Child and Adult Core Set Stakeholder Workgroup:
2021 Annual Review Meeting Day 1 Transcript
April 28, 2020

Hello, everyone, and thank you for attending today's event, the 2021 Child and Adult Core Set Annual Review Meeting, Day 1. Before we begin, we wanted to cover a few housekeeping items. Next slide, please.

At the bottom of your audience console are multiple application widgets that you can use. You can expand each widget by clicking on the maximize icon on the top right of the widget or by dragging the bottom right corner of the widget panel. Next slide, please.

The slide deck and additional materials for this webinar are available in the resource list widget indicated by the green file icon at the bottom of your screen. Next slide, please.

For those who are listening in today, audio for this event can be streamed through your computer speakers or headphones. If you are a Workgroup member, measure steward or a member of the public who is planning to participate in the public comment portion of the webcast, please use the call-in number and access code provided in the content widget to connect to the webinar audio. Next slide, please.

During opportunities for public comment, participants can comment over the phone by pressing star one to raise their hand. Then listen for your queue to speak. The operator will indicate when your line has been unmuted. Note, you must be connected to the teleconference via your phone. For this meeting, Workgroup members will be able to mute and unmute themselves to speak using their telephones. If you find that you are unable to mute yourself-- excuse me, to take yourself off mute, please dial star zero to reach the operator or contact us through the Q&A panel. Next slide, please.

If you have any technical difficulties, please click on the yellow help widget. It has a question mark icon and covers common technical issues. Also, submit technical questions through the Q&A widget. Please note that most technical issues can be resolved by pressing F5 or command plus R on Macs to refresh the player console.

Finally, an on-demand version of the webcast will be available approximately one day after the webcast. It can be accessed using the same link that you used to access today's event. Now, I'd like to introduce Margo Rosenbach from Mathematica. Margo, you have the floor.

Thank you, Brice. Next slide. Hi, everybody, and welcome to the virtual meeting of the 2021 Core Set Annual Review Workgroup. Thank you to our Workgroup members, federal colleagues, and members of the public for joining us for this virtual meeting. We sincerely apologize for the delay and appreciate your joining us. Next slide.

I wanted to take a moment to acknowledge my colleagues at Mathematica, who are listed here. This has truly been a team effort to prepare for the meeting in terms of both content and logistics. I also want to acknowledge our colleagues at Harbage Consulting, who will be helping to write the report summarizing the Workgroup discussion and recommendations. Next slide.

We have a full agenda and important objectives to accomplish over the next three days. Our four meeting objectives are listed on the slide. First, the Workgroup will review the 13 existing measures that were suggested for removal and the 12 measures that were suggested for addition to the Child and Adult Core Sets. Second, the Workgroup will vote on the measures suggested for removal or addition and make recommendations for updates to the 2021 Core Sets. Third, we'll discuss gap areas and areas for future measure development.

This year, instead of saving the gaps discussion for the last day of the meeting, we'll invite Workgroup members to identify gaps as part of each domain discussion. On the last day, we'll provide an opportunity for Workgroup members to reflect on areas for future measure development. Fourth, we'll provide multiple opportunities for public comment to inform the Workgroup discussion about the measures.

I'd like to pause for a moment and note that we're committed to a robust, rigorous, and transparent meeting process despite the virtual format. That said, we acknowledge that attendees may be facing challenges working from home in terms of technology, family distractions, or adjustments to a makeshift home office. I hope everyone will be patient as we all do our best to adhere to the agenda and fulfill the objectives of this meeting.

Now, I'd like to turn to our co-chairs, Gretchen Hammer and David Kelley, if you're on the line to offer the welcome remarks. Gretchen?

Welcome, everyone. Thank you, Margo. It is a pleasure to be with you today virtually. I am, however, sad that we aren't together. I have very fond memories of this process last year and the chance to have met you all who were on the Workgroup as well as those who participated via the public.

As Margo said, we continue to be very committed to this process and to fulfilling the rigor of this process. We recognize that obviously, the world is shifting as we go through a global public health pandemic, but this work remains as important as ever, if not more important, so that we can continue to provide a steady vision for how Medicaid and CHIP can serve its members and how we can assess and understand the quality of services provided to Medicaid enrollees and CHIP enrollees.

It is, I know, hard to suspend that uncertainty that we all face. But the Medicaid program has been around for decades. It will likely be around for decades in the future. We need to continue to set the vision for how quality can be measured and how the clinical delivery system and members can continue to work together to maximize the health of Medicaid enrollees and CHIP enrollees. So, thank you in advance.

As Margo said, we recognize that everyone is going to need a little grace, including Mathematica, as we all waited to get in. This is just part of our new reality, and we have to roll with it. We appreciate it. I'm looking forward to the next two and a half days, and really diving into the measures and hearing from my colleagues.

I did want to just set a few ground rules before we dive in, just because I think it's always important when a group of people come together, that we have some rules of engagement. The first is we recognize that each of you come from a point of view. You come from an organization that you represent. You come from your own clinical practice or your own area of health services research that you do. But really, when we come

together as this Workgroup, we are stewards of the Medicaid and CHIP program. We value your personal perspective, and we value your professional experience. But when we get to voting and debating, it really is around us acting as a steward for the program. I said debating, and I mean that in a good way. Debating is how I think our conversation was so rich last year.

I know from follow-up conversations with CMS that our rigorous discussion of the value of a measure and whether or not it's driving the right clinical behavior and clinical experience and whether or not we were comfortable with a gap versus having a bad measure, that is really rich dialogue and important. Again, it will be more challenging given the virtual format, but I'm looking forward to that discourse.

We do though, because it is virtual, continue to need to navigate this stepping over and talking over each other. We're going to be patient. We're probably going to have to find our way on that one. But we ask that you are engaged. You are active. And that we try and have robust dialogue even in the face of the virtual nature.

Lastly, we do recognize that it's not great to spend all day on a call. To the extent that you want to repeat something another Workgroup member has said, just hold your comment, and we can have it in our collective thought. We don't need to repeat it. Lastly, we do ask that people are punctual returning from breaks just because we want to be able to move forward. In particular, when we get to the part of the formal voting, we want to make sure that everyone has had equal opportunity to participate in the debate before we move us along to the vote.

I'll stop there, Margo. I don't know if you had other things you wanted me to cover or if anything I forgot. But other than that, I think we can dive in.

Well, that's great, Gretchen. Thank you. I think we have David on the line. David, are you able to unmute and speak?

Yes, good morning. Hopefully, you can hear me.

We can. Thank you.

All right. Good morning. I want to welcome everyone to our meeting to look at the core measure sets. This is very, very vital, important business, and really looking at how to measure the quality of care rendered to our Medicaid and CHIP enrollees. I will appreciate all the comments that Gretchen had. I'm going to be brief and just thank everyone for your time, commitment, and energy towards this process. After the end of three days, hopefully, we'll come out with some great recommendations. I really look forward to working with everyone. Thanks.

Thanks, David. Next slide, please. Now, we're going to introduce the Workgroup members and any disclosures of interest. Next slide.

To ensure the integrity of the review process, we asked all Workgroup members to submit a form that discloses any interest, relationships, or circumstances over the past four years that could give us a potential conflict of interest or the appearance of a conflict related to the current Child and Adult Core Set measures or new measures that will be reviewed by the Workgroup. Members deemed to have an interest in a measure

suggested for removal or addition will be recused from voting on that measure. During introductions, members are asked to disclose any interest related to the existing or new measures that will be reviewed by the Workgroup. Next slide.

On the next few slides, we have listed the Workgroup members in alphabetical order by their last name. I'll do a roll call and ask each of you to indicate whether you are here and whether you have anything to disclose. We're also going to do a brief icebreaker. After you give your name and disclosure, please indicate one thing you have learned or a silver lining you have experienced during the COVID-19 pandemic. Remember to unmute if you are muted and please be brief.

So, Gretchen, starting with you, please indicate whether you have a disclosure and one thing you have learned or a silver lining.

Sure. My name is Gretchen Hammer. I'm with the Public Leadership Consulting Group. I have no disclosures of conflict. One of the silver linings that I have observed is I've been going deep into the back of my kitchen cupboards and cooking with things I am finding there. The four cans of pumpkin have become pumpkin bread, et cetera. It's been nice to dig deep into the cupboards and use up some of those odd ingredients.

Thanks, Gretchen. David Kelley, you're next.

Hi, good morning. This is Dave Kelley, Chief Medical Officer for the Office of Medical Assistance programs, Medicaid program in Pennsylvania, and my disclosures that I was part of the consensus standards approval committee for NQF from 2015 to 2018. Currently I am part of the NCQA's Committee for Performance Measurement as of last January.

I think one of my lessons learned recently, since I have been telecommuting for several weeks now, is that there's one-hour meetings that we have had as routine that can usually be broken down into 25 to 30-minute meetings. That's the great thing about it. The problem with that then is instead of having eight meetings I now have 16 meetings in a given day. But that's the fun of it all. Thanks.

Great. Thanks, David. Richard Antonelli. You're next.

Yes. Can you hear me okay?

Yes, we can.

Oh, good. I'm Richard Antonelli, Medical Director of Integrated Care of Boston Children's Hospital. I have no disclosures. Personally, I have discovered that with the need to make daily, and sometimes, several times a day changes in operations of Boston Children's during COVID, it's allowed me to, "Work around the clock." That's brought me a fair amount of time to actually finish several of my watercolors and acrylic paintings since my easel is right next to my office working remotely.

Professionally, I have been told by people around the world that in the current pandemic, our care coordination tools are more important than ever. We're actually busier with implementation of them than we ever have been before. I look forward to the discussion over the next three days. Thank you.

Thank you. Lowell Arye.

Hi. This is Lowell Arye. I'm at Aging and Disability Policy Leadership Consulting. I have a disclosure that I have worked with ADvancing States, formerly NASUAD. ADvancing States is one of the stewards of the NCI-AD, which will be brought up during the LTSS discussions. It was a very small contract in 2019 for $850 working on quality issues.

What I have learned throughout this time is that there is impermanence as well as compassion and interdependence for everyone. That is what I've learned during this time.

Thank you. Tricia Brooks.

Yes. Hi. This is Tricia Brooks. I'm a research professor at the Georgetown University Center for Children and Families. I do not have any disclosures of conflicts. I know that those of us in the Medicaid world, but not as much as those on the front lines, we are living and breathing COVID 24/7, which I think adds stress to the work that we do. But I do believe there's a silver lining, and that is the acceleration of telehealth.

Great. Thank you. Laura Chaise.

Hi. This is Laura Chaise. I'm the Vice President of Product Strategy for LTSS as well as the Dual Demonstration Programs at Centene. My disclosure is that because I do work for a managed care company, and I also own some stock in that managed care company, it is possible that as a company, we could have financial incentives tied to these different measures. That's my disclosure.

My silver lining is getting to be in close proximity with my kids, and particularly my nine-month-old who said her first word, which is mama in the last couple of weeks. I'm enjoying and relishing every time she says it.

That's great. Thank you. Lindsay Cogan.

Hello. My name is Lindsay Cogan. I am the Director of the Division of Quality Measurement at the New York State Department of Health. I do not have any disclosures as they relate to the measures being discussed today. As a part of my role in the department, we often will work with organizations on measure development. I have received, or New York State has received, a subcontract from Q-METRIC the University of Michigan. But I don't see any of those measures being discussed this round. I am a member of the NCQA TMAP as well.

Any lesson learned or silver lining?

Oh, and my silver, my silver lining is that my hour and a half each-way commute has been cut down significantly. So, that my commute involves just walking into my kitchen.

Thank you. Jim Crall.

Yes. Hi, Margo, and everyone. Jim Crall. I'm a Professor and Chair of the Division of Public Health Community Dentistry at UCLA School of Dentistry. My disclosures are that

I have been involved as a representative of the American Academy of Pediatric Dentistry on the Dental Quality Alliance since its inception and since 2019 a representative of the American Dental Association on the DQA.

Also, I have a small consulting arrangement with Georgetown University as part of a project, a Maternal and Child Health Oral Health Resource Center in which we're working with MCHB to identify set of measures and pilot testing those measures with various states at the moment.

My silver lining is in recognizing just how much of a mental health asset my bicycle rides out along the Pacific Ocean are. Even though we can't ride right on the beach anymore because the beaches are closed here in Los Angeles County. I can still see the ocean and enjoy getting out to do that.

Great. Anne Edwards.

Hello, all. This is Anne Edwards. I am the Senior Vice President for Primary Care and Subspecialty Pediatrics at the American Academy of Pediatrics. Someone said that means, yes, I have been part of the team working 24/7 thinking about COVID-19.

I think both silver linings: I have seen colleagues across specialties come together in ways that I had not seen in the past. It gives me hope that we can continue to really transform the health care delivery and really support all families and patients. On the personal, I am working outside of Minneapolis a block and a half away from the Mississippi River. Sunrise runs along the river with a bald eagle flying overhead is a really nice thing to be able to do.

Thank you. Kim Elliott.

Kim Elliott, I'm an Executive Director at Health Services Advisory Group, an External Quality Review Organization. I have no disclosures, other than that I do approximately ten audits a year of performance measures or HEDIS measures. I'm a certified auditor.

My silver lining, I would say, is really seeing the good in people and the care that people are taking out in public situations or even in private situations throughout this pandemic.

Thank you. Tricia Elliott.

Hi, good morning. This is Tricia Elliot. I'm the Director of Quality Measurement of The Joint Commission. I do have a disclosure that the Joint Commission measures are part of the Core Set and the elective delivery measure being suggested for removal. I will be recusing myself from voting on that measure. I think it's during Day 2 tomorrow.

My silver lining probably, I thought our house was going to be very quiet for a while without our couple of college students. But they're all back. We were able to spend some time together. They may not enjoy it as much as I do, but I very much enjoy having them home. Thank you.

Great. Thank you. Steve Groff yesterday informed us that he's unable to attend the meeting this week due to his commitments related to the COVID-19 pandemic, and he sends his regrets he will not be able to attend. Moving along to Shevaun Harris.

Hi. Good morning. I'm Shevaun Harris. I'm with the Agency for Health Care Administration in Florida. We administer the Medicaid program. I'm the Assistant Deputy Secretary for Medicaid Policy and Quality. The thing that I have learned from a professional perspective is the resiliency of our health care delivery system in spite of all of the challenges, and the partnerships that have formed during this time.

Personally, I am really starting to question whether I'm smarter than a fifth-grader. I have a fifth-grader, an eighth-grader, and my brain is being taken back to times that I have long since forgotten related to math, and science, and other subjects. It's a little bit of a struggle here. Other than that, that's it.

Well, thank you. Diana Jolles, are you able to talk now?

All right. Can you hear me?

Yes, we can. Thank you for your patience.

Okay, all right. Yeah. This is Diana Jolles. I have no disclosures. My silver lining is that I discovered that my husband can wash dishes. It's been amazing, so, yay.

That's great. Okay. Next slide, please. Okay. David Kroll, you're next.

Hi. This is David Kroll. I'm a psychiatrist at Brigham and Women's Hospital in Boston. My disclosure is that I'm involved in the American Psychiatric Association's efforts to develop a quality strategy for the field of psychiatry.

What I have learned during this pandemic is that it's actually possible to call my mother more than once a week, which has been a great surprise to me.

Great. Thank you. Carolyn Langer.

Good morning. Can you hear me?

Yes, we can.

Okay. Thank you. Glad I'm able to join you. This is Carolyn Langer, Chief Medical Officer at Fallon Health. We're a regional health plan based in Central Massachusetts. We do work across almost all product lines: Medicaid, Medicare, PACE, commercial.

In terms of the silver lining, from a professional standpoint, as someone said earlier, I've been really gratified to see a lot of uptake of telehealth. I think we're learning some good lessons in terms of what types of services are amenable to telehealth, and which ones maybe are less amenable to telehealth. On a personal note, I have to say, I have been fortunate enough to take more walks with my husband in the last three weeks than I probably have in the last 20 years.

