric] payments.
	Although moving upward, feasibility scores less than 50%.
	Mirrors the information from measure 1.
Usability	Upward performance trend among states seems to imply the rate is impactable, though not a lot of great evidence on usability.
	Difficult to draw any conclusions.
	Documented efforts to improve, mixed performance trend.
	Useful in MCO contracts to drive quality improvement.
	Poor methodological studies to date but that does not diminish the importance of this measure.
General Comments	When combined with the timeliness measure, is the best available measure for process on prenatal care. Also, measure included in other federal sets. Vote not to retire until a measure that will assess content of prenatal care is available.
	States should be incentivized by CMS to make system improvements to capture claims/encounter data instead of vital statistics data in order to increase timely reporting for all prenatal care measures #1-#4.
	While content measures would be better--would continue this measure until new measures of content are developed.
	I had noted in last scoring round that it might be worth considering using 1 of these 2 prenatal measures and retire the other given the concerns raised about the lack of evidence re: specificity of either of the measures and the importance of both of the measures as an indicator of access to care. In reviewing some of the other comments, it may make more sense to retire frequency but retain timing. I think having at least 1 is important but do not think it is of great value to have both given lack of supportive data.
	Should consider an improved measure that measures quality of visits but would not want to eliminate this focus.
	Retirement of any of measures 1, 2, or 3 diminishes the importance of the other two. I feel these are linked and still vitally important given the US ranking on infant mortality.

Measure 3: Low Birth Weight
Summary of 2013 SNAC member scores (N = 22)

	Importance	Scientific Acceptability	Feasibility	Usability	Total	Retire?
Minimum	3	1	3	4	2.75	Yes:1
25th percentile	9	5	6	7	6.75	No:21
Median	9	7	6	7	7.25	
75th percentile	9	8	8	8	8	
Maximum	9	9	9	9	9	



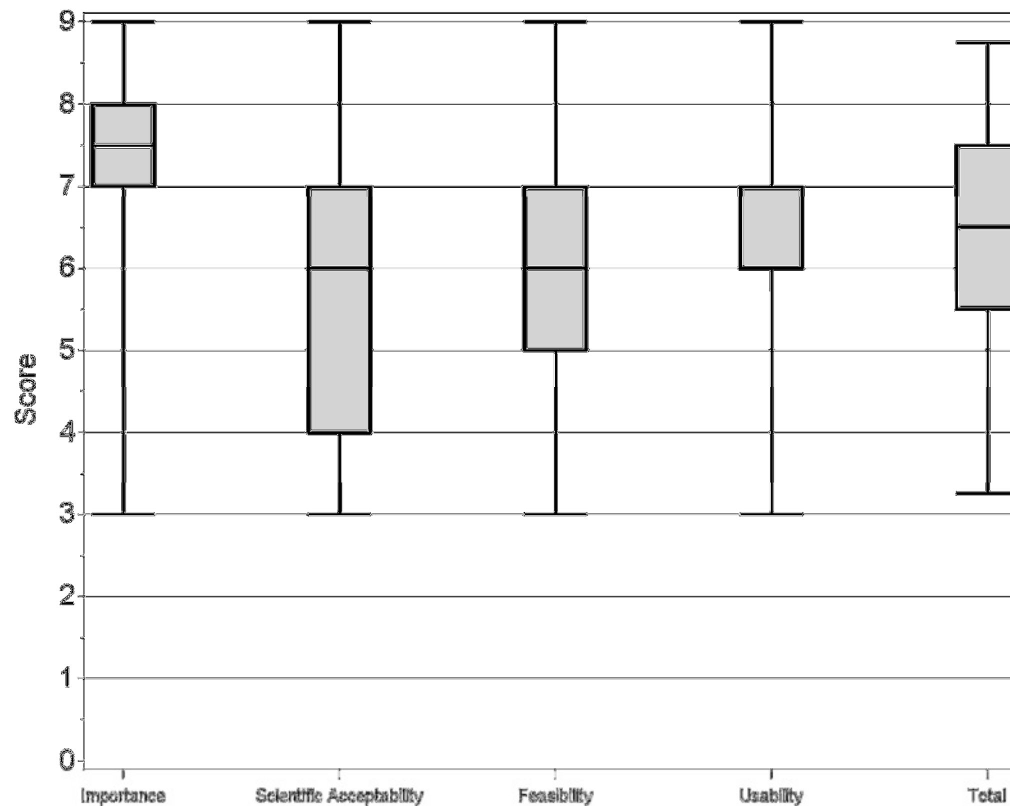

Distribution of Total Score (Measure 3)
Number of scorers
Total Score
0
1
2
3
4
5
6
7
8
9
1
2
3
4
5
6
7
8
9

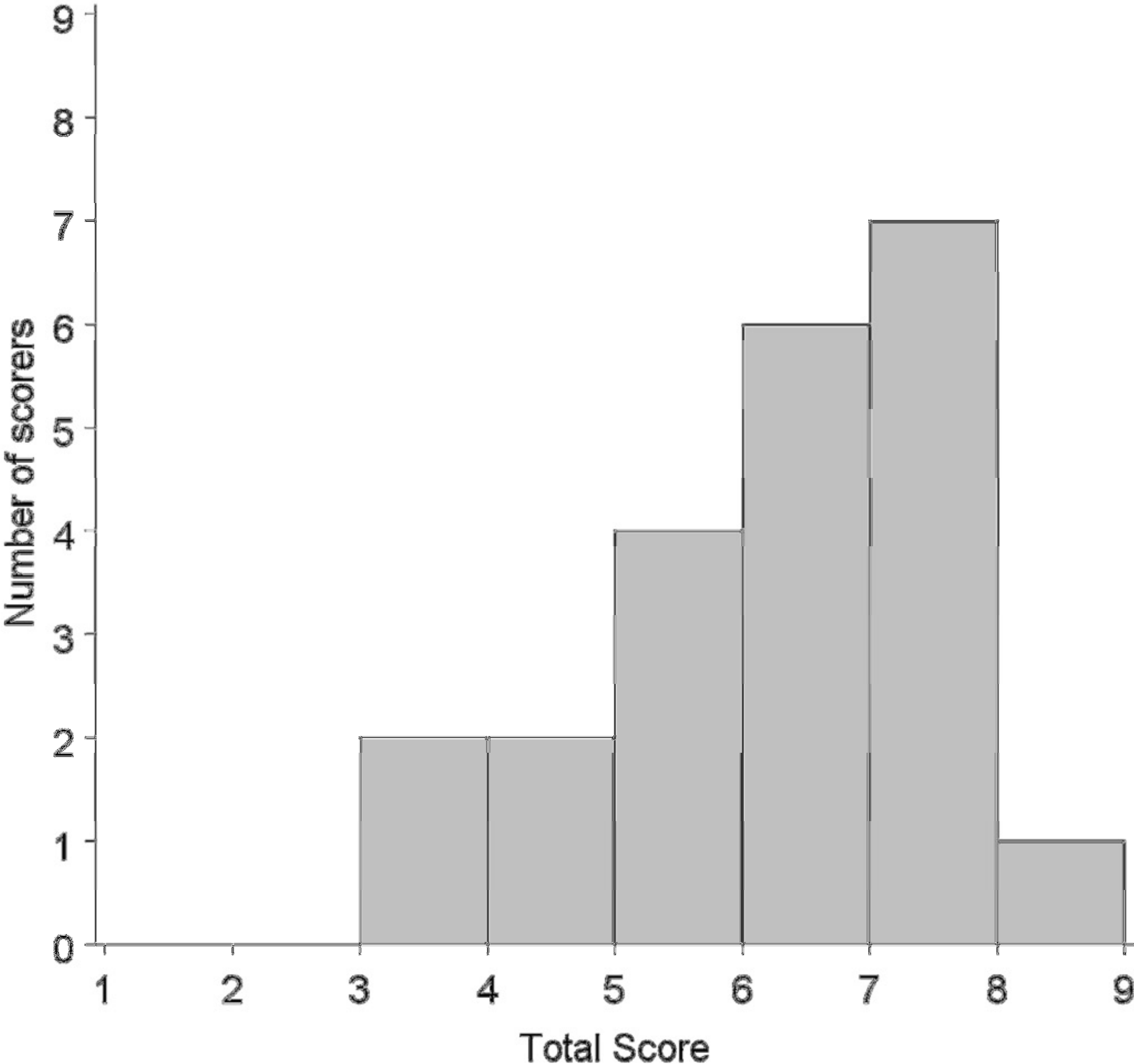
Criterion	Comment on Measure 3 : Low Birth Weight
Importance	A true health outcomes measure.
	One SNAC member noted that low birth weight is the leading cause of infant mortality, which clearly highlights the importance of this topic area. The issues impacts a large N and the data demonstrate room for performance improvement.
	Insufficient data.
	Huge cost; good evidence for focus.
	Most important for health improvement in child population overall / not just one setting.
	Outcome of importance.
	Hugely important outcomes measure.
	One of the few outcome measures!
	Major outcome for Medicaid.
	Performance extremely low but given importance of assessing, needs focus on how to improve or make easier to document.
	The importance of low birth weight correlated to infant mortality and the place it holds in reflection to the US health quality correlation overall makes this measure very important for retention.
Scientific Acceptability	Information not available on validity and reliability.
	No data.
	R unknown; V high in measure report (but unknown in summary sheet).
	Many State demonstrations driving quality improvements already.
	No risk adjustment -- important population indicator; suitable for QI but not profiling.
	Variables leading to poor outcomes are not well defined.
	Lack of data on this measure in reporting does not diminish the accuracy of the measure based on birth certificate findings and the importance of the variable.
Feasibility	With technical assistance for some states.
	This measure, though of an important clinical area, requires data that is not necessarily easy to access. Often, the data, when available, is dated. Accurately reporting on this measure given current data sources, is difficult.

Criterion	Comment on Measure 3 : Low Birth Weight
	Low percentage reporting.
	V
	Depends on vital records-Medicaid matching ability.
	Feasibility issues should be overcome by efforts to link Medicaid to state vital statistics offices.
	Often requires hospital chart review.
	Regardless of the low percentage, the evidence that states do collect this information and have it available supports the feasibility.
Usability	Impacting low birth weight is multi-factorial, and therefore, difficult to impact. However, as one SNAC member noted in their comments, even a small impact is likely to have important effects.
	Insufficient data.
	Apparently highly improvable.
	Useful in MCO [managed care organization] contracts to drive quality improvement.
	Drive improvement.
	Depends on vital records-Medicaid matching ability.
	Using the methodology of Pacala and Socolow of wedge design for reducing CO2 emissions, a similar approach could be utilized to reduce low birth weight. This is supported by the data reported here.
General Comments	Though this is a difficult measure to collect, and though it is difficult to affect low birth weight, the clinical importance of this measure is clear and the measure should be retained in the measure set.
	States should be incentivized by CMS to make system improvements to capture claims/encounter data instead of vital statistics data in order to increase timely reporting for all prenatal care measures #1-#4.
	One of our only outcomes
	Retirement of any of measures 1, 2, or 3 diminishes the importance of the other two. I feel these are linked and still vitally important given the US ranking on infant mortality.

Measure 4: C-Section NPSV
Summary of 2013 SNAC member scores (N = 22)

	Importance	Scientific Acceptability	Feasibility	Usability	Total	Retire?
Minimum	3	3	3	3	3.25	Yes:5
25th percentile	7	4	5	6	5.5	No:17
Median	7.5	6	6	6	6.5	
75th percentile	8	7	7	7	7.5	
Maximum	9	9	9	9	8.75	



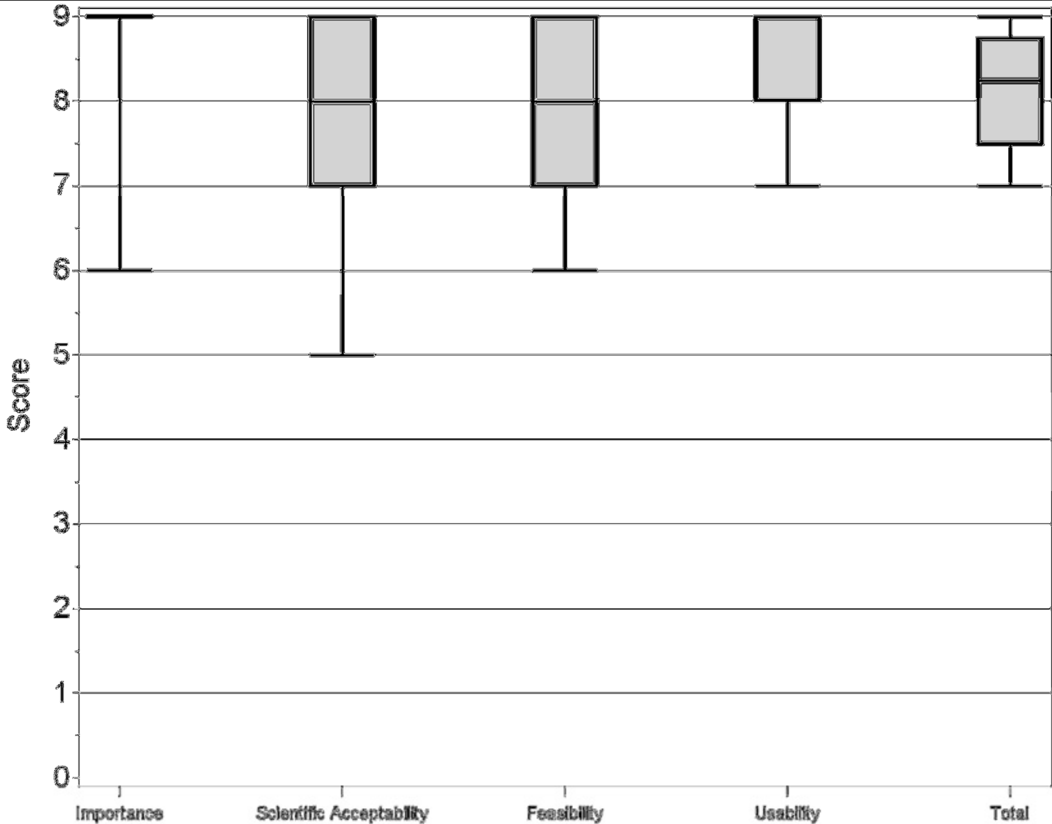

Distribution of Total Score (Measure 4)
Number of scorers
0
1
2
3
4
5
6
7
8
9
1
2
3
4
5
6
7
8
9
Total Score

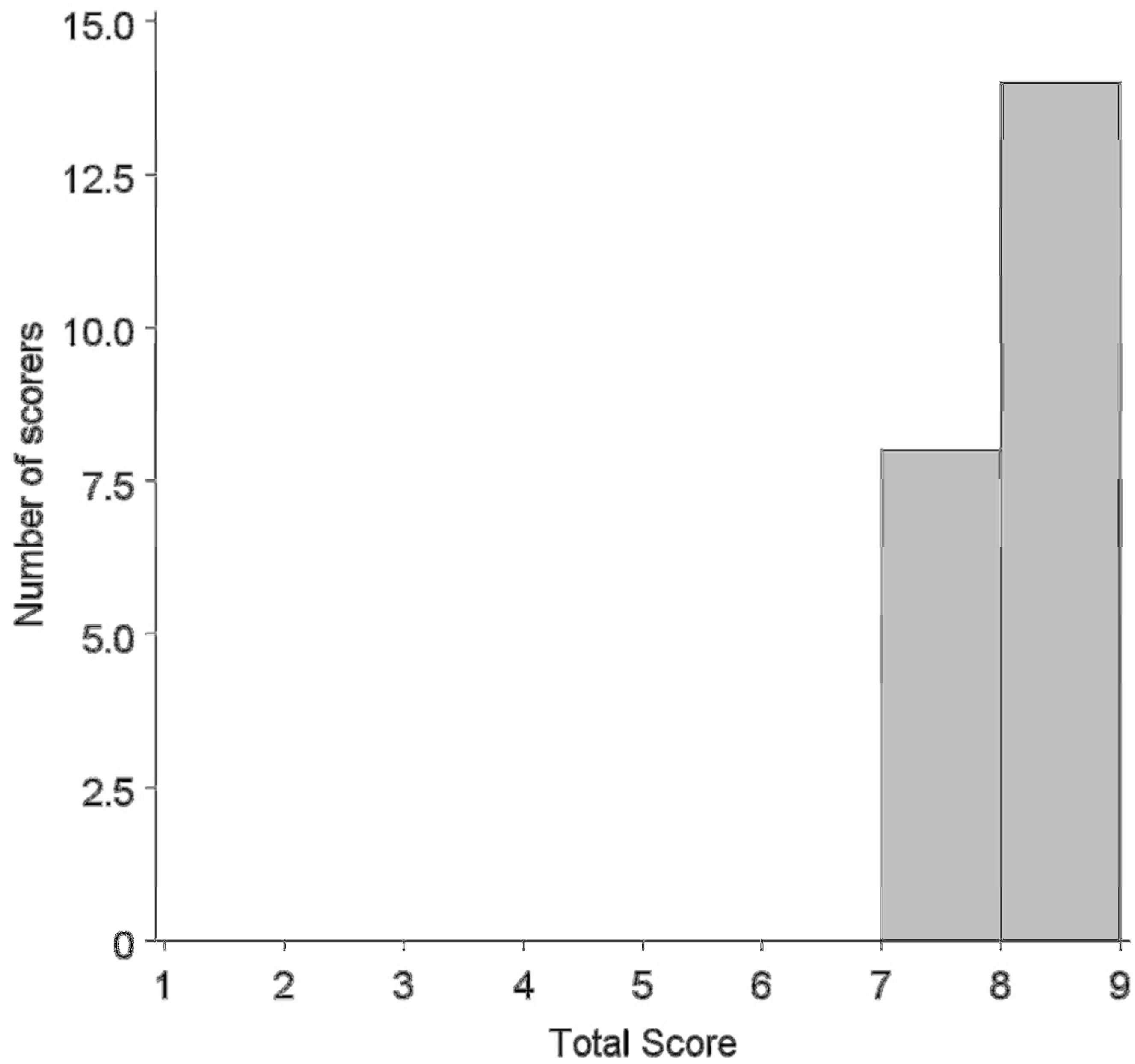
Criterion	Comment on Measure 4 : C-Section NPSV
Importance	A measure of potential harm/waste.
	High cost, and safety issue, when C-sections are done more than necessary.
	Low performance.
	Good evidence; likely large cost implications.
	Most important for health improvement in child population overall / not just one setting.
	Very good measure of most of the variation in cesarean section rates (NTSV--term, singleton, vertex).
	Too many complicating factors. Once we get payment equalized - vaginal delivery vs. C-section, this will go away.
	High cost problem but performance data low as is reporting data.
	Though the rate may be linked to some of the features in 1-3, the data are insufficient to draw good conclusions. The number at risk, the impact financially and the number of states that look at this as a QBR [“quarterback rating”] give some support for this measure but it may belong in the OB-GYN rather than in pediatrics.
Scientific Acceptability	No data available on reliability and one noted question on validity.
	Insufficient data.
	Seems to be disagreement.
	Many State demonstrations driving quality improvements already.
	Needs risk adjustment.
	No risk adjustment -- lots of exclusions; what is the right rate?
	No data available so hard to score.
	The validity of the rate based on the lack of risk adjusted features is problematic and questions the role of this measure.
Feasibility	This measure, though of an important clinical area, requires data that is not necessarily easy to access. Often, the data, when available, is dated. Accurately reporting on this measure given current data sources, is difficult.
	Low percentage reporting.
	V
	Depends on vital records-Medicaid matching ability.

Criterion	Comment on Measure 4 : C-Section NPSV
	Feasibility issues should be able to be overcome with efforts to link vital statistics to administrative data.
	Often requires hospital chart review.
	Although reporting trend is upward, it is quite low.
	Because of the reliability of the ICD-9 (and soon to be 10) CM codes it should remain highly feasible to collect and report.
Usability	Not great data on the ability to impact C-section rates, but logically, seems to be impactable, at least through payment mechanisms that provide disincentives.
	Insufficient data.
	Actions to improve underway, but evidence for improvability lacking.
	Useful in MCO [managed care organization] contracts to drive quality improvement.
	Despite the ease of coding correlation, it is poorly reported with very [word missing] states giving results.
General Comments	Use until C-section rates are <15% or handled differently in payment reform. Then consider post-partum visit measure to connect to inter-conception care.
	SNAC member comments and votes on whether or not to retain this measure are mixed. This is a measure that is difficult to collect, and to impact, and that it might be better to measure other things, such as C-sections before 39 weeks, or to look at evidence of post-partum visits. However, there seems to be agreement that the clinical area being measured is important, and this measure aligns with the HP [health plan] goals. Given that the messages are mixed, my vote is not to retire at this point (though would like future SNACs to consider substituting a different measure for this one).
	States should be incentivized by CMS to make system improvements to capture claims/encounter data instead of vital statistics data in order to increase timely reporting for all prenatal care measures #1-#4.
	Might be better served by focusing on scheduled C-sections before 39 weeks.
	Will become more important for states in reducing variation.
	For QI, would not worry too much about lack of risk adjustment; May not be suitable for comparisons/profiling; Would keep measure to help improvement and caution against comparisons without risk adjustment.
	Would be improved upon if risk adjusted.
	Although there would be good value in correlation between prenatal care and C-section rates the data sets are so poorly reported and existing publication methodologies so bad it suggests that this measure may be costing more resources than it provides useful data.

