Child and Adult Core Set Stakeholder Workgroup:
2021 Annual Review Meeting Day 3 Transcript
April 30, 2020

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

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Now, I'd like to introduce Margo Rosenbach from Mathematica. Margo, you now have the floor.

Thank you, Brice. Next slide. Hi, everybody, and welcome back to Day 3 of the stakeholder review of the 2021 Child and Adult Core Set. I hope everyone had a nice evening and is recharged for the final day of our virtual meeting. And why don't we give a quick recap of yesterday's meeting? The Workgroup discussed measures in three domains: Dental and Oral Health Services, Maternal and Perinatal Health, and Experience of Care. A total of 11 measures were reviewed, including five measures suggested for removal and six measures suggested for addition. After robust discussion in each domain, the Workgroup did not recommend any measures for removal. However, the Workgroup did recommend two measures for addition, Sealant Receipt on Permanent 1st Molars and Postpartum Depression Screening and Follow-Up. We have

another full day today with measures in two domains to review, Behavioral Health Care and Care of Acute and Chronic Conditions.

We'll follow the same format as the last two days with an introduction of the measures by the Mathematica team, followed by Workgroup discussion, then public comments, next voting on the measures, and finally a discussion of gaps within each of the domains. We'll wrap up today's meeting with the discussion of future directions, including remaining gaps, areas for measure development, and opportunities for technical assistance to support states in their reporting of Core Set measures. For those who missed the meeting, or who would like to listen again, the recording is available On Demand on the Core Set Review website where you registered for the meeting.

Before we get started, I have a few housekeeping announcements. First, Operator, could you make sure the Workgroup members are able to mute and unmute themselves? Second, I want to remind the Workgroup members to please keep your line muted on your phone or headset when you're not speaking. And third, Workgroup members, could you please make sure you're logged into the voting app and navigate to the Core Set Review page? We're going to try a practice vote after the roll call. Before we do the roll call, I'd like to ask Gretchen Hammer and David Kelley, our two co-chairs, if they have anything to add. Gretchen and David?

Thanks, Margo. Thanks for the introduction and the recap. I don't have anything to add. I look forward to our continued dialogue today, and I'm glad that we're on Day Three and in the home stretch. So, I look forward to our ongoing conversation.

Thanks, Gretchen. Yeah, this is David. Good morning, everyone. And this is our third and final day, and we're headed down the home stretch. Hopefully, folks will keep in mind, that through the remaining measures and wrap up discussion that as a state Medicaid program, at least Pennsylvania Medicaid, it’s very, very important business for our state and all the states. With that being said, there also are state feasibility challenges. So, as we put on our thinking caps today, I think we need to really think in terms of practicality and that is, which of these measures are really feasible for states to be able to do, because that's vitally important. Even though a measure may be extremely important and actionable, if it's not feasible, it makes it very difficult to state Medicaid programs to actually operationalize. So, again, thanks everyone for all the hard work that's been put into this, and thanks to Mathematica and our federal partners.

Thanks, Gretchen and David. Before we begin our review of measures this morning, I wanted to do a roll call of Workgroup members. When I say your name, please unmute and let us know you're here. And of course, we know that Gretchen and David are here, so moving along, Richard Antonelli?

Good morning. I'm here.

Lowell Arye?

I am here.

Tricia Brooks?

Sorry, I'm here. How's it going?

Okay. Laura Chaise.

Hi, good morning.

Lindsay Cogan?

Good morning.

James Crall?

Good morning, Margo.

Anne Edwards?

Good morning to all.

Kim Elliott?

Present.

Tricia Elliott?

Good morning. I'm here.

And Steve Groff is unable to attend, because of commitments related to COVID-19.

I think Shevaun Harris has the same situation this morning, but I'll double check. Shevaun, are you on? I think not. She's going to try to attend if she can but said that she has several requirements on her time today.

Diana Jolles?

Good morning.

Next slide. David Kroll?

Here.

Carolyn Langer?

Good morning. I'm here.

Lauren Lemieux?

Good morning. I'm here.

Jill Morrow-Gorton?

Good morning.

Amy Mullins?

Here.

Fred Oraene?

Good morning. I'm here.

Lisa Patton?

Good morning here.

Sara Salek?

Good morning. I'm here.

Marissa Schlaifer?

Good morning.

Linette Scott?

Good morning.

Jennifer Tracey?

Good morning.

Ann Zerr, I think you're here today. Is that right?

I am here.

Great. We're glad to have you. And Bonnie Zima?

Good morning.

Great. We're getting the hang of it. Now I just wanted to identify our federal liaisons who are joining us. And I'll just mention the names of the agencies, 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 U.S. Department of Veteran Affairs. They are non-voting Workgroup members. So, thank you, everybody. We know how busy you are and appreciate all your time. Now, I'm going to turn it over to Dayna to do a practice vote before we get started. Dayna?

Sure. Thanks, Margo. So, Lindsay, could we turn to - perfect, the practice vote slide. So, we're reusing one of the practice votes from the first day, the question is, have you had

any coffee or tea today? And the responses are yes, I've had my coffee or tea today or no, I haven't had any coffee or tea today. I will go ahead and open the poll. Getting a good number of responses and let's wait for a couple more. Okay, so we currently have 21 votes in, out of our 25 Workgroup members attending. If you're having any difficulties, please reach out to us over Q&A, and we can resolve those before we start voting on the upcoming measures. And let's say we have 23, so maybe just two. So, while we proceed with the conversation today, we'll go back and see who was not able to cast their vote, and make sure you're able to vote on the upcoming measures. And it looks like we're up to 24, so maybe just one individual.

So, in the interest of time, I will go ahead and close the poll. And if you're interested in the results, if having coffee or tea was a measure, it would've passed with 18 Workgroup members saying they have had their coffee or tea today. Okay, thanks, everyone. Could we go ahead to the behavioral health slide?

All right. Thank you, Dayna. So, now I'd like to turn it over to Chrissy Fiorentini to lead the discussion of measures in the Behavioral Health domain. Chrissy?

Right. Thank you, Margo. So, we're going to start off today with the Behavioral Health Care domain. I will start with the current 2020 Core Set measures. There are four Child Core Set measures and 12 Adult Core Set measures. Next slide.

So, starting with the Child Core Set measures, Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication assesses the percentage of children newly prescribed ADHD medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported, assessing follow-up during the 30-day initiation phase and within 270 days after the initiation phase ended.