Great.

It's nice to have time with the family.

Thank you. Lauren Lemieux.

Oh, yes. This is Lauren Lemieux. I am a Program Director in the Strategic Health Care Initiative Department at the American College of Obstetricians and Gynecologists. My disclosure is that ACOG as an organization is a participant on the national adult and influenza immunization summit quality performance measures working group. I co-chaired the maternal immunization subgroup that was responsible for the development of the prenatal immunization status measure, which will be considered for addition later this morning. So, I will be recusing myself from the vote on that measure.

My silver lining is that I have had an opportunity I think to connect with people that I haven't really connected with in years that are all throughout the country on virtual meetings, like people from school. It's really connecting with people that are all across the country that I haven't seen, but otherwise, wouldn't have reconnected with. That has been great.

Great. Thank you. Jill Morrow-Gorton.

Hi. I'm Jill Morrow-Gorton. I'm a Senior Medical Director for the Community Health Choices and the DSNP program in Pennsylvania for UPMC Health Plan. The health plan, the University, probably do some measure development, but none of the current measures are ones that they're involved with.

My silver lining is that I now have two children living in the same household with me and close to my third child for the first time in probably the last ten years, which is not all COVID related. But it's nice to have everybody close.

Thanks, Jill. Okay, Amy Mullins. I think you're in now.

Yeah.

Can you introduce yourself? Thank you.

I dialed in.

Great.

Yeah. This is Amy. I'm the Medical Director of Quality and Science at the American Academy of Family Physicians. I have a couple of disclosures. One, my husband works for Cerner. He is a family physician that is employed there. Also, I am the co-chair of the core quality measure collaborative PCMH, ACO workgroup working on those core measure sets. I'm also a member of several other core measure workgroups through the CQMC. My silver lining for the quarantine time, there's several that I agree with of other people. Having my kids home from college and being able to spend time with them is one. The one that I've enjoyed the most, I think, is being able to go to work in my yoga pants every day.

Awesome. How many people are wearing yoga pants today? Fred Oraene, you're next.

Good morning, everybody. This is Fred Oraene. I'm with Oklahoma Medicaid Organization here in Oklahoma, Oklahoma Health Care Authority. I'm the director of our

data governance and analytics area within that agency. I do not have any disclosures. A silver lining for me during this period has really been more family time. Thank you.

Thank you. Lisa Patton.

Hi, everyone. This is Lisa Patton. I'm a clinical psychologist. I have changed roles since our last meeting. My current position is Vice President for Health Optimization at JBS International. Most of my work focuses on the opioid epidemic and has for quite some time.

I think Tricia Brooks mentioned this first. So, going third, the impact on telehealth has been great to see in this environment and is part of my silver lining. Personally, doing lots of Zoom dance calls with my 10-year-old nephew, I found out how important that is for my own well-being. No disclosures to report.

Thank you. Sara Salek.

Yeah. Hi. Good morning. This is Sara Salek. I'm the Chief Medical Officer of Arizona Medicaid. I do not have any disclosures. My silver lining is the health care community supporting one another. One example of that is in Arizona. We have had mental health professionals, including psychiatrists, volunteer their time to provide a free telephone support group up for other physicians, for doctors by doctors. That was really cool. That's it for me.

Great. Thank you. Marissa Schlaifer.

Hi. This is Marissa Schlaifer. I'm Vice President of Policy at OptumRx. My disclosures are just that I work for OptumRx, UnitedHealth Group. Therefore, I have stock in the UnitedHealth Group.

My silver lining is as of last night, I'm volunteering two nights a week as a pharmacist at the Arlington Free Clinic, where I normally only have time to do that once a month with travel and other things. Last night as I did that, I found out it was the most normal thing I've done in the last month. It just felt so refreshing.

Great. Thank you. Linette Scott.

Hi. Yeah. I'm Linette Scott. I'm with the California Medicaid Program, Department of Health Care Services. I serve as a Chief Data Officer. The only disclosure I listed was just that one of my areas of focus is around Core Set measures and reporting them to CMS as well as to other entities, stakeholders, and such. So, sometimes present on those topics. Thank you.

Oh, silver lining. Sorry. I think the silver lining people have said it telehealth and telework is just absolutely incredible to me how so many organizations turned on a dime and went from maybe less than 10% teleworking in a week to being at over 80% teleworking. It really changes the norm and such. I think it's going to be a transformative event in our culture and our society related to telehealth and telework, that will shift things long-term, not just during COVID. It's been a silver lining.

Great. Thanks. Jennifer Tracey. Jennifer, are you there? Are you on mute?

Apologies, I was on double mute. Thank you. Good morning everybody. I'm Jennifer Tracey. I'm the Senior Director of Growth and Sustainability with Healthy Steps, which is a program of Zero to Three. I focus mainly on all things early childhood and supporting families with young children. No disclosures to report.

One silver lining for me has been slowing down a little bit and spending more quality time with my family since there are no sports and other activities. Also, teaching my three children how to navigate around the kitchen a bit. Thanks so much.

Great. Thank you. Now, we're down to the Z's. We may not have Ann Zerr or Bonnie. But Ann Zerr, are you on? Bonnie Zima, are you on? We have a whole team behind the scenes that are monitoring mailboxes and chats, and so on. I think we've determined that Ann and Bonnie are not on yet, but we'll come back to them after we continue the rest of the introductions, and hopefully, they'll be back on by then. Okay. Next slide, please.

We're also joined by federal liaisons who are non-voting members. I'll read the name of agencies, but not do an individual roll call. First, Agency for Healthcare Research and Quality, Center for Clinical Standards and Quality, Centers for Disease Control and Prevention, Health Resources and Services Administration, Office of Disease Prevention and Health Promotion, Office of the Assistant Secretary for Planning and Evaluation, Substance Abuse and Mental Health Services Administration, and the US Department of Veteran Affairs.

I'd also like to take the opportunity to thank our colleagues in the Division of Quality in the Center for Medicaid and CHIP services or CMCS, and also, the measure stewards who are attending and available to answer questions about their measures.

Let me go back and see if maybe we have Ann Zerr. Ann, if you're there, could you unmute? Bonnie Zima? Okay. We'll keep on the lookout for them. Why don't we move along? I know we fallen pretty far behind because of the delays in getting started and also the introductions. But very much appreciate all the introductions, silver linings, lessons learned. I think it's just really nice to hear everybody's voice and everybody's reflections. So, next slide.

I'm going to talk about the context for measure review before we review the measures. I'm going to go rather quickly in the interest of time. But also, please note that the slides and other background materials are available in the resource section of the webinar platform. Next slide.

This slide is a recap of material presented at the March 19th webinar. A few key points I wanted to emphasize here about the purpose and uses of Core Set measures. The purpose of the measures is to estimate the national quality of care for Medicaid and CHIP beneficiaries. These measures can be used to monitor program performance and drive improvements in care delivery and health outcomes. Improvement on the measures should be actionable by state Medicaid and CHIP programs.

We asked the Workgroup to review the measures from the lens of the purpose and uses of the Core Sets. Now, there are many quality measures, not all would be a good fit for the Core Sets. That's the charge to the Workgroup members to recommend measures

that are a good fit for the Core Sets. Also, to note which measures may not be a good fit for the Core Sets but can be used for other purposes by Medicaid and CHIP agencies. Next slide.

This slide also provides a recap of material presented at the March 19th webinar. The Workgroup should seek to optimize the desirability, feasibility, and viability of measures by recommending measures for addition that are desirable, that are actionable, and aligned with strategic priorities in Medicaid and CHIP. Also, that are feasible and viable for states to implement. Conversely, the Workgroup should recommend measures for removal that are no longer considered desirable, feasible, or viable for state-level reporting in the Core Sets. Next slide.

Now, for a bit of level setting about the Core Sets, currently, the Child Core Set includes 24 measures, and the Adult Core Set includes 33 measures. As we discussed last year, CMS does not have a target number of Core Set measures, either minimum or maximum. We encourage the Workgroup members to consider each measure on its own merits according to the criteria that Dayna will discuss shortly.

Next, we wanted to note how frequently states report measures in the two Core Sets to give a sense of the feasibility of the current measures. For FFY 2018, which is the most recent cycle for which data are available, states reported a median of 18 out of 26 measures in the Child Core Set and 20 out of 33 measures in the Adult Core Set.

As you'd expect, the most frequently reported measures are those that states can calculate accurately using claims and encounter data. Those less frequently reported required other data sources and methods to produce accurate results such as medical record abstraction, electronic health records, or survey data collection. Perhaps not surprisingly, it often takes a year or two to publicly report new or revised measures since it takes time to ramp up for reporting. Next slide.

This slide lists the seven Core Set domains, including one domain added last year, namely, Long-Term Services and Supports. We want you to keep in mind that CMS will assign the domains when updating the Core Sets for 2021 and we will not be focusing on domain assignments during the meeting. We also wanted to note that some measures cut across the Child and Adult Core Sets. Again, CMS decides which Core Sets to assign the measures to. Next slide.

Next, we wanted to note that measure stewards typically update various aspects of the measure technical specifications annually. Changes can reflect a variety of factors such as new clinical guidance, coding updates, new data sources, and technical corrections identified by users. Many of the measures being reviewed are in the process of being updated or were recently updated. We've done our best to reflect the most accurate and up-to-date information about each measure. Next slide.

My final introductory slide is about the context for the 2021 Core Set Review. We wanted to mention a few factors that Workgroup members may want to consider as part of the discussion and voting about measures. First, as I mentioned briefly during the March 19th webinar, CMS is actively exploring the use of alternate data sources to support calculation and public reporting of several current measures. The purpose is to reduce state burden, and improve the completeness, consistency, and transparency of measures.

I've listed a few examples here, including the use of T-MSIS for calculation of the PDENT measure, which is a dental measure in the Child Core Set; the use of the AHRQ CAHPS database to report CAHPS measures for both the child and adult populations; and the use of CDC WONDER for two measures based on vital records, namely low birth weight rates and low-risk C-section rates.

The next factor acknowledges the increasing use of digital measures and electronic data sources. As we noted in the March 19th webinar, there are four measures suggested for addition that use electronic clinical data systems or ECDS.

This review is also part of what CMS calls the path to 2024, when mandatory reporting goes into effect for all Child Core Set measures and behavioral health measures in the Adult Core Set. These measures will need to be reported by all states, for all their Medicaid and CHIP populations. As a result, measure feasibility is a key consideration for the 2021 Core Set Review.

The final contextual factor, of course, is the implication of COVID-19 for quality measurement, and in particular the feasibility of measures requiring medical chart reviews or using the hybrid methodology. Before we move on, I'd like to invite Gretchen and David to comment on the charge and context for the Workgroup discussions. Gretchen and David?

Thank you so much, Margo. I really appreciate the overview. It always feels great to have you ground us in what we're doing. I think the only other things I would say is we have fewer measures this year to review, which will give us all, I think, a sigh of relief given the amount of content we worked through last year, but I do think that these concepts of feasibility, et cetera, are really critical. I think as we go into this again, keeping our eye on the long-term is really important, out of recognition of the soon-to-be mandatory reporting requirements and the changing landscape of the health care delivery system. I look forward to diving in and don't have any other additional context. David?

Thanks, Gretchen. Again, I think the COVID pandemic has really enlightened us to some of the challenges of feasibility and really making chart review very difficult to do, being face-to-face in hospitals and office settings. I think that we should really view this and say, an opportunity to learn from what's going on currently in the land of quality measurement. Moving again, hopefully, more and more to digital and e-measurement whenever possible, and also, while taking into consideration the use of telemedicine and including that in some of the measure sets, some of the measurements that are up for-- to be looked at.

Again, I think that feasibility is really an important note here. But obviously, we want to make sure that we're selecting or deselecting, selecting measures that are really very important and actionable whether gaps in care-- Obviously, we're deselecting and we're thinking in terms of feasibility, but maybe in terms of certain measures that we've topped out. It's time to dive into our work.

Great. Thank you, Gretchen and David. Before we move along, I just wanted to find out if Bonnie Zima is here yet, and if so, if you can unmute and introduce yourself?

Yes. I'm here. I have nothing to disclose.

And Bonnie, we all went to -

Can you hear me?

Yes. Can you hear me?

Yes.

Okay, great. Do you have a silver lining or something that you've learned as a result of the COVID-19 pandemic? We all did an introduction with a little icebreaker.

Yeah. I think in reflection probably, what I'm most grateful for it's actually my patients and their families, and thinking about all of my medical colleagues who, really together, we've been able to continue caring for most all of our patients through telehealth. I think it's been an absolute pleasure to see our children in their homes with their parents and even sometimes they bring their pets to their medical visits. Just giving a really nice dimension to continue to care for the kids in our clinic.

That's great. Thank you. Let me check whether Ann Zerr is on. We think that she's not on yet. Is Ann on? Are you able to unmute? Okay. Well, let's keep going. At this point, I'm going to turn it over to Dayna to talk about the criteria for reviewing the measures and to share the voting logistics. Next slide.

Dayna? All yours.

Thanks, Margo. Before I get started, I just want to remind Workgroup members to make sure you're signed into the voting app or the voting website. We'll be ready to practice voting in just a couple minutes. Next slide.

I know our Workgroup members have seen these criteria a couple times, including in the call for measures. I'll quickly walk through these just to keep them top of mind, and for any public attendees who may be seeing these for the first time. The first category of criteria for suggesting measures for addition are minimal technical feasibility requirements. All suggested measures must meet these requirements. The measures we'll discuss today have passed through Mathematica's initial screen based on these criteria. This means that the measures up for discussion should be fully developed and have detailed technical specifications for producing the measure at the state level, have been tested or used by at least one Medicaid or CHIP program, have an available data source or validated survey that includes an identifier for Medicaid and CHIP beneficiaries, and should allow for consistent calculations across states. Next slide.

The second category is actionability and strategic priority. Measures that are recommended for addition to the Core Set should contribute to estimating the overall national quality of health care in Medicaid and CHIP; provide useful and actionable results to drive improvement in state Medicaid and CHIP programs; and must address a strategic priority in monitoring the performance of these programs. Next slide.

Finally, a few other questions to consider: is the prevalence of this condition or outcomes sufficient to produce reliable and meaningful results across states? Is this measure

aligned with those used in other CMS programs? Will half of the states be able to produce this measure by federal fiscal year 2021 or 2022? And will all states be able to produce this measure by 2024 for all their populations? Next slide.

When Workgroup members are considering measures for removal, we ask them to consider the following questions. Are states able to access the data needed to calculate the measure? Does this measure provide actionable results for state Medicaid and CHIP programs? Is there another measure suggested for addition that better aligns with those used in other CMS programs? Looking ahead to mandatory reporting, will all states be able to produce this measure by 2024? Those are just some of the examples we have included on this slide. Next slide.

With those criteria in mind, a quick overview of the voting process today. Voting will take place by domain after both Workgroup discussion and public comment. Each measure will be voted on in its specified form. If a measure is being considered for removal, a yes vote means I recommend removing this measure for the Core Set. If a measure is being considered for addition, a yes vote means I recommend adding this measure to the Core Set. Measures will be recommended for removal or addition if two-thirds of eligible Workgroup members vote yes. Next slide.

Before I go on, are there any questions from Workgroup members about the criteria or voting before we move along to a practice vote?

Remember to unmute if you have something to say.

Okay. Hearing nothing, I will move us along. Next slide. Okay. As a reminder for all attendees, voting will be just for Workgroup members. Workgroup members, please make sure you're logged into your voting account and have navigated to the Core Set Review voting page. You can remain on this page for the duration of the webinar. New voting questions should appear as we make them available. If you're not seeing them, try refreshing the page, and they should show up. If you need any help, please refer to the voting guide we've provided you with or send us a chat through the Q&A widget.