Measure 5: Child Immunization Status (2y)
Summary of 2013 SNAC member scores (N = 22)

	Importance	Scientific Acceptability	Feasibility	Usability	Total	Retire?
Minimum	6	5	6	7	7	Yes: 0
25th percentile	9	7	7	8	7.5	No: 21
Median	9	8	8	9	8.25	No response: 1
75th percentile	9	9	9	9	8.75	
Maximum	9	9	9	9	9	



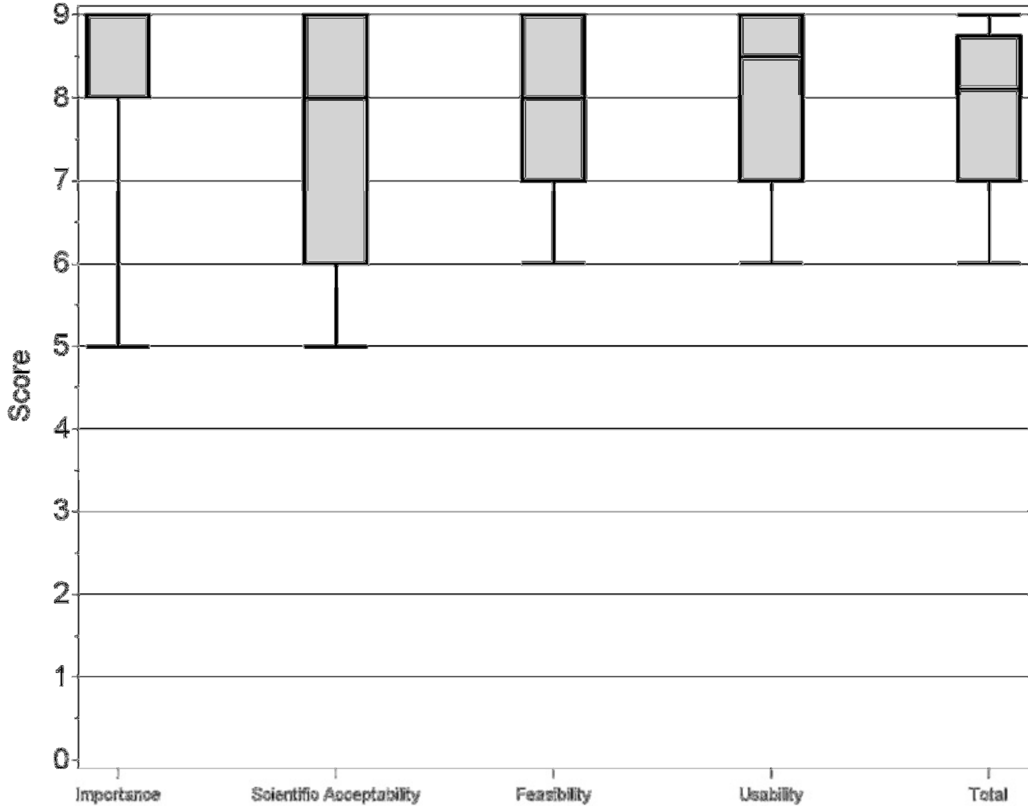

Distribution of Total Score (Measure 5)
Number of scorers
15.0
12.5
10.0
7.5
5.0
2.5
0
1
2
3
4
5
6
7
8
9
Total Score

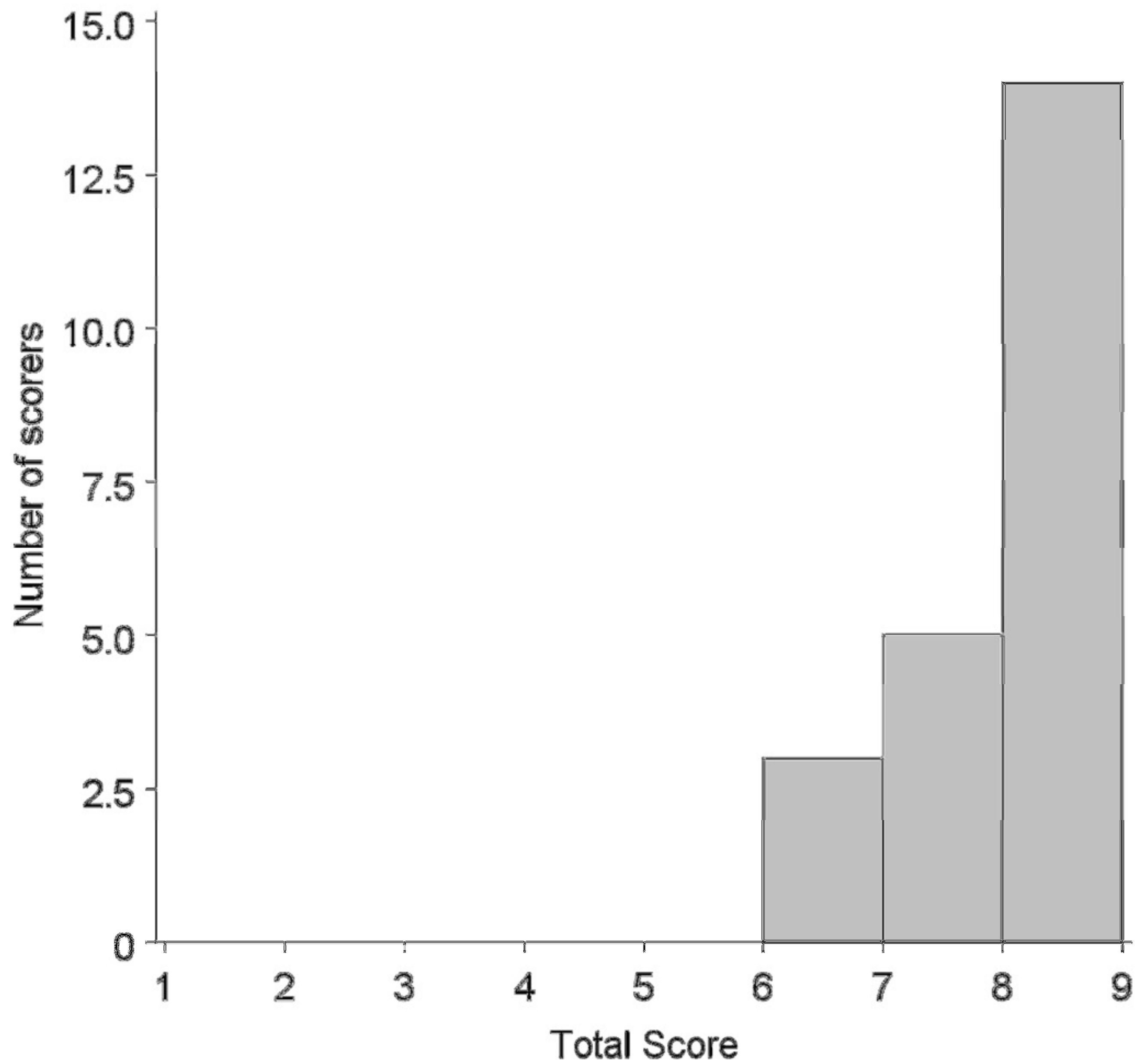
Criterion	Comment on Measure 5 : Child Immunization Status (2y)
Importance	Large N, room for improvement in performance and important public health issue.
	High performance, low cost.
	Massive public health impact.
	Most important for health improvement in child population overall / not just one setting.
	Public health success.
	Remains important for protection of overall population.
	High evidence grade and performance been fairly high consistently, though increasing.
	Immunizations remain the cornerstone of preventative care and the huge difference in societal costs burden between immunized and non-immunized relates to the importance of this variable. Until such time as > 90-95% of all children under 2 are hitting this measure it should be retained.
Scientific Acceptability	High reliability, no data on validity.
	Fair.
	Excellent reliability; validity unknown.
	Reliability high; no validity data.
	High percentage of states with large numbers of children suggest the scientific feasibility for this core measure should remain high.
Feasibility	Specifications well understood, many states reporting now. Measure is expensive to collect in universal distribution states, as it requires medical record review.
	Percentage of states reporting increasing.
	A or H.
	Issue with coding and administrative burden at provider levels.
	Percentage reporting increasing.
	Most states have reporting mechanisms for this and measurement using EMR in the future should improve reporting.
Usability	Good evidence that rates are improvable, and measure aligns well with other federal measure sets.
	Rates are improvable.

Criterion	Comment on Measure 5 : Child Immunization Status (2y)
General Comments	Improvable and improving. Useful in MCO [managed care organization] contracts to drive quality improvement. Strong evidence that rates are improvable. Excellent evidence to use the data for performance improvement. Important for monitoring basic public health access; disparities. Systems can feedback the information to drive improvement. Given the importance of this clinical issue, and the fact that this measure is feasible to collect, and very actionable, my vote is to retain this measure. CMS should encourage CDC to work with Medicaid on data improvement strategies. Important measure but perhaps potential for every other year reporting due to relatively high performance that has been fairly consistent, i.e., compared to adolescent immunization where performance has not been as consistently good. Will remain a key core measure for the foreseeable future in my mind- too much at risk until the population herd immunity is so high that these diseases disappear.

Measure 6: Adolescent Immunization Status (13y)
Summary of 2013 SNAC member scores (N = 22)

	Importance	Scientific Acceptability	Feasibility	Usability	Total	Retire?
Minimum	5	5	6	6	6	Yes: 1
25th percentile	8	6	7	7	7	No: 21
Median	9	8	8	8.5	8.13	
75th percentile	9	9	9	9	8.75	
Maximum	9	9	9	9	9	



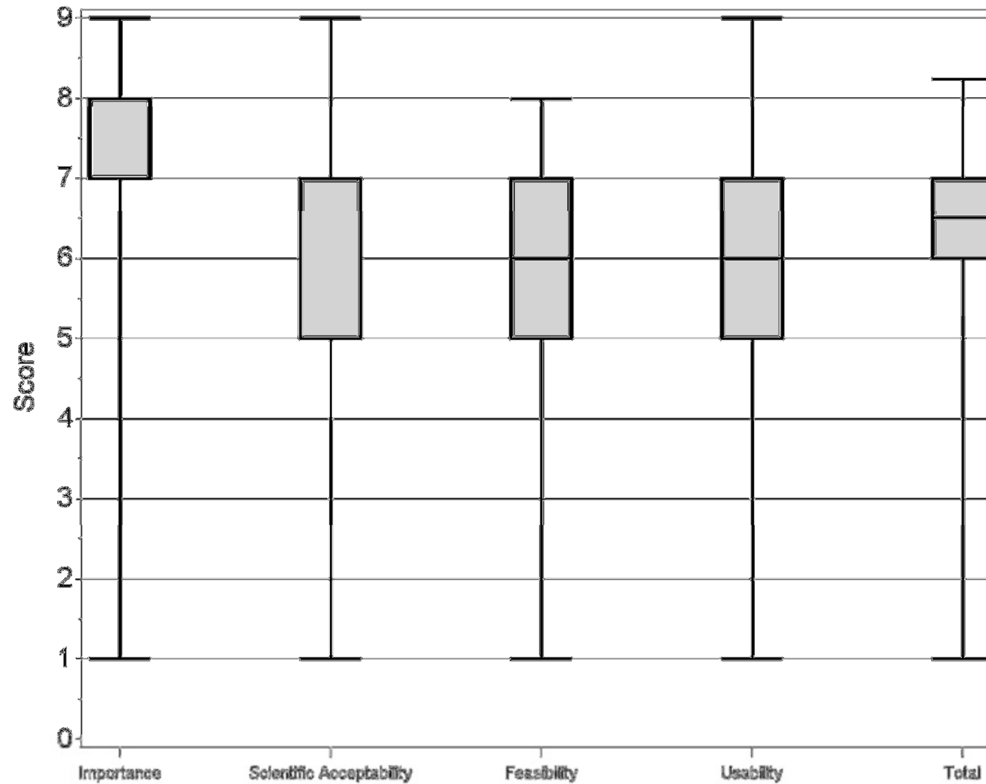

Distribution of Total Score (Measure 6)
15.0
12.5
10.0
7.5
5.0
2.5
0
Number of scorers
1
2
3
4
5
6
7
8
9
Total Score

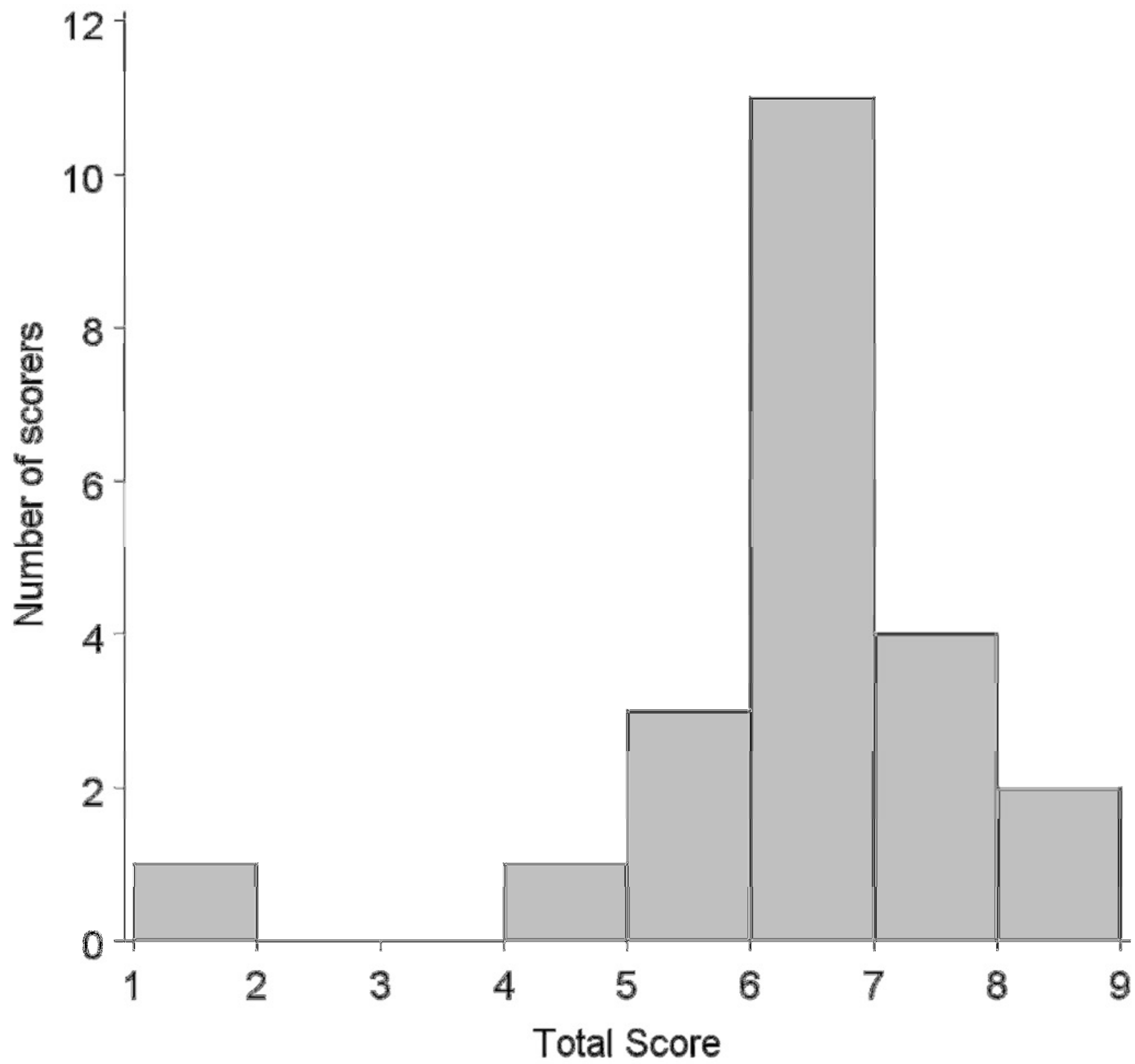
Criterion	Comment on Measure 6 : Adolescent Immunization Status (13y)
Importance	Weight without height is meaningless overtime.
	Large N, room for improvement in performance and important public health issue.
	High performance, low cost.
	Massive public health impact.
	Most important for health improvement in child population overall / not just one setting.
	Public health success.
	More challenging, but same importance as child.
	Current results show significant need for improvement.
	High evidence grade and comments that [it has] driven improvements in health plans; part of ACA coverage; since room for improvement and evidence that can improve, good to continue.
	Preventable diseases that have a high-value relationship compared to those who are non-immunized and contract the disease. Large population at risk and still ground to cover with evidence it is improving over the last few years.
Scientific Acceptability	High reliability, no data on validity.
	Mixed data.
	Excellent reliability; validity unknown.
	No validity data.
	Reliability high; not validity data.
	States have increasing percentage and the reliability scores are good (>.9).
Feasibility	Specifications well understood, many states reporting now. Measure is expensive to collect in universal distribution states, as it requires medical record review.
	Percentage of states reporting increasing.
	A or H.
	Issue with coding and administrative burden at provider levels.
	Percentage reporting steadily increasing.

Criterion	Comment on Measure 6 : Adolescent Immunization Status (13y)
	Increasing percentage of States able to have the measures reported.
Usability	Good evidence that rates are improvable, and measure aligns well with other federal measure sets.
	Improvement in rates.
	Improvable and improving.
	Useful in MCO [managed care organization] contracts to drive quality improvement.
	Consistent data re: improvement.
	Excellent evidence to use the data for performance improvement.
General Comments	Improvement opportunity.
	Given the importance of this clinical issue, and the fact that this measure is feasible to collect, and very actionable, my vote is to retain this measure.
	CMS should encourage CDC to work with Medicaid on data improvement strategies.
	The benefits of disease prevention and the ground still needed to be covered suggest the need to retain this measure. EMR should help with the data repository.