Follow-up After Hospitalization for Mental Illness: Ages 6 to 17, assesses the percentage of discharges for children ages 6 to 17, who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported assessing follow-up within 30 days and within 7 days.

Metabolic Monitoring for Children and Adolescents on Antipsychotics assesses the percentage of children ages 1 to 17 who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported assessing blood glucose testing, cholesterol testing, and both.

Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics assesses the percentage of children and adolescents ages 1 to 17 who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.

Now, turning to the Adult Core Set, Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment assesses the percentage of beneficiaries age 18 and older with a new episode of alcohol or other drugs, or AOD, abuse or dependence who received initiation of AOD treatment within 14 days of diagnosis, and engagement of AOD treatment within 34 days of the initiation visit. Each rate is stratified by the following

diagnosis cohorts: alcohol abuse or dependence, opioid abuse or dependence, other drug abuse or dependence, and total AOD abuse or dependence. Next slide.

Medical Assistance with Smoking and Tobacco Use Cessation assesses different facets of providing medical assistance with smoking and tobacco use cessation. There are three measure components: advising smokers and tobacco users to quit, discussing cessation medications, and discussing cessation strategies. This measure has been suggested for removal.

Antidepressant Medication Management assesses the percentage of beneficiaries age 18 and older who are treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment. Two rates are reported, assessing medication for at least 84 days and at least 180 days.

Follow-up after Hospitalization for Mental Illness: Age 18 and Older is the same measure as the one in the Child Core Set but with an older age range.

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications assesses the percentage of beneficiaries age 18 to 64 with schizophrenia, schizoaffective disorder, or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

Diabetes Care for People with Serious Mental Illness: Hemoglobin A1C Poor Control (>9%) assesses the percentage of beneficiaries ages 18 to 75 with a serious mental illness and diabetes whose most recent Hemoglobin A1C level during the measurement year is greater than 9%. This measure has been suggested for removal.

Use of Opioids at High Dosage in Persons Without Cancer assesses the percentage of beneficiaries age 18 and older who received prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine milligram equivalents over a period of 90 days or more, and this measure has also been suggested for removal. Next slide.

Concurrent Use of Opioids and Benzodiazepines assesses the percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice are excluded.

Use of Pharmacotherapy for Opioid Use Disorder assesses the percentage of beneficiaries ages 18 to 64 with an opioid use disorder who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder during the measurement year. Five rates are reported, including a total rate capturing any medication and four separate rates representing different types of approved medications.

Follow-up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence assesses the percentage of emergency department visits for beneficiaries age 18 and older, with a principal diagnosis of alcohol or other drug abuse or dependence, with a follow-up visit for AOD abuse or dependence. Two rates are reported, assessing follow-up within 30 days and 7 days.

Follow-up After Emergency Department Visit for Mental Illness assesses the percentage of emergency department visits for beneficiaries age 18 and older with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. Two rates are reported, assessing follow-up within 30 days and 7 days.

And the last one is Adherence to Antipsychotic Medications for Individuals With Schizophrenia, which assesses the percentage of beneficiaries age 18 and older with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period. So, now we're going to discuss the three behavioral health measures in the Adult Core Set that were suggested for removal. Next slide.

The first measure suggested for removal is Medical Assistance with Smoking and Tobacco Use Cessation. NCQA is the measure steward. It is NQF endorsed and is calculated using data from the CAHPS 5.0H Adult Medicaid Survey. Next slide.

No new measure has been proposed for replacement. Twenty states reported this measure for FFY 2018. And this measure was part of the initial Adult Core Set and it is also included in the Marketplace Quality Rating System. This measure was suggested for removal due first to feasibility concerns. The Workgroup member who suggested this measure noted that fielding and analysis of the CAHPS survey is very expensive and response rates are decreasing. The Workgroup member also noted that because CAHPS responses and completed surveys vary widely across cultures, age groups, and other demographics, the measure does not allow for consistent calculations across counties and states. The Workgroup member indicated that the measure does not contribute to estimating overall quality of health care in Medicaid and CHIP because of the limitations of the data source. In addition, the Workgroup member noted that there's an insufficient link between this measure and better outcomes. Next slide.

The next measure suggested for removal is Diabetes Care for People with Serious Mental Illness: Hemoglobin A1C Poor Control. NCQA is the measure steward. It is NQF endorsed, and it is calculated using administrative or hybrid methodology. No new measure has been proposed for replacement. However, one Workgroup member suggested stratifying another Core Set measure, Comprehensive Diabetes Care: Hemoglobin A1C Poor Control or HPC-AD measure for individuals with SMI. Another Workgroup member advocated for use of another Core Set measure that captures diabetes screening among an SMI population, Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication or SSD-AD. Four states reported the measure for FFY 2018. The measure was added to the Adult Core Set in 2017.

It was suggested for removal by two Workgroup members primarily due to feasibility concerns. One Workgroup member noted that producing an additional sample for hybrid medical record reviews is burdensome for states and suggested that this measure be calculated by stratifying the existing sample for the HPC measure, which most states are reporting. The other Workgroup member noted that many states cited data access issues as a reason for not reporting this measure and believes that it will be a heavy lift to achieve the goal of 100% of states reporting by 2024. Given the limited real estate on the Core Set and the fact that care provision is tougher to measure than screening, the

Workgroup member would prioritize the diabetes screening measure for the SMI population. Next slide.

The last measure suggested for removal from this domain is Use of Opioids at High Dosage in Persons Without Cancer. Pharmacy Quality Alliance is the measure steward. It is NQF endorsed, and it is calculated using administrative data. This slide shows the criteria for the denominator, which includes beneficiaries who had an opioid episode of 90 or more days during the year with an index prescription start date on January 1st to October 3rd, and who had two or more prescription claims for opioid medications on different days of service and with a cumulative day's supply of 15 or more days. The numerator is any beneficiary in the denominator with an average daily dosage of greater than or equal to 90 morphine milligram equivalents during the opioid episode. Next slide.