Also, during the voting on measures, I know we're all working with this new technology, if for any reason, you're unable to submit your vote, please send us your vote through the Q&A widget; that way we will be able to count your vote. Your votes will be visible just to the Mathematica team. So, no concerns about privacy there. Next slide.

Okay. Our first vote. I will go ahead and activate it now. You should see it if you are logged in. The question is, have you had any coffee or tea today? The options that should appear on your voting page are yes, I have had coffee or tea today, or no, I have not had any coffee or tea today. We are expecting 26 votes if everyone is on. Voting is open. For our West Coast Workgroup members joining us early in the day today, this one's for you. Okay. We've got 21 so far. We're waiting on just a couple more. Again, if you're having any difficulties, feel free to submit them through the Q&A or just let us know. Okay. We have most votes in. Hopefully, those who are unable to do this one, we can talk to you in the Q&A and get you online for the next one. Let me lock the results. The results are 18 of our Workgroup members have had coffee or tea today and 4 have not had any. I will move on to the next question. Next slide.

The second vote is, which kind of snacks do you prefer? The options are, I'm a salty snacker, or I opt for sweet treats. Voting is now open. Okay. We'll give it just another couple of seconds. We already have 22 results in. Okay. We'll go ahead and call it for now. The results are, we have 12 Workgroup members who are salty snackers, and that just edged out the 10 who opted for sweet treats. I know a lot of us have snacking on the mind right now. If anyone wasn't able to vote, just talk with our team members in the Q&A chat, and we will get you ready to go before that first vote starts. Okay. Next slide.

Now, I will turn it over to Tricia to discuss the first domain, Long-Term Services and Supports.

Great. Thanks, Dayna. We'll begin by discussing the Long-Term Services and Supports or LTSS domain. There is one LTSS measure in the current Core Sets, and two measures have been suggested for addition, which we'll discuss in turn. Next slide.

The LTSS measure in the 2020 Adult Core Set is the National Core Indicators Survey or NCI. The NCI is new to the Core Set for FFY 2020. The NCI includes the family of surveys that provide information on beneficiary experience and self-reported outcomes of long-term services and supports for individuals with intellectual and developmental disabilities and their families. State developmental disability services agencies voluntarily conduct the survey.

The Adult Core Set includes the NCI in-person survey, which can be administered by state staff or a contracted survey vendor. To report state-level performance results for the Adult Core Set, CMS plans to use data that state developmental disability services agencies submit to the measure steward, which is the National Association for State Directors of Developmental Disabilities Services and the Human Services Research Institute. Next slide.

The first measure that has been suggested for addition to the 2021 Adult Core Set is the LTSS Admission to an Institution from the Community or MLTSS-6 measure. MLTSS-6 measures the number of admissions to an institutional facility among managed LTSS plan members age 18 and older who have been residing in the community for at least one month. The measure captures three rates: short-term stays of between 1 and 20 days, medium-term stays of between 21 and 100 days, and long-term stays of 101 days or more. Institutional facility admissions are reported per 1,000 enrollee months. CMS is the steward for this outcome measure, and it is not currently endorsed by NQF. Next slide.

MLTSS-6 uses paid administrative claims as a data source, and it's specified at the plan level. The denominator includes the number of enrollee months where the beneficiary was residing in the community for at least one day of the month. The numerator includes the number of institutional facility admissions between August 1st of the year prior to the measurement year through July 31st of the measurement year.

Admissions are reported in the three categories I mentioned earlier: short, medium, and long-term stays. The Workgroup member who suggested this measure noted that it is an indicator of access to services and support and care coordination needed to avoid institutional admissions. The Workgroup member indicated that this measure is under consideration as part of CMS's starter set of national home and community-based service measures.

Additionally, a similar measure is included in the Health Home Core Set and was reported by 16 health home programs for FFY 2018. The Workgroup member who suggested this measure acknowledged that states define their LTSS waivers differently. This measure might not lend itself well to comparisons across state. However, the Workgroup member noted that this would be the case for any LTSS measure and doesn't diminish the importance of the measure for monitoring and improving LTSS. Next slide.

The second measure suggested for addition in the LTSS domain is the National Core Indicators for Aging and Disabilities Adult Consumer Survey or NCI-AD. NCI-AD is a voluntary effort by state Medicaid, aging, and disability agencies to measure and track the performance of LTSS programs. The indicators address 18 different areas, which are listed on the slide. This measure is stewarded by ADvancing States and the Human Services Research Institute. The data source is an in-person survey, and it's not currently endorsed by NQF. Next slide.

The sampling frame for the survey includes older adults age 55 and older or adults ages 18 and older with a physical disability who received LTSS at least two to three times a week. The denominators and numerators include individuals who respond to the survey question or questions from which the indicator is drawn. The slides have some examples of these indicators.

Sixteen states collected data in 2018 to 2019, which is the most recent year for which data collection is complete. A total of 28 states have ever conducted the survey. The Workgroup member who submitted this measure indicated that the measure is focused on the unique and complex needs of older adults and people with disabilities who receive LTSS. This population accounted for 23% of Medicaid enrollment, and 55% of Medicaid expenditures in FFY 2016. The measure would complement the current NCI measure, which is focused on beneficiaries with intellectual and developmental disabilities. The measure steward provides technical assistance to states, which could promote completeness and validity of the data. Next slide.

Now, I will pass it back to Margo to facilitate the Workgroup discussion.

Thank you, Tricia. Now, we'll invite comments and questions from the Workgroup members. This also includes federal liaisons. Unmute your line if you wish to speak, and please remember to say your name before making your comment. Let's begin with discussion of the MLTSS-6 measure, and then separately, we'll go on to a discussion of the NCI-AD measure. To start, I welcome Workgroup comments on MLTSS-6. Remember to unmute if you wish to speak.

Hi. This is Marissa Schlaifer. Mine is definitely a question, not a comment. It really probably applied to the newer measures, more than the older measure. But I always get so much out of the discussion from our Medicaid program people who are currently at Medicaid programs doing quality work. On this one more than in any other, I feel I need some good input on as far as the logistics of surveying and how easy or hard these measures would be to either currently implement or the new measures be implemented. Was asking across all of them.

That's great, Marissa. Yeah. Go ahead, Lowell.

I'm sorry. This is Lowell Arye. Although I'm not current, I'm current enough for MLTSS. I was Deputy Commissioner in New Jersey when we implemented MLTSS. This actual indicator is one that we actually included in our quality measurement with the managed care companies. It was very easy for them to keep up with, and it was not an onerous kind of thing. In fact, it was something that we have been doing this for fee-for-service as well. For our MLTSS, it was something that was easy, and it was definitely something that all four, and we got a fifth managed care entity came in and to have no problems tracking this quarterly if I remember correctly.

Lowell, this is Lindsay Cogan from New York State. Can you talk a little bit about whether those plans had an integrated product line -- because our plan is long-term care services in New York State. We have a particular product line that looks at just the Medicaid services. Then we have more integrated services, but I worry about those managed long-term care arrangements that don't include both the Medicare and the Medicaid piece but looks just at the Medicaid portion of that because that's the payer of last resort. A lot of the hospitalizations may be covered by Medicare.

That's my first concern of that measure. The second concern I have is just on risk adjustment. I'm not seeing any mention of risk adjustment in a measure where you're looking at transfer from the community to an institutional setting. We often work on pretty robust risk adjustment to ensure that we're not penalizing for appropriate care or moving someone to a setting which they really needed to be based on the severity of their condition.

Right. I can speak to New Jersey, when we implemented MLTSS in 2014. We did not have an integrated approach. We did move forward towards an integrated approach over the next couple of years. We're not an abiding state but close enough to abiding state. But when we first implemented this particular measurement, we were just looking at Medicaid because we were looking at it, specifically for people who were in home and community-based services primarily under our waiver, which became an 1115 waiver when we moved to MLTSS. With that regard, that was the case.

There were certain pieces on your second question with regards to risk adjustment. We did want to make sure, and we did put in some specifics in New Jersey, and other states have done this as well. Specifically related to ensuring that there was at least some push to keep the people in the community with the understanding that, as you're likely saying, that there are just some people that will need nursing home care at some point in the future. I don't believe that this quality indicator gets into that, from what I understand of it. Because from the risk adjustment side, simply all it's doing is looking to see if people who have been in the community, if it's for at least one month, at least one day of the month are then moved into nursing homes. It's more of a process-oriented piece rather than an outcome measurement piece from what I know of this. I hope that helps.

Hi. This is Laura Chaise. Can I just address some of these questions directly in terms of the integrated versus non-integrated? Within the CMS specifications for the admission measure, it actually defines the eligible population as people who receive both long-term services and supports as well as having a benefit for medical care and services. It allows plans and states to exclude people who do not have aligned enrollment between their duals between Medicare and Medicaid.

This is Jill Morrow.

This is Gretchen. Go ahead.

I just wanted to say, I think from the standpoint of philosophy and the measure in terms of looking at people either going into facilities or coming out of facilities from a long-term services and supports in-home and community-based setting is a really good thing to look at. I had a little concern about the measurement of the definition of residing in the community, which is that you've spent one day in the community in the last month. That seems to be a really-- not necessarily a reflection of whether or not somebody really has been in the community. I just had a little concern about that.

This is Gretchen. I just think globally, when I look across the landscape of Medicaid programs, and this will come up, I think later in our deliberations on a number of measures. I am hesitant to endorse or to recommend for addition measures that are just oriented towards health plans. Not every state in the nation uses a managed care infrastructure to deploy their Medicaid program.

I just worry that we are not going to account for those other states, when either the measures are defined at the health plan level, or only relates to that type of delivery system. I don't know if we want to have a general conversation about that Margo or if Mathematica has wrestled with that or had conversations with CMS about that larger global issue of when it's a measure that's really oriented towards managed care, but managed care is not the way all Medicaid is delivered across the country.

Yeah. This is Margo. That's a really good point, Gretchen. One other point I wanted to make specifically about this measure is that it is used in the health home program. We did see 16 SPAs or state plan amendments, which is the unit of reporting for the health home programs, that they were able to report the measure. There have been adaptations to what we would call the program level, which isn't specifically managed care. I think it could be adapted outside of managed care, but I think it's a really good point. We certainly welcome Workgroup member perspectives on that, and also the measure steward or with the folks working on the measure. Happy to open the line for Roxanne or for someone else who wants to make a comment about that.

Hi. This is Linette Scott from California. Sorry, I'm not one of the measure stewards but just to echo along those lines. I'm a little confused reading it as to whether this is one of the measures supposed to be used for long-term support services across the board, or if it's specific for managed long-term support services because, in California, we've done MLTSS in a subset of our county. It's not the whole population. So, echoing the other comment that not everything is in managed care. Is this proposed to use the measure specifications for all LTSS across the board, or is this really specifically to MLTSS?

I think we have somebody, Colleen McCarron. Perhaps who can speak to that. Colleen, if you're on the line, I think you need to press star one to be able to speak. Colleen, are you there or Roxanne? Colleen?

Are you able to hear me?

Yes. Now we can. Is this Colleen?

Yes, this is Colleen.

Yes. Can you please introduce yourself?

Sorry, I was double muted.

Sure. Thank you.

Yes. The question about whether it would be appropriate for use of this measure outside of a managed care state. The measure was tested for use in managed care. That is the primary vehicle that we would recommend using it for. That said, I don't foresee a reason why the specifications couldn't be expanded to accommodate long-term services and supports that are outside of the managed care domain.

Yeah. This is Margo. As I said, it's already being used in the health home program for the Health Home Core Set, which is another Core Set not being reviewed today. But it has been used at a program level in that Core Set.

I appreciate that, Colleen. Thank you for the clarification. This is Gretchen. One of our guiding principles has been, however, we vote on the measure as it's currently defined not as it could be modified. It was a clear line that we set last year. I think we want to continue this year, which is there's no modification. There's no adjustment. It is what it is. That's the measure we're voting on. I appreciate the flexibility and how it may be. But to the extent it's framed the way it is, I think it would be my understanding, and please confirm, that this would only be applied to managed care, if it were to be added to the Core Set as written today.

Gretchen, this is Laura Chaise. May I add just an important piece of context on this. I'm the one who recommended the measure, I will out myself, and I had actually recommended a pair of measures. This measure is specific to managed care plans. There is an additional measure with specifications that is specific for fee-for-service programs, which is called Admission to an Institution from the Community Among Medicaid Fee-for-Service, Home and Community-Based Service Users, or HCBS-1. There's actually a corresponding measure that can be used in non-managed care space and population.

That second measure, Mathematica determined had not sufficiently been tested. That is why we're not discussing it today. However, as we think about a longer-term pathway, I think we could potentially see a scenario in which over the next year or two, that second measure could potentially meet the qualifications to be considered for the Core Set as well.

Thank you. That's very helpful context.

This is Kim Elliott.

Margo, this is Jennifer Tracey. Oh, sorry, go ahead.

Oh, okay. There are a couple things with this one. What are we really trying to incentivize by measuring this? Because there are really good reasons to admit people for short-term medium or long-term stays into nursing facilities based on health

conditions or different procedures or things that occurred in that individual's life. I'm not confident that we have a real clear understanding of what we're really trying to accomplish in measuring this because increases could be good, or decreases could be good in those rates.

Could you say who was just speaking?

This is Kim Elliott.

Oh, Kim. Thank you very much. Okay. Jennifer, did you have a comment as well, or question?

Yes. It was just Margo, on the Mathematica side to Gretchen's point around not all states have MLTSS. I was curious from the Mathematica side if you all had statistics handy? I didn't see them in the write-ups for the measures in regard to how many total Medicaid beneficiaries receiving LTS Services since they're covered under MLTSS arrangements now in the states. Also, just a total number of how many states this may exclude that do not use MLTSS as their delivery systems for LTS Services.

It's a great question, Jennifer. I don't actually have those numbers available at this point. I don't know if anybody else does who could speak to that. It is a good question. I know it is not the majority, for sure.

Yeah. I was just thinking in light of the fact that these measures ideally would be mandatory in 2024. Gretchen's point seems to be a valid when about how the non-managed care fit into something like this.

This is Jill Morrow.

Thanks, Jennifer.

I can bring the perspective from Massachusetts that while Massachusetts does have managed care and managed long-term services and supports, it also has a fee-for-service, fairly large fee-for-service program. This measure would be totally doable. The Medicare or Medicaid piece is always an issue because you don't always have both of the data sources.

The other thing that I think about in terms of why we look at the different timeframes is the short-term admissions often are appropriate. It's the short-term admissions that turn into the long-term admissions that sometimes indicate that you don't have a program or the appropriate community-based supports for people, for them to come back out of the nursing facility.

Yeah, there always are a small group of people for whom long-term nursing facility is going to be kind of the end result. But I think there is many people and the people that we want to prevent from ending up in nursing facilities for the long-term are people who can be supported in the community. That's how I think about those timeframes and how to use them.

Thanks, Jill. I did want to mention that we did receive through the Q&A some information to answer Jennifer's questions, that there are 24 states using MLTSS, and approximately

1.8 million individuals are getting their LTSS through managed care plans. So, thank you for that information. Thank you, Laura, also for providing that information. With that, are there any other comments before we move on to talk about NCI-AD? So, that we can vote and get you on your way to a break.

This is Dave Kelley. Just again, a quick comment, one thing about this measure is that you have to go into calendar years. The programs that are starting up that delays its use given in managed care. I think that the fact that I didn't hear anything about risk adjustment that is a little bit concerning. I will just say that in Pennsylvania we have three plans that I'll just say have massively struggled to report the four basic NCQA measures to us. I can't understand quite honestly why they have struggled, but they have. This is actually one we have not, at this point anyway, have not implemented in Pennsylvania. But I also have concerns that only 24 states have managed LTSS.