Measure 7: BMI Assessment (3y-17y)
Summary of 2013 SNAC member scores (N = 22)

	Importance	Scientific Acceptability	Feasibility	Usability	Total	Retire?
Minimum	1	1	1	1	1	Yes: 4
25th percentile	7	5	5	5	6	No: 18
Median	8	7	6	6	6.5	
75th percentile	8	7	7	7	7	
Maximum	9	9	8	9	8.25	





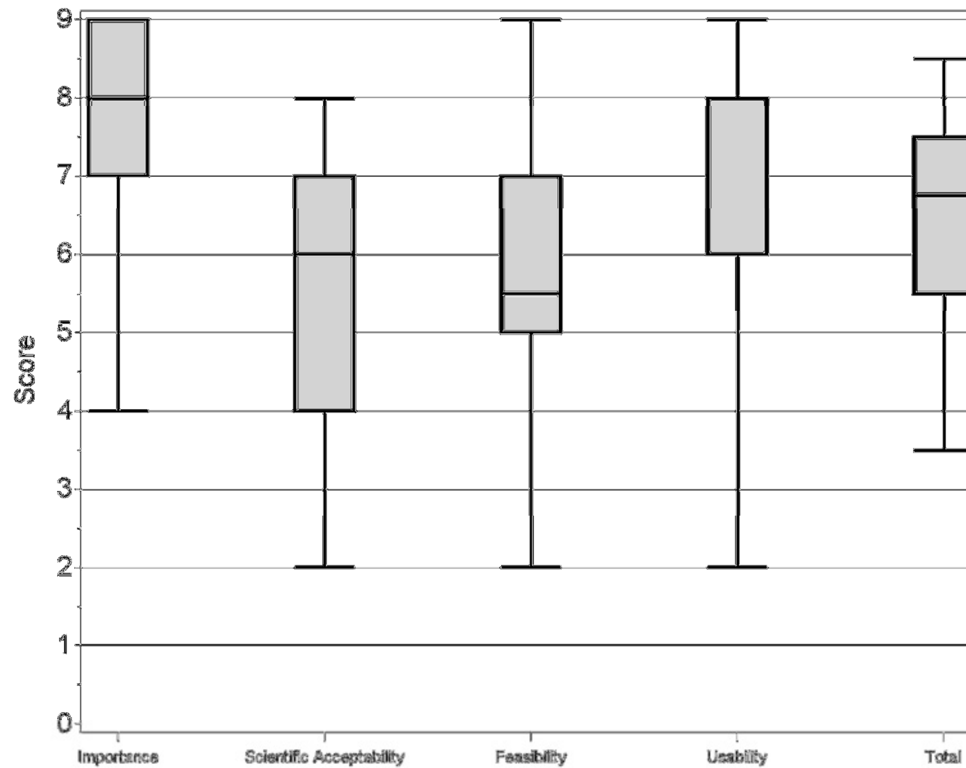
Distribution of Total Score (Measure 7)
Number of scorers
Total Score
0
2
4
6
8
10
12
1
2
3
4
5
6
7
8
9

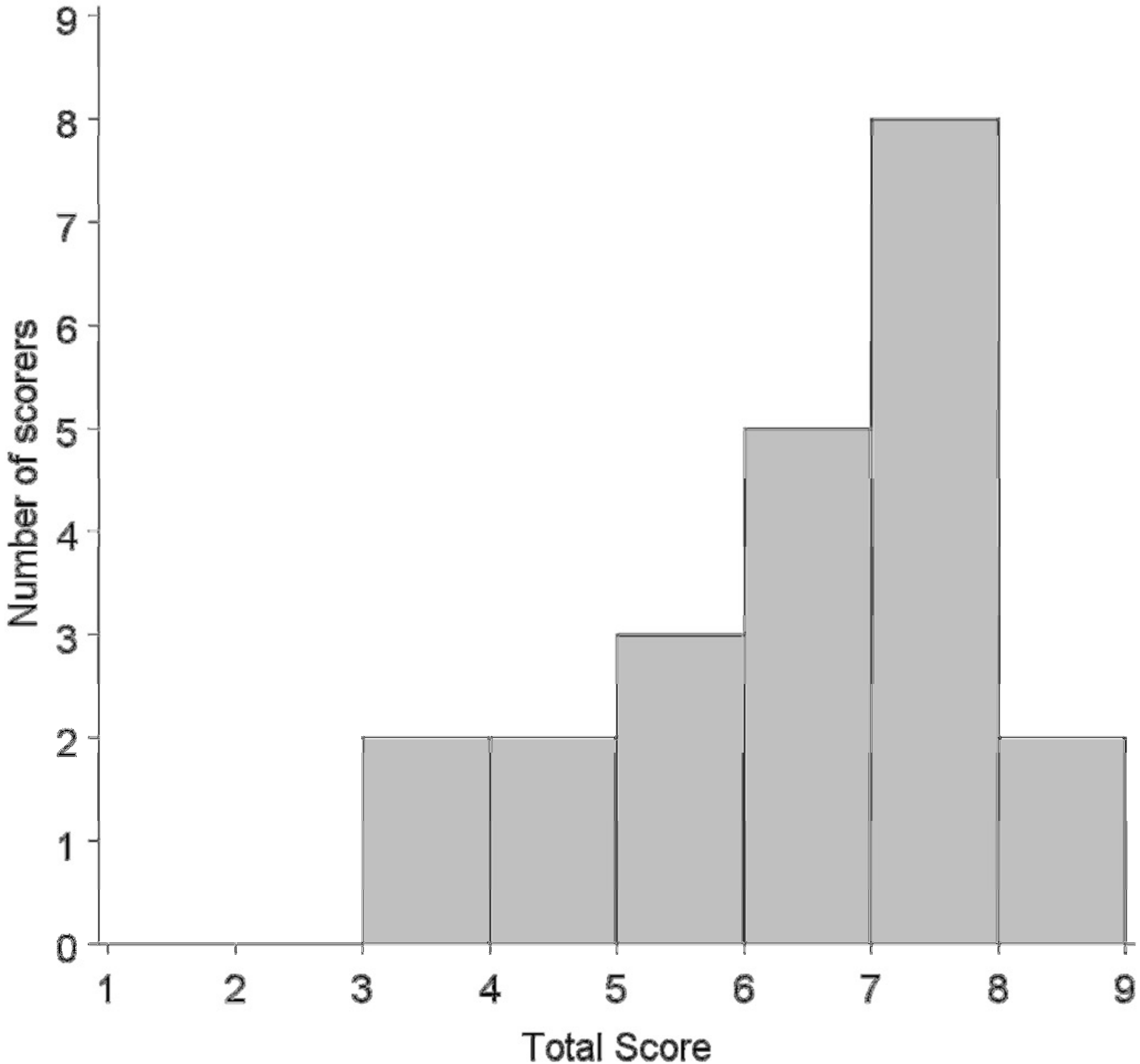
Criterion	Comment on Measure 7 : BMI Assessment (3y-17y)
Importance	The issue of obesity is a large and growing issue, particularly in the Medicaid population, and the impact of overweight on the overall health of children now and in the future is high. The data demonstrate room for improvement.
	Insufficient data.
	USPTF recommends; obesity a growing problem.
	Most important for health improvement in child population overall / not just one setting. Should be hybrid measure for greater impact
	High prevalence, disparities.
	I rank it low, because I'm not sure it’s the right measure. It has to be coupled with intervention to really be of highest importance.
	Prevalence/incidence data supports importance of focus in this area.
	Obesity and BMI are key measures for intervention assessment. The reliability of this measure, its relative importance for study and opportunity for population outcome driven research are key to its retention.
Scientific Acceptability	Measure highly reliable, no information on validity.
	Mixed data.
	Excellent reliability; validity unknown.
	Documenting only.
	There is certainly lots of increasing evidence that addressing obesity earlier than later is better, however, this one measurement is not necessarily addressing. BMI has an evidence base, but again, there is no evidence that just checking makes it better.
	Possible concern about rates being different if collect via hybrid versus only administrative claims data. EHR is probably a better source because providers may not code appropriately.
	Interventions for treatment of obesity not very effective.
	Reliability good; no validity.
	Very high reliability of the measure suggest it is a valid variable to use in study.
Feasibility	Measure specifications well understood, as they are HEDIS specs. But, the measure currently must be collected via medical record review, which is costly.
	Mixed data.

Criterion	Comment on Measure 7 : BMI Assessment (3y-17y)
	A or H.
	Requires chart review.
	Percent reporting going steadily up but still at about 53%.
	The number of states reporting is increasing yearly suggesting feasibility for reporting is getting easier. Again - as meaningful use increases this measure should be more easily obtained.
Usability	Rates seem to be improving among states reporting. Logically, it seems possible to impact BMI assessment (similar to the ability to impact immunization, or other components of a well-visit) One SNAC member points out that assessing BMI will not result in decreased obesity rates, but assessment of obesity level is a necessary first step in supporting improvement in obesity rates.
	Emerging evidence is promising.
	Improvable and improving.
	Useful in MCO [managed care organization] contracts to drive quality improvement.
	EMR.
	Emerging evidence.
	EMR use can and will increase the feasibility and usability of this measure going forward.
General Comments	Am in favor of keeping BMI (but not the prior weight measure without height/context).
	I agree with the tenor of the SNAC member comments indicate that though there is room for improvement in this measure, that the issue of obesity is of a high level of importance, and that, for that reason, the measure should be retained.
	Need better measures.
	Very difficult for our Medicaid program to obtain, only through chart reviews, we are considering working with the public school system to obtain this information in Louisiana.
	Replace it with a more meaningful measure or couple it with a forced intervention measure.
	While outcome measures of obesity (e.g., BMI) would be better--would continue this measure until new measures are developed.
	[Yes response] only because of importance, otherwise I would retire this.
	There is still so much work to do and the impact on obesity will likely be across multiple interventions so measurement will be of value to these studies and core measure outcomes in the future.

Measure 8: Developmental Screening (1y-3y)
Summary of 2013 SNAC member scores (N = 22)

	Importance	Scientific Acceptability	Feasibility	Usability	Total	Retire?
Minimum	4	2	2	2	3.5	Yes: 4
25th percentile	7	4	5	6	5.5	No: 18
Median	8	6	5.5	8	6.75	
75th percentile	9	7	7	8	7.5	
Maximum	9	8	9	9	8.5	




Distribution of Total Score (Measure 8)
Number of scorers
Total Score
0
1
2
3
4
5
6
7
8
9
1
2
3
4
5
6
7
8
9

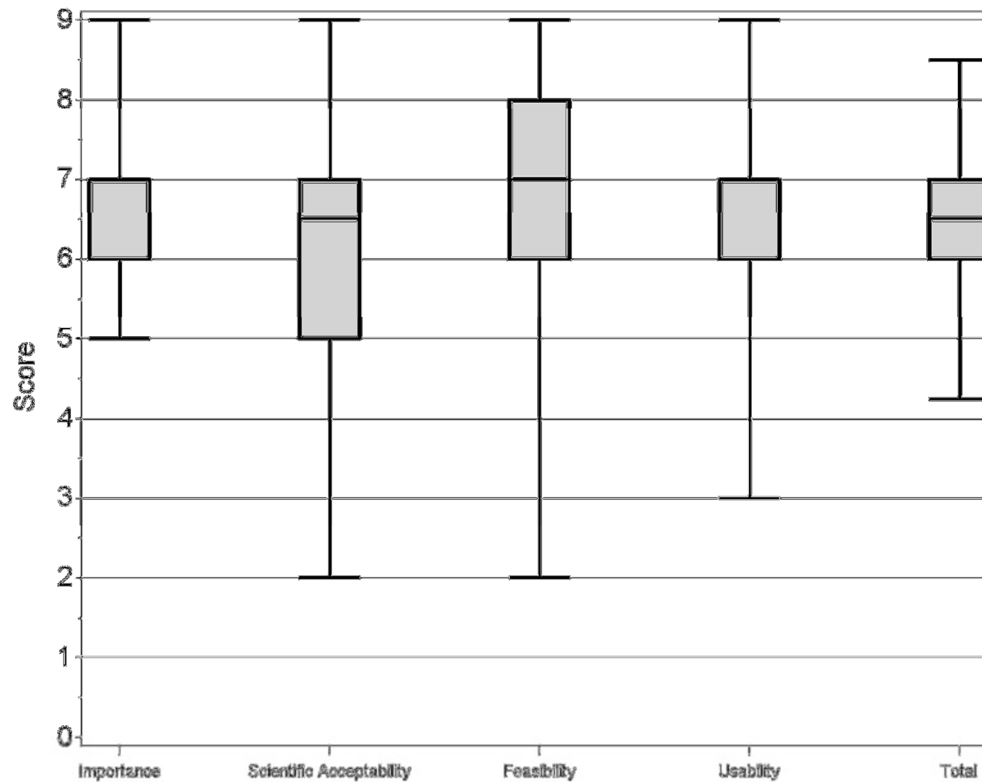
Criterion	Comment on Measure 8 : Developmental Screening (1y-3y)
Importance	The importance depends upon context (prevalence/population) subsequent action taken (appropriate referrals & follow-up).
	Large number of children in this age group insured by Medicaid, and developmental issues are a large and growing concern in the Medicaid population. The data shows room for improvement.
	Limited data, poor performance.
	Good evidence; big potential for impact through early intervention.
	Most important for health improvement in child population overall / not just one setting. Should be hybrid measure for greater impact.
	Hard to think this is missed.
	Current results show significant need for improvement.
	Important screening area but performance fairly low and needs additional focus re: measure and integration.
	Despite difficulties in reliability, feasibility and usability the potential for this measure and the upward trend in reporting suggests retention would be appropriate.
Scientific Acceptability	False positives a problem as well.
	No data available on reliability or validity.
	Lack of data.
	SNAC members suggested that the measure definition could be improved.
	Missed screening opportunities result in late or no referrals for early intervention.
	No reliability or validity data.
	Brand new measure-- reliability should improve over time to make this a scientifically valid measurement.
Feasibility	Duplication in pediatric offices, public health, EI [early intervention], Help Me Grow, problematic with fragmented action plans.
	Measure likely requires at least some medical record review to complete it, given that the measure specs call for looking at only certain screens, therefore, it is a costly measure.
	Absence of data.
	A.

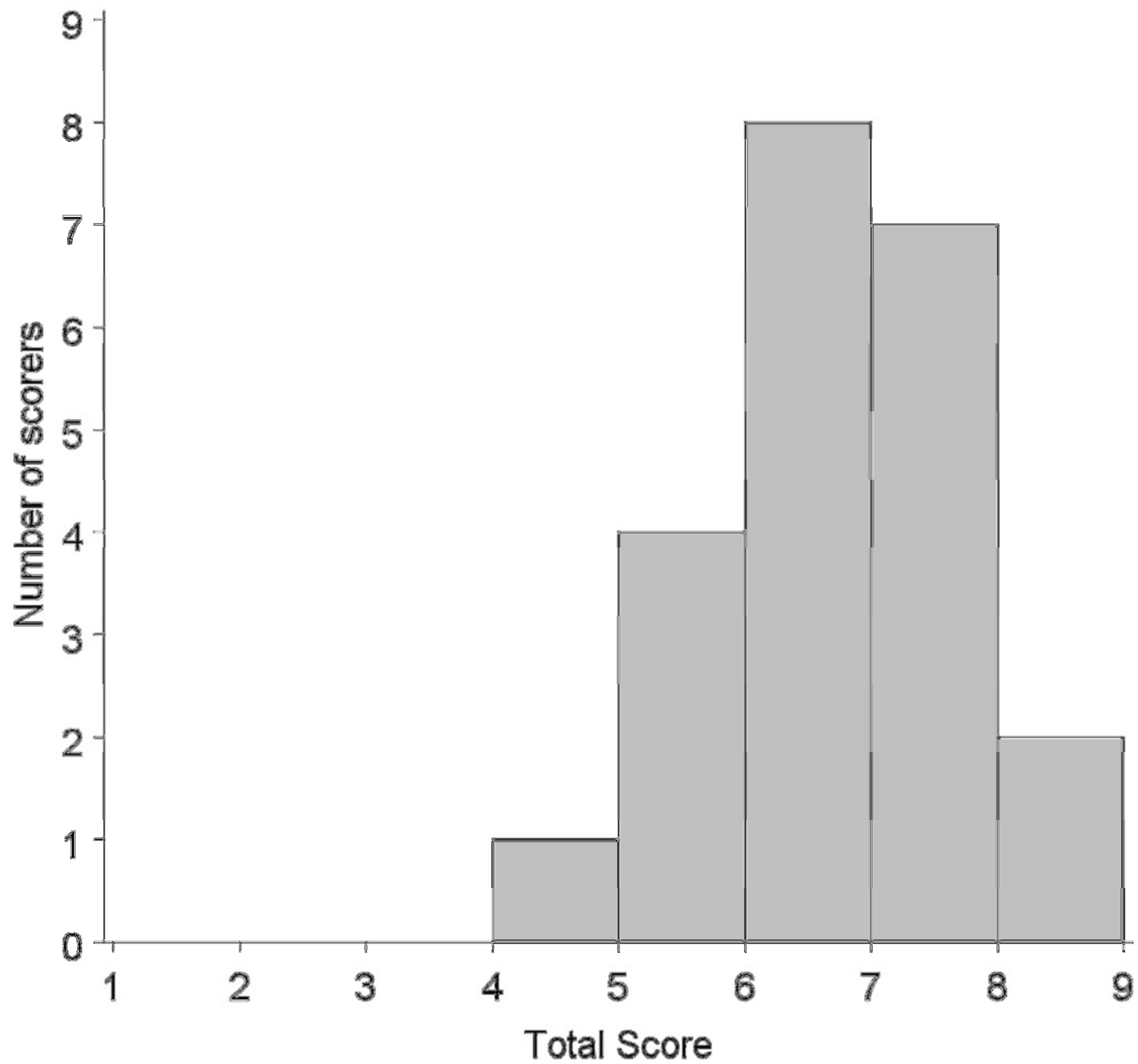
Criterion	Comment on Measure 8 : Developmental Screening (1y-3y)
	No standardized tool.
	Heard on SNANC call that this is not a priority for states, so they are not collecting this data. Also, administrative data source may not provide the necessary information on type of screening tool used.
	Requires chart review unless captured in electronic health records.
	Percent reporting on low side with some increments but small. Input from SNAC on some reasons.
	Feasibility issues have crept in due to this being a new measure and problems in the reporting structure.
Usability	The code (96110) for standardized screening applies to ADHD, and other screening not connected to development.
	This measure is very impactable, based on our experience in MA (though admittedly, this takes a lot of resources to do so).
	Mixed support.
	Efforts underway; some evidence for improvability.
	Useful in MCO [managed care organization] contracts to drive quality improvement.
	Good deal of discussion about need to link with standardized measures of assessment.
	New measure and few studies reported yet.
General Comments	May be better to drive improvement through academy of pediatrics/FP [family practice] with maintenance of certification; payment reform, PCMH standards, etc., not Medicaid.
	Given the importance of this clinical issue, and the fact that this measure is feasible to collect, and very actionable, my vote is to retain this measure, though I agree with the SNAC member's comments that an important component to consider by future SNACs is to identify measures, if available, to measure follow up on positive screens, and to measure how well the loop is closed between referral sources and PCPs [primary care providers].
	The potential positive impact of widespread developmental screening is extraordinary. This must be assessed and encouraged.
	In my State, recent audits and technical support for primary care practices by State's EPSDT program resulted in significant increases in reporting (though overall rates remain about 50% level).
	Screening done or not done has little validity since valid tool must be used, no tool(s) specified, and practices have been slow to adopt validated tools. Screening is critical - a measure that specifies validated tools would be powerful.
	While measures of follow-up after screening (receipt of appropriate services) would be better--would continue this measure until new measures are developed.

Criterion	Comment on Measure 8 : Developmental Screening (1y-3y)
	Still much work and currently reported data appears to be internally consistent suggesting some hope for future study on outcomes

Measure 9: Chlamydia Screening (16y-20y)
Summary of 2013 SNAC member scores (N = 22)

	Importance	Scientific Acceptability	Feasibility	Usability	Total	Retire?
Minimum	5	2	2	3	4.25	Yes: 5
25th percentile	6	5	6	6	6	No: 17
Median	7	6.5	7	7	6.5	
75th percentile	7	7	8	7	7	
Maximum	9	9	9	9	8.5	



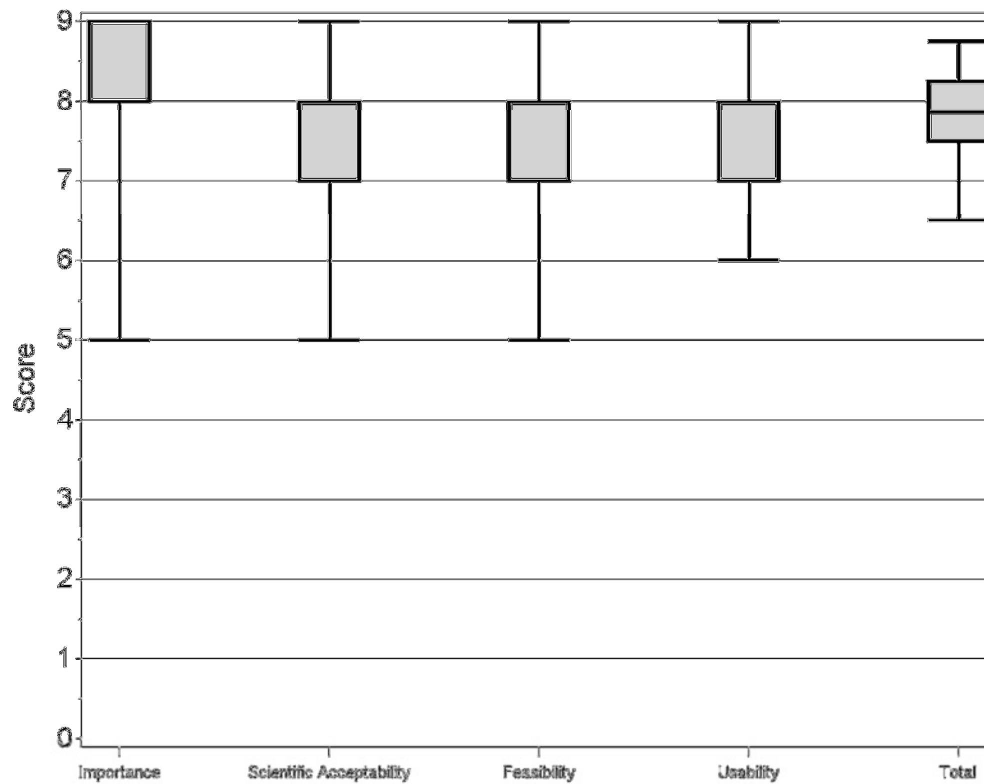

Distribution of Total Score (Measure 9)
Number of scorers
Total Score
0
1
2
3
4
5
6
7
8
9
1
2
3
4
5
6
7
8
9