No measure has been proposed for replacement. However, the Workgroup member who suggested this measure for removal noted that the Adult Core Set already has two related measures: Concurrent Use of Opioids and Benzodiazepines and Use of Pharmacotherapy for Opioid Use Disorder. Twenty-seven states reported this measure for FFY 2018, but 3 of the 27 states did not use Core Set specifications. These states reported a similar HEDIS measure, Use of Opioids at High Dosage, instead of the PQA measure. This measure was added to the Adult Core Set in 2016. And we also want to provide some updated information around the use of this measure in other CMS programs, which we recently received from the measure steward. For example, the measure has been included in the Medicare Part D Patient Safety Report since 2019, will be a Medicare Part D Display measure in 2021 and 2022 using 2019 and 2020 data, and will be publicly available in Medicare Part C and D Star Ratings Display measures beginning in 2020.

The measure was suggested for removal, because according to the Workgroup member who suggested this measure, the use of opioids at high dosage is not a reflection of behavioral health system performance but rather a measure of how chronic pain is treated. The Workgroup member indicated that behavioral health system performance is better reflected in another measure in the Adult Core Set, Use of Pharmacotherapy for Opioid Use Disorder. Next slide.

So, with that, I'm going to pass it back to Margo to facilitate the Workgroup discussion.

Thanks, Chrissy. And I just wanted to follow-up on a comment that David made at the start, of balancing the desirability and feasibility of these measures. Just to remind everyone, as we talked about the last couple of days, that behavioral health measures in the Adult Core Set, along with all the measures on the Child Core Set, will become mandatory in 2024. And all three of these measures are in the Behavioral Health Care domain in the Adult Core Set, so they would become mandatory. So, I just wanted to frame the Workgroup discussion around that point as well.

So, now, we would like comments and questions from the Workgroup members. You may unmute your line if you wish to speak. And please remember to say your name before making your comment. So, to start the discussion, let's start with the Medical Assistance with Smoking and Tobacco Use Cessation measure. I invite Workgroup members to make comments at this point on that measure.

This is Jill Morrow. I'll start the conversation. I think that smoking and smoking cessation is one of the most important things that we can do in terms of promoting health for that population. This is another one of the areas where there is a public health/Medicaid partnership around smoking cessation. And many states have been involved in that partnership. And it's a good way to prevent a lot of conditions that down the road create a fair amount of disability for people.

And this is Kim. I agree that it is probably one of the most important things from a health perspective. I think the biggest challenge though from a Core Set measure is that this is a survey measure. And with the challenges that all states seemed to be having in getting a really good response rate through the CAHPS survey, how meaningful the results of this particular measure, also becomes a concern.

And this is Linette Scott from California. The other thing, last year, I think we looked at a potential replacement for this. This year, this suggestion is just around removal of this particular item. No doubt that tobacco use is a very important topic. And there is an administrative measure that would take advantage of CPT codes that could be considered in the future, that could potentially replace this. So, even though it wasn't proposed for addition this year, it's something that could be done. We're actually including that in our value-based payment program this year. So, we're starting to work with it.

The challenge with some of the administrative replacements for some of these surveys is that they really need the use of those G codes and such. And providers aren't necessarily using those as much as they might to date, but by making it part of various programs it will encourage the use of those coding, because in administrative data without that, we don't get some of this robustness, without then going to chart review. And there are a number of different kinds of surveys related to tobacco. I know when I sat on the public health side, there were multiple. And we got the question, "Which one should we spend the money on?" And so, tobacco is very important. But since this one doesn't meet the threshold for public reporting, because not enough states are reporting, it echoes on that feasibility issue.

This is Carolyn Langer. Can you hear me?

Yes, we can.

Yeah, thank you. I appreciate all of the above that was said. I'm a little concerned about removing it without a replacement, especially in these COVID-19 times. And I definitely appreciate, much like the discussion yesterday, some of the challenges, the feasibility of measuring this. I do also wonder though with greater use of telehealth, now that primary care physicians cannot necessarily do in-person physical examinations, I do wonder if the availability of telehealth for more counseling might help improve some of these scores.

Hi. This is Lisa Patton. I also wanted to say that I am concerned about removing it without adding something in its place. And I would also just mention with the issues related to vaping, we're seeing some people returning to smoking. And so, just some of the concerns around new-old smokers returning to that also weighs heavily on my mind.

This is Lindsay Cogan from New York. I wonder if we could understand a little bit more about why states are not reporting it. I wonder if they're not reporting it because they're not meeting the sample size threshold or if they're not including these questions when they field their CAHPS survey. Because I think yesterday, we voted to maintain the CAHPS. So, that's going to continue to flow. It would help me to understand better why states are not reporting it, if we have any information about that, Margo on your side.

Yeah. I think there are a few factors. One is, I believe, could be, the sample size issue in terms of the minimum requirements for sample size. The other could be the fact that it is based on the 5.0H, the HEDIS survey as opposed to 5.0, and there's some variation in which surveys are being used. And I think also the fact that sometimes the plans conduct a survey, and it doesn't get reported up in an aggregated way to the state level. So, I think there's variety of factors. As I said previously, one of the things we're exploring with AHRQ is the dry run of using the AHRQ CAHPS Database for reporting Core Set measures based on CAHPS. And so, this would be one of them along with the flu measure that you mentioned the other day and the smoking measure, and more generally the CAHPS measures. So, I would put this in the category of the potential for using an alternate data source to calculate the measure. And so, I think there is a lot of potential there.

Jennifer Fuld, are you trying to speak?

Yeah. I am. Hi, sorry.

Okay. Go ahead.

I've been unmuting myself several times. So, hi, Jennifer Fuld from CDC, and there may be I'm not sure, some CDC subject matter experts from the Office of Smoking and Health, and if so, they can certainly speak to this better than I can, but we, CDC, strongly opposes the removal of this measure without a suitable substitute measure to assess delivery of clinical treatment for tobacco use and dependence. And I know that another Workgroup member had mentioned that last year, there were discussions of other measures, which I realized for this year or for 2021, is not possible. But CDC would recommend, maybe in the future, the adoption of NQF 0028, which would align with HRSA’s required clinical quality measures.

And just to probably tell us all what we already know, tobacco use remains the leading cause of preventable disease, disability, and death in United States. Cigarette smoking kills nearly half a million Americans every year and costs the U.S. approximately $300 billion including $170 billion in direct medical costs. So, quitting smoking reduces the risk of premature death, improves health, and enhances quality of life. And tobacco use and dependence is a chronic relapsing condition, which often requires multiple interventions and long-term support. So, evidence-based, cost-effective treatments that increase smoking cessation success are available, including behavioral counseling and medications. However, these interventions continue to be underutilized. So, clinical quality measures play an important role in ensuring that clinicians consistently deliver smoking cessation treatment.