I understand the reason for removing the fee-for-service components of this measure. Again, if we are looking at a Core Set, that right now only 24 states could even possibly measure that, I'm not sure it's really hitting some of the thresholds that we've set forth. I think there also was a comment about mandatory reporting. Maybe I can be clarified on this and corrected on this. But I think only the pediatric and behavioral health measures are being mandatorily reported by 2024.

I like this measure overall. I think in Pennsylvania, it's something that we will queue up. We'll probably going to put it on hold because of the COVID pandemic and challenges with quality measurements in general for this year. But it's certainly one that I think in Pennsylvania in our LTSS program we will queue up over the next year or two.

Thanks, David. We also do have somebody waiting to speak. Operator, can you unmute Lisa on the public line?

Hi. Can you hear me?

Yes, we can. Thank you.

Hi. This is Lisa Alecxih. I'm with the Lewin Group currently stewarding this measure. There is a risk adjustment for it. It involved dual eligibility, age, gender, diagnosis, number of hospital stays, and months of enrollment. There is a key component there.

Thanks, Lisa. Any other comments from the Workgroup members before we move on to the NCI-AD measure? Okay. Lisa, can you mute yourself again? Thank you.

Okay. Let's move on to the NCI-AD measure. Are there comments from the Workgroup?

This is Lowell. I'm sorry. This is Lowell. I did put forward this, and it was recommended by the Workgroup last year, which was not mentioned. It was not accepted by CMS. However, just for people to know. Although in FY18 there are less states, there are currently-- my understanding currently 24 states this year will be utilizing it one way or the other. Three of those states are still in the technical assistance year. But that means that the 21 states currently are utilizing it with three additional coming on as well. I wanted to let people know that. I think that's an important component for people to know. Thank you.

This is Amy with AAFP. I'm digging back through my memory banks of what we talked about last year in this measure. I think one of the questions we raised was, who was eligible to fill out the survey as part of the measure? I can't remember what the answer to that question was. But I think that's what I remember as being a question. That perhaps those that were required to fill out the survey would not be completely 100% capable of doing so. That was part of the problem.

Amy, that's a good question. It is an in-person survey. Camille Dobson or someone from HSRI, do you want to say a little bit more about the in-person nature of it to collect the information and who responds to the survey? Also, maybe a little bit more about the current status of the survey? Camille, are you unmuted, or are you able to speak or someone else from HSRI? You need to press star one. Thank you.

Hello. Can anyone hear me?

Yes. Is that April?

Yes. Okay.

Okay. Well, go ahead. Thank you.

Hi. This is April Young with ADvancing States. We are one of the measure stewards for NCI-AD. Yes, that is correct, this is an in-person survey. Since the COVID crisis has happened, I think we understand that a lot of states would prefer other modalities in addition to the in-person. That's something we are considering absolutely going forward. But we want to be really careful about how we proceed. We haven't made any definitive decisions about that. As it stands now, it is in-person survey.

Great. Thank you, April. Camille, are you able to speak? Press star one. And operator, can you unmute Camille Dobson?

Hi, this is Camille. Can you hear me?

Yes, we can.

Oh, perfect. I've been hitting star one, and somehow, I have not been able to unmute myself. I apologize. I think you had a couple of questions about who get surveys, the states, the universe of individuals eligible for the survey are receiving LTSS either older adults or people with physical disabilities. They're randomly selected. We do require the states to do a minimum of 400 surveys, in-person surveys every year. Though, many of our states over sample and do more than that, so that they can compare by regions, by accountable entity, in some cases health plans, by gender and racial backgrounds, of racial makeup. I think that's the only fundamental question about who's eligible to these surveys.

Lisa, did that answer your question?

This is Amy. Mine was really—could the proxy help with the patient with the survey.

Yes. The survey you're asked, the first I think eight or nine questions if the individual is not able to answer the survey questions, they're able to select a proxy. We do allow

proxy to answer a number of the questions. Obviously, not ones that are related to the individual's specific experience, but majority of the questions can be answered by the proxy.

Thank you. Other comments?

This is Jill Morrow. I just wanted to add that the NCI, both the ID and the AD versions, have a lot of experience, a lot of data, and information behind them. They have really nice ways to accommodate, asking the same questions for people who may be nonverbal, which is true even in the group of people, elders, and people with physical disabilities. I think that's a real strength of this survey tool.

Operator, I think we have another comment. April, are you able to speak now?

Hi. This is April. Can you hear me?

Yes, we can.

Okay. No, I didn't have anything to add. Sorry. I was trying to make sure I was muted. I think I unmuted myself, but if there're any other questions, we're here.

Okay. Thank you. Okay.

This is Laura Chaise. May I make a comment?

Yes, please, Laura.

Thank you. I'll just say that in addition to what was said before about this being just an absolute treasure trove of information. I was knee-deep in looking at results across multiple states just a couple weeks ago. There's so much good information in this survey. But also, I would just say from a global standpoint, when we think about what's important to measure in the realm of LTSS, beneficiary experience is just so critical. I think this is just a great compliment to the NCI for persons with intellectual and developmental disabilities. This allows us to measure another considerable chunk of the LTSS population and their beneficiary experience. That for me is pretty important.

Thanks, Laura. Any other comments?

Yeah. This is Lowell again. I just wanted both to reiterate what Laura was just saying, but also, to make sure to remind people that the only LTSS components that we recommended-- both the NCI and NCI-AD, last year -- the only one that CMS agreed to was the NCI, which was for the IDD population. Given that 61%-- 30 or more percent of Medicaid expenditures are for long-term services and supports, and 61% of total LTSS expenditures are for individuals-- older individuals and people with physical disabilities. It's important that we continue, and that we do have an LTSS Core Set for seniors and people with disabilities.

In addition to that, I would just say, that for people who might be concerned that currently, only 24 states are currently utilizing it. I can say, that I've looked at the Core Set even in the current Core Set there are nine Core Set measurements that have less than 25 states doing it. Several of them are up for potential removal. But I must say that

there are, as I said, nine in the adult and three in child that have less than 25 states. I just wanted to let people know that as well. Thank you.

Thanks, Lowell. Gretchen and David, do you have any additional comments before we move on to the opportunity for public comment?

No, I have no additional comments.

Yeah. I'm fine as well.

Okay, very good. Next slide, please. Now, we'd like to provide an opportunity for public comment. If you would like to make a comment or ask a question, please press star one to enter the queue, and please remember to say your name and affiliation before you make your comment. Operator, do we have anybody in the queue for public comment. Again, just a reminder, press star one to enter the queue. We'll give it a couple of minutes.

Okay. I think now we'll move on to voting on the measures. Thank you, Workgroup members, for all of your input and also to the measure stewards for being available for comment as well. Now, I'll turn it over to Dayna for voting on the two LTSS measures. It's all yours, Dayna.

Great. Thank you, Margo. Next slide. Okay. One more. Okay. For our first vote, the question is, should the Long-Term Services and Supports Admission to an Institution from the Community (or MLTSS-6 measure) be added to the Core Set? The options are, yes, I recommend adding this measure, or no, I do not recommend adding this measure. The vote is now live.

Okay. We have 23, just waiting on a couple more. As a reminder, if you have any questions or are unable to submit your votes for any reason, please enter it through the Q&A. This is just for Workgroup members. Okay. We'll give it just two more seconds. I believe we're getting a couple answers under Q&A. I'll just tally those and have an answer to you. Okay.

Results are in. Voting is now closed. For the results, we received eight yes votes. That does not meet the threshold for recommending this measure. The LTSS Admission to an Institution from the Community measure is not recommended by the Workgroup for addition to the 2021 Core Set. Next slide.

Great. The next question is, should the National Core Indicators for Aging and Disabilities NCI-AD Adult Consumer Survey be added to the Core Set? The options are, yes, I recommend adding this measure, or no, I do not recommend adding this measure. Voting is now open.

Okay. So, it appears that all the votes are in. I am now going to lock voting. Okay. For the results, we received 13 yes votes. That does not meet the threshold for recommendation of two-thirds. The National Core Indicators for Aging and Disabilities Adult Consumer Survey is not recommended by the Workgroup for addition to the 2021 Core Set. Okay. Now, I will turn it back to Margo to facilitate a discussion of gaps in the LTSS domain. Margo?

Well, thank you, Dayna. And thank you, everyone, for testing out our voting software for real. I appreciate everybody staying with it. We're a little bit behind schedule. But I'd like to try and go for about ten more minutes if everybody can bear with us so that we can talk about gaps in the LTSS area. That is something as I mentioned, we wanted to try and do within each domain, and then we'll come back at the end of the meeting to reflect on the gaps in the areas for measure development.

We would like to hear from Workgroup members about possible gaps in the LTSS area, what types of measures or measure concepts are missing in the Core Sets. And are there existing measures to fill the gap, or would a new measure need to be developed? Please remember to say your name before making your comments. Opening up the lines for Workgroup members.

This is Jill Morrow. I think that I'm going to talk about two gaps. I think one gap is the measurement of institutional placement, whether you do it from the community to the institution or from the institution back into the community. I think the other gaps that we have is some way to measure the benefits of the services and some outcomes related to what the services are doing.

Thanks, Jill.

Excuse me. This is Gretchen. I would add to that. I think the measure around admission to the institution from community, whether it be in the managed care space, or in the fee-for-service space is an important one. In the Long-Term Planning Workgroup, we've talked about trying to find measures that indicate whether or not the health care delivery system and Medicaid and CHIP programs are helping people through those transitions or those cross-delivery system experiences for people.

We know from our own experiences as patients and loved ones of patients as well as from the data that that part of our health care system is really broken in most places. Those transitions are often very difficult for the patient. A lot of duplicative work has had to be done by the provider, community, etcetera. Just in the gap area, I think, pushing to see measures that would appropriately improve care at those points of transition or understanding how those are working seems like a good goal. I don't know quite how to do that, but I would identify that as an aspiration.

This is Kim Elliot. One thing I would also think of as a gap area is member experience or how patient-centered our approaches are to providing the services that the members really want, in addition to what they need, and how those two would balance out.

Hi. This is Carolyn Langer. I hope you can hear me. My reception is not great. Can you hear me, Margo?

We can. Yes, we can.

Yes, thank you.

Thank you.

I want to agree with the previous three comments. I do think that it's important, both to have some clinical outcomes because we know that there are very significant health

disparities in this population, but also, the notion of some patient experience. We know it's very challenging for this population, in particular, to access basic primary care to find providers who really understand how to work with this population. The third part of that also is just more broadly quality of life, quality of care. Someone may not be institutionalized, but they still may not have a high quality of life.

Hi. This is Lowell Arye. I just wanted to say that I wish we had this conversation before the vote because I think that the NCI-AD focuses specifically on the person-centered piece, specifically on member experience, as well as a variety of other issues. Clearly, that is a gap issue. I think that it would have been nice to have been able to hear this prior to. I think that it is important. I think there are a variety of other measurement tools out. There are a variety of other measures out there. A number of states have been utilizing things like looking at care management as well as person-centered type work with regards to LTSS. But when you look at the tools, we already have one. I just want to throw that out there. Thank you.

Thanks, Lowell.

This is Jill Morrow, again. I think what might also be helpful is to look at-- and this group is made up of varying groups of people with different kinds of disabilities and medical conditions and whatnot. But looking at what is important to these groups might also be something that would be a good thing to measure. I know that's nebulous but thinking about it from that vantage point. The person-centered planning what's important for me, what's important to me. It is also something that I think we need to measure better.

Thanks, Jill.

Hi. This is Laura Chaise. I will just say, a lot of that is measured in the NCI-AD. But I will move on from that. In terms of gap areas, another clear gap area based on this conversation as well as the conversation last year, is just the need for more measures that correspond across both the managed care and the fee-for-service landscape. I think the fact that there is this pairing of the admission measures is a good start. I think, hopefully, we will see more measure pairs like that that ideally have gone through the rigorous testing in both environments going forward.

Thanks, Laura.

This is Linette Scott. I think one of the challenges of understanding the environment, there was a comment earlier around whether or not folks have LTSS or not, and some of those different components. Process measures are often a good place to start.

The other comment that came up earlier was, what are we trying to measure? When we were talking about the LTSS, MLTSS measure, what is the goal? Is the goal having people out of institutions, having the right balance? What is the right balance between in a skilled nursing facility versus in the home? When does that threshold get reached?

What we're trying to measure and what the goal and the outcome we're trying to reach is important to understand. Looking at being clear that perhaps this is a process measure that's looking at what is the use of different types of services. But the challenge is that the Medicaid program is implemented in so many different ways across the states. The

mix in one state may vary dramatically from the mix in another state in terms of the kinds of services available.

A different approach might be looking at a measure that just literally is looking at that kind of process and benefit mix across different states to understand what that is. Because we almost need to understand that before we can then look at a measure that would be compared across states to know how comparable it really is. That's a different kind of idea.

Thanks, Linette. Other comments? Okay. Well, it's 1:00. We'd like to take a break right now. We'll take our 20-minute break that we had planned on before. Back at 1:20, and please, please, please don't hang up. Just put your phone down. Put it on mute. But don't hang up because we know how hard it was for all of you to get back in. I hope everybody has a nice break and recharges and comes back for the next area. Thank you, everyone, for this, spending the morning with us. We will be back at 1:20.

BREAK

Okay. It's 1:20. Welcome back from the break. The virtual break, it was a little bit odd being by myself during the break. But I hope everybody had a nice break. Now, I'd like to turn it back to Dayna to walk us through the next section in Primary Care Access and Preventive Care. But before I do, I just wanted to say one thing about the voting. I know there might be some question about what the threshold is, in terms of the number of votes required to pass. I wanted to mention that this morning for the LTSS domain. We had 25 people eligible to vote. We required 17 yes votes to pass. For the first measure MLTSS-6, we had eight yes votes. For NCI-AD, we had 13 yes votes, and so neither of those were recommended. I just wanted to clarify that before we move into the next area. Dayna, it's all yours. So, the next slide.

Great. Thank you, Margo. We are now going to discuss measures in the Primary Care Access and Preventive Care domain. Next slide.

This is a big domain. So, let me give a quick overview of what the 2020 Child and Adult Core Sets contain. In the interest of time, I'm going to read the measure names and not necessarily a full description of all the measures. Note that the highlighted measures as we go through the slides are suggested for removal from the current Core Sets and will be discussed today. The slide also shows the number of states reporting each of the measures for Federal Fiscal Year 2018.

The first two measures in the Child Core Set. Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents measures the percentage of children ages three to 17, who had outpatient visit with a PCP or OB/GYN during the measurement year and also had evidence of BMI percentile documentation, counseling for nutrition, and counseling for physical activity. The two counseling components were added after last year's Core Set Review in response to stakeholder input. Next we have the Chlamydia Screening in Women Ages 16 to 20, and Childhood Immunization Status. The Screening for Depression and Follow-Up Plan, Ages 12 to 17 measure, was suggested for removal. We'll discuss it shortly. Other Child Core Set measures in this domain include Well-Child Visits in the First 15 Months of Life, Immunizations for Adolescents, and Developmental Screening in the First Three Years of Life. Next slide.

Other well-child visit measures include Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life, and Adolescent Well-Care Visits.

Moving on to the measures in the Adult Core Set, we have Cervical Cancer Screening and Chlamydia Screening in Women Ages 21 to 24. Next is Flu Vaccination for Adults Ages 18 to 64, which has been suggested for removal. We'll go over it in more depth shortly. The Screening for Depression and Follow-Up Plan: Ages 18 and Older is the same as the child measure, but with a different age range, and is also suggested for removal. Next slide.

Also included in the Adult Core Set, is Breast Cancer Screening. Lastly, Adult Body Mass Index Assessment. This last measure is also suggested for removal. Those are the existing Primary Care Access and Preventive Care measures in the Core Sets. With that framing in mind, let's dive into the measures suggested for addition or removal we'll be considering today. Next slide.