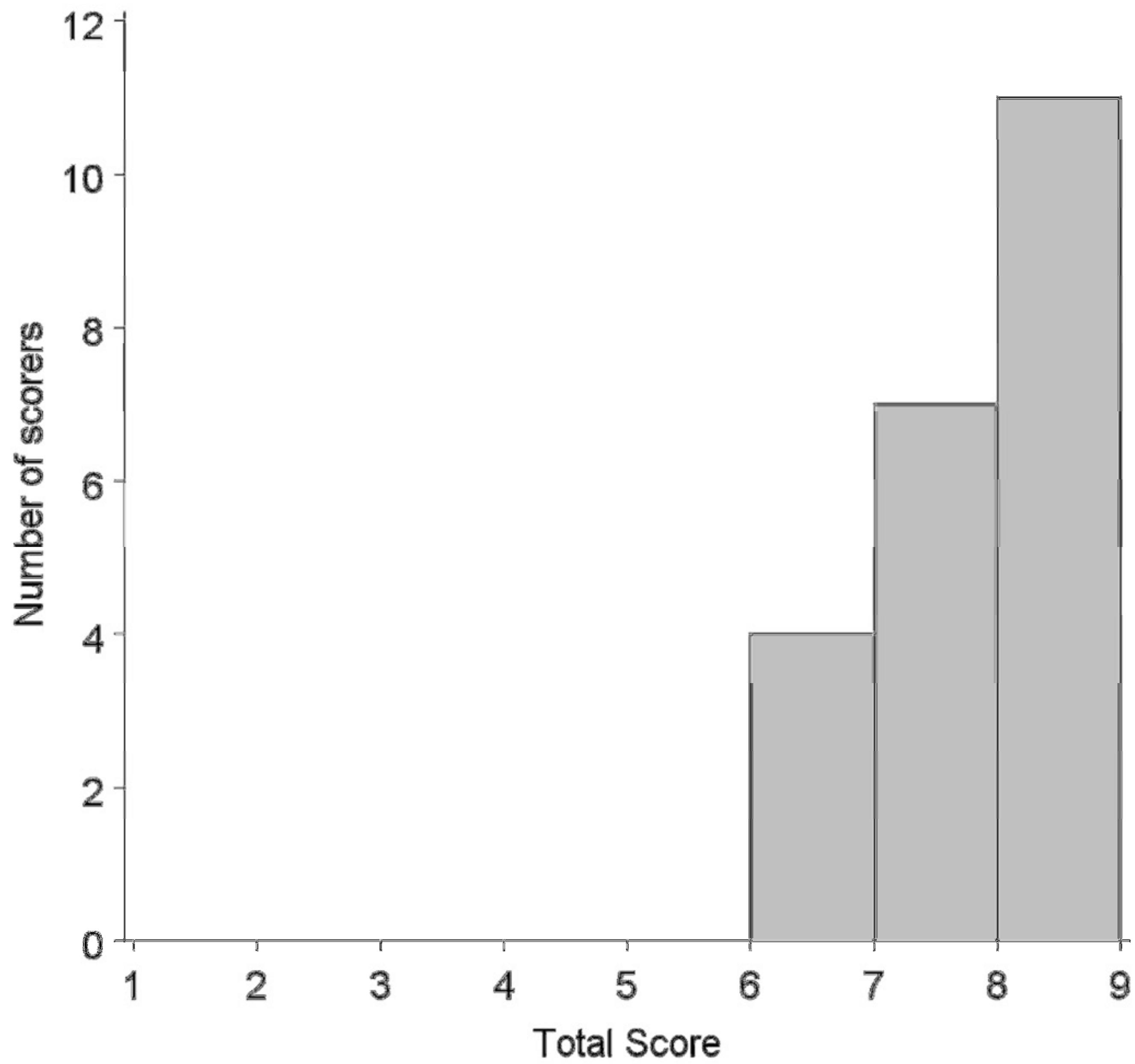
Criterion	Comment on Measure 9 : Chlamydia Screening (16y-20y)
Importance	Important clinical area, is a measure that gets at the content of a well-visit agree with SNAC comments that this is the only gyn measure.
	Moderate performance measures.
	Denominator small, but important population.
	Very important indicator for adolescent health, rates extremely high in certain populations, particularly Medicaid.
	Very important in vulnerable population.
	Performance not particularly goo but evidence of potential for improvement. Agree with comment that indicator of good gyn care.
Scientific Acceptability	Good reliability, but a concern about validity.
	Mixed data.
	Some disagreement.
	Concerns about underestimating denominator and about accurate billing coding due to confidentiality.
	Very high reliability score regardless of the controversy about screening versus measurement.
Feasibility	Specifications well understood, many states reporting now. However, it is difficult to determine whether who is in the denominator (sexually active) is accurate.
	High percentage of utilization.
	A.
	Coding / Confidentiality issues.
	Know who's sex active? I question validity of this measure denominator.
	Rates gone steadily up.
	Increasing number of states reporting.
Usability	Logically, this seems impactable, and some of the evidence suggests it is impactable.
	Conflicting data.
	Mixed results; some efforts underway.

Criterion	Comment on Measure 9 : Chlamydia Screening (16y-20y)
General Comments	Good potential for improvement. Questions regarding usability of the measure. Particularly important to identify high risk HIV population. As this is a measure that is easily collectable, and aligns with other federal priorities, I am voting to retain this measure. Not clear to me that this is high importance for state in itself -- I don't think we know whether it is a broader marker of adolescent gyn care. Redundant to MCO/HEDIS reporting of 2 age bands 16-20, 21-24. Difficulties in defining the population at risk clouds the usability and-- subsequently the scientific study design.

Measure 10: Well-Child Care Visits (15m)
Summary of 2013 SNAC member scores (N = 22)

	Importance	Scientific Acceptability	Feasibility	Usability	Total	Retire?
Minimum	5	5	5	6	6.5	Yes: 1
25th percentile	8	7	7	7	7.5	No: 21
Median	8	8	8	8	7.88	
75th percentile	9	8	8	8	8.25	
Maximum	9	9	9	9	8.75	



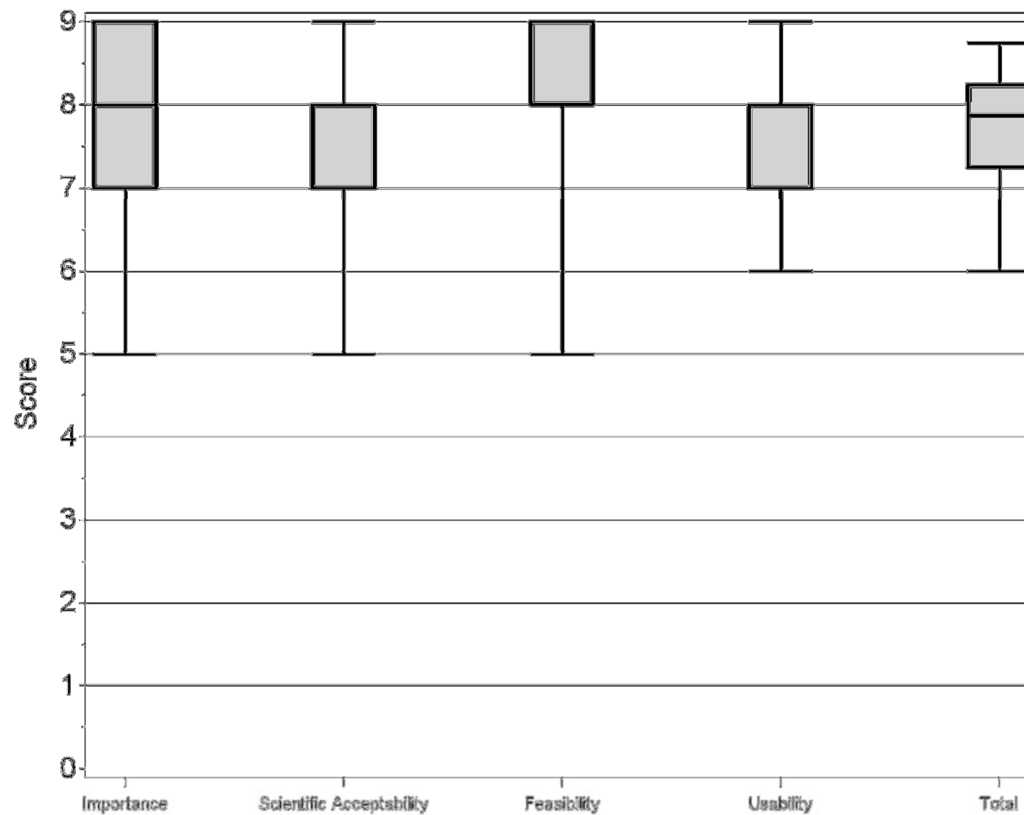

Distribution of Total Score (Measure 10)
Number of scorers
Total Score
0
2
4
6
8
10
12
1
2
3
4
5
6
7
8
9

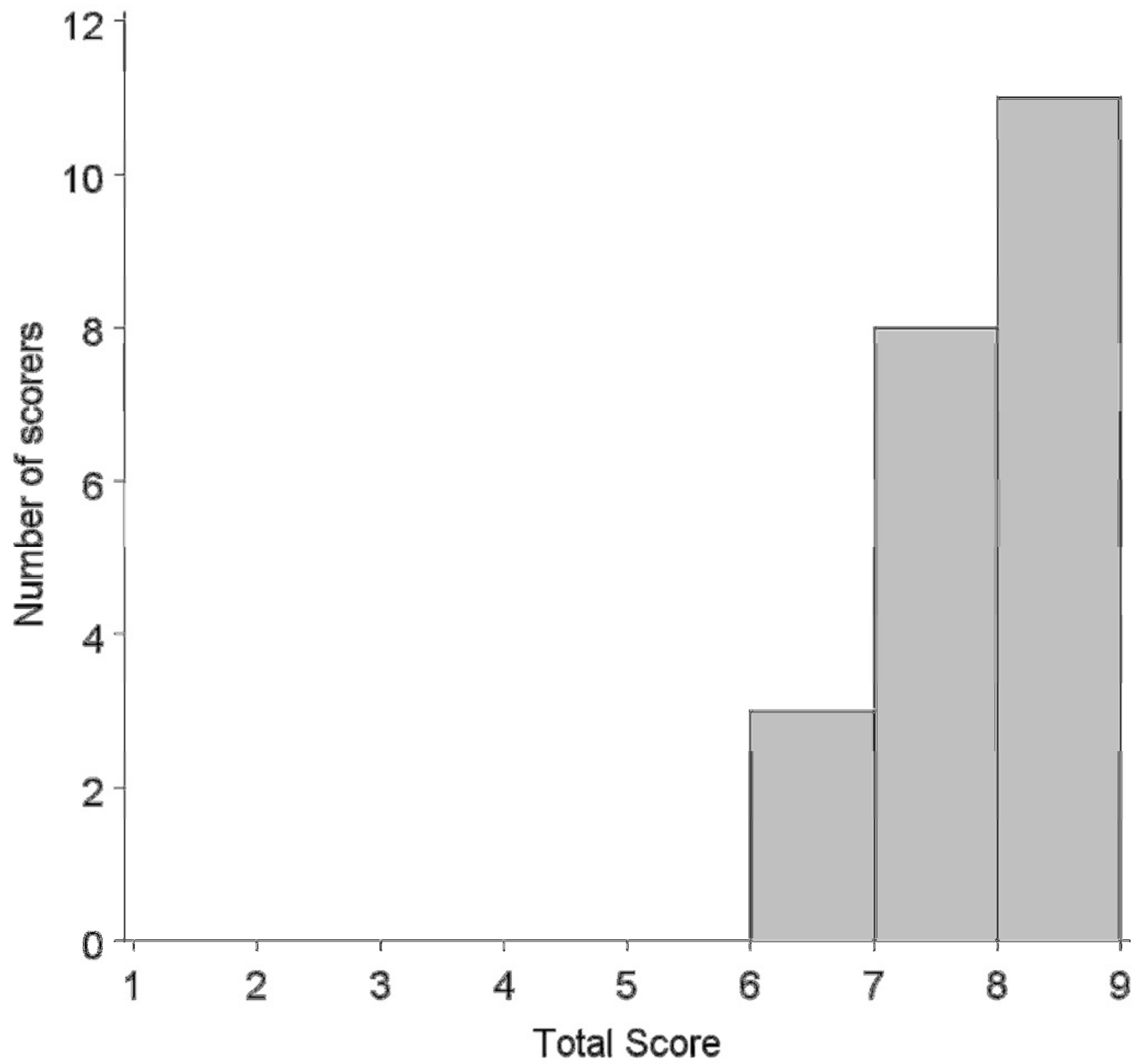
Criterion	Comment on Measure 10 : Well-Child Care Visits (15m)
Importance	Key facet of pediatric care - prevention focus. Large number of kids, and data shows room for improvement.
	Moderate performance measures.
	Well care very important.
	Most important for health improvement in child population overall / not just one setting.
	Very important measure and predictor of primary care effectiveness in the infant.
Scientific Acceptability	Excellent reliability, validity unknown.
	Good data support.
	Excellent reliability; validity unknown.
	Very high reliability scores in this group making scientific validity very high.
Feasibility	Specifications well understood, lots of states reporting.
	High percentage of utilization.
	A or H.
	Often requires chart review and complete EPSDT requirements not always met.
	Increasing trend with a large number of states reporting.
Usability	Data suggests this is a very impactable measure, and this is an area of focus for many states, given its importance to the foundation of child health – prevention.
	Randomized studies promising.
	Good evidence, many ongoing efforts.
	Useful in MCO contracts to drive quality improvement.
	Continuous eligibility requirements significantly reduce the denominator.
	Usability index is high here.
General Comments	Important for monitoring basic public health access; disparities. Systems can feedback the information to drive improvement.

Criterion	Comment on Measure 10 : Well-Child Care Visits (15m)
	Important for monitoring basic use of preventive care. Would be great if future SNACs had the ability to assess a measure that was able to look into what was happening at these well-visits. All Well Child Visit measures should be hybrid allowing for medical record reviews to assure comprehensiveness full preventive value is present (which can have different emphasis by age strata) e.g. age emphasis on developmental screening; oral health; mental health. There is no validity data for this or the other visit measures; Seems more important to keep for younger patients, where the link between process and outcomes is likely tightest. While content measures would be better--would continue this measure until new measures of content are developed. Data suggests that >6 visits correlates to better outcomes and data is robust—retain.

Measure 11: Well-Child Care Visits (3y-6y)
Summary of 2013 SNAC member scores (N = 22)

	Importance	Scientific Acceptability	Feasibility	Usability	Total	Retire?
Minimum	5	5	5	6	6	Yes: 1
25th percentile	7	7	8	7	7.25	No: 21
Median	8	8	8	8	7.88	
75th percentile	9	8	9	8	8.25	
Maximum	9	9	9	9	8.75	



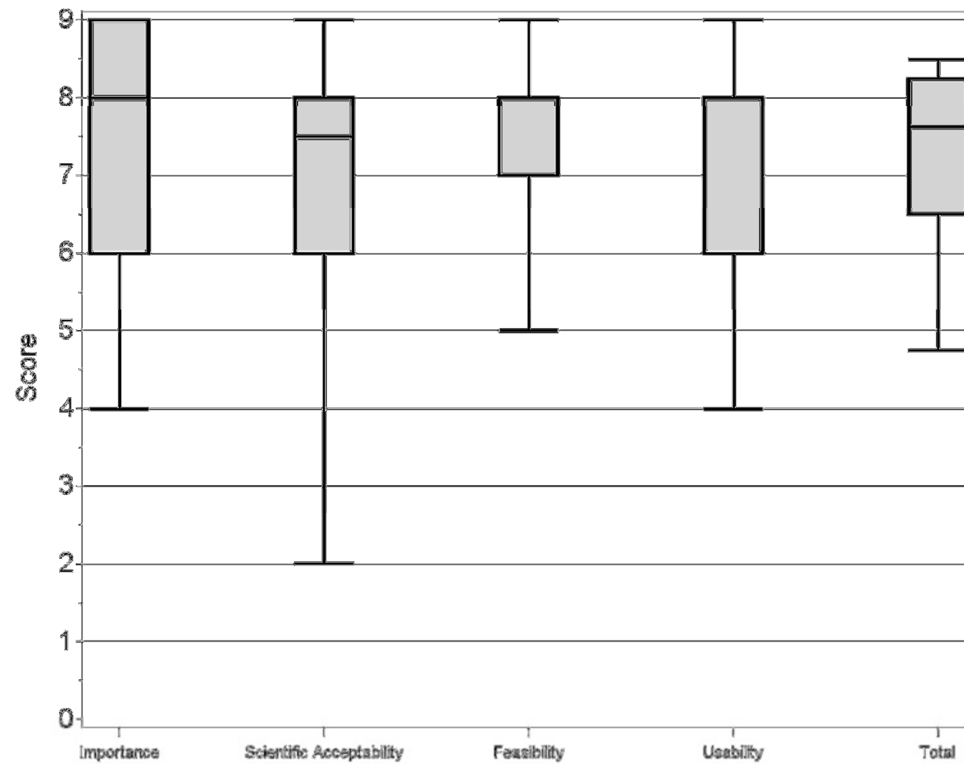

Distribution of Total Score (Measure 11)
Number of scorers
Total Score
0
2
4
6
8
10
12
1
2
3
4
5
6
7
8
9

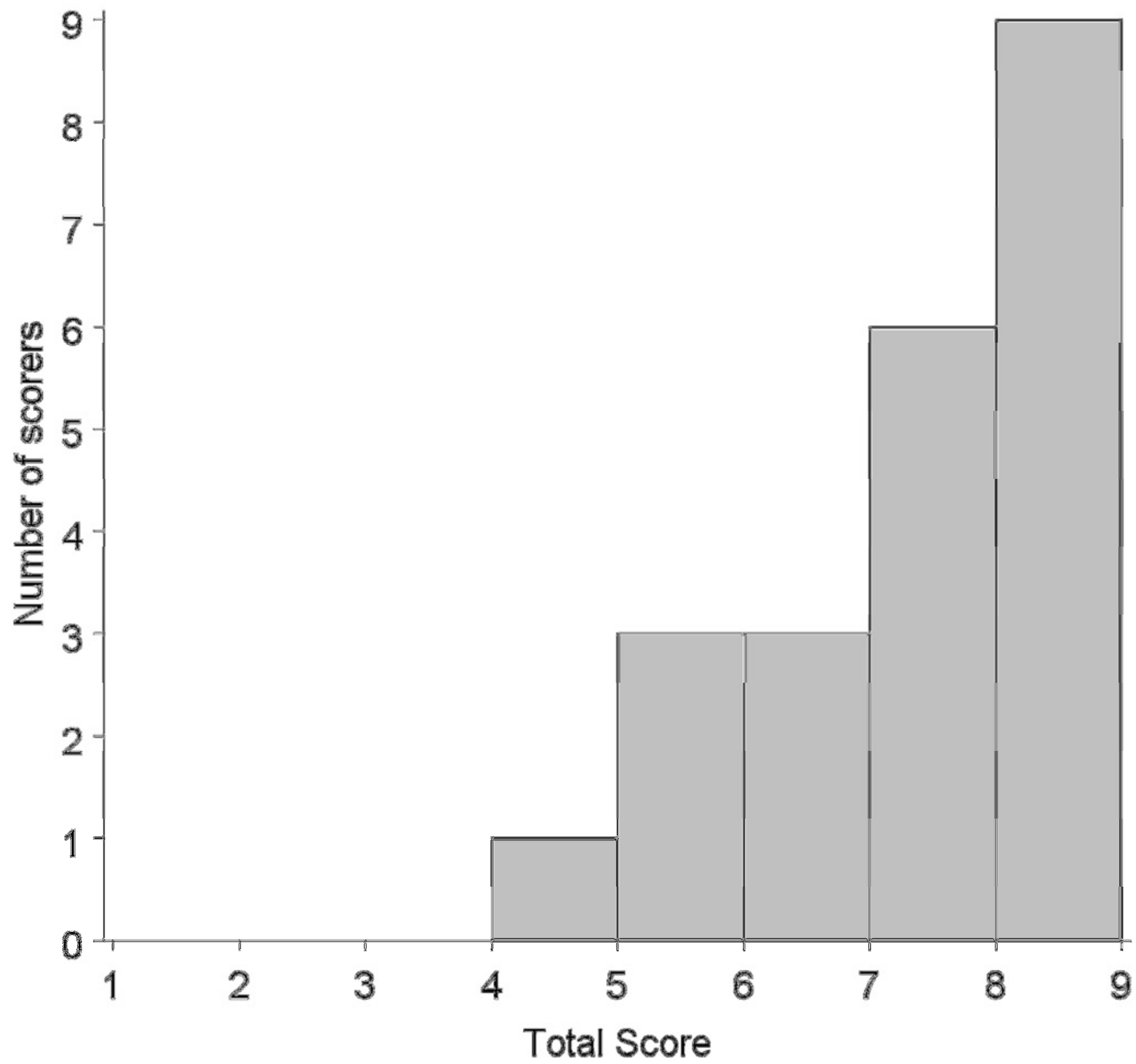
Criterion	Comment on Measure 11 : Well-Child Care Visits (3y-6y)
Importance	Key facet of pediatric care - prevention focus. Large number of kids, and data shows room for improvement.
	Mixed performance measures.
	Well care very important.
	Most important for health improvement in child population overall / not just one setting.
	See above- Very important factor for predictor of primary care.
Scientific Acceptability	
	High percentage of states.
	Excellent reliability; validity unknown.
	Very high reliability of the reporting measure.
Feasibility	Specifications well understood, lots of states reporting.
	High percentage of utilization.
	A or H.
	Often requires chart review and complete EPSDT requirements not always met.
	Good reporting and increasing trend.
Usability	Data suggest this is a very impactable measure, and this is an area of focus for many states, given its importance to the foundation of child health – prevention.
	Good evidence, many ongoing efforts.
	Useful in MCO [managed care organization] contracts to drive quality improvement.
	Continuous eligibility requirements significantly reduce the denominator.
	High index.
General Comments	Important for public health access, disparities, mental health screening & reproductive health planning.
	Important for monitoring basic use of preventive care. Would be great if future SNACs had the ability to assess a measure that was able to look into what was happening at these well-visits.