And evidence shows that strategies that link smoking cessation related quality measures with payments to clinicians, clinics, or health systems increase the rate of delivery of

clinical treatment for smoking cessation. The current measure, NQF 0027, measures clinical delivery of three evidence-based cessation interventions: delivery of advice to quit counseling, discussing behavioral strategies and providing discussion, providing discussing cessation medications. Excuse me. So, again, CDC really strongly opposes the removal of this measure, particularly without a comparable measure to replace it. Thank you.

Thanks, Jennifer. I'd like to actually go back to some of the state Workgroup members, specifically about the issue of G codes. I've actually been thinking about this the last couple days, because it also affects the depression screening measure that we talked about the other day. And that's also not frequently reported by states specifically because of the G codes, and I'm curious if there's any feedback or commentary from state folks about use of G codes in state Medicaid programs.

This is Lindsay from New York. I think anytime you ask a provider to drop another code and you don't put money behind it, there is a danger that you're not going to get it. And I think they're being overwhelmed with the amount of codes they're being asked to add for different measures. And so, it's good, I think it's always good to provide administrative specifications as an option, because for those that have that ability to enter those codes or want to do that or - it's great. But to expect that you're going to get all of the information that you need based off of these codes, we find that to be unrealistic especially when we don't have extra money to pay specifically for that code. And especially moving into very tight financial times, those options, those doors are closing very quickly to even think about adding payment to a code. So, I think it's always great to have as an option, but we do need to continue to think about how we can capture this information in different ways to supplement the ability of administrative specifications. And that's going to be our challenge moving forward.

Thanks Lindsay.

This is Ann Zerr from Indiana, and I would absolutely agree with that. Among the issues is in our FQHC environment, they're paid a PPS rate, so they are very much not incented to list all of the codes and all of the services that they provide. And that's about 17% nationwide Medicaid members use FQHCs for their primary care. So, I think that all of us share this. This is an incredible problem. Indiana has a rising smoking prevalence among poor people. So, this is a huge problem for us, but it has to be a measure that we can use.

Any other comments about the measure that we're talking about now based on the CAHPS survey? All right, why don't we move onto the next measure, which is Diabetes Care for People with Serious Mental Illness.

Hi. This is David Kroll. I'll go ahead and start. So, I was not someone who made a recommendation on this measure. And I actually think I don't feel super strongly about the outcome of this vote. I don't feel totally wedded to the idea that we necessarily need to keep this measure on particularly with the other measures that cover a lot of the same stuff. But I do want to point out that it's not entirely redundant with the other measures, including the one for diabetes screening and the one in general for diabetes care, in that part of the risk associated with serious mental illness for diabetes and other metabolic related adverse events is not entirely related to antipsychotic medication that is a part of

it, but individuals with schizophrenia and other serious mental illnesses are at high risk of developing these conditions regardless of what kind of treatment they're receiving.

And these conditions remain a leading cause of death in this population. And so, it's something that I think still needs attention, independent just from the prescribing piece. Although, I don't necessarily feel super strongly that it needs to be its own separate measure on the Core Set just for that, just to keep in mind, it's overlapping without necessarily being entirely redundant.

This is Lindsay from New York. I just missed what specific measure were you talking about again? I'm sorry, I missed it.

Sorry. Yeah. No, I'm scrolling across all the slides. So, there's the other behavioral health measure for Screening for Diabetes in Individuals with Schizophrenia and Bipolar Disorder using Antipsychotic Medications. So, that's the overlapping piece. But under care of chronic conditions, there's also diabetes care for individuals with diabetes. And one of the Workgroup members did suggest potentially stratifying that measure to include individuals with serious mental illness. And I agree that sounds like a good idea. I wonder how feasible that is considering that states are unable to report on the measure as written but do agree with that suggestion.

Yeah, I guess so -

And just a reminder that the measure - I just want to remind everyone that the measure that we're going to be voting on is the measure as it is currently specified and the measures in the Core Set as they are currently specified, so just as a reminder. Lindsay, I'm sorry to cut you off.

No. That's okay. Somebody else had a comment, I can wait.

This is Lisa Patton, and I was just going to say that the diabetes screening and the management and follow-up measures along with cardiovascular screening and the monitoring measures were created to get at access issues and health disparities. So, part of what you're mentioning, David. But yeah. So, these measures and we always had some conversation about social determinants of health. And I was hoping we might revisit that later today as well in terms of gaps. But it was in many ways to be an access measure.

This is Lindsay from New York. So, just to clarify, the diabetes screening measure is different, in a different population than the monitoring measures for people with diagnosed diabetes. So, the screening measure, the individuals, actually are not diagnosed with diabetes. Am I correct on that, Margo?

Yes. I believe so. And just to further clarify, the measure that we are talking about is the Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c Poor Control.

Yeah. So, I'm actually the Workgroup member that…

Yeah, and Lindsay - yeah, Lindsay, there's a counterpart.

There is a counterpart measure that's screening for individuals with schizophrenia and bipolar as well.

That's right. That's right. I am actually the Workgroup member that suggested the removal of the - so, we have two poor control measures currently in the Core Set. We have one that looks at the entire population and the proportion with poor control. And then the second measure is a subset of that first measure. It is for individuals with serious mental illness, poor control. So, that is two very similar measures or two of the same measures holding up or creating real estate on the Core Set.

Now, that's not to say that I don't think that monitoring diabetes outcomes is important for people with serious mental illness. I do not think that at all. I actually think that we have a real opportunity here to stratify all of our measures by those people with serious mental illness, because in the measure specifications, you look for instances of serious mental illness, by looking for certain diagnosis codes. You can absolutely. This is what the State of New York has been doing for years is we have not been going out and pulling two separate samples for the same measure. We've been taking our poor control results and then looking for evidence of those diagnostic codes and segmenting out and stratifying those individuals in our sample that have evidence of serious mental illness and reporting that. So, I think there's a way to free up some real estate on the Scorecard as well as measure a very important disparity. We have disparity on gender; we have disparities on disability. And we report disparities on race, ethnicity. Adding a disparity for all measures for individuals with serious mental illness I think would be an optimal way to ensure that we're still looking at this, but at the same time not duplicating efforts and having states pull two samples, and reporting information duplicatively to the Core Set.

This is Bonnie Zima; I'm a child psychiatrist. Lindsay, I really appreciate your comments, and I believe I was one of the Workgroup members that was supportive of stratifying existing measures by SMI.