The first measure suggested for removal is the Adult Body Mass Index Assessment. This measure is the percentage of beneficiaries ages 18 to 74 who have an outpatient visit and whose BMI was documented in the measurement year or the year prior to the measurement year. The measure steward is the National Committee for Quality Assurance or NCQA. It is not NQF endorsed. It's calculated using the administrative or hybrid methodology. No measure has been suggested for replacement, but the Workgroup member did suggest that a measure would need to be developed for follow-up. Next side.

Thirty-five states reported the measure for FFY 2018. A Workgroup member suggested this measure for removal because BMI screening for all adults is no longer recommended by the US Preventive Services Task Force. Instead, the current recommendation is that clinicians offer or refer adults with a BMI of 30 or higher to intensive multifaceted behavioral interventions.

The most frequent reason that states noted for not reporting the measure is concerns about the reliability and accuracy of the rates calculated using administrative claims data. Note that this measure is proposed for retirement from HEDIS measurement year 2020, which aligns with the 2021 Core Set. NCQA proposed the measure for retirement from HEDIS for several reasons, which include that EHRs automatically calculate BMI, and the measure does not assess counseling or follow-up. Updates to the ICD-10 codes allow for use of the BMI codes only if the BMI falls outside of the normal range, and high performance on the measure limits room for improvement. NCQA also noted that CMS is removing the measure from the star ratings program beginning in the 2020 measurement year. Next slide.

The next measure suggested for removal is Screening for Depression and Follow-Up Plan: Ages 12 to 17. The measure is defined as the percentage of beneficiaries age 12 to 16, screen for depression on the date of the encounter, using an age-appropriate standardized depression screening tool. If positive, a follow-up plan is documented on the date of the positive screen. The measure steward is the Centers for Medicare and Medicaid Services. It is NQF endorsed. It is calculated using administrative or EHR data. Three states reported the measure for FFY 2018. No measure has been suggested for a replacement. This measure was suggested for removal because states have had

challenges using claims or encounter data to verify that the screening was completed, that a valid tool was used, and that a follow-up plan was documented.

Additionally, not all states pay providers to complete standardized screening tools, which results in artificially low rates and leads concerns about data completeness or accuracy. The Workgroup member who suggested this also noted that three states reported this measure in FFY 2018. With the data collection challenges, is unlikely that all states will be able to report the measure by 2024. Next side.

The next measure suggested for removal is the Screening for Depression and Follow-Up Plan: Ages 18 and Older. This measure is the same as the previous measure except for a different age group. Six states reported this measure for FFY 2018. Five of the six states used Core Set specifications, whereas one deviated substantially from those specifications. The same reasons were given for suggesting this measure for removal, namely feasibility issues that make it unlikely that all states will be able to report the measure by 2024. Before we move on to the immunization measures, I'd like to turn it back to Margo to facilitate a discussion on the Adult Body Mass Index Assessment measure and the two Depression Screening and Follow-Up Plan measures. Margo?

Yeah. Thanks, Dayna. I think as you've gathered, we're trying to break up the discussion in smaller chunks given the virtual nature of the meeting. We thought we would start with the Adult Body Mass Index Assessment measure. I now invite discussion from the Workgroup members. You may unmute your line if you wish to speak. Please remember to say your name before making your comment. So, comments on the Adult BMI Assessment measure.

This is Amy with AAFP. This measure is topped out and is pretty much a checkbox measure. I would have no heartburn seeing this go away.

Thanks, Amy.

This is Jill. I would agree. Although, it really needs that next step, which is not just measuring it but doing something about it.

This is Rich Antonelli. I actually agree with that as well. I am feeling a little bit odd about it, though, because I'm mindful that we've added some specifications to the pediatric measure, at the same time as we're making an argument this year that the adult measure doesn't add value. I'm not convinced that I've seen the literature that suggests documenting exercise and nutrition solely in the primary care setting makes an impact on BMI.

But in fact, I was thrilled with the commentary that the Mathematica staff person raised that the screening of the adult folks and the referral for a multimodal intervention, that, actually, is where the pediatric evidence is. I also am in the favor of removing the adult measure, but I just want to be mindful of the message that the committee will be sending that we're keeping the pediatric measure and potentially removing the adult measure.

This is Linette Scott. Last year, I think we talked about both the pediatric and adult measure. They were in parallel last year. There was a sense of-- it's an EHR checkbox, not necessarily getting at the goal of follow-up. But the child measure was modified. That's why it's sticking around, I think. But this one wasn't able to be modified yet. But

the changes in the Preventive Services Task Force recommendations-- it's been recommended, or it's being recommended for removal because it's not achieving the goals that it was set out for.

Hello. This is Fred in Oklahoma. One of the things I think understanding the-- some of the issues that we've talked about for the adult BMI measure. One of the things as a state that we are having to consider at this point, is our state just recently submitted a waiver application for the Healthy Adult Opportunity waiver, kind of as we move towards value-based care, and so within that application – within that template --there are some measures that are mandated, are considered mandatory to be in compliance, right, once you get approved, understanding that there are discussions around maybe this going away. For work at this point until that happens, that is at a CMS level, we would still as a state we will still be required to essentially report this measure until it comes off the list from the CMS standpoint.

Thanks, Fred.

Hi. This is Carolyn Langer. I agree with what's been previously stated. I think it's also important that this measure was proposed for retirement by HEDIS. Again, it is captured, especially in the EMR, frequently captured. I am concerned that there's nothing to replace it in terms of the follow-up. But the measure as it stands today, I agree with what previous individuals recommended

Hi. This is Jennifer Fuld from CDC. Can you hear me?

Yes, we can, Jennifer. Thank you.

Great. Could I make some comments now, or are there other Workgroup members who want to comment first?

You are more than welcome to make comments now.

Thanks. Again, I'm Jennifer Fuld from CDC. I did send Margo a write-up for a few of the measures that we have some concerns about their removal. I won't read through the write-up for this measure. I don't know, Margo if that's something you can also pass along or has been passed along?

So, this is a public meeting. I think it would be good, Jennifer, if you make those comments publicly at this point. If you wish them to be part of the record.

Okay. Yeah. I do. Apologies that this may be a little bit long, but we do think it's important. Again, I'm representing CDC, and we do recommend retention of this measure. CDC has also recommended that NCQA maintain this as a HEDIS measure. Of course, we know that obesity is a common and serious and costly problem in the United States. Almost 19% of children aged two through 19 and almost 40% of adults have obesity. As we know, adults with obesity are at higher risk for many serious conditions including heart disease, stroke, type 2 diabetes, and certain types of cancer that are some of the leading causes of preventable premature death.

The estimated annual medical cost of adult obesity in the United States was $147 billion in 2008. In order to address the obesity epidemic, accurate measures of the problem are

needed. Since adoption of the adult obesity screening measure in 2009, screening rates improved dramatically across all plan types, including commercial HMOs, PPOs, Medicaid, and in Medicare, particularly, screening rates have likely reached nearly maximum rates about 96%.

Despite these overall improvements in commercial HMO, PPO, and Medicaid, HMO, there is still room for improvement as the screening is suboptimal. In 2018, as I was just previously mentioned, USPSTF updated the recommendations on screening for obesity in adults with a new recommendation to refer adults with a BMI greater than or equal to 32 to intensive multicomponent behavioral interventions.

The updated recommendations did not include a review of the evidence on screening, as it is well-established is a necessary part of clinical practice and clinical guidelines. Additionally, the updated recommendations continue to hinge on the identification of an elevated BMI, including BMI screening as a core measure, not only provides a better understanding of the prevalence of the problem but also enhances utility of related claims data to support health services research, health care quality improvement, and program evaluation.

For example, HRSA's Bureau of Primary Care, Diabetes Quality Improvement Initiative, a national initiative to improve diabetes outcomes and lower health care costs, has identified adult weight assessment as the primary prevention clinical activity and uses the adult HEDIS weight assessment measure, which was adopted as a Medicaid measure as one of the five metrics that program success.

The negative health outcomes associated with obesity continue to be identified, and administrative claims data with BMI information is critical to advance learnings. Most recently, based on data available in April 2020, people of any age living with severe obesity appeared to be at higher risk for severe illness from COVID-19, including death. Better understanding of the risk factors for severe illness from COVID-19 is critical to reducing morbidity and mortality, especially among vulnerable populations. Severe obesity is more common in certain populations, including those of minority race, ethnicity, and those with lower income.

It is possible that the relatively higher prevalence of severe obesity in those populations is contributing to reports of poor outcomes from COVID-19. Tracking these trends with any available data is a critical need. Administrative claims data will be an important means of understanding type, trends, and disparities in health services provided for those with COVID-19, including by risk factors of concern such as obesity.

I'm gonna stop there. We do have some more information, but just in the interest of time. I know that last year-- and I was not the liaison, Dr. Laura Seeff was. There was a lot of discussion about both the pediatric and adult measure. Our concern is not having a replacement measure, at this time, would really lead to in some ways going backwards in terms of a better understanding of BMI. In addition, with the current pandemic, having this type of information may continue to be really critical for states in working on addressing COVID-19. I'll stop there. Thank you very much for your time.

Thank you, Jennifer. I think we have a comment from the NCQA from Emily. Emily, if you do want to make a comment, please press star one, so the operator can unmute you. Let us know when you're on.

This is Emily. I did not have a question. Sorry for that.

Oh, I'm sorry. Okay. Emily, I thought you might have raised your hand to speak. Thank you. Okay, other Workgroup members' comments on the adult BMI assessment measure? Okay, hearing none, for now, I will turn to the two Depression Screening and Follow-Up Plan measures. One is for ages 12 to 17, and the other is age 18 and older. Comments from Workgroup members about these two measures?

This is Lindsay Cogan from New York. The comment I have is in relation to the screening for clinical depression. Can you remind me again, when we added the child portion of this to the set? Was it two years ago?

Hello, Lindsay, we're going to have to go look for a Core Set history table.

Okay.

Alli, would you be able to do that?

I just would like to see-- yeah. I'd like to see a little bit more time. Especially with adolescents and identifying depression, we feel we have spent a great deal over the last five years working in the screening for depression and follow-up for adults, the age 18 and older in our state district program and found a great deal of success and a lot of really meaningful work that has come out of screening and identifying adults in Medicaid for depression. A little bit concerned about removing it, especially from the Child Core Set, because we feel that work needs to be extended and moved towards adolescence.

We understand that there are issues with data collection, and we too, are transitioning as a state over from more of a hybrid medical record review to using electronic specifications. I get a little troubled in the justification in that because it's too hard that we shouldn't do it. I do think that we need to continue to keep our eye on what's important, and major depression is a huge issue for this population at large. That early identification is a really important first step. We thought at times about moving to just more outcome-based measures of treatment for depression. But we felt that really narrowed our focus and didn't give the attention that was needed on the identification and screening from the population at large. I have some pause with removing these measures, especially from the Child Core Set.

This is David Kroll. I also feel similarly to Lindsay. I'm very nervous about seeing these suggested for removal and want to add that speaking probably more so on the adult side because I'm an adult psychiatrist, and if there are people with expertise in child psychiatry or pediatrics, I welcome new thoughts as well. But over the last really three to five years, we've seen an increasing amount of attention towards screening and managing depression in primary care specifically as part of the expansion of what's called the Collaborative Care Program.

I apologize if this is something everyone's already very familiar with. But what Collaborative Care is, is a pretty rigorous program that applies a team approach to screening for and managing the first steps in depression care at the primary care level because primary care is the de-facto location for most depression care. In fact, there actually are billing codes available for Collaborative Care services. Although, not

necessarily applications of the depression screening tool, but because there's been so much investment in the infrastructure for these programs, but also, I think makes it easier to create and further invest in standardized methods of tracking whether or not parts of these are really implemented. I see this as an area of not only enormous need and importance but also, an area of likely growth and ongoing investment that I think it's feasible and important to lean into the problem rather than back away from it.

This is Jill Morrow. I'm just going to add to what you said in terms of the pediatric perspective, but from a pediatrician who spends a lot of time working with adults. One, the screening for teenagers, is a United States Preventive Task Force recommendation. Two, depression and anxiety are so prevalent and have a huge impact on functioning both for kids and for adults. I suspect transition from childhood to adulthood. I think this is a really important thing to measure. I think it creates a lot of issues in people's lives, including people with disabilities.

Go ahead, Jennifer.

I think I'm going to echo some of that. Okay.

This is Lowell Arye. I really appreciate what everybody is saying about not removing it, but my question is for the children, there are only three states that currently do it, and for the adults, only six states currently report it. I'm wondering if somebody could explain to me - I know that there are usual reasons why. But are there specific reasons why these have such low reporting rates? Is there something that could potentially be done to increase the reporting rates and/or there are other ways to get this that can be used like we've been talking about at the very beginning?

I'd like to pose that question to some of the state folks. Lindsay, I know that might be something that you might comment on from New York, whether New York has been able to report according to the Core Set specifications for Child and Adult, or what it would take to be able to do that?

Mm-hmm. Using the administrative only specifications, I suspect that states are not reporting it because when you use the administrative only, the rate is very low. That was what we found in our state. For our DSRIP project, we did have the additional funds to actually open some medical records to get what we felt was a more accurate reflection of the measure results. It was significantly higher when we can get into those records. Now, we've also spent a great deal of resources and time looking into electronic data. Because as I mentioned earlier, there's been a huge investment in standardized screening tools, especially the PHQ-2 and PHQ-9 integration with the electronic medical record for some of these standardized screenings.

We've spent a great deal of time looking into: how can we extract that information? We know that it's a regularly done part of the intake, right? We want to get to where adult BMI is. We want to see that-- we know it's being captured in the EMR. We just want to be able to extract it correctly. We have spent some resources, and that's where we're pivoting and moving towards.

I don't think, necessarily, that it's not possible. I think that when we do run it within a state-- feel free to jump in and say that I'm wrong about this. But when you do the administrative specifications, the rate it's particularly low. I suspect that's probably why

we're not seeing a lot of states reported, but please jump in on the states, and correct me if I'm wrong.

Yeah. This is Linette Scott from California. I don't think we reported it because the numbers were so low that we didn't really have confidence in that. We've actually included this as part of our value-based payment program to try to incentivize those G-codes being used so that it can be a strong administrative measure, but it's hard because if you don't do a chart review, then you're dependent on getting the codes in the claim data.

Right now, the G-code that would be used is not showing up in our claims data very much. It's from just a practical perspective. In that context, the data isn't quite there to have it be meaningful. We completely agree with the importance. Absolutely agree with the importance, and very much would like to see this go, which is why we included it in our value-based payment program.

Sara Salek, are you able to make a comment?

Yeah. Can you hear me?

Yes, we can. Thank you.

Yeah. This is Sara Salek, with Arizona Medicaid. I'm also an adult and child psychiatrist by training. I agree with many of the comments stated and would be concerned about removing both the adult as well as child depression screening at this time. I think given the history and the concerns and trying it-- In Arizona, we've also incentivized this measure through our targeted investment program and have really pushed for behavioral and physical health integration. It's a key component of that. I also think given the ongoing concerns and the trauma experience with the COVID time and the ongoing evolution of COVID. I think the mental health of Americans, and just globally, it's going to be critically important to keep a close tab on.

At this point, if the measure steward is on or the measure developer, could you please speak to the feasibility of this measure for Medicaid if you're aware of that? Specifically, the point that Linette made about the lack of G-codes in the claims data because we think that that's been one of the big challenges to states. If you have any other suggestions knowing that electronic health records are not fully feasible in Medicaid, and also, this is not specified for hybrid methodology for chart obstruction. That is either administrative or electronic health records. Linette or Anita or someone else on the line, and you may have to press star one for the operator to unmute you.

Hi. This is Carolyn Langer from Massachusetts. Massachusetts moved a significant portion of the Medicaid population into 17 ACOs. There is a depression screening measure, it's a hybrid measure that is part of the quality slate for the ACO initiative, for individuals 12 and older. In the first two years, it was paid for reporting, and then it's going to shift to pay for performance. I would have to go do a little bit of research to see what codes and what the specifications are. I'm happy to do that, try to get into that maybe offline.