Criterion	Comment on Measure 11 : Well-Child Care Visits (3y-6y)
	All Well Child Visit measures should be hybrid allowing for medical record reviews to assure comprehensiveness full preventive value is present (which can have different emphasis by age strata) e.g. age emphasis on developmental screening; oral health; mental health. While content measures would be better--would continue this measure until new measures of content are developed. Evidence that this measure supports better outcomes and room for performance improvement.

Measure 12: Adolescent Well-Care Visits (12y-21y)
Summary of 2013 SNAC member scores (N = 22)

	Importance	Scientific Acceptability	Feasibility	Usability	Total	Retire?
Minimum	4	2	5	4	4.75	Yes: 3
25th percentile	6	6	7	6	6.5	No: 18
Median	8	7.5	8	8	7.63	No response: 1
75th percentile	9	8	8	8	8.25	
Maximum	9	9	9	9	8.5	



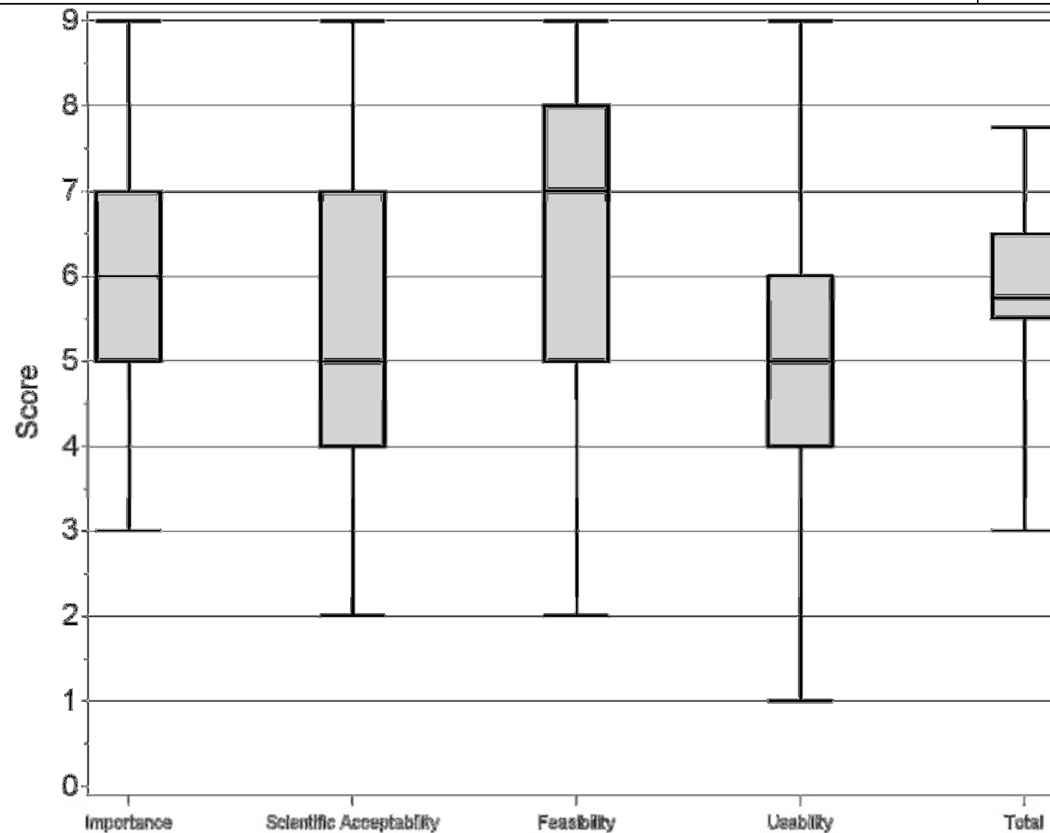

Distribution of Total Score (Measure 12)
Number of scorers
Total Score
0
1
2
3
4
5
6
7
8
9

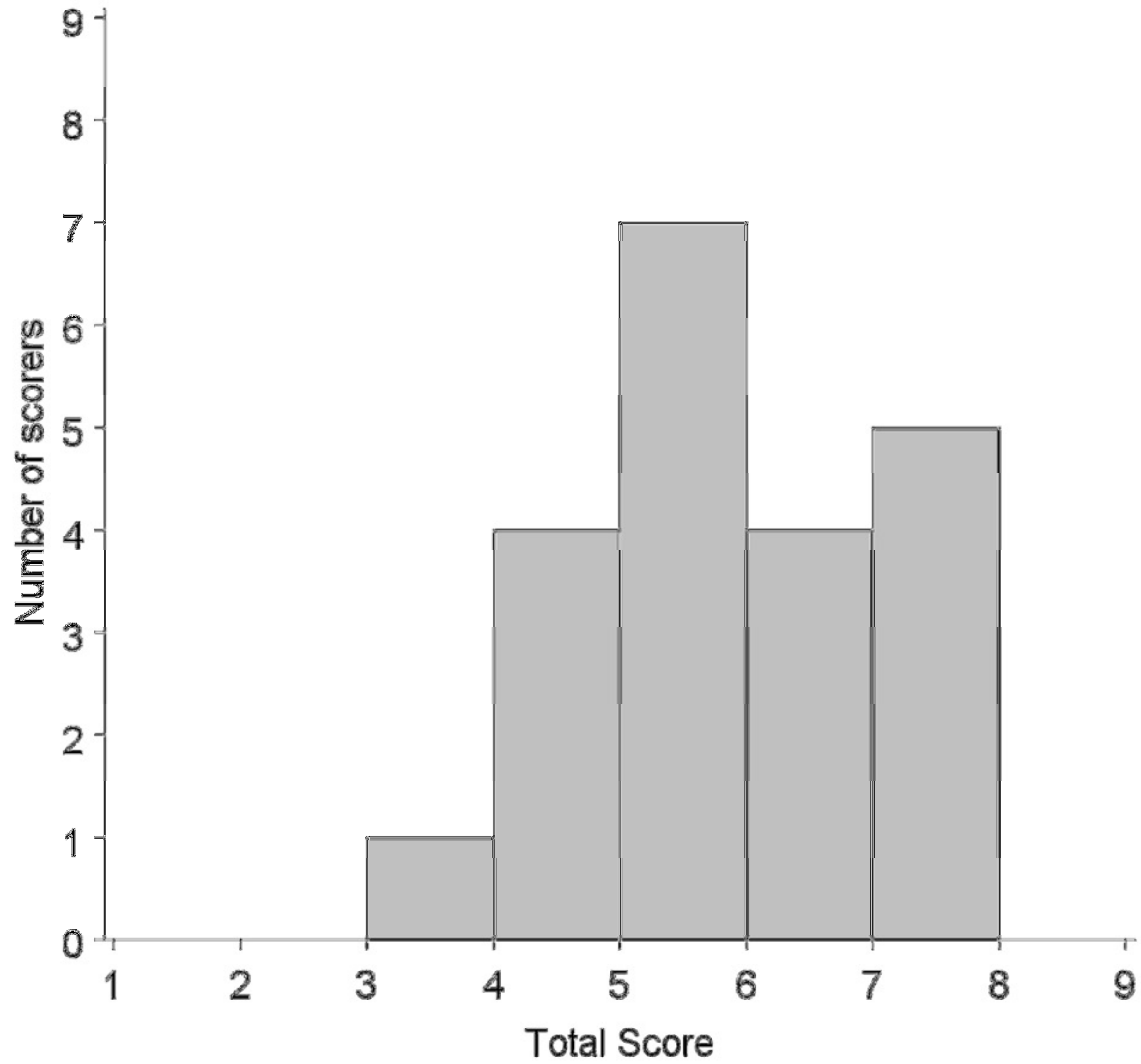
Criterion	Comment on Measure 12 : Adolescent Well-Care Visits (12y-21y)
Importance	Key facet of pediatric care - prevention focus. Large number of kids, and data shows room for improvement.
	Low performance measures.
	Well care very important.
	Most important for health improvement in child population overall / not just one setting.
	Very important to preconception health- reproductive and sexual health, one of our priority measures for managed care.
	Linked to preventive guidelines; some USPSTF recommendations; covered under ACA.
	Large number of visits, high expenditures and opportunity for improvement are high. However, reporting has not changed much in the last 3 years.
Scientific Acceptability	
	Excellent reliability; validity unknown.
	Use of claims data appears to make the reliability of the reporting very high.
Feasibility	Specifications well understood, lots of states reporting.
	High percentage of utilization.
	A or H.
	Often requires chart review and complete EPSDT requirements not always met.
	Feasibility appears to be good due to the high percentage of states reporting.
Usability	Data suggest this is a very impactable measure, and this is an area of focus for many states, given its importance to the foundation of child health – prevention.
	Only one study.
	Good evidence, many ongoing efforts.
	Useful in MCO [managed care organization] contracts to drive quality improvement.
	Continuous eligibility requirements significantly reduce the denominator.
	At least 1 rigorous US study indicating interventions can increase access. Potential for further examination with ACA.

Criterion	Comment on Measure 12 : Adolescent Well-Care Visits (12y-21y)
General Comments	At least one study that suggests payment reform can increase this number- performance improvement opportunity. Important for monitoring basic public health access; disparities. Systems can feedback the information to drive improvement, important for public health access, mental health, disparities, health screenings and reproductive health screenings. Important for monitoring basic use of preventive care. Would be great if future SNACs had the ability to assess a measure that was able to look into what was happening at these well-visits. All Well Child Visit measures should be hybrid allowing for medical record reviews to assure comprehensiveness full preventive value is present (which can have different emphasis by age strata) e.g. age emphasis on developmental screening; oral health; mental health. Access remains too much of an issue in this population. Could we have a better measure? Maybe. Need to find better ways to test. While content measures would be better--would continue this measure until new measures of content are developed. Performance improvement opportunity though the percentage is "stuck"-- meaning may be a candidate for retirement.

Measure 13: Access to Primary Care (12m-19y)
Summary of 2013 SNAC member scores (N = 21 for total score, due to one missing value)

	Importance	Scientific Acceptability	Feasibility	Usability	Total	Retire?
Minimum	3	2	2	1	3	Yes: 16
25th percentile	5	4	5	4	5.5	No: 6
Median	6.5	5	7	5	5.75	
75th percentile	8	7	8	6	6.5	
Maximum	9	9	9	9	7.75	





Distribution of Total Score (Measure 13)
Number of scorers
Total Score
0
1
2
3
4
5
6
7
8
9

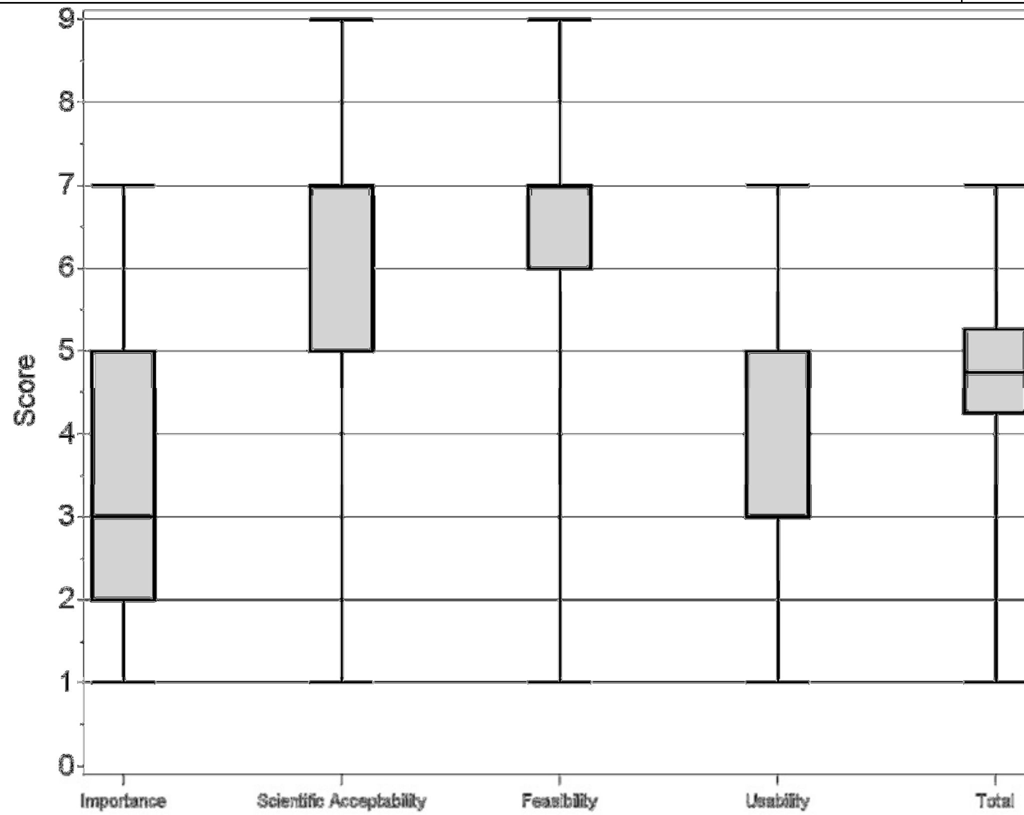
Criterion	Comment on Measure 13 : Access to Primary Care (12m-19y)
Importance	Measure has high evidence grade, and the number of kids impacted is large. However, performance is very high, and therefore not a lot of room for improvement. Also, this measure just measures contact with PCP, and not whether the visit was for well-care.
	High performance, low cost.
	This is the only measure with "A"-level evidence for focus; in principal the importance is obvious.
	Preventive visits a better measure, access can be measured through contracts with MCOs and by other means.
	Access is an important concept, but scored lower because: (1) performance already high at 89-97% and narrow IQR, (2) this is a measure of utilization, not access.
	Well child visits with specific age bands more important.
	High evidence grade - access to primary care important for children.
	Large number of visits and claims.
Scientific Acceptability	Reliability good, but no info on validity.
	High percentage of states.
	Look good on paper, but SNAC (me included) was concerned that this is more a measure of utilization than access, and may not give info distinct from measure #10,11,12.
	Complex measure.
	Major issue is that it measures utilization and not access – there are other better measures of access.
	High reliability; no validity data.
	Extremely high reliability.
Feasibility	Most states are reporting, measure specs are standardized (HEDIS measure).
	High percentage of utilization.
	A.
	Easy to measure.
	High percentage reporting.
	High feasibility with large number of states reporting.

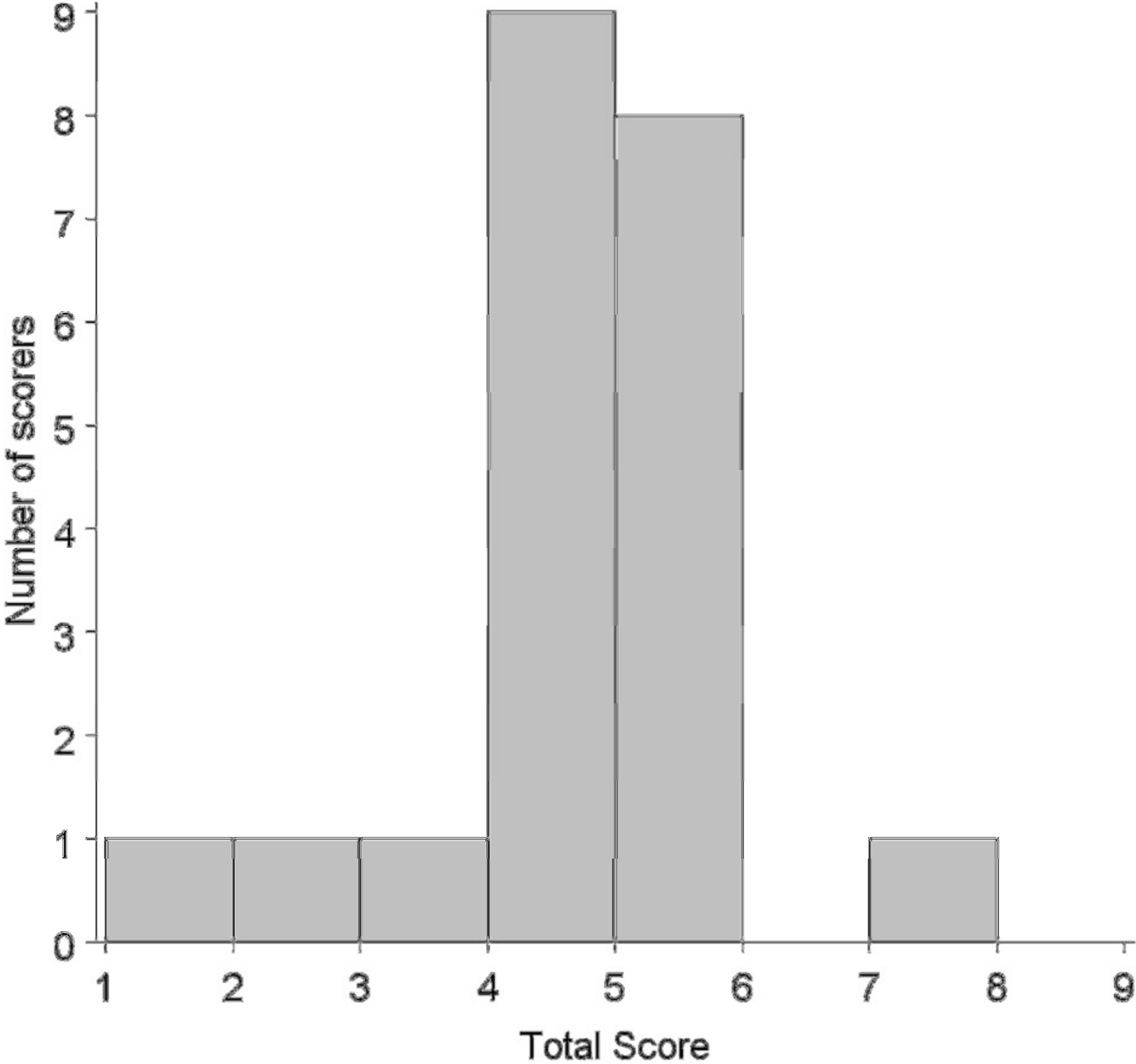
Criterion	Comment on Measure 13 : Access to Primary Care (12m-19y)
Usability	SNAC members noted that as performance is very high, achieving more gains would be difficult.
	No studies.
	PCP [primary care provider] utilization already very high; improvements in this measure may be attributable to increased utilization by people who have access rather than increasing the proportion of children with access.
	Useful in MCO [managed care organization] contracts to drive quality improvement.
	Provides a reasonable proxy for access to episodic care but not more comprehensive care.
	Notes that evidence limited that can increase rates but date indicates rates are already quite high.
	No studies looking at performance improvement that increases access.
General Comments	Tracks with well checks retire in favor of PCMH-like [patient-centered medical home-like] measures as measure does not get to concept of care for prevention and chronic condition care.
	Performance high already, and so little room for improvement. As there are other measures on the list that get at measuring patient contact with PCP [primary care provider] for preventive care, I see little benefit to keeping this measure on the list.
	Very difficult to call Y/N on this one.
	Easy to collect, but the measure definition does not fit the name. I would not want to see performance on this utilization measure be misinterpreted to imply that access is good. Measures 10, 11, 12 are superior. I would retire this and recommend it be replaced with a better measure of access.
	Can be useful to assess regional variation within a State/MCOs; but not as important for national set.
	Access is covered by CAHPS; visit rates covered by measures above; recommendation depends on what we do with 10-12.
	Access remains too much of an issue in this population. Could we have a better measure? Maybe. Need to find better ways to test.
	Not patient centered, better measure would be survey of patients (CAHPS), and most states do this survey periodically. Performance already very high. Seems to duplicate measures #10-12 because tracks with these 100%.
	Well child visit measures are more of a priority.
	Some have commented that this tracking in same way as well visits so may not be necessary but performance much higher on this measure than adolescent well visits.
	This is not a quality measure --- is more PCP visits better?