This is Linette.

This is Lisa again. Now, I'll just say quickly, Linette.

Go ahead.

I'm actually excited about this conversation, Lindsay, because these measures were developed, probably NCQA can give us the exact dates, but probably 2012/2013. And so, it's wonderful to see that we no longer have to do that in a separate situation that you can - there are stratifications we can use now.

And this is Linette from California. I was just going to put on sort of the Workgroup hat of highlighting the feasibility issue. We're actually a state that does report this, but in California, we have an integrated environment that in our common data warehouse, we have mental health claims. We have physical health claims, dental claims, substance use disorder claims. It's all in one place. But I know as I've listened to other states, depending on how the environment is set up, they may not have the behavioral health claims to help calculate this measure. And I think that's why we see only - I believe it's

like four states reporting this measure. And so, because of the way they're set up, they just don't have that data readily available without doing some sort of extreme effort to get at it. And so, that's one of the other challenges here.

So, from the feasibility perspective and recognizing this is one of the measures that will be required in 2024, four states are reporting it, that this potential to be considered for removal from here. But based on the conversation, there's lots of avenues around making sure we continue to monitor and to talk about it and look at disparity and other things. And we can do that outside of the Core Set measure environment. And maybe that's something that it can have a focus with a workgroup or a technical assistance arena. And then if we see that states do have the data to report this in the future, maybe it's reconsidered. But right now, it looks to me like it's something that would be appropriate to remove for the reasons we have stated.

Hi. We have somebody from NCQA, the measure steward, who wants to speak. So, you have one or two minutes, very brief, so that we can move onto other measures. Operator, can you unmute the line?

And their line's now open.

Hello. This is Junqing Liu at NCQA. Could you hear me?

Yes, we can hear you.

Excellent. So, let me try to help here. And regarding the feasibility, this measure can be reported using claims data, because there are claims codes for the HbA1c value over 9%. So, the feasibility is the same as the states are able to report to the general population diabetes control measure. Second point about this idea of stratifying the existing diabetes poor control measure for the general population, there's challenge for doing that, because the measure is reported using a sample of 411 patients. So, if we want to stratify within that sample of people with serious mental illness, we will end up having small denominator for many plans and states. So, that's an issue there. So, speaking to the necessity to have a sample of its own, of patients who have diabetes and the serious mental illness diagnosis, so these are all - this measure is purely claim-based.

You can use the schizophrenia and depression diagnosis claims code to identify this population just like how the state and the plans can report the other measures like the follow-up after hospitalization for mental illness measure. All the diagnoses exist in the measure as well. And lastly, I think I did - probably this panel all agree the importance of having outcome measure for this population. So, this is the outcome measure. And when we test it a few years ago we demonstrated that for the Medicaid population specifically, 20 to 40 percentage points higher of population with schizophrenia had poor A1c control than the general Medicaid population. So, there's a real need to demonstrate the disparity of care for this population, as this cannot be accomplished by stratifying the general population diabetes measure, because the sample will be too small, and you'll need to draw a separate sample if we were to track the quality of this outcome measure. Thank you.

Thank you so much. Other comments, Lindsay, anything more you wanted to respond or any other comments on this measure?

This is Linette again. Just to affirm, I totally agree that it can be done administratively. And that is how we're doing it in California, but it can only be done administratively if you have the behavioral health claims to identify the people with severe mental illness. And we've heard from a number of states in different arenas that don't have that readily available.

Thanks Linette.

All right. Let's turn now to the measure, Use of Opioids at High Dosage in Persons Without Cancer. That is a PQA measure that we're going to be discussing. So, who would like to discuss this measure?

Hi. This is Marissa Schlaifer. And I just have several comments on this measure. And first, I noticed that the Workgroup member that recommended that it be removed did so primarily or at least for the first reason that it's not a behavioral health measure. And I do not disagree with that at all, but I think that's more about how it's categorized and less about whether or not the measure belongs in the Core Set. So, I think that's kind of a question to throw back to CMS and maybe Mathematica about “could measures be rearranged” rather than “should a measure be removed” from the Core Set? I just want to note a couple things, one that 27 states are reporting this or a similar measure. So, I think there is recognition that it is important. And the other thing that the Workgroup member put forward was that we already have a measure for pharmacotherapy for opioid use disorders.

And I don't see that as a good reason to recommend for removal of this measure, because that's really how do we take care of patients who have been diagnosed as abusing opioids, or abusing or misusing, or have been diagnosed and are being treated. And I think this measure is so much more important, I mean so much need for this measure in addition to that, in the Medicaid population and in the broader population, because we really right now have to continue to focus on how do we make states, how do we make Medicaid managed care plans, how do we make prescribers and pharmacies accountable to address overprescribing, over dispensing, overuse of opioids? And we don't have another measure that does that. I think ideally, and we talked about this over past years, we would have a measure that could identify that misuse within the first 45 days.

But in not having that in the set or not having that widely available, or available, we need something that serves as a red flag that says we have a problem there that needs to be addressed and really serves as somewhat of an outcomes measure of not an individual health outcomes measure, but do we have a problem there that has not been addressed? And that do we have states and Medicaid managed care plans or physicians or others that are outliers in having higher incidence of patients that may be misusing or abusing opioids? And I just want to mention, I think I've mentioned in the past that my background is not quality measurement in the Medicaid program. It's in the Medicare Part D and Medicare Advantage Program.

And this is a measure that we use in the Medicare Part D world. It's been for several years a measure that CMS uses to report back to Part D plans and MA plans. And, going forward, that data is being reported starting with 2019 data, is being reported publicly as a part D display measure. So, just basically to sum it up, with opioid misuse being one of our top health issues, although in today's COVID world is probably not top of mind, I can't see this measure set being complete without an opioid misuse measure and think this one serves that purpose well.

This is Sara. Can you hear me?

Yes.

Yeah. Hi. So, this is Sara Salek. I'm with Arizona Medicaid. And as I've mentioned before, I am an adult as well as child psychiatrist by training. I've also worked in addiction medicine and treating individuals with opioid use disorder, specifically Suboxone for medication assisted treatment, and I was actually the one, the Workgroup member that had put this forward - that I do not think it's a reflection of the behavioral health care sub-component of the Core Set. And just to reiterate, I agree with the previous commenters' note that this is a critically important measure. And so, I'm not recommending removal from the Core Set, rather reclassification, rather than Behavioral Health Care, under Care of Acute and Chronic Conditions.