But I do want to just also reiterate what a number of folks said earlier in the discussions. We are seeing this as a really significant area. There's really an epidemic, particularly

among adolescents with depression and anxiety. We have some really high performing ACOs that are fully integrated with behavioral health. It's still a challenge, but I would definitely support keeping this measure.

Thanks, Carolyn. We've actually been working very closely with Massachusetts in helping answer a lot of technical assistance questions to make it feasible for their ACO program to report. They are definitely working on it. But I think we also have somebody queued up from the measure steward. Anita, are you there?

I am on. We have the Medicare, what's reported to the CMS, the Quality Payment Program data for the regular claims, not administrative claims, registries, and ECQMs. We do not have access to any other Medicaid data. It would only be the dual eligibles that report through the quality payment program. But what we can say, is for the expert workgroups that have met for this, they still see as does CMS that this is a very, very important measure. It is included in the Medicare shared savings program, which is handled as-- there is an abstraction tool that is used to get the data for this, and then it is reported electronically to CMS. But this measure has consistently-- even been one of the ones that CMS deems as very necessary in their quality payment program.

Thanks, Anita.

Hi, Margo, can you hear me? I've been trying to get in a little bit. This is Lisa Patton. I just want to make a couple of points. One is that this measure was initially added in part to get at one of the issues that Lindsay mentioned earlier. In the larger context, we have med management for depression in there. The thinking on that was, that was a really important measure to have. But at the same time, we were missing a large block of the population who were perhaps suffering from depression, but didn't want to take medication for that, wanted to pursue other interventions or who weren't being screened at all and have no type of follow-up plan.

That we've had the conversation about that a couple of times which I think it's just important to remind members of the panel about that, sort of, larger context for why this measure was put in the first place. It's important.

A previous speaker mentioned. In terms of the COVID environment, we're seeing much higher rates of mental health issues, and at least anecdotally for now and other ways. But I think looking forward, being able to screen for depression and make it more normative and part of regular care is very important.

Thanks, Lisa.

This is Amy with AAFP. I was just going to say that this has been voted on to be added to the pediatric core measure set for the CQMC, and it's about to be voted on to go into the adult or the PCMH ACO workgroup core measure set. It's likely going to get voted in, just to context there.

Great. That's helpful, thank you.

Hi. This is Jennifer Fuld from CDC. Could I make a few comments?

Sure.

Great. Thank you. Specifically, for the Screening for Depression, and Follow-Up Plan for Ages 12 through 17, CDC recommends retention of this measure due to a lot of the reasons that folks have already mentioned. We know that there's data showing that the major depressive episodes among adolescents has been increasing, that their stamps of data from 2018 that shows that. We also know that depression is associated with a higher risk for other medical conditions as well as more difficulties with seeking care, taking prescribed medication, eating well, and exercising. We also know that once identified, depression can be treated and that many mental disorders have an onset during childhood.

In addition, there are several Healthy People 2020 goals. These are goals certainly that many states use that are relevant to screening for depression and adolescents. They include reducing the proportion of adolescents age 12 through 17, who experienced major depressive episodes, increasing the proportion of children with mental health problems, who received treatment, and increasing the proportion of primary care physician office visits-- excuse me, where youth aged 12 to 18 years are screened for depression.

From CDC's perspective, we think that it's really important to retain this measure to improve children's mental health. The data are used for children's mental health surveillance, promoting school-age mental health, the community preventive task force recently recommended school-based cognitive therapy programs to reduce depression and anxiety among children at increased risk for these disorders. These screening data are important for CDC to estimate the number of children who might be identified through screening protocols to be eligible for these programs. Also, important for children's mental health champions. And also, important to understand for co-occurrence with other disorders.

Lastly, as a few of the members have mentioned. It's also important - excuse me, for emergency response. We are seeing the potential for increased rates of depression among adolescents during the COVID-19 pandemic. It's essential for us to understand the impact of these emergencies to track baseline screening levels and to use these data to be able to have plans in place to be able to mitigate that. Thank you very much for letting me speak.

Thanks, Jennifer. We're going to move on to the immunization measures in a couple of minutes. But Gretchen and David, is there anything you wanted to say before we move on?

This is Dave Kelley. I would echo a lot of the comments about the importance of depression screening and follow-up in both children and adults. I know that a lot of states have struggled to measure this and report it. However, I think that as we move more and more towards electronic measurement and get away from chart audit, that states will help develop the infrastructure. I know that various programs are implementing these measures. I think that it's a very similar, I think, to how developmental screening went several years ago, where rates are low, very few states are willing or able to report it, and increasingly more and more states were able to report it. I think we just need to get both of these measures more time. They're vitally important from a public health standpoint, and from a mental health standpoint.

Thank you, David. Gretchen?

I agree with David, and just would commend the Workgroup for a very robust conversation and appreciate the federal partners also sharing their perspective.

Thanks. I know that there are probably people who want to make some public comment. What we're going to do is move on to the immunization measures, and then we'll come back to public comments at the end. With that, I will thank everyone for this great robust conversation that Gretchen mentioned, and move along back to Dayna for the immunization measures.

Great. Thanks, Margo. Next slide. Okay. Now moving on to the immunization measures. The Flu Vaccinations for Adults Ages 18 to 64 measure was recommended for removal. This measure is derived from the CAHPS 5.0 Adult Medicaid survey. This measure is defined as the percentage of beneficiaries aged 18 to 64 who received a flu vaccination between July 1st of the measurement year and the date when the CAHPS survey was completed. The measure steward is NCQA, and it is NQF endorsed.

The Adult Immunization Status measure was suggested as a replacement for this measure. I'll present that measure shortly. Note that CMS does not currently collect raw data for this measure. However, a total of 22 states reported that they collected this measure for FFY 2018. As Margo noted earlier, CMS is collaborating with AHRQ on an effort to report state-level CAHPS data that's submitted to the AHRQ CAHPS database. CMS is planning to conduct a dry run of this reporting method for states in spring 2020.

This measure was suggested for removal for a couple of reasons. The first is feasibility, fielding of the CAHPS survey is expensive, and response rates are decreasing over time. The Workgroup member also noted that responses and completion rates vary widely across the demographics, and therefore, does not allow for consistent calculations across counties and the states.

The second reason is related to accountability, actionability, and priority. The Workgroup member stated that the limitations of the measure prevent it from contributing to an overall estimate of the quality of health care. Instead, the Workgroup member suggested replacing this measure with the Adult Immunization Status measure, which would be more actionable for Medicaid programs. We'll turn to that measure now. Next slide.

As just noted, the Adult Immunization Status or AIS measure is suggested for addition and is proposed to replace the flu vaccination measures in the Adult Core Set. The AIS measure is defined as the percentage of beneficiaries 19 years of age or older who are up-to-date on the recommended routine vaccines for influenza, tetanus, diphtheria, or tetanus-diphtheria, and Tdap, zoster and pneumococcal. Next slide.

The Medicaid rate is limited to beneficiaries ages 19 to 65 and excludes the pneumococcal vaccine rates. The measure steward is NCQA, and it is not NQF endorsed. The data collection method is HEDIS electronic clinical data systems or ECDS. As a reminder, ECDS includes data from administrative claims, electronic health records, case management systems, and health information exchanges or clinical registries. This measure includes denominators for three individual vaccine rates and a composite rate. Next slide.

This slide shows a numerator for the three individual vaccine rates and the composite rate. The first three is the influenza vaccine rate, which would replace the FVA measure from CAHPS. As for field-testing, Pennsylvania Medicaid is requiring Medicaid health plans to report this measure beginning in the measurement year 2020, which aligns to the 2021 Core Set. According to the measure steward, 21 Medicaid health plans located in 14 states reported data on this measure in measurement year of 2018.
This measure is suggested for addition because the receipt of recommended vaccinations is important to reduce illness and deaths from vaccine-preventable diseases. There are currently no measures of Tdap or zoster vaccination in the Adult Core Set.

Surveillance data also shows that recommended vaccine coverage is generally lower for adults with public health insurance compared to privately insured adults. The Workgroup member believes that the use of this measure would help Medicaid programs increase vaccination rates and their adult beneficiary populations and reduce the disparity.

The Workgroup members acknowledge that states may need to supplement administrative data sources with electronic data sources such as immunization registries to identify immunizations provided outside of medical appointments. Currently, Medicaid and CHIP agencies vary in their ability to identify immunizations and electronic clinical data or immunization registries. However, many states have been developing capacity to share immunization data between Medicaid and public health agencies. Next slide.

Okay. The other measure suggested for addition in this domain is Prenatal Immunization Status. It measures the percentage of deliveries in which women have received influenza and tetanus, diphtheria toxoids, and Tdap vaccinations. The measure steward is NCQA, and it is not NQF endorsed. The data collection method is ECDS. The denominator includes deliveries during the measurement period among those who are eligible 28 days before delivery through the delivery dates. It excludes deliveries that occurred at less than 37 weeks gestation. Next slide.

This measure has two individual vaccine rates and a combination rate as shown on the slide, and as for field-testing, multiple states are testing the measure or have calculated prenatal immunization levels for Medicaid populations using similar approaches. Colorado and California have calculated the measure as specified. New Mexico, Wisconsin, and Minnesota have calculated prenatal immunization levels using immunization information systems and claims data. They're not using these measure specifications. Pennsylvania Medicaid is requiring Medicaid health plans to report this measure beginning in measurement year 2020.

This measure was suggested for addition for a few reasons. First, the CDC, Advisory Committee on Immunization Practices, and ACOG recommend that women who are pregnant receive the influenza vaccine as well as a dose of Tdap. One Workgroup member noted that this measure could encourage states to meet these guidelines.

Only a small proportion of women enrolled in Medicaid received Tdap during pregnancy, and this is not a covered benefit in all state Medicaid programs. Another Workgroup member noted that the maternal and perinatal health has been identified as an area to strengthen in the Core Sets, particularly, as nearly half of all US parts are covered by Medicaid. The Workgroup members suggesting this measure also noted that pregnant women are more likely to have severe illness from influenza, and receipt of

recommended vaccinations is a critical strategy to improve the health of pregnant women and their neonates. Next slide.

Now I will pass it back to Margo to facilitate the Workgroup discussion.

Okay. Thank you, Dayna. We have three measures to discuss. I'd like to start with the two measures that are paired: Flu Vaccinations for Adults Ages 18 to 64, which is based on CAHPS, and Adult Immunization Status, which is based on ECDS. With flu vaccinations based on CAHPS being suggested for removal, and Adult Immunization Status based on ECDS suggested for addition. So, open it up for a discussion of those two measures. Who'd like to go first?

Hi. This is Marissa Schlaifer. I just had a quick question, or hopefully, an easy question for possibly NCQA or NQF or anyone else who can answer. The two measures that were discussed were not NQF endorsed. I was just wondering if anyone can fill me in on whether they've been considered and not endorsed, or whether they have not been considered or what the backstory is on that?

Do we have anybody from NCQA on the line? I will say while we're waiting, that the flu vaccination measure is part of the CAHPS 5.0H. That measure is not NQF endorsed. It's part of a larger measure that is not NQF endorsed. It is based on the AHRQ CAHPS survey, which is endorsed. That's maybe a little bit more of a complicated story about the flu vaccination measure. Is anyone on from NCQA? Press --

Hi. Yes. This is Lindsey Roth from NCQA. Can you hear me okay?

We can. Thank you.

Okay, great. Yes. I can address the question about NQF endorsement. The Adult Immunization Status and the Prenatal Immunization Status measures are both currently going through the NQF endorsement process. The Prevention and Population Health Steering Committee had reviewed the measures back in February of this year. They're currently in those cycles. The next event related to that is NQF is currently collecting public comment on the measures, I believe, through the end of May.

Thanks, Lindsey.

This is Amy with AAFP. I don't know the answer to this question, but I know it's not 100%. On the Adult Immunization Status, can someone tell me what percentage of those vaccines are covered by every state Medicaid? If we're going to require a composite rate or even pull out-- if we're going to require that to be in a measure that someone has to get every one of those vaccines, then we need to ensure that every state Medicaid is paying for them. I guarantee to you they're not.

Amy, just to clarify, is this a payment benefit issue or also potentially a data issue? Thinking again, about linkage between Medicaid and Immunization Information Systems, just as an example.

Both. Yeah. It's both. How can we want to measure something that the patient sometimes they're not going to have access to because they can't pay for it?

It's not a benefit.

To follow-up on Amy's question. Would asking for this to be reported, because those states that are not paying for it to -- would this highlight the need to pay for it? And would that, hopefully, push that along?

I haven't seen that happen as of yet. I don't know. It's very frustrating for-- well, it's frustrating for providers because sometimes they feel the trickle-down from our state Medicaid in reporting this. Who are we pushing that pressure down to get it done? You're pushing it down onto the providers to get it done. But they can't because there's no coverage for it.

Other comments?

This is Lindsay from New York. Have any states collected this information on a large-scale basis to date? I know like Pennsylvania, if this is on the slate of measures for us to add in next year, for Measurement Year 2020, we're going to add it to our health plan reporting. But I just don't know if anyone has - any states have tied to capture this on a large-scale basis.

This is Dave Kelley from Pennsylvania Medicaid. We do pay for all of the adults' vaccines that are mentioned in both of these measures for adults and for pregnant women. We did some preliminary data runs to look at just the administrative runs, and we know that there are gaps there. We also have the ability to use-- we have a statewide immunization registry for both adults and kids. It's more heavily used by our pediatric providers to put in the pediatric immunizations. We also have the Philadelphia State or a Philadelphia City immunization. Our managed care plans actually have the ability to go into the state as well as Philadelphia's immunization registry to supplement claims.

We're also working with our health information exchanges, and we have five of them. We are trying to partner with them to be able to capture data as well. Under ECDS, you're able to use multiple data sources that can be verified. We've done some preliminary things. We know that admin data only is probably under-reporting. With the ECDS program, we are actually going to be requiring that for this calendar year with the expectation-- We also required their plans join the health information organization, at least one health information organization. We know there are some challenges that we feel that from a public health standpoint, this is extremely important to measure.

Thanks, David.

So, like you, David, in New York, we do have an immunization registry. But I just want to remind people that it is not being used for adults. It's not required for adults. It's virtually untapped for adults. For pediatrics, totally different story. I just want to make sure people are clear on the immunization registry has been just amazing for pediatrics, but for adults, it's largely not been used. For these measures, I almost feel better about the ones that are on the docket, like screening for clinical depression, where we've seen low reporting because at least I know states are working on it. And we have an idea of what the challenges are.

These types of new measures when no one is actually doing anything with them yet or large-scale trying to operationalize them at the state level, we just have a hard time

putting that into the Core Set until we start to really understand what the challenges are to collection, reporting, interpretation. I don't know. I think I bring this up every year. It helps me to make a more informed decision when at least I know what the challenges are.

I think David, you're probably right on the mark with your pilot results for sure. I think maybe you're probably absolutely right about where you've been. But it's just, for me, in making a decision and taking these technical measures to the next step and putting them in the Core Set. It really would be good to have a couple of years of large-scale, at least more than one state really operationalizing those to fully understand what we're getting into. Are we measuring what we want to measure? Those kinds of things.

Hi, this is Lauren from ACOG. I just want to add. I pulled up the comments from the NQF endorsement discussion. Because I know that the Adult Immunization Status measure was not recommended for endorsement by the committee and thought I might be able to pull the reason why that was.

It looks like the specification of the measure is based currently on the 2018 Advisory Committee on Immunization Practices guidance, where only a booster for the TD is recommended. In January 2020, the committee recommended that people over 19 years of age are eligible to receive either the TD or Tdap booster every 10 years. I think that the developer is considering making updates to the specification, but it looks like that's the reason why, at the current moment, the committee did not recommend the measure for endorsement if that's helpful.