Criterion	Comment on Measure 13 : Access to Primary Care (12m-19y)
	If we keep measures of well-child care this may not provide value-added. Despite the large number of children measured, the importance of this measure in the ACA era and the feasibility one has to question whether or not any performance improvement intervention could statistically move the needle, especially for the youngest age group (currently at 95%). It would be an important but difficult measure to prove. One could argue that measuring the difference before and after the 2014 ACA would be of scientific and policy importance it is doubtful that a statistically significant difference is possible.

Measure 14: Testing for Pharyngitis (2y-18y)
Summary of 2013 SNAC member scores (N = 21 for total score, due to one missing value)

	Importance	Scientific Acceptability	Feasibility	Usability	Total	Retire?
Minimum	1	1	1	1	1	Yes: 20
25th percentile	2	5	6	3	4.25	No: 2
Median	3.5	5	6	3.5	4.75	
75th percentile	5	7	7	5	5.25	
Maximum	7	9	9	8	7	



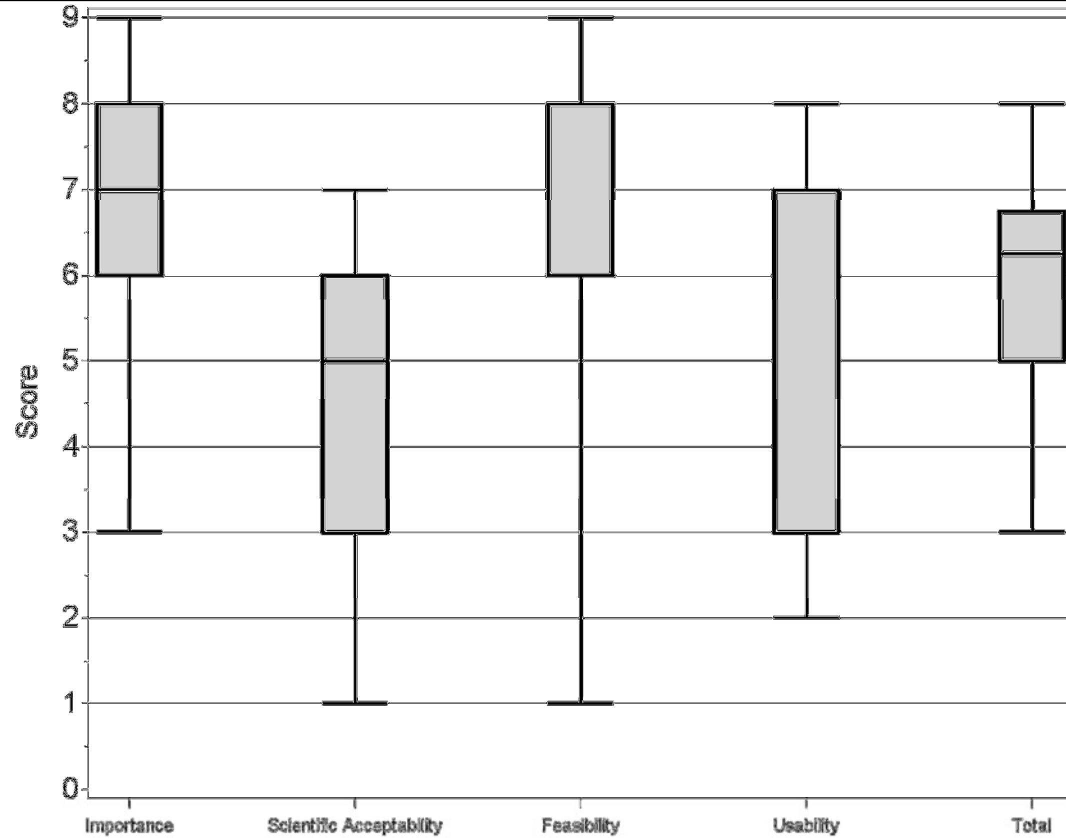

Distribution of Total Score (Measure 14)
Number of scorers
0
1
2
3
4
5
6
7
8
9
Total Score

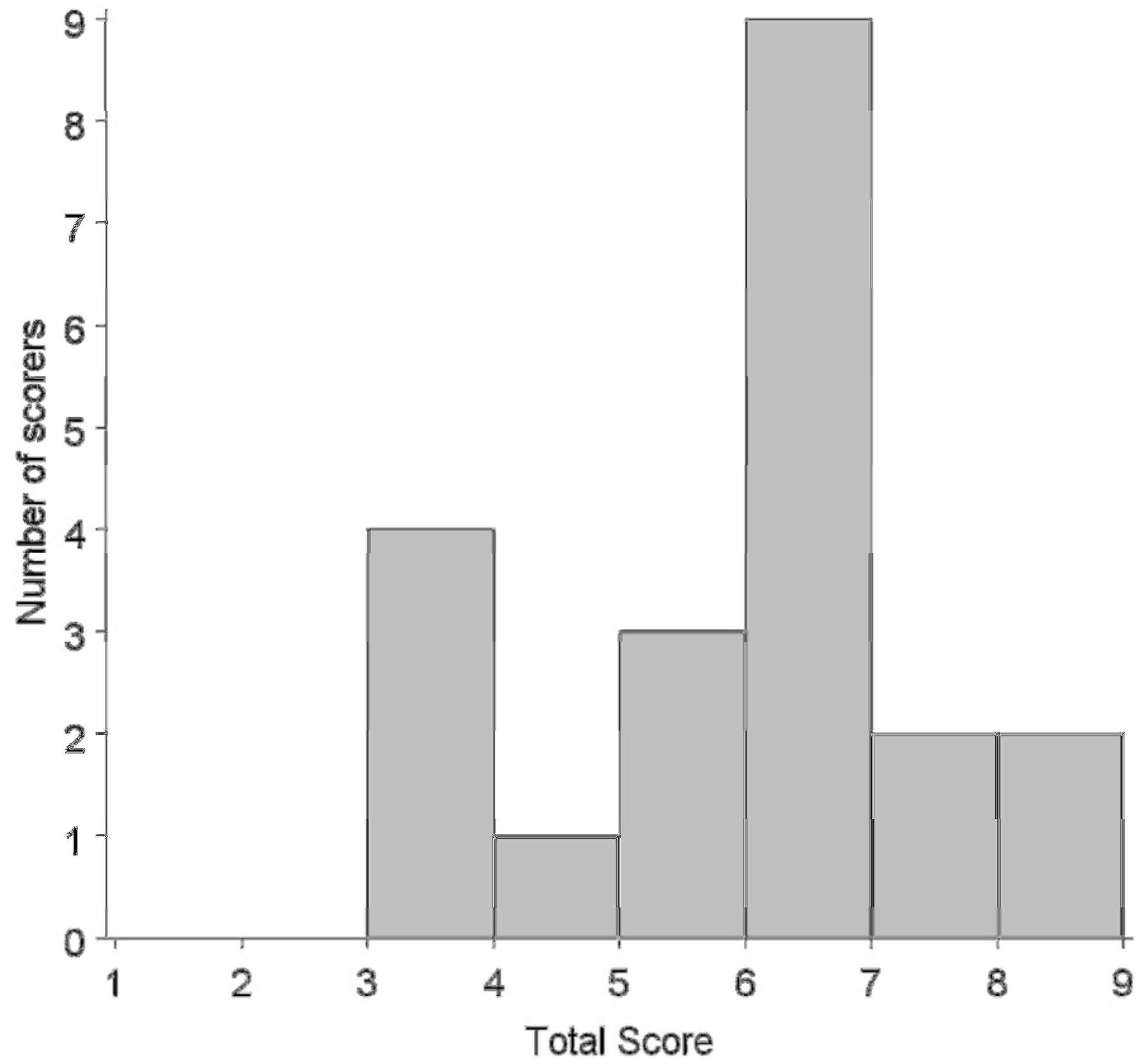
Criterion	Comment on Measure 14 : Testing for Pharyngitis (2y-18y)
Importance	SNAC discussion suggests evidence for the clinical importance of this measure is obsolete. One SNAC member even noted that this measure may be encouraging unnecessary testing.
	Mixed performance measures.
	SNAC discussion suggests evidence for importance is obsolete; not worth doing this.
	Important given antibiotic resistance and no other accountability for overprescribing.
	Promotes unnecessary testing.
	Key practice to target is inappropriate antibiotics screening, but this measure does not really target that; it may not be inappropriate for the 1/4 of kids who received antibiotics to have not had a throat swab (e.g., may be encouraging unnecessary testing).
	High frequency clinical event with the potential to overuse antibiotics.
	Performance fairly high but discussion that this is not strong rationale for focus (importance) of measure.
	Despite the relatively large numbers, the percent of prescription costs seems small in overall Medicaid expenditures.
Scientific Acceptability	Reliability good, but no info on validity.
	Limited data.
	Excellent reliability; validity unknown.
	Validity unknown.
	Dependent on accurate coding.
	Reliability high but no validity data.
	Very high reliability in the measure reporting.
Feasibility	Majority of states reporting. However, administrative data likely missing in-office lab tests, so results may not be accurate
	high percentage of utilization.
	A.
	Recent improvement.
	Feasibility is moderate to high.

Criterion	Comment on Measure 14 : Testing for Pharyngitis (2y-18y)
Usability	Little evidence of performance being impactable. Also, SNAC comments hint that efforts to increase performance may lead to an increase in some unnecessary testing.
	Few studies.
	May actually encourage unneeded testing.
	Measure focuses on reducing inappropriate antibiotic use.
	Issue of secular trends rather than interventions in this area.
	Current studies (despite A evidence for the clinical practice) suggest difficult to impossible ability to look at PI opportunity for improvement.
General Comments	Promotes unnecessary testing. The real issue is not using antibiotics for viral infections.
	SNAC comments indicate that this measure may be clinically outdated, and may be encouraging unnecessary testing.
	The sentiment of the SNAC toward this measure suggests that Importance may require a higher weight in the aggregate score. Scientific acceptability and feasibility shouldn't matter if the thing being measured has no importance.
	Other ways to drive quality improvement to reduce antibiotics.
	This is the only appropriateness measure in the group. The range of performance for Medicaid HMOs was 50-84 -that's broad! Providers don't like this measure -but what are the exact arguments against it?
	Access remains too much of an issue in this population. Could we have a better measure? Maybe. Need to find better ways to test.
	Not useful.
	Need better measure for reducing antibiotic use for viral infections.
	Low opportunity for PI impact on this measure as a stand-alone change.

Measure 15: ED visits (0y-20y)
Summary of 2013 SNAC member scores (N = 21 for total score, due to missing values)

	Importance	Scientific Acceptability	Feasibility	Usability	Total	Retire?
Minimum	3	1	1	2	3	Yes: 7
25th percentile	6	3	6	3	5	No: 14
Median	7	5	6	7	6.25	No response: 1
75th percentile	8	6	8	7	6.75	
Maximum	9	7	9	8	8	



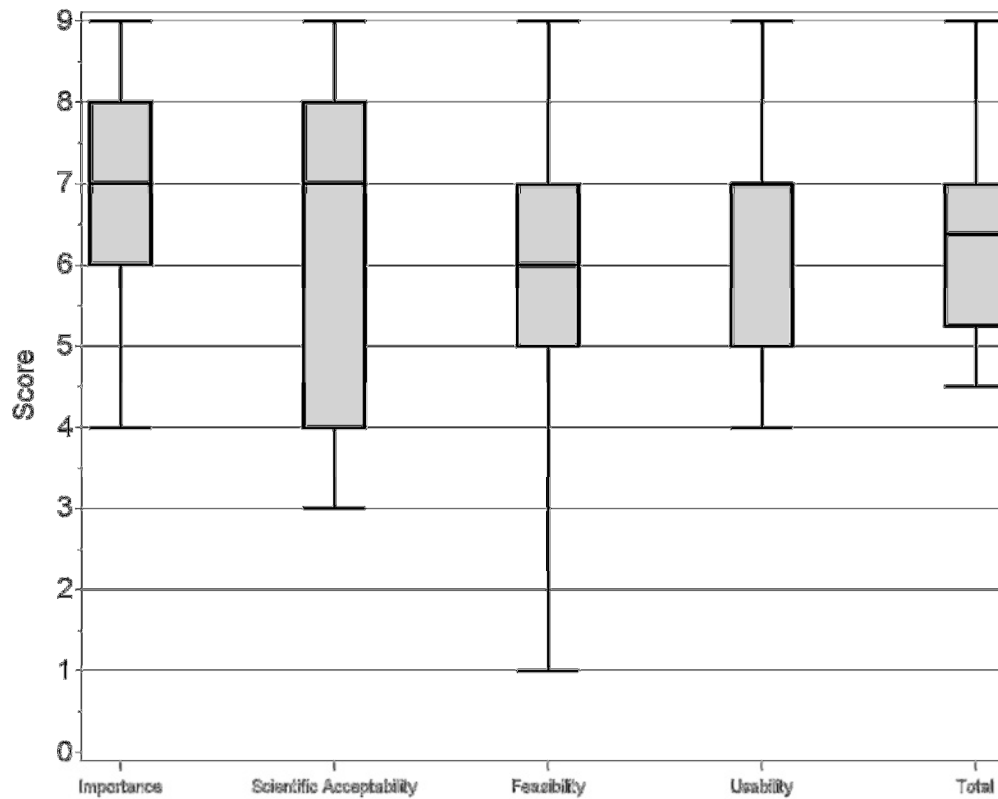

Distribution of Total Score (Measure 15)
Number of scorers
0
1
2
3
4
5
6
7
8
9
1
2
3
4
5
6
7
8
9
Total Score

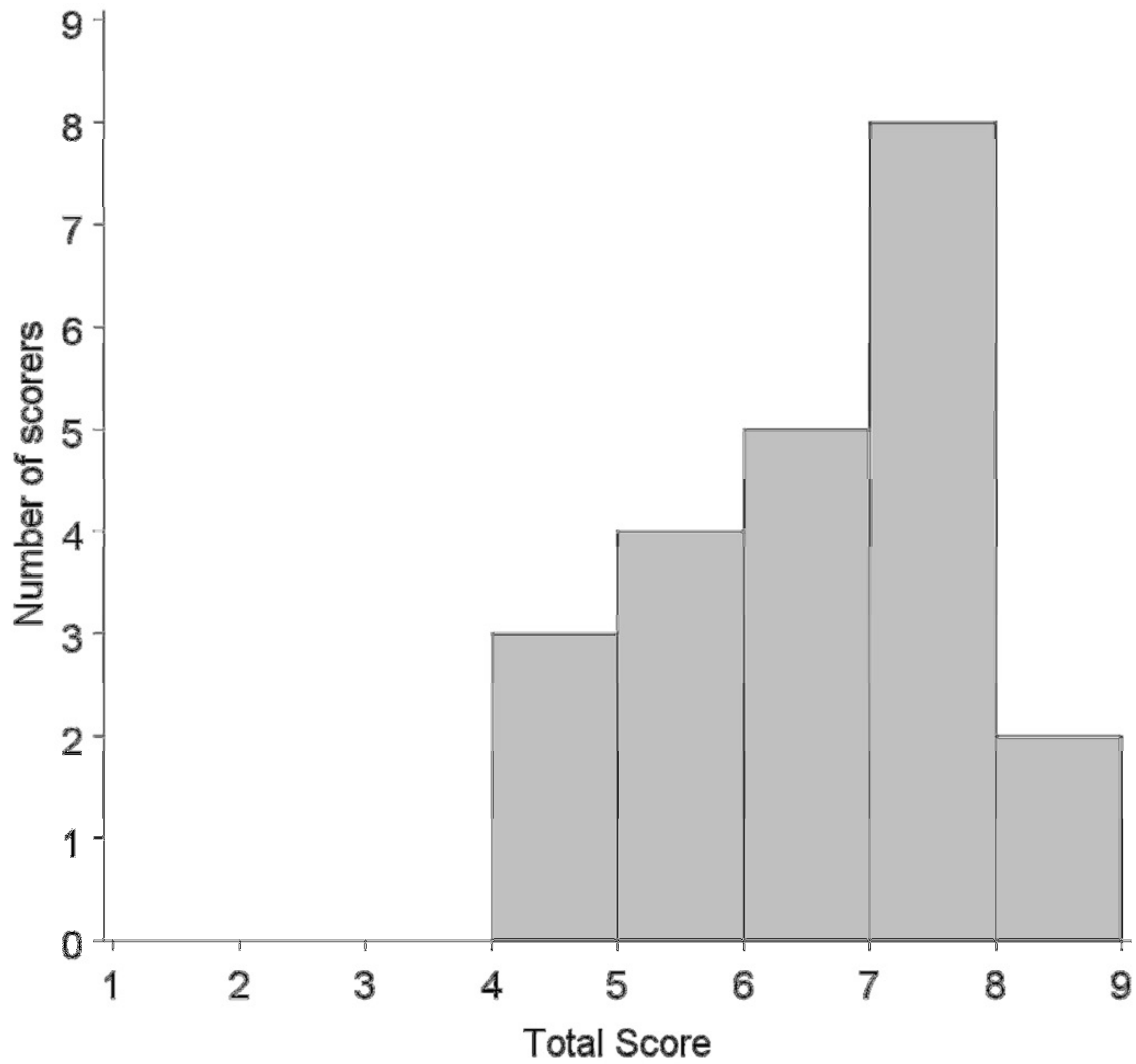
Criterion	Comment on Measure 15 : ED visits (0y-20y)
Importance	High cost
	Large number of children access the ED, many more than once in the reporting period. Cost is high. ED visits lead to great potential for uncoordinated care. This is a very important area of concern. Though the measure doesn't differentiate between primary care treatable visits, and those that are true emergencies, the large number of visits implies that it is likely that many visits were for primary care treatable conditions.
	Low performance.
	Big numbers and big costs.
	Important measure for evaluating person-centered medical homes/networks.
	Important measure for efforts at decreasing ER utilization and improving access to primary care -- high priority.
	Most useful if viewed within context of other primary care measures. Hard to interpret as individual measure re: appropriateness of visits.
	Hugely important information though the validity of the measure needs to be questioned.
Scientific Acceptability	No information on reliability and validity.
	No data.
	Hard to know if a visit was appropriate or not. What should the target be?
	Unclear if visit necessary.
	Not risk adjusted.
	Not available so hard to score.
	No data available on the validity of the measure.
Feasibility	Only about 1/3 of states are reporting. Measure has clear specifications, and states are used to collecting this measure, which is calculable from administrative data.
	High percentage of utilization.
	A.
	Percent reporting increasing but still less than 50%.