And the reason being is that we have really tried to, with the direction of the Substance Abuse Mental Health Services Administration, SAMHSA, we've really tried to get more people into treatment for opioid use disorder. And I think it sends a mixed message on our Core Set to say we want to try to get people into treatment and we're measuring the use of pharmacotherapy for opioid use disorder. And then we have misuse of opioids at high dosage. And specifically, I think the use of opioids at high dosage is really related to what got us into the opioid epidemic in the first place, which is treatment for non-cancer, non-terminal pain, i.e., chronic pain. And so, when we have individuals that do receive a diagnosis of opioid use disorders, they're referred to medication assisted treatment. That's exactly what we want to see happen.

And initially, they may need a high dose, for example Methadone, in order to prevent opioid withdrawal symptoms and to treat their opioid use disorder. But eventually, they get tapered down to the most effective dose. And so, really, I feel the use of opioids at high dosage in persons without cancer is a reflection of treatment of non-terminal, non-cancer pain within the Care of Acute and Chronic Conditions rather than a reflection of Behavioral Health Care. And I feel very strongly that we do not want to send mixed messages to our community related to accessing treatment for opioid use disorder. And so, again, my recommendation is to reclassify this measure under the Care of Acute and Chronic Conditions.

Thanks, Sara. That was very helpful. I think to just clarify the task at hand, I think we should discuss this as a measure for removal and then I think you have just recommended that it be reclassified - CMS is listening, we're taking good notes. So, I think that is something that we heard loud and clear as you said if this remains in the Core Set, that it should get reclassified. So, I'd like to find out if there's anyone else who wanted to speak to this measure in terms of retaining it or removing it before we move on to further comments from Gretchen and David?

This is Jill Morrow. I'd like to add something to that. States have done a lot of work around identifying people with high use opioids about trying to prevent that. And I think this measure supports those state activities, and many of which have happened at the level of the Medicaid programs.

Hi. This is David Kroll from Boston. I also wanted to add that one of the concerns about high dose opioid prescribing is not just that it's associated with addiction and diversion, but also associated with a number of worse medical outcomes that are unrelated to the behavioral health component of it. That one of the concerns with patients who are on high dose opioids, do sometimes end up dying from other causes related to respiratory suppression for example. And so, I think we have to be careful if there are a lot of downstream consequences to this that go beyond just the addiction piece, which emphasizes how important it is.

Hello. This is Fred Oraene from Oklahoma. Hello. Okay. So, I just wanted to - without restating some of the things that we talked about earlier - I just wanted to add that as the state or as the Medicaid program, we've also been in lot of activities around this and around opioid misuse. And we look at this measure beyond just not necessarily within the behavioral health component, we - because that's beyond that. And the other thing to add is on Tuesday, I've mentioned that as a state, we recently submitted a waiver application for a Healthy Adult Opportunity waiver. And this measure is one of the mandated measures as well within that framework. So, definitely, it would be something that we would continue as a state. Thank you.

Thanks, Fred. At this point, I'd like to turn it back to Gretchen and David if they have any additional comments.

This is Gretchen. I have no additional comments. I've appreciated the robust conversation about all three of the measures.

And likewise, I don't have any additional comments, appreciate the robust discussion.

Sorry. This is Sara again from Arizona Medicaid. I just also wanted to know - obviously, we've talked about the measure stewards, and there's a HEDIS as well as PQA component to this measure. And at least, been looking at the PQA, Suboxone for opioid replacement therapy is excluded from that measure. But if there are measure stewards related to that, just clarifying around both for the HEDIS or PQA measure if Methadone for opioid replacement therapy and Suboxone for opioid replacement therapy are included in this measure, because that's really where we're using it for medication assisted treatment. And again, it will speak to the reclassification of this measure into acute and chronic conditions.

So, Sara, we do have PQA attending. Is that something that you wanted clarification about before we move to public comments?

Yeah, just in regards to - so if we got those - because I noted in the presentation that some states are reporting on the HEDIS measure, so it'd be helpful to hear from both NCQA as well as PQA, related to if Methadone prescribed out of opioid treatment programs, OTPs rather than for pain. So, again, for opioid replacement therapy, as well

as Suboxone for opioid replacement therapy, if those are included in the calculation for this measure.

So, we do have PQA who will speak to that. And at this point, we are unable to have - the HEDIS specifications are not part of the Core Set. So, let's focus on the PQA specifications, that does become a question for the future as we move to mandatory reporting, because HEDIS specifications, as you noted, are being used by some states and do not adhere to the Core Set specifications. So, Lisa Hines, a consultant with PQA, has her hand up. So, we'll call on her specifically to speak to the PQA specifications. Lisa?

Hi. Thank you, Margo. Can you hear me?

Yes.

Great, thank you. So, thank you for the question. I appreciate the opportunity to clarify. So, all medications for medication assisted treatment are excluded from the measure. And any Methadone identified would be through prescription claims, outpatient and not the federally certified opioid treatment program. So, it is strictly for pain.

Great. Yeah, that does clarify the question and reiterates the importance to not confuse this measure with medication assisted treatment, which would be under behavioral health.

Great. Thanks for that clarification, Sara and Lisa. Any other questions, comments from Workgroup members before we move to public comments?

I just had one, Margo. This is Lindsay from New York. In regards to sample size concerns or stratifying our current Hemoglobin A1c Poor Control measure, here in New York State, our collective samples of all of our health plans - they’re each using a sample of 411 - we end up with about 12,000 in our total denominator and a little over 50% have evidence of serious mental illness. So, there is quite a bit of overlap between these two measures. And we're able to satisfactorily stratify out half so we have a denominator of 6,400 for the work that we do with looking at poor control, stratifying those individuals with evidence of serious mental illness.

Thanks, Lindsay. All right, with that, why don't we open it up for public comments? 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?

And we do not. As another reminder, it is star-one if you'd like to make a public comment, star-one.

I believe, Abby Kahn had contacted us that she would like to make a comment. So, Abby, could you press star-one?

Hear me?

Hey, Abby. Your line's now open.

Hi. This is Abby. Can you hear me?

Yes, we can.