This is Jill Morrow. That's always an issue, ACIP updates every year, sometimes there are changes, sometimes there aren't. There are a couple of other thoughts that we should have about the multi-immunization measure, which I actually-- if you're going to prevent things, this is one of the ways to do it. However, Tdap, or TD or DT or whichever order is every ten years. The zoster vaccine, there's been a shortage, so even if you wanted to get it at 50, you often couldn't because it wasn't available.

There are some of those other issues that, yes, could impact on any of these, but that have the potential to impact on the particular ones in this list. That said, and I know the flu vaccine is reported, and it's not that accurate, but it is something that I think we should be encouraging people to do if there's a way to do that.

This is Amy.

Go ahead, Amy.

I was going to ask a question on the Adult Immunization Status measure that excludes from Medicaid the pneumococcal vaccine but not the zoster if it starts measuring at 19 years.

This is Jill again, sorry. That may be because the pneumococcal vaccine is the two ends of the age spectrum. There's the kid version, and then there's the older adult version. The adult version applies to people 65 and above or people 50 and above with a significant health condition. I think there are some people that they would do lower than that. But if you've got heart disease or lung disease or that sort of thing -- the problem is then you have-- it doesn't apply to the whole population. You have to be able to try to

match the diagnosis to whether or not they got it. It just becomes a much more complex activity.

Thank you.

Thanks, Jill. Do we have someone from NCQA who wanted to make a comment?

Hi. This is Lindsey Roth from NCQA. Are you able to hear me?

Yes, we can.

Okay. Thank you. Sorry. I was trying to jump in there. I can actually clarify a couple of things, first starting with the NQF endorsement for the Adult Immunization Status measure. You are correct that the committee did not reach consensus on endorsement for that measure. However, the measure is currently out for public comment. We have the opportunity to respond to some of the committee's feedback. I believe they are planning to bring that back to the committee for additional consideration either next month or shortly after that. I did just want to clarify one thing about the NQF endorsement process for AIS.

The second thing also was, yes, so the questions right now about why the measure does not include pneumococcal for Medicaid adults but does include zoster. For zoster, the measure looks at zoster vaccination for adults 50 and older or 50 through 65. We do then not report pneumococcal because the measure is -- it just focuses on routine vaccine for adults. We exclude the more high-risk population that is on a different immunization schedule for pneumococcal. Therefore, for adults 19 through 65, we don't include pneumococcal.

Thanks very much for that. I think now we'll switch over to have Workgroup members discuss the Prenatal Immunization Status measure.

Sure, I can start. This is Lauren from ACOG again. If I remember correctly, when we discussed this measure last year, some of the concerns were around the feasibility of the measure. That at the time, it wasn't being widely used, and there was a limited availability of testing data. In the measure information sheet that you got prior to the meeting, there's details on specific states that are either currently using, testing or are preparing for testing of the measure.

Also, in the information sheet, there is some information, I think, sharing that an estimated ten states are currently using IIS. I did share with a few of the Workgroup members a fact sheet that was developed by the Association of Immunization Managers and the American Immunization Registry Association, that shows that that number is a bit higher with at least 37 states sharing Medicaid data and are using IIS for reporting. I just wanted to share that. I think it gives the committee a little bit of better insight into the potential feasibility of this measure.

In regard to the NQF endorsement, since that was brought up in on the last one, the committee did recommend this measure for endorsement and as with the Adult Immunization Status that's currently out for public comments. Also, some other good news. In September 2019, NCQA did announce that this was going to be the first publicly reported measure calculated using the ECDS or the Electronic Clinical Data

Systems structure. It's selected, namely, because it's shown to be feasible. It's able to be collected widely, and reported on, and that there were opportunities identified for improvement in the rates that were shown through that method.

Lastly, more broadly, in this conversation around immunization measures. I would just like to share and get us thinking about some of the opportunity potentially given the current COVID-19 epidemic. Hopefully, the impending availability of a vaccine-- state Medicaid agencies that are not currently sharing their data with IHS, I'm sorry, IIS, will be more likely or in the position to potentially do that so that they can track that vaccine going forward. I know it's a little bit of a catch 22, and that states may not be sharing that data because they don't have the reason to do so. I'm not saying that we should capitalize on the COVID-19 epidemic, but there might be some opportunity there to push states to foster those connections that would be required for reporting of this measure. I think that's it.

Thanks, Lauren. Other comments or questions?

Hi. This is Linette Scott from California. A quick question just to confirm, these measures related to adult immunization and prenatal immunization, they fall in the category of measures that are not going to be required in 2024, is that correct?

Linette, we can't say that, it will depend on the domain, and how CMS classifies this. I don't think we're in a position to say that at this point.

Okay. Well, because I know that based on the statutory changes, the things that were called out were the child set measure and the adult behavioral health measures. The other adult measures, I don't think had been declared to be required. But I would have expected that would happen at some point.

Yeah. The one thing I could say, again, to basically underscore the uncertainty is that, as you probably know, prenatal measures, some are in the Child Core Set for Maternal and Perinatal Health, some are in the Child Core Set and others in the Adult set. I don't think we could say where if this measure were recommended and CMS decided to update the Core Set, whether it would fall into the Child Core Set or the Adult Core Set.

Got you. Yeah, I know. That's fair. Just for context, I wanted to double-check that. I think the other thing, one of the things that folks raised on the previous adult immunization conversation, is that there may be differences in coverage related to adult immunizations compared to child immunizations. While we have the coverage for the children, adults may vary by state. That's one of the things that's a little bit different, I think, as we talk about this.

Sorry. The other aspect of it, though, is that on the child side, at least, there has been good connection. Folks just talked about that related to the immunization registries in the state in the Medicaid program, and that there's probably more than 25 states in which that's been going well. There needs to be more of that. There's some of the chicken and egg conversation with some of this. That without an incentive, do people start working on it, but do they work on it to get ready for there to be an incentive, where the incentive is reporting in the Core Set measure. I know that that's been part of the conversations as we think about these different measures as well.

From a strictly feasibility perspective, given the differences in coverage between states, the fact that they're not being used fully, that there is still conversation in the NQF endorsement arena... From that perspective, it sounds like we may be about a year early from the perspective of trying to make a shift and going from the CAHPS version of the flu vaccine. The survey versus doing a more population-based approach, which is what these bring. I think that's a transition that I would definitely support happening sooner than later. The question is, are we truly feasibly there or not? Thank you.

Other comments about any of the immunization measures? Before we move into public comment, Gretchen and David, do you have any comments?

This is Gretchen. I don't. I think that, again, a robust discussion, lots to consider. I do think, in particular, this issue of feasibility is important, but also, the critical nature of immunizations and our opportunities to understand how immunizations influence the health of Medicaid beneficiaries and CHIP beneficiaries. Again, lots to weigh, very good robust discussion. I look forward to the public comment and the vote.

Thanks, Gretchen. David, anything also from the perspective of feasibility looking further?

Again, I definitely appreciate the comments of feasibility, and as a state Medicaid Program, we are probably pushing the envelope with our managed care plans. I also would say, that in terms of the CAHPS survey measure, this is something that we've reported on for many years and do look at it. In light of having something better, perhaps it's time to keep that particular measure until we do have something that's better. From my standpoint, I think the adult immunization measure is better and could replace that, just a matter of timing.

Thanks, David. Okay. Now, we're going to open it up for public comments. What I'd like to try to do is do it by measure to the extent that we have that ability to do that. I am starting off with the Adult BMI Assessment measure, whether we have any public comments. For those who want to get in the queue, press star one, and the operator will unmute you. Again, star one to get in the queue. We're starting with the Adult BMI Assessment measure.

Okay. We'll come back at the end to anybody who has any remaining comments. Why don't we move on to Screening for Depression and Follow-Up Plan? Both the child measure and the adult measure. Any states that want to make comments or any others? Again, star one to get in the queue, and the operator will unmute you. Operator, do we have anyone in the queue? Abby Kahn, it looks like you may want to be making a comment on the depression screening measure from DC. If so, can you press star one to get in the queue and get unmuted? Anyone else? Anyone who is in the queue? It sounds like somebody is unmuted. Caitlyn Wells, perhaps, are you unmuted?

It sounds like it. I'm sorry about that. I had comments about the prenatal measure.

If you could hold off, I think Abby wanted to speak to the depression screening measure. Abby, if you can press star one again. Then, Ifeoma, I think you're also in the queue. Whoever's in the queue is next. Operator, please unmute.

Hi, can you hear me?

Yes.

Hi. This is Abby Kahn. I'm with the DC Department of Health Care Finance, the state Medicaid agency for the District of Columbia. I just wanted to weigh in on the depression screening measure. This is one that we have historically not been able to report, neither our MCOs nor the District has been able to report this measure. Through talking with our MCOs, it's clear that our providers are not billing the correct codes or the codes that are at least listed in the specification. It's impossible for us to get an accurate picture of when these depression screens and follow-up plans are happening faithfully.

I think it has to do with the fact that the codes and the specifications, there's no payment associated with those, whereas there are other similar billing codes that encompass an emotional screen that are associated with payment codes. We have not been able to achieve the behavior change with providers to bill the correct codes in order to reflect the underlying utilization that is intended in this measure.

Thank you, Abby. Just a reminder that in order to make a public comment, you need to be called in on the audio lines. If you're not called in, you will not be able to make a comment. Why don't we move to the next person in the queue? We'll open it up for immunization measures as well at this point. Operator, the next person in the queue, a reminder to press star one to get into the queue. Operator, do we have anybody in the queue? Okay. Somebody sounds like they're unmuted, please introduce yourself.

Hi. Is it me?

Well, we can hear you. So, go ahead.

This is Abby. Oh, so wonderful. This is Abby Bownas. I help manage the Adult Vaccine Access Coalition, which is a multi-stakeholder coalition that works on a range of issues on adult immunization. I just wanted to call and share AVAC's strong support for both the adult immunization status measure as well as the prenatal immunization status measure. AVAC has been tracking both of these for the last couple of years as they've started to come online. We believe that they will be extremely valuable in helping to address immunization status within Medicaid beneficiaries, particularly pregnant women and other vulnerable adults with chronic conditions in adult measure, including those with diabetes and heart disease.

It's really important that these conversations happen between patient and provider during visits. It's very likely that when there is that assessment, which the composite measures will allow for, it'll improve the likelihood of the patient being immunized as part of that provider encounter. Or if the provider does not carry that vaccine in the office, then there's an opportunity for them to make a strong recommendation to go to a pharmacy and get the vaccine there.

We really appreciate the Workgroup both this year and last year. We appreciate that the report last year did note some of the gaps in terms of immunization quality measures as it related to both prenatal and adult population. We hope that this is the year where both of these measures will be able to be adopted. I just wouldn't know.

I think as part of the discussion, you guys also discussed that these measures have been tested by various health care plans, at this point. They are feasible, especially since they are optional. The IIS is there, something that are widely used as a trusted source in immunization data. I think as we enter post-COVID world, we're going to see even more strengthening as the IIS as moving forward. That would be a real opportunity there to build a stronger infrastructure and really utilize those systems that are in place.

Finally, I just wanted to note that because the measures within the Adult Core Set are currently voluntary, we think that this could be a really important way to help address a critical public health gap, while still allowing states that perhaps need more work to build upon this new method as data collection and measure reporting moving forward. Thank you so much for the opportunity and for letting us listen in to this public discussion, really great conversation. Appreciate your consideration.

Great. Thank you so much for your comments. Okay, next person in the queue, Elizabeth?

Hi. Can you hear me?

We can. Can you give us your full name and where you're from?

Absolutely, yes. My name is Liz Abbott, and I am the Adult Program Manager for the American Immunization Registry Association. I want to thank you for the opportunity to provide comments. On behalf of AIRA, I'm providing public comment today in strong support of adding both the Adult Immunization Status and the Prenatal Immunization Status to the Core Set.

According to the 2019 Association of Immunization Managers Annual Survey, an additional state outreach at least 37 states already shared data between the IIS and their state Medicaid agencies, and/or the state Medicaid agency users IIS data for Medicaid reporting. IIS data helps state Medicaid agencies calculate childhood immunization measures in the Medicaid Core Set, which are reported to CMS, and which states can adapt and build upon for pregnant women and adult.

As highlighted by AIM as well, AIRA would also like to emphasize the importance of using the IIS to contribute to more complete quality vaccination data, composite measures put in place for child immunization status can help to make great strides in vaccination coverage, and we expect a similar pattern for adults.

Each year, there are more and more opportunities to capture adult vaccination data. We continue to see significant progress among the numbers of adults represented in IIS. In 2018, 56% of adults were represented in an IIS, compared to only 25% or less than 2010. At least 18 states and jurisdictions captured between 75% and 95% of adults, further demonstrating that progress. The percent participation among children are improved from 82% in 2010 to 95% currently.

Thanks to recent legislative changes in two states, all IIS are now able to capture lifespan vaccination data that takes time to capture data for a full population and taking steps today will help to ensure we achieve the progress we've made for children. COVID-19 has heightened the importance of vaccination and assessing vaccination coverage for all ages, especially adults in this current situation. The old adage, what gets

measured gets done, couldn't be more applicable today. So, let's continue to help produce the burden of vaccine-preventable diseases among adults. Thank you for your time.

Okay. Thank you. Who is the next person in the queue?

Our next question from Caitlyn Wells. Please go ahead.

Hi. This is Caitlyn. Can you hear me?

We can. Thank you.

Great. Thank you. Well, good afternoon. I'm Caitlyn Wells, and I'm the Research and Development Director for the Association of Immunization Managers. We're the only membership organization representing the 64-state city in territorial immunization program managers. AIM joins other organizations like the National Quality Forum, the Adult Vaccine Access Coalition, and AIRA to fully endorse the adoption of the prenatal immunization measure.

As an immunization community, we've taken great strides to advance the use of IIS to collect and report quality pediatric immunization data. Now, we think we should take action now to extend the success to our most vulnerable, our pregnant women and their newborn infants. In order to address some of the gaps noted in last year's Workgroup meeting, AIM and AIRA collected information that demonstrates the feasibility of using IIS to assess immunization levels in Medicaid programs. Now, what we did find is that state IIS are widely used as a trusted source of immunization data by state Medicaid programs.

This has been said before, but our survey did find that at least 37 states or 74% of states share data between IIS and the state Medicaid agency, and/or the state Medicaid agency uses IIS data for Medicaid immunization coverage reporting. The adoption of the prenatal measure will further support collaboration between state Medicaid agencies and IIS in order to be functionally connected systems.

Now, we know this will become more vital during the COVID-19 vaccination campaign as we use the IIS to identify high-risk populations, track vaccine uptake, and conduct reminder recall. Since a nearly half of all pregnant women are on Medicaid, promoting collaboration and data sharing between Medicaid and immunization programs, including a prenatal measure, will not only make an impact on routine vaccine-preventable diseases but also, can make a difference in how we protect pregnant women and their newborn babies against COVID-19 because what gets measured gets done. Thank you for this opportunity.

Thank you. The next person in line.

We'll take our next question from Julia Skapik. Please go ahead. Julia Skapik, your line is now open.

Could you possibly be double muted? We're not hearing you. Operator, can you give us the next person in line.

Our next question from Ifeoma Nwankwo. Please go ahead.

This is Ifeoma Nwankwo from Connecticut, Department of Social Services. We support the position of CDC on this measure [CDF]. We have a number-- I can't give the percentage now of the adolescent issues that we feel we should be monitoring through this measure. But we are not able to bill the codes that are used currently for this measure. But we do internally use this measure in a modified approach for our own purposes. We feel that this measure is very important for monitoring this cohort right now, and all the reviews that CDC has given is exactly what we have heard from families and adolescents. We would like to support the position that this measure should be retained. Thank you.

Thank you, Ifeoma. Next person in the queue.

There are no further questions at this time, please, continue.

Again, a reminder if you would like to make a public comment, please press star one to get into the queue.