Criterion	Comment on Measure 15 : ED visits (0y-20y)
	Feasibility needs to be questioned. Few states measure and report (8) and the variations from year to year are so vast as to render the measure un-interpretable.
Usability	Measure results in an indication of utilization at a high level, without allowing users to determine to what extent the visits were for primary care treatable conditions or not. As such, activities designed to decrease use of the ED for primary care treatable, even if successful, will not likely lead to changes in the overall rate for this measure.
	Insufficient data.
	Efforts underway; mixed evidence for improvability.
	Data suggests possible to reduce ER visits. Issue is interpreting the data without context of other measures.
	Because of the variation the measure should be questioned which translates to a seriously limited PI opportunity.
General Comments	A measure of the health care system and access and maybe waste, unnecessary testing. Would retire in favor of a measure that gets to appropriateness of ED visit.
	A measure of ED use that gets at whether the visit was for a primary care treatable condition would be more useful. But, our task is to decide if a measure should be retired. Given the negative impact of any unnecessary ED use, to my mind, it is worth tracking ED use, until a future SNAC hopefully is able to identify a better ED use measure.
	Also useful to assess regional variation within a State.
	Difficult measure without knowing if visit was necessary.
	In a population in which access may be an issue, an unadjusted ED visit rate is not informative.
	Access remains too much of an issue in this population. Could we have a better measure? Maybe. Need to find better ways to test.
	Very conflicted on this measure; CMS likes this measure, feels it is valuable for payment reform and will be important in ACO care, but measure seems flawed.
	Not a measure of quality, inappropriate use of the ER would be a better metric. As is this is not a good measure, there are many instances that going to the ED is good quality of care….
	PI issues abound in a measure with poor reporting, wide variation and questionable validity

Measure 16: CLABSI – NICU & PICU
Summary of 2013 SNAC member scores (N = 22)

	Importance	Scientific Acceptability	Feasibility	Usability	Total	Retire?
Minimum	4	3	1	4	4.5	Yes: 8
25th percentile	6	4	5	5	5.25	No: 13
Median	7	7	6	7	6.38	No response: 1
75th percentile	8	8	7	7	7	
Maximum	9	9	9	9	9	



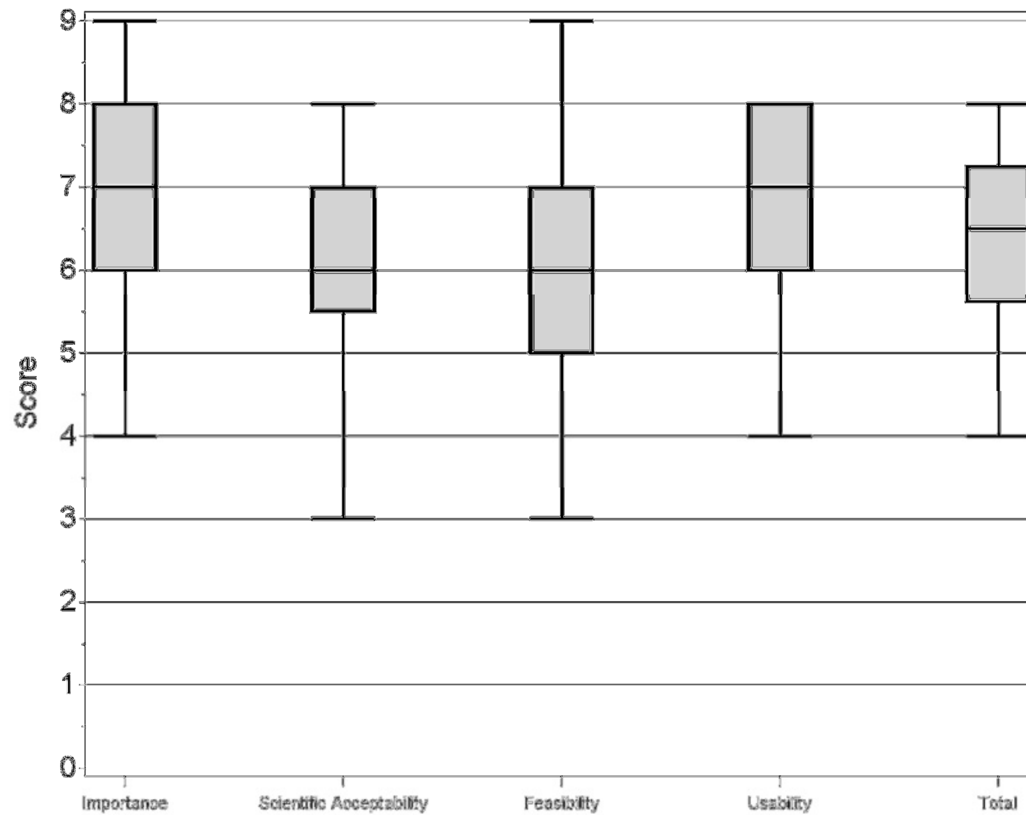

Distribution of Total Score (Measure 16)
Number of scorers
0
1
2
3
4
5
6
7
8
9
1
2
3
4
5
6
7
8
9
Total Score

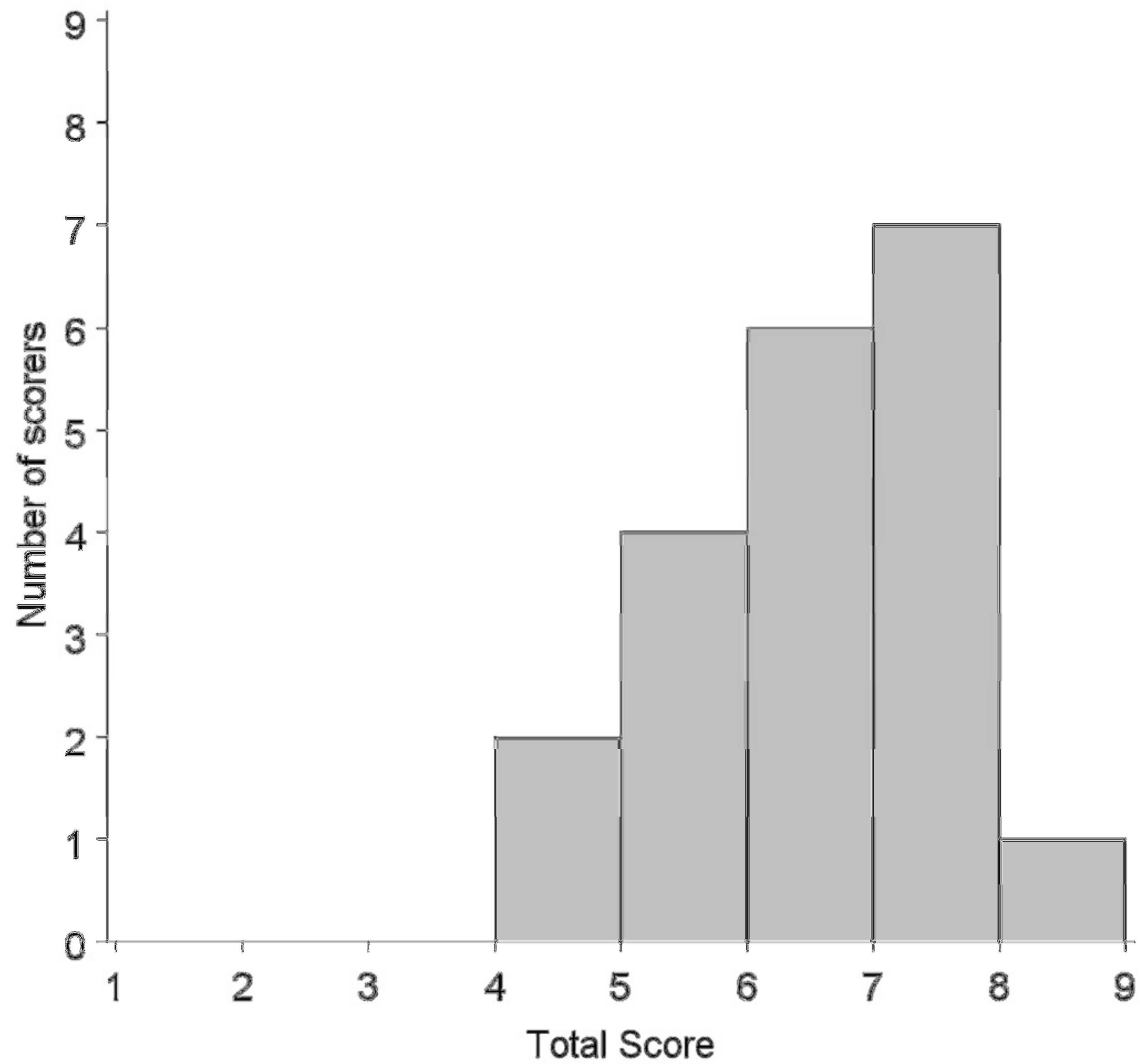
Criterion	Comment on Measure 16 : CLABSI – NICU & PICU
Importance	Low frequency, but high cost, and a 'never' event. Also, this is the only acute hospital based measure on the list.
	Low performance measures.
	Small volume, but huge cost.
	Should be driven by hospital quality improvement / very expensive to get data from hospital records.
	Number affected small but costly.
	Few patients.
	Measures of NICU quality are needed, many hospitals engaged with the HENs may have reported this data, need for stronger partnerships between Medicaid and the hospitals who could work on this measure jointly.
	Low frequency events.
	Little question that CLABSI relates to overall mortality in the NICU.
Scientific Acceptability	High reliability, concerns about validity.
	Limited data.
	"Multiple studies, including some published in 2013, find problems with the reliability and validity of the NHSN measure, and HAI measures in general."
	Strong outcome measure.
	While new references may question measure validity, it is widely used.
	No reliability data and updated material indicates concerns with validity.
	Validity in the measure as well as shifting definitions make this a moving target.
Feasibility	CMS collects the data for this measure directly from CDC.
	High percentage of utilization.
	M; I’m concerned that state reporting data not available. Not sure how "upward" trend in reporting was identified.
	CMS workgroup concluded that CDC data are relatively representative of Medicaid/CHIP.
	Requires hospital chart review.
	Understand that data collected by CDC but hard to know how this translates re: feasibility.

Criterion	Comment on Measure 16 : CLABSI – NICU & PICU
	Hospital reported data to CMS will likely represent a feasible and reproducible measure.
Usability	As this should be a 'never' event, and as the locus of care is the NICU, logically, performance should be impactable if the state (and other payers) were to work with NICUs on this issue.
	Insufficient data.
	Efforts underway; not much evidence for or against improvability.
	This is clearly able to be improved by hospitals; extrapolating from adults, could be amenable to payment reform and/or partnerships between hospitals and Medicaid to reduce CLABSI.
	Regardless of the issues identified, there are relatively strong indicators that central line bundles, best practices and PI interventions can reduce CLABSI rates.
General Comments	Focus for this measure is at hospital not Medicaid level.
	Due to the high cost, and that the goal should be a zero infection rate, and given that there is an existing data source for this measure that does not require states to provide data, and given that there is not a cap on the number of measures that can be on the list, I am changing my vote, and voting to retain this measure on the list.
	Good measure in the wrong measure set; if you have to narrow the set, this is already being measured through other hospital reporting programs.
	Access remains too much of an issue in this population. Could we have a better measure? Maybe. Need to find better ways to test.
	Measure is very technical, requires manual chart review, and involves very small percentage of Medicaid pediatric population.
	I think there is quite a bit questionable about this measure, including validity and lack of data re: usability. I would also suggest continued discussion of whether most appropriate at state level vs hospital reporting given very low participation of states at this point and other evidence concerns.
	Need to get this data from CDC NHSN -- Medicaid children are a high percentage of NICU cases, thus it should remain.
	important to keep pediatric quality hospital measure, but this measure is not Medicaid/CHIP-specific.
	Despite the limitations, this measure is likely to be retained by CMS and most states as a QBR [quarterback rating] and should continue as a core measure.

Measure 17: Asthma ED visits (2y-20y)
Summary of 2013 SNAC member scores (N = 20 for total score, due to missing values)

	Importance	Scientific Acceptability	Feasibility	Usability	Total	Retire?
Minimum	4	3	3	4	4	Yes: 6
25th percentile	6	5.5	5	6	5.63	No: 15
Median	7	6	6	7	6.5	No response: 1
75th percentile	8	7	7	8	7.25	
Maximum	9	8	9	8	8	



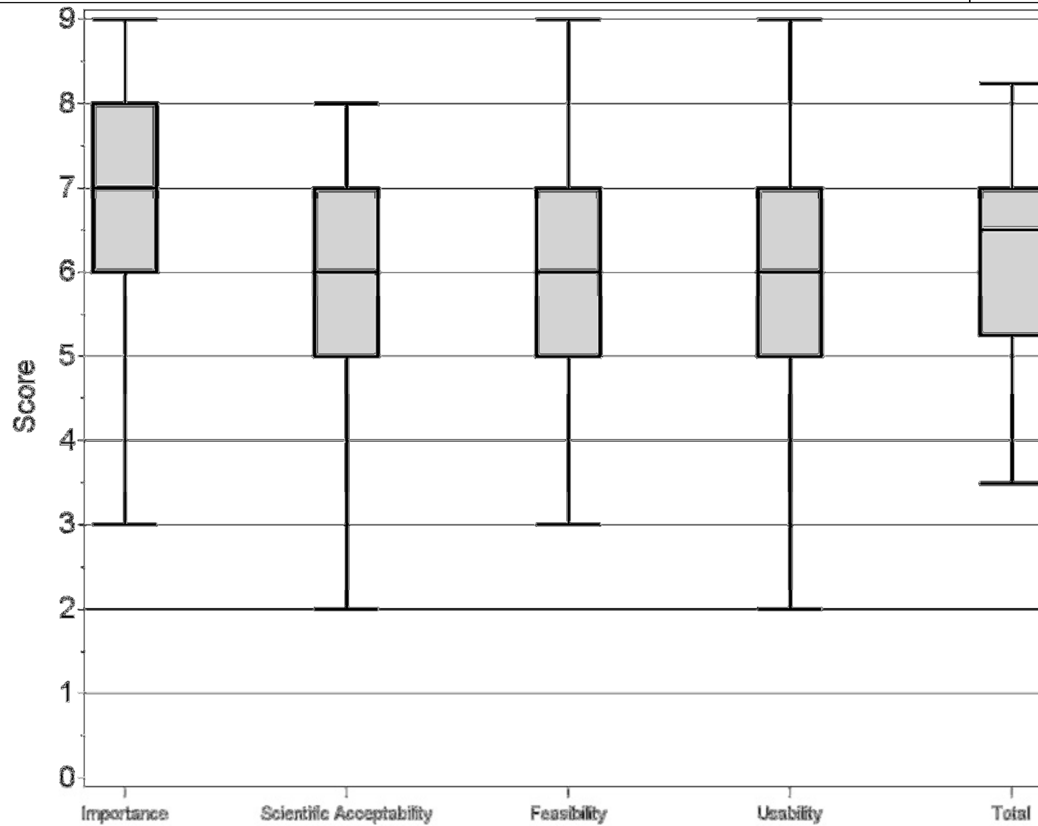

Distribution of Total Score (Measure 17)
Number of scorers
Total Score
0
1
2
3
4
5
6
7
8
9
1
2
3
4
5
6
7
8
9

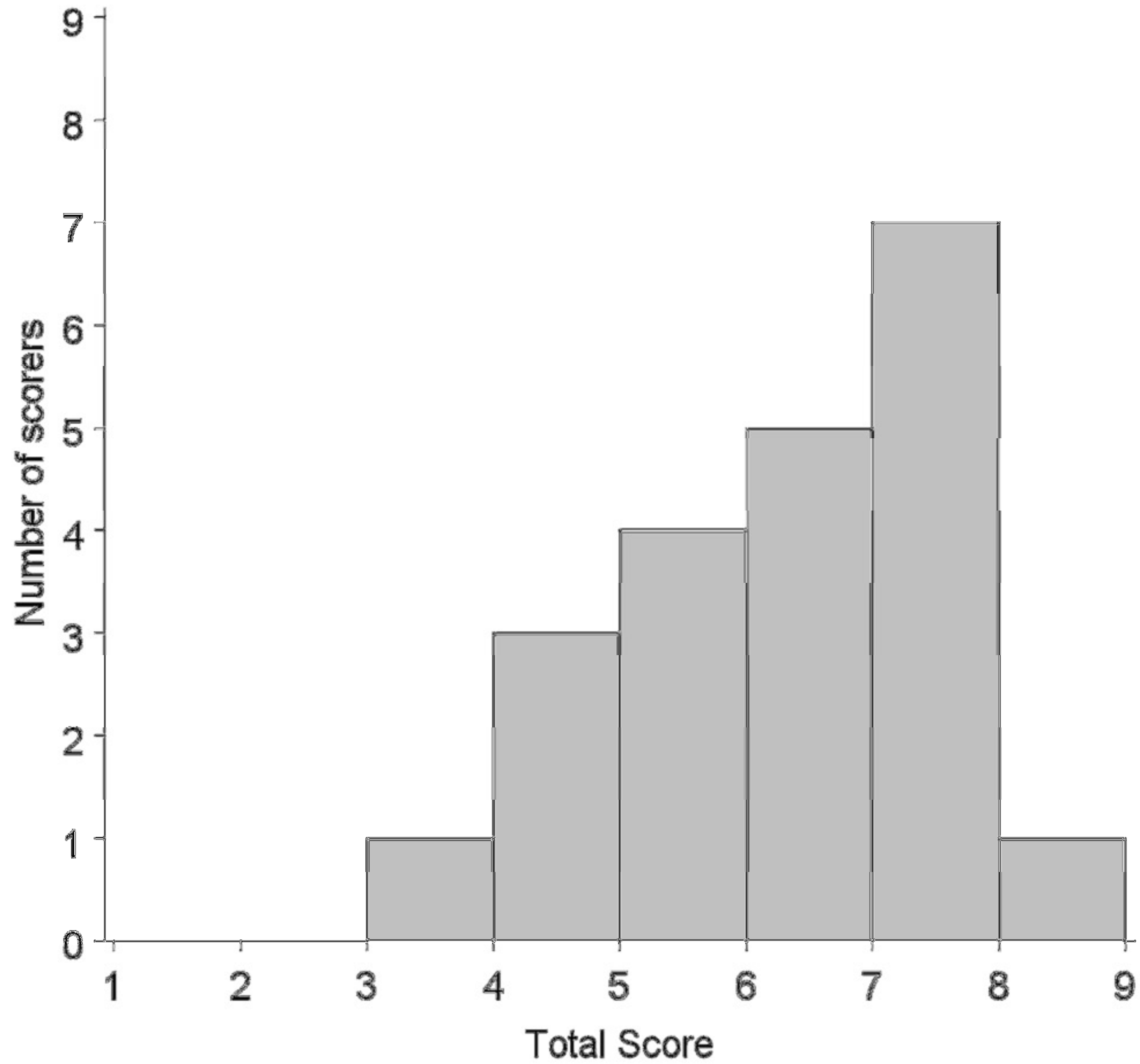
Criterion	Comment on Measure 17 : Asthma ED visits (2y-20y)
Importance	Large number of children impacted, and this ED measure attempts to get at a set of ED visits that is potentially primary care treatable. Asthma care delivered in the ED will potentially not be well-coordinated with PCPs [primary care providers].
	Mixed/too little data.
	C-level evidence for importance; fairly large denominator; "measure steward…not to continue maintenance".
	Very prevalent, and an important care coordination measure.
	These should be preventable.
	Very prevalent problem but lower level of evidence, relatively low performance.
	Very important measure and an important correlative of primary care effectiveness to ED utilization with careful focus on one important disease category.
Scientific Acceptability	Some promising info on reliability and validity.
	Mixed data.
	Issues with appropriateness of visits (see #15); may be environmental differences between states that drive this.
	Validity data; lack of reliability data.
	Poor validity measure.
Feasibility	Measure is collectable from administrative data. However, AHRQ needed to modify the specifications to get at additional ED visits, and the resulting calculation using the modified specifications resulted in a large increase in ED visits identified. Thus, the measure specifications may contain some room for improvement. As the measure steward has indicated that it will not be continuing in that role, it seems that there will not be an 'owner' of this measure to continue to make changes. Therefore, I am rating this low on the feasibility scale.
	Low percentage reporting.
	A.
	Difficulty in reporting and few states reporting effectively.
Usability	As a multi-factorial cause issue, ED use for asthma care is a hard one to impact. SNAC comments note that without risk adjustment, it is hard to know when one has reached the 'right' rate.
	Mixed study results.

Criterion	Comment on Measure 17 : Asthma ED visits (2y-20y)
General Comments	Can probably be improved, but without some kind of risk adjustment, each state may have a different ceiling.
	High number of good studies showing a positive impact of good primary care on ED asthma visit reduction.
	Could be a systems measure, better managed by PCMH [patient-centered medical home]/ Hospital payment reform.
	Due to the impending absence of a measure steward to address questions/issues on the specs (as reported by CMS to the SNAC), and due to the difference in rates when AHRQ modified the specifications to identify ED visits that were not identified using the original specifications, I am voting not to retain this measure.
	If the steward is dropping it, is there any reason to retain it?
	Hugely important in vulnerable populations where the prevalence of asthma abounds.
	Not sure I understand the implications of the measure steward no longer taking responsibility of this measure.
	Issue is interpretation of this measure without context of other measures.
	No steward, better asthma measures are available.
	Despite the obvious problems with reliability of the index and feasibility the PI impact suggests this measure be retained and more extensive work directed at the feasibility issue.