Hi. So, hi, this is Abby Kahn. I'm with the District of Columbia Department of Health Care Finance, a state Medicaid Agency. I wanted to comment about the poor control for diabetes care for people with serious mental illness, poor control. D.C. Medicaid is unable currently to report this measure. And so, I wanted to comment about the feasibility. We're unable to report this measure using claims, because our providers are not billing using the procedure code that indicates the lab results for this measure. So, we're currently exploring alternate methods of reporting, but we've so far been unsuccessful. We're exploring, asking our - like I think somebody else mentioned, asking our MCOs who currently report the poor control measure for the HPC measure, to stratify by members with serious mental illness.

However, that would only get us the subset of our population enrolled in managed care. Likewise, we're exploring a data sharing agreement with LabCorp to get the lab results directly. But again, that would only give us the subset of the population whose lab results are sent to the LabCorp. And so, just wanted to reiterate that this measure has been historically very difficult, and we're still not reporting it for those reasons.

Thanks, Abby. If there are any other state folks who wanted to comment on these three measures, we'd love to hear from you. And as a reminder, star-one to raise a hand and get in the queue, I'll give it a couple more minutes. Operator, is there anyone else in the queue?

And we currently don't have anyone in queue.

Hi. Is there someone in the queue? Operator, do you have anyone in the queue?

We do not, currently.

Okay. Well, in that case, I think it's time to move to voting. So, we have three measures that we're going to be voting on. And I just want to clarify that the vote that we'll be taking about Use of Opioids at High Dosage in Persons Without Cancer is to remove the measure from the Core Set, from the Adult Core Set. It is not about the domain. The domain will be assigned separately as we talked on the first day, but that is a decision that CMS makes about the assignment of domains. So, just as a reminder, these three measures that we're going to be voting on in the Behavioral Health domain as currently classified are for removal of these measures. And we will address if the Use of Opioids at High Dosage in Persons Without Cancer remains in the Core Set. We have heard the recommendation that this measure be considered in another domain, Care of Acute and Chronic Conditions.

So, with that, I'd like to turn it over to Dayna, and walk you through the voting. And as a reminder, if you're having any issues, please e-mail us through the Q&A box. It's all yours, Dayna.

Great. Thanks, Margo. Next slide. So, for our first vote, the question is should the Medical Assistance with Smoking and Tobacco Use Cessation measure be removed from the Core Set? And the options are yes, I recommend removing this measure, or no, I do not recommend removing this measure. And voting is now open. Okay. We have 25 votes and so far, I believe we are waiting on one more vote. So, I'll give it just another couple seconds. Okay. It appears that we now have all 26 votes in. So, I will go ahead and lock the poll. Okay. So, voting is now closed. For the results, the two-thirds threshold for this measure is 18 yes votes to pass. We received five yes votes. That does not meet the threshold for recommendation. So, the Medical Assistance with Smoking and Tobacco Use Cessation measure is not recommended by the Workgroup for removal from the 2021 Core Set.

Next slide, great.

So, the next question is should the Diabetes Care for Serious Mental Illness: Hemoglobin A1c Poor Control measure be removed from the Core Set? And the options are yes, I recommend removing this measure, or no, I do not recommend removing this measure. And the poll is now active. Okay, we have 25, waiting on one more vote. We'll give another couple of seconds. Okay. All the votes are in. I will go ahead and close polling. Voting is now closed. The two-thirds threshold for this measure is 18 yes votes to pass. We received 21 yes votes. That does meet the threshold for recommendation. So, the Diabetes Care for Serious Mental Illness: Hemoglobin A1c Poor Control measure is recommended by the Workgroup for removal from the 2021 Core Set. Next slide.

Okay. The final question is should the Use of Opioids at High Dosage in Persons Without Cancer measure be removed from the Core Set? And the options are yes, I recommend removing this measure, or no, I do not recommend removing this measure. And voting is now open. Okay, just waiting on one more vote, we'll give another couple seconds. Okay. All results are in. I'll go ahead and close polling. The voting is now closed. So, the results, the two-thirds threshold for this measure is 18 yes votes to pass. We received five yes votes. That does not meet the threshold of recommendation. The Use of Opioids at High Dosage in Persons Without Cancer measure is not recommended by the Workgroup for removal from the 2021 Core Set. And now, I'll turn it back over to Margo to facilitate a discussion of gaps in the Behavioral Health Care domain.

Okay. Thanks, Dayna. And thanks Workgroup members for the very efficient votes. So, now, as Dayna said, we want to talk about possible gaps in the Behavioral Health Care area. What types of measures or measure concepts are missing in the Core Set, and are there existing measures to fill the gap, or would a new measure need to be developed? And please remember to state your name before making your comments. So, I'll open it up to the Workgroup members.

This is Lindsay from New York. I kind of want to challenge us to think about gaps in this area a little bit differently. So, this is a particular domain of the Core Set where I think we have done a lot of really good work and added quite a few measures over the last couple of years, where I think the discussion around gaps was notable a few years ago when there was real limited information, particularly on substance use. But I want to challenge us to think about are we making the best use of the measures on the Core Set? And are

they tying back to clinical care and recommended receipt of care? And are these the measures that matter? Rather than thinking about the addition of new measures, I think our gap discussion here should be is this what really matters, and is this where we're driving the most improvement? And really have a fresh set of eyes as opposed to adding but thinking about gaps in a new way.

And perhaps, it's either not the measures that matter, what are, or can we start to think about paring this down a little bit? Because we are swelling, I think in this one area and that's reflective of this being a large driver for many of our Medicaid members. So, it's not without completely valid rationale behind it. But I want to challenge us to think about gaps in a little bit different way for this area of the Core Set.

Lindsay, do you have specific examples you wanted to suggest or leave it up to others to suggest?

I see some overlap in the initiation and engagement and some of our newer follow-up measures. And I think I brought this up last year, and I think I've spoken to NCQA about this as well. You do have some areas of overlap. And I do think we need to think about where do we want to focus, right? So, the follow-up after emergency department for substance use, actually the initiation and engagement. There's some degree of overlap there. And one is an event-based measure, and one is the first event, and it may or may not overlap. So, that's just one that I could think of, of where do we want to start to think about that the real measure that matters and start to think about maybe we could hone in and drive improvement there. That was just one off the top of my head, but I don't know of others - I'd be interested to hear about others.