We have a question from Julia Skapik. Please go ahead.

Great. Go ahead, Julia.

Hi. This is Julia Skapik. I'm the Medical Director for NACHC, the National Association of Community Health Centers. We wanted to also put in a comment in support of the Adult Immunization Composite and Prenatal Composite Measures. We believe that these measures are to treat the clinical suite of activities around preventive care as a single unit, which they appropriately are. We like how providers can see partial credits for their efforts across the continuum, working with different patients, and working on different vaccinations. Thank you.

Thank you. Any further public comments before we move into the voting? Operator, is there anyone else in the queue?

There are no further questions at this time, please, continue.

Okay. Now, I'd like to turn it back to Dayna to take us through the voting on these measures. Dayna, all yours.

Great. Thanks, Margo. Next slide, and one more, thank you. Okay. For our first vote, the question will be, should the Adult Body Mass Index Assessment measure be removed from the Core Set? Options are, yes, I recommend removing this measure, or no, I do not recommend removing this measure. The question is now active. Again, if you're not seeing it on your screen, try refreshing, and it should show up for you. But it looks like a lot of votes coming in now. Okay. We have 23 votes. We're expecting 25. Have we received any other Workgroup votes from the Q&A?

Not yet. There are no questions.

Okay. We'll just give it another couple of seconds. Okay, final check, anything in the Q&A?

No, nothing in the Q&A. I think we're good to go.

Okay. With that, I will lock the results. For the results, two-thirds threshold for this measure is 17 yes votes to pass. We received 15 yes votes, that does not meet the threshold for recommendation. The Adult Body Mass Index Assessment measure is not recommended by the Workgroup for removal for the 2021 Core Set. Next slide.

The next question is, should the Screening for Depression and Follow-Up Plan: Ages 12 to 17 measure be removed from the Core Set? The options are, yes, I recommend removing this measure, or no, I do not recommend removing this measure. Voting is now open. Okay. We have 24 votes. We're expecting 25, but we did receive 24 last time. Is there anything in the Q&A?

No, nothing at the time.

Okay. I will go ahead and close voting. For the results, the two-thirds threshold to this measure is 17 yes votes to pass. We received one yes vote, that does not meet the threshold for recommendation. The Screening for Depression and Follow-Up Plan: Ages 12 to 17 measure is not recommended by the Workgroup for removal from the 2021 Core Set. Next slide.

Okay. The next question is, should the Screening for Depression and Follow-Up Plan: Ages 18 and Older measure be removed from the Core Sets? The options are yes, I recommend removing this measure, or no, I do not recommend removing this measure. Voting is now open.

Okay. We've reached 24 votes, just confirm there's nothing in the Q&A from Workgroup members. We have 25 this time. That should be everyone today voting, I will be closing. Okay. For the results, the two-thirds threshold for this measure is 17 yes votes to pass. We received one yes vote, again. That does not meet the threshold for recommendation. The Screening for Depression and Follow-Up Plan: Ages 18 and Older measure is not recommended by the Workgroup for removal from the 2021 Core Set. Next slide.

Okay. I just want to remind everyone that only Workgroup members are able to vote. Thank you. Go ahead, Dayna.

Okay, great. Moving on to the next one, our next question is, should the Flu Vaccinations for Adults Ages 18 to 64 measure be removed from the Core Set? The options are, yes, I recommend removing this measure. No, I do not recommend removing this measure. The voting is now open.

This is Richard Antonelli. Can I ask a question please before we proceed?

Sure, Rich. Go ahead.

Since this vote is connected with the other measure coming forward, is it possible to reverse the order that we're voting on?

In other words, you would like to vote for addition before removal?

Exactly. Because if we pull this one and that one doesn't pass, we just put a big donut hole in the set. Unless that is out of order, I'd love to vote on the addition, and then come back to the removal.

Sure.

Thanks for the consideration.

Thank you. Well, I'd like to ask our co-chairs if they have an opinion on that, Gretchen and David.

This is Gretchen. I endorse the suggestion. I was wrestling with the same issue as I was contemplating my votes.

Okay. with that, we're going to be flexible and nimble. Can we go to the next slide, and then we'll go backwards?

Okay. Give me one minute to clear the responses from the current one.

Is that going to be a problem, Dayna?

Well, we had already opened voting, but it shouldn't be an issue to reset that and have everyone do it again.

Okay, great. Thank you.

Okay. So instead, we will be voting on the Adult Immunization Status measure. The options will be yes, I recommend adding this measure, or no, I do not recommend adding this measure. I will now open voting on this one.

Okay. We have 24 votes. We're looking for 25. One more vote, please. Okay, and that takes us to 25, which is the number we're expecting. I'm going to go ahead and lock this poll and share the results. For the Adult Immunization Status measure, the two-thirds threshold is 17 yes votes to pass. We received 14 yes votes, and that does not meet the threshold for recommendation. The Adult Immunization Status measure is not recommended for the Workgroup for addition to the 2021 Core Set. Go back to the previous slide, is that right?

Yes, that's correct, and the previous votes.

Okay. Now, we'll do the-- with that in mind, we will go ahead and do voting on the Flu Vaccinations for Adults Ages 18 to 64. The question is, should the Flu Vaccinations for Adults Ages 18 to 64 measure be removed from the Core Set? The options are, yes, I recommend removing this measure, or no, I do not recommend removing this measure. Voting is now open.

Okay. We have 24. I'll give it just another minute for that last person to cast their vote. Okay. We have 25 votes in. I will go ahead and lock the poll and share the results. For the Flu Vaccination for Adult Ages 18 to 64, the two-thirds threshold to pass this measure is 17 yes votes. We received four yes votes. That does not meet the threshold

for recommendation. The Flu Vaccinations for Adults Ages 18 to 64 measure is not recommended by the Workgroup for removal from the 2021 Core Set.

Okay, great. If we could jump ahead to the Prenatal Immunization Status measure. Wonderful. Our final vote in this section is, should the Prenatal Immunization Status measure be added to the Core Set? The options are, yes, I recommend adding this measure, or no, I do not recommend adding this measure. The vote is now live.

Okay. We now have 24 votes in. That is the number we're expecting because we do have one recusal on this measure. I will go ahead and lock the voting and share the results. For the two-thirds threshold for this measure is 16 yes votes to pass. We received 17 yes votes. That does meet the threshold for recommendation. The Prenatal Immunization Status measure is recommended by the Workgroup for addition to the 2021 Core Set.

Okay. With that, I will turn it back to Margo to facilitate a discussion of the gaps in the Primary Care Access and Preventive Care domain.

Thank you, Dayna. Thank you, Workgroup members. Thank you, public commenters. This was quite an exciting conversation culminating in recommendation for the prenatal immunization status measure to be added to the Core Set. Thank you, everybody, for the good conversation.

Now, we would like to hear from Workgroup members about possible gaps and the Primary Care Access and Preventive Care area, what types of measures or measure concepts are missing in the Core Sets, are there existing measures to fill the gap, whether new measure need to be developed. Again, please remember to say your name before making your comment. With that, we'll open up the lines for Workgroup members.

This is Jill Morrow.

Oh, go ahead.

I just wanted to bring us back to the concept of the adult BMI measurement and the parallel to the child measure, which I don't think exists, but referral for multimodal approach to treatments.

This is Gretchen. I was also going to toggle back to some of our discussion. I think that I'm confident that Harbage will collect that, and I know CMS has been listening, but I think there was a clear discussion about the importance of understanding the immunization status of Medicaid enrollees only will be exacerbated by the importance as we move toward a potential vaccine for COVID-19 or for COVID.

I just hope that the notes reflect the rigorous debate and the positive stakeholder feedback on that. I certainly understand from a former state Medicaid director perspective that some of the issues of feasibility for that were of concern for some as well as the coverage. I think Amy made a very important point there. But it would be, I think, good to have that reflected as an ongoing gap with a potential almost ready for primetime approach to helping fill that gap moving forward.

Other comments?

This is David Kroll.

Go ahead, David.

Thanks. I wanted to just add one thing in the area of depression screening. I think that the point that has been made that the current measure leaves some room for desired improvement, I think, is very well taken. I do think that it's important to keeping the eye on future status, which is the goal ultimately to move towards better management of outcomes of depression, not just the screening and next steps of that.

Because the most common way that depression is screened for in primary care is the use of a PHQ-9 tool, it's not the only tool that can be used. But one of its benefits that it also measures performance and outcomes related to depression. I think that as systems do an increasingly sophisticated and effective job of measuring screening for depression, I think outcomes could follow behind very quickly. It might actually be a relatively rapid transition. I think people, states, and measure developers should keep an eye on that to try to facilitate that transition as fast as possible.

This is Gretchen, I would piggyback on to that with children's developmental screening. Similarly, we have a screening measure on the Child Core Set. We have Well-Child Visits in the First 15-Months of Life as well as for older children. But the real goal is to understand if the health of children is being supported and if their social and emotional development and personal development is on track. There's been a lot of work to improve pediatric practice in that space. I think just keeping an eye on-- these are great measures that currently occupy real estate, but they may not get us what we're really after, similar to what Dr. Kroll was just saying. A parallel discussion on children's overall development.

This is Rich Antonelli. I'm glad that David and Gretchen jumped ahead because I'd like to elaborate on that a little bit. I know we're in the gap area for primary care. Part of the reason that I am really particularly keen on the behavioral health aspect, is in many cases it is a chronic condition, and while the screening can be of paramount importance on the primary care setting, and David Kroll referred to some of the collaborative care models, sometimes there has to be care that is done in a coordinated or integrated way over time.

This is a real important distinction; I'd like to bring this one step forward. And Gretchen, you did me the favor by trying to bring out the developmental screen. There are folks around the US working on a kindergarten readiness measure, for example. I just wanted to put out there. I have no interest in that or no conflict of interest, and I know it's not up for the session. But I wanted to use it as a point of demonstration to think about gaps.

Longitudinality is a necessity to view an assessment and to make sure that there is a coordinated approach to accessing the right disciplines along the way. This is exquisitely important for children and youth with complex care needs, and whether those are significant developmental disabilities, chronic medical conditions, or significant mental health issues.

I just want to call out the fact that, I'm okay in this domain of primary care discussing the gaps. But when we start opening this up to entities that need access to services outside

the primary care setting, I'd like to encourage the committee and to encourage CMS and measure developers to think of this as integration measures. Thank you.

Rich, this is Jennifer Tracey from Zero to Three. I'll just echo what you and Gretchen mentioned. Social-emotional health, social-emotional screening has been shown to be a key factor in school readiness, as children are getting ready to go into kindergarten. Of course, we know that that social-emotional health begins in birth to three. Definitely a gap, I think in this measurement set is some a measurement around social-emotional screening.

I'll just put out there also social determinants of health screening around that, that also seems to be a big gap. I know there's a lot of issues with standardization of tools. But because we know physical health is so impacted by social determinants of health, that's also feels like a real gap here in this area.

Hello. This is Lowell Arye. I wanted to bring in the issue of seniors, specifically given that right now, someone 65 and older, about 16% of our population is 65 and older. They're going to increase to 23% by 2060. We really need to look at alleviating both for screening of depression as well as for pre-vaccinations, specifically for this population group.

I think COVID-19 is showing us the importance of understanding the needs of the elderly populations, specifically as it relates to the things like flus and things like that.

Also, for depression, seniors are more apt to be depressed than many individuals, social isolation as well. I really think this is a gap if we're only looking for individuals-- if we're looking at people over age 18 to 64 for flu vaccinations and then just 18 and older for screening for depression. We really can identify the needs of the population, given the large percentage of seniors who are getting Medicaid. I really think this is an important component that we really need to look into. Thank you.

Hi. This is Linette Scott. I think in terms of gaps, just looking at the measures we have under the prevention side for adults. We have three measures that are primarily focused on women with cervical cancer screening, chlamydia screening, and breast cancer screening. But we don't really have comparable screening measures for men. I don't have a specific one in mind, but I just thought I'd highlight that since we're talking about gaps.

Other comments on gaps?

Hello. This is David Kelley. Last year, I might have suggested trying to look at colorectal cancer screening as a gap. I still don't think it's an NCQA-endorsed measure that's for Medicare and commercial. But again, that might be in the future something to think about-- is looking at colorectal cancer screening, and I know there are challenges because of the length, the intervals between screening.

Okay. Thanks, David. Anyone else?

Hello. This is Jill Morrow. The other thing that as David was talking came to mind is-- and I'm looking at the list. I don't think we have something that is cholesterol screening in the absence of other disease or some other measure that could lead to risk prevention of

disease. That's just a thought. I don't know if the cholesterol screening is a good one or not or are there measures that might either lead to early detection or early identification of risk that could then change behavior treatment.

Other comments before we move into the wrap-up and the preview of tomorrow?

We do have a question from Anne Edwards.

Sure. Go ahead, Anne.

Hi. Can you hear me now?

We can. Thank you.

Okay.

Anne is a Workgroup member. Thank you.

I am a Workgroup member, but for some reason, I got bumped off in my audio. I wanted to thank the earlier comments regarding the pediatric issues that were brought up. The one other thing that I note is when we think about this from a life course that many of the measures are in earlier childhood up to maybe kindergarten age and then adolescence. We have this six-year period where children, unfortunately, we're seeing grand rates of mental health, behavioral health, weight assessment, other needs ongoing. I know the group has grappled with before, but I just wanted to point that out as a potential gap area.

Also, just a brief comment as we talk about depression screening and follow-up and outcomes. The rising rates of suicide, and some work in thinking about suicide screening. I know that that has been addressed in behavioral health, it looks like in the past. But certainly, to keep that on our radar is improved measures might develop in that space. Thanks.

Thanks, Anne.

Anyone else? All right. Well, why don't we move to the wrap-up and the preview of Day 2. Next slide. Okay. We are in the home stretch now. We got off to a little bit of a rocky start with everybody trying to call in. We apologize for that at the beginning and appreciate everybody's patience as we got ramped up.

Like Gretchen has said and others have said, today's conversation was incredibly robust, and it's very rich. We heard lots of great comments both from Workgroup members as well as the public. We appreciate everyone's contributions as we navigated this agenda virtually rather than in-person. Thank you for managing the time by being punctual with the breaks, and for learning the new voting process. So, we very much appreciate everybody's contributions there.

I did want to mention that for those who have remaining public comments, we definitely encourage you to review the draft report when it's released. We'll be talking about that on Thursday, what our schedule is. But it will come out roughly at the beginning of July with a one-month public comment period. We definitely encourage people to take a look

at the report and make public comments if you still have some public comments. Now, I'd like to preview the agenda for tomorrow. Next slide.

Tomorrow, we'll discuss measures for removal and addition in three domains: Dental and Oral Health Services, we'll have one measure suggested for removal and four measures suggested for addition; Maternal and Perinatal Health with two measures suggested for removal, and two measures suggested for addition; and Experience of Care with two measures suggested for removal.

We will begin promptly at 11 AM again tomorrow. We ask Workgroup members to sign in early as well as the public. Hopefully, we won't have the same gridlock and log jam today getting people online. We encourage you to try and get on early. Apologize in advance if there is a long wait. Before we sign off, Gretchen and David, do you have any final remarks to close out the meeting today, or preview for tomorrow?

This is Gretchen. Again, just my gratitude for everyone's participation and sadness that we didn't get to debate these concepts together in the same room but appreciate that we were able to continue to do the good work that the Medicaid program and CHIP program need of us. Thanks to everyone. I look forward to our conversations tomorrow.

Likewise, I appreciate everyone's participation and conversation. We look forward to tomorrow's work again. Thank you.

All right. Thanks, Gretchen and David and Workgroup members and federal liaisons and other public attendees. We wish everyone a nice rest of the day. Stay well. This concludes Day 1 of the 2021 Child and Adult Core Set Annual Review Meeting. “See you,” in quotes, tomorrow. Thank you.