Measure 18: ADHD Follow-Up Care (6y-12y)
Summary of 2013 SNAC member scores (N = 21)

	Importance	Scientific Acceptability	Feasibility	Usability	Total	Retire?
Minimum	3	2	3	2	3.5	Yes: 5
25th percentile	6	5	5	5	5.25	No: 17
Median	7	6	6	6	6.5	
75th percentile	8	7	7	7	7	
Maximum	9	8	9	9	8.25	




Distribution of Total Score (Measure 18)
Number of scorers
0
1
2
3
4
5
6
7
8
9
1
2
3
4
5
6
7
8
9
Total Score

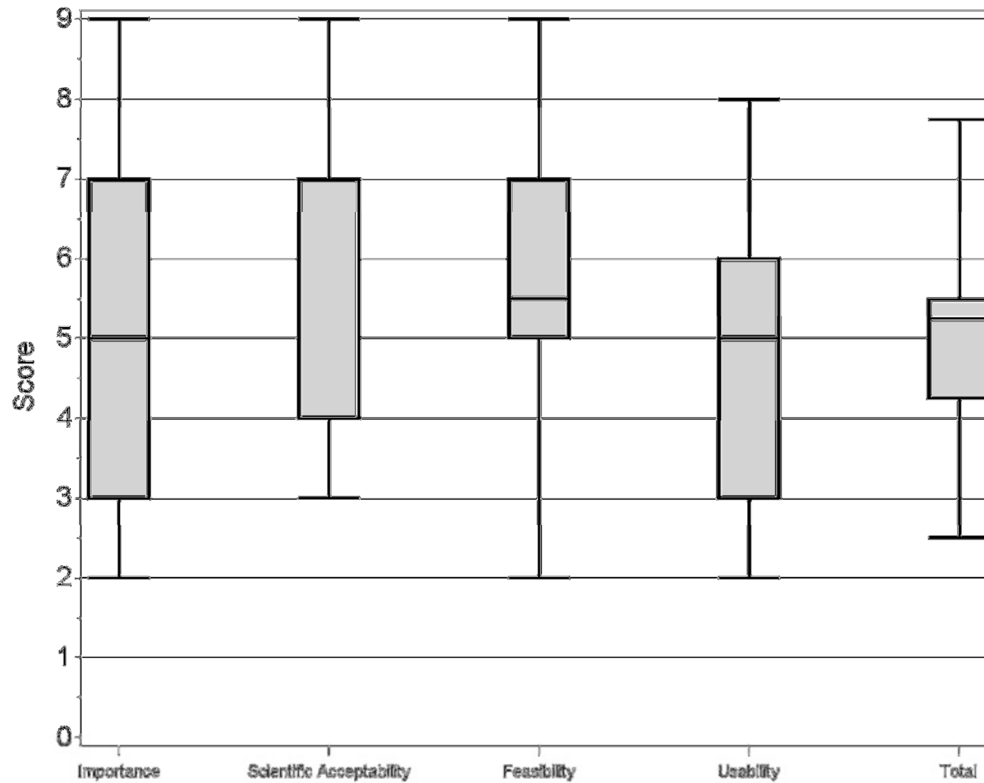
Criterion	Comment on Measure 18 : ADHD Follow-Up Care (6y-12y)
Importance	Large number of children impacted, and the data show room for improvement. Measure looks at in-person visits with prescribers. As there is more movement toward bundled payments, and use of alternative visit methods (phone, email), this measure may become less useful, but, given that FFS [fee-for-service] is still very prevalent, and given the large number of kids with ADHD diagnoses and medications, I see a good argument for this measure being clinically important at this time.
	Low performance.
	Huge numbers (especially cost) outweigh "C-level" evidence.
	Follow up may be by phone.
	High prevalence, disparities.
	One of the most important variation issues in our state-- expect great overuse and need to measure ongoing care, abuse, criteria is high.
	So overdiagnosed.
	This is an important issue but the measure does not address the true issue of episodic and inappropriate use of ADHD medications.
	Performance data not bad given specificity of requirement; also question of whether the "in person" appointments are reflecting other types of follow-up contact, and if this is best way of measuring the quality of care.
	Important measure given the volume of patient numbers and the expenditures at risk, including the high percentage of this medication as part of the prescription cost burden.
Scientific Acceptability	Good reliability, no date on validity.
	Mixed data.
	Major issues with limiting definition to include only face-to-face. May exclude many kids who are actually getting other kinds of follow up care.
	Phone follow up common.
	High validity for the Medicaid managed care group.
Feasibility	HEDIS measure, so well-understood specifications, many states reporting.
	Low percentage reporting.
	A.

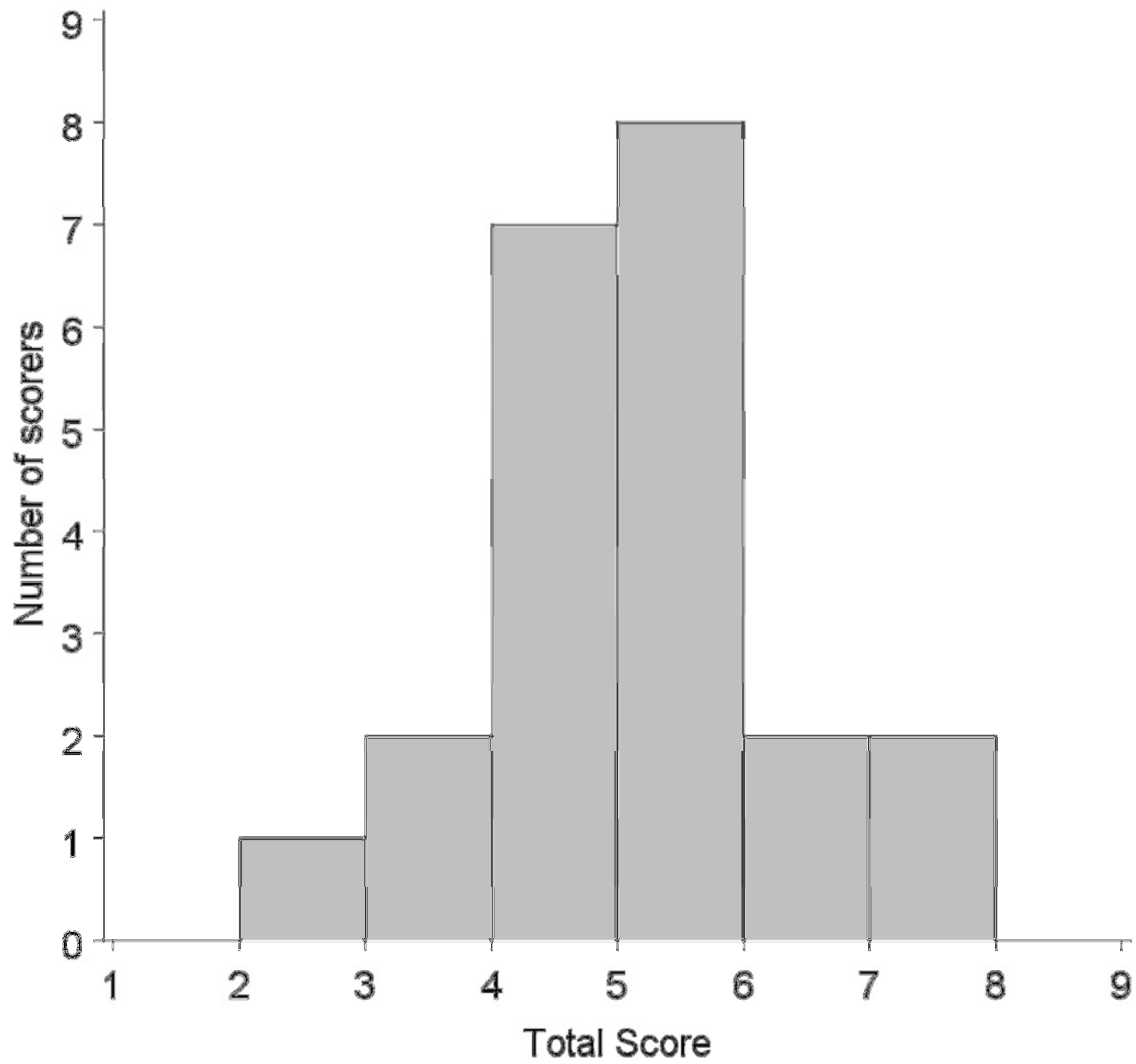
Criterion	Comment on Measure 18 : ADHD Follow-Up Care (6y-12y)
	Measure ends up excluding large numbers of children prescribed these drugs. Medicaid programs may not have access to the behavioral health office follow-up claims if prescribed by a psychiatrist.
	Percent reporting gone up quite a bit in past 2 years but still at about 57%, but promising trend.
	Minority at first but upward trend in states reporting and data seem reliable.
Usability	Data on impactability seems promising.
	Mixed study results.
	Efforts are underway, but I'm concerned that measure "rewards" potentially more expensive in-person visits that may not be needed.
	Measure results usually meaningless since either claims are not available for behavioral health providers, many children are not continuously on the medications so they fall out of the denominator.
	Data appears promising but only 1 study.
	Prior studies demonstrating better outcomes for continuation of medication.
General Comments	Gets to integration of care & mindful monitoring of dangerous medications.
	Measure looks at kids with BH issues, which is a clinically important area. As new payment methodologies become more prevalent, and better measures to look at closing the loop for kids with BH issues, perhaps future SNACs will consider other measures to replace this one. For now, I think the BH issues and follow-up issues are important enough that I am voting to retain this measure.
	Would like to see this replaced with a more comprehensive definition of follow-up care to include texting, email, phone, etc. I would recommend retiring this measure if a new, more inclusive measures would be introduced in its place.
	Outdated.
	Critical area for pediatrics and mental health; couples prescription to follow up; patient-centered.
	Need better measure.
	Doesn't make sense anymore because providers use phone and email for follow-up; should be replaced by true measure of follow-up that reflects care other than just providing a prescription.
	NCQA needs to develop a better simpler measure.
	Because these are high risk kids with MH comorbidity, include.
	Should consider an improved measure but would not want to eliminate this focus.

Criterion	Comment on Measure 18 : ADHD Follow-Up Care (6y-12y)
	Excellent PI opportunity given size of the population, degree of expenditures and reliability of the measure.

Measure 19: Annual HbA1c (5y-17y)
Summary of 2013 SNAC member scores (N = 22)

	Importance	Scientific Acceptability	Feasibility	Usability	Total	Retire?
Minimum	2	3	2	2	2.5	Yes: 19
25th percentile	3	4	5	3	4.25	No: 3
Median	5	4	5.5	5	5.25	
75th percentile	7	7	7	6	5.5	
Maximum	9	9	9	8	7.75	



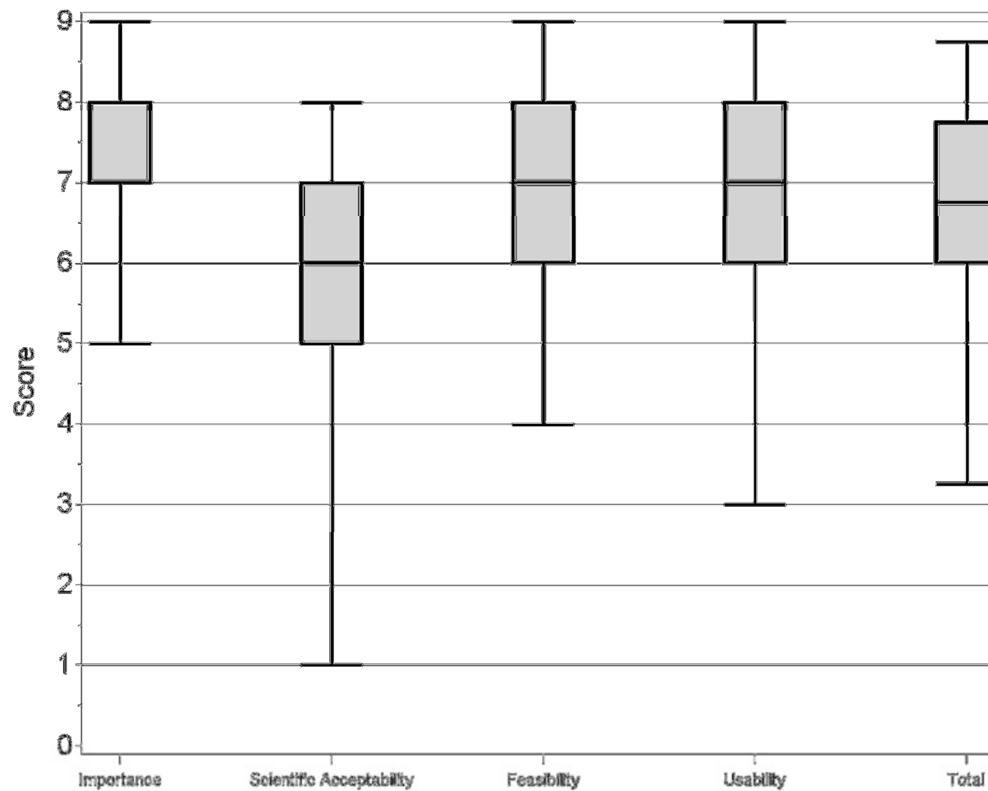

Distribution of Total Score (Measure 19)
Number of scorers
0
1
2
3
4
5
6
7
8
9
1
2
3
4
5
6
7
8
9
Total Score

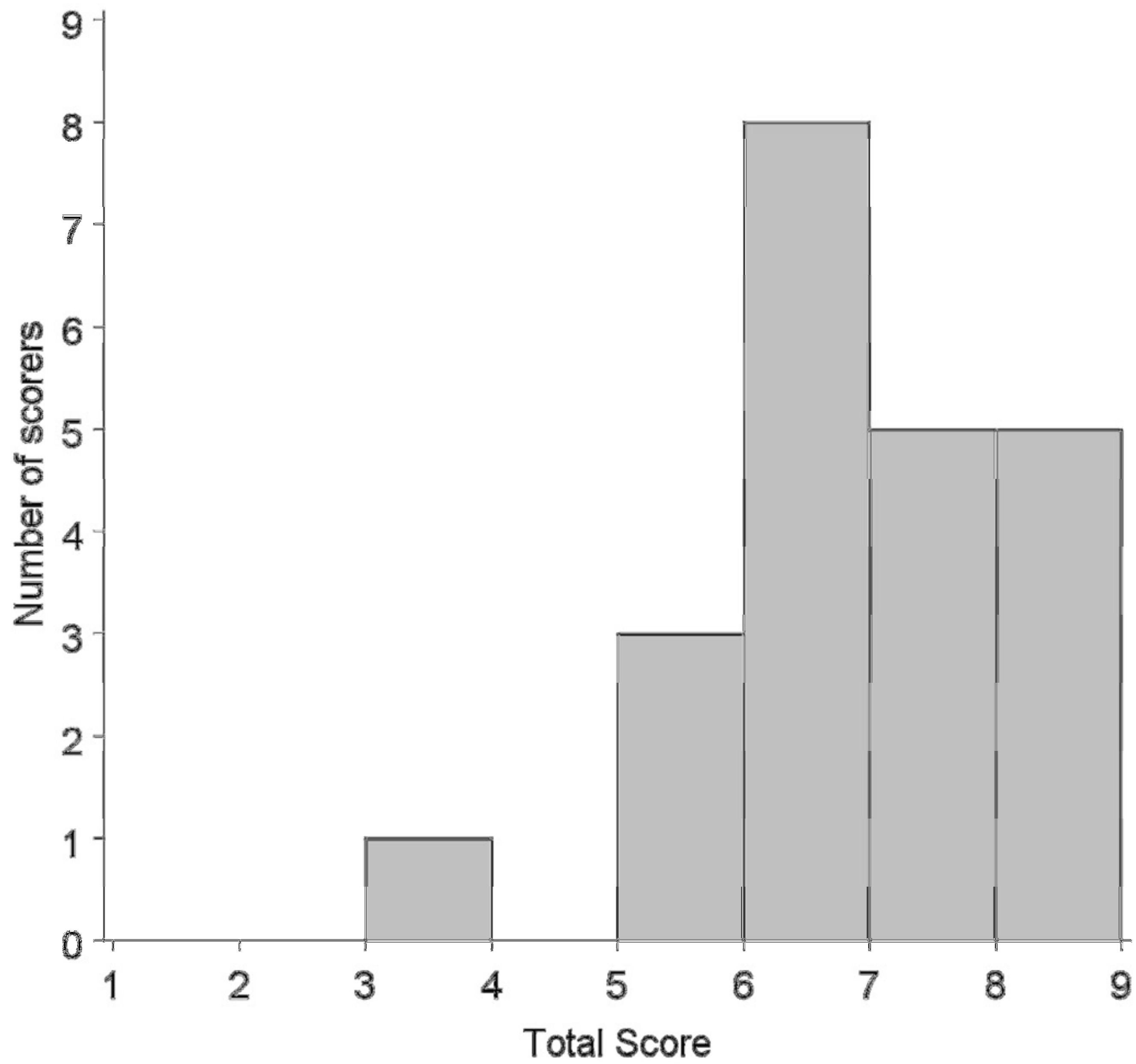
Criterion	Comment on Measure 19 : Annual HbA1c (5y-17y)
Importance	Small number of children are eligible for the denominator , and state rates seems to be relatively high, so less room for improvement.
	High performance, low cost.
	Poor (D-level) evidence for focus, low volume.
	This rate runs consistently high in this reviewer's State; question value for further quality improvement (and given low evidence grade).
	0.3% of Medicaid/CHIP.
	Applicable to small percentage of overall pediatric population.
	Little evidence (although high performance among states reporting); comments reflect that measure affects relatively small number of children.
	Hgb A1c annual measurements are the hallmark of adult diabetes management but have found slight evidence for monitoring in children. However, as diabetes is a chronic condition that manifests late outcomes it seems to be a measure of importance to establish during childhood.
Scientific Acceptability	Evidence grade for this measure is low.
	Mixed data.
	"Concerns raised re: using A1c to dx T1D" not relevant because denominator includes only those who are diagnosed. This measure likely captures what is intended, but importance is not high.
	Mixes Type I and II.
	Data exist questioning validity of this measure.
	Very little data regarding the reliability of this measurement precludes its evaluation for scientific importance.
Feasibility	Measure is a HEDIS measure, so specifications well understood. Is collectable from administrative data, however, not a lot of states are reporting, implying either a low priority for states, or that there are feasibility issues with this measure.
	Low percentage reporting.
	A or H.
	Similarly, few states report this consistently.

Criterion	Comment on Measure 19 : Annual HbA1c (5y-17y)
Usability	State performance on this measure is relatively high, so less room for improvement. SNAC member notes that since this measure does not differentiate between types of diabetes, that activities targeted at improvements with one type will be obscured in the data for the overall measure.
	No studies.
	Rates rising steadily; easy to improve but likely approaching ceiling.
	No findings specific to children.
	Inconsistent data correlate annual levels to outcomes. The data regarding using it for diagnosis seems less relevant when considering this as a chronic disease management.
General Comments	Only a small number of children impacted and mixes type I and type II diabetes.
	Small number of kids impacted, methodological issues with the measure, and current relatively high performance.
	Easy to measure, but falls heavily on the "not sufficient" side of "necessary but not sufficient".
	A general problem for using this and other HEDIS measures as a state measure is that it only assesses insured kids already diagnosed with diabetes mellitus.
	Small number of children impacted, low level of evidence, minimal utility; therefore, recommend retiring.
	Very small numbers, measurement may not be useful.
	Given the importance for this measure in adults and the possibility for PI opportunity it would seem prudent to focus on opportunities for improved reporting and continue this measure.

Measure 20: Mental Hosp. Follow-up (6y-20y)
Summary of 2013 SNAC member scores (N = 22)

	Importance	Scientific Acceptability	Feasibility	Usability	Total	Retire?
Minimum	5	1	4	3	3.25	Yes: 1
25th percentile	7	5	6	6	6	No: 21
Median	8	6	7	7	6.75	
75th percentile	8	7	8	8	7.75	
Maximum	9	8	9	9	8.75	




Distribution of Total Score (Measure 20)
Number of scorers
Total Score
0
1
2
3
4
5
6
7
8
9
1
2
3
4
5
6
7
8
9

Criterion	Comment on Measure 20 : Mental Hosp. Follow-up (6y-20y)
Importance	I agree with SNAC member comment that this is a critical measure related to classic care coordination. Impacts a large number of children, and addresses a clinically important issue in the Medicaid population: behavioral health.
	Low performance.
	Massive costs (even with smallish denominator). B-level evidence for focus. I agree with SNAC comment: "Not perfect BUT--It is a critical measure related to classic care transitions. It addresses concerns about children's lack of re-integration into the community".
	As behavioral health services are more available through Exchange plans, this will increase in importance to delivery system/integration improved service for children. It should be a federal priority to do studies with this measure and system capacity.
	Important measure for our behavioral health managed care plan--carved out of medical.
	Remains important measure and we are still not hitting on it 100%.
	Good evidence and performance fairly good for within 30 days.
	The issue of mental health and high expenditures in pediatric age group is enormous and a current gap in preventative care.
Scientific Acceptability	No information on reliability and validity.
	No evaluation data.
	R and V unknown.
	No validity data.
	No reliability data available yet.
Feasibility	About 1/3 of states reporting, but increasing. This is a HEDIS measure so the specs are likely to be well understood by staff.
	Average numbers.
	A.
	Some state Medicaid programs may not have access to behavioral health claims.
	Consistent increase.
	Upward significant trend in the reporting of this measure suggesting feasibility.
Usability	State's performance seems to be trending upward, so, despite there being little evidence in the literature of being impactable, it seems reasonable to determine that this is an impactable area.

Criterion	Comment on Measure 20 : Mental Hosp. Follow-up (6y-20y)
	Insufficient data.
	Efforts underway; some evidence for improvability; upward performance trend.
	Useful in MCO [managed care organization] contracts to drive quality improvement.
	Drive improvement.
	Insufficient evidence on PI impact but evidence does exist that improvement in outcomes are correlated to post hospitalization visits.
General Comments	A systems measure of integration, still problematic. Keep until payment reform moves to this.
	Given the clinical importance of this topic, it is important to keep this measure on the set.
	Most important for health improvement in child population overall / not just one setting.
	Good to have a continuity of care measure for mental health -- services hard to arrange.
	Important to have a measure of pediatric mental health; because there are concerns about this measure performance in adults, the measure should be replaced by a better one, when available.
	Should consider an improved measure but would not want to eliminate this focus.
	The potential for PI impact here is high and the need for validation of the measurement for scientific acceptability as well as the importance of this measure suggest retention and not retirement.