This is Bonnie Zima, child psychiatry, and I really appreciate Lindsay's point about maybe putting more energy into refining some of the existing measures. And I think a good example is the ADHD follow-up measure, where if you look over the last 10 years, there's been really little change. And it raises questions of whether there's room for improvement or how effective this measure is. And just again, that's an example within this measure. For example, the C&M phase had a high attrition rate, about 60%. It only requires a telephone contact as one of the visits during a nine-month period of time for children on schedule two drugs, which raises questions about medication safety monitoring for children. And I just share that as maybe one example of a more established mental health measure that could be put - could use some improvement.

Hi. This is David Kroll and my - go ahead.

Okay. I'll be quick. I'd like to bring up the concept that some of the Workgroup members talked about related to measures that are in the chronic care or in the primary care, and the concept that the group of people with serious mental illness is a subset of the general population. There are other groups, people with disabilities who also are at higher risk for some of the same things. And thinking about stratifying by subgroup or by characteristic or whatever, some of those other measures might do what Lindsay was talking about, give us a way to look at those specific populations using the same measure as the general population, and then leaving room in the Scorecard and in the Core Set for those things that are more specific to these populations in general.

Thanks. This is David Kroll again. And so, what I wanted to add also is that one of the things that we're starting to notice clinically in behavioral health with the current pandemic is how as we've transitioned to more effective telehealth strategy as an application of technology, the Medicaid population has been left behind a little. And we're starting to see how important the technology gap is with the Medicaid population. I think advances in this field are likely to increasingly rely on technology also. And so, I think that as we start to think about future measures and future measure inclusion, recognizing that access to care might look different and might be more complicated. And thinking about measures that acknowledge and sort of speak to and describe the new methods and the new modalities, which that access to care is going to look like I think is important.

This is Gretchen.

Go ahead, Gretchen.

I would just add quickly that - thank you. I just want to add quickly that from a non-clinical perspective, many of these measures look very treatment oriented and few very prevention-oriented. So, I think as we've seen in the oral health measures, right? We're moving toward, “What does the evidence show us about prevention, and can we begin to build a measure set that helps us incent that?" And I think in particular, the children's Core Set perhaps misses the opportunity to understand the impacts of toxic stress on a developing child. And even as the common phrase being the depths of despair, clearly the measures that have been added are clinically important and they are about the treatment of individuals once they have been diagnosed.

But I just wonder if there's an opportunity to begin to explore a more prevention-oriented set of Core Set measures that could be added over time to help reduce the need for such additional treatments, if that's possible, right? Certainly, it's not possible to the extent that some of the mental health conditions are physical chronic conditions as I think was already described. But for young children in particular and I think even for others, there may be a prevention opportunity that we want to raise up and identify.

Yeah. This is Lisa Patton. I just wanted to say that this conversation around behavioral health measures has changed considerably over the past eight years. And I like the way Lindsay is shaping this and suggesting we look at it. And I think we do have the opportunity now to think about where some of the more, the broader measures can work for us to stratify and look more at the behavioral health population without losing some of the hard work that we've done over these years. And I also just wanted to mention as Gretchen was saying something, in terms of health disparities, being able to grapple with some of the social determinant of health issues that really affect health care of all age groups, access, living in poverty, a lot of those issues that I know we are not necessarily able to grapple with at this point in our quality measures and the existing quality measures. I think that we really have to start to think more so about the impact of those overall health care outcomes and how do we get there with some of the measure development efforts we have underway now.

This is Dave Kelley. A couple of comments. I think an obvious gap in our discussion is around being able to identify those individuals that have used tobacco. And I think it would be NQF measures, discussed last year and was mentioned today, so it would be

really nice if our measure steward friends could maybe re-look at how can we make those measures even more feasible, because I think that being able to identify those individuals who use tobacco and then being able to actually look at interventions and being able to determine if individuals actually have quit. We've done that through chart reviews for our pregnant women for probably the last decade. It's intensive. It's chart review.

And so, it would be really nice if we could take a better harder look at tobacco, identification of tobacco use, and then really be thinking in terms of getting those individuals in for appropriate counseling and treatments, and then looking at actual quit rate, believe it or not. Another area that I think is ripe for what I'll call harmonization and we danced around this a little bit, and I don't really want to re-bring it up, but I will, is that around the OHD measure, there needs to be harmonization between PQA and NCQA. As a state, we report both and require our plans to report both. It would be nice way to harmonize - just pick one and let's go with it, instead of having to be redundant. Another big gap area is related to the diagnosis and treatment and follow-up with anxiety. This is a huge factor, I believe, in our Medicaid individuals.

I think going along with that is looking at adverse childhood events and trauma-informed care, and really developing better measures to really look at what is happening with identifying childhood trauma and adverse childhood events, and then actually addressing that. It's a huge gap. And then lastly, I think around stratifying, some of the clinical addiction measures for behavioral health and other variables. I think looking at things like high blood pressure control, diabetes control, and perhaps some of the cardiovascular measures. In times, there are limitations, and I think the chart review - I think NCQA somewhat limits how high the chart review sample can get, and they do make some exceptions I believe, but maybe they need to re-look at that top number. I think they do limit the number of chart audits that plans can go above and beyond the usual.

Okay. With that, Gretchen, do you have any final comments before we take a break?

No. I just appreciate the conversation in this domain, obviously a very important domain, and I really appreciate the reflection of how different this conversation is than it's been in the past that shows that we are making progress. Progress in the Medicaid program can feel slow. So, I appreciate that frame and I really appreciate the seriousness with which we talked about all of these measures.

That's great. Thank you. Any final comments before we take a break, from Workgroup members? Okay. So, with that, we'll take a 20-minute break. So, please be back at 12:50. And please do not disconnect your line, so that you would have to reconnect. So, enjoy your break. Thank you.

BREAK

Hi, everyone. Welcome back from the break. We'd like to get started again. We're now going to discuss measures in the Care of Acute and Chronic Conditions domain. And I'd like to turn it over to Patricia Rowan to lead the discussion. So, Patricia, it's all yours.

Thank you, Margo, and hi everyone. There are currently 11 measures in the Care of Acute and Chronic Conditions domain, two in the Child Core Set and nine in the Adult Core Set. Today, we'll be discussing one measure that was suggested for removal and two measures that were suggested for addition to the 2021 Core Set. Next slide.

The Child Core Set contains two measures in this domain. The first is the Asthma Medication Ratio or AMR measure. AMR measures the percentage of beneficiaries aged 5 to 18 who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year. The second Child Core Set measure is the Ambulatory Care: Emergency Department Visits measure or AMB. This measure captures the rate of ED visits per 1,000 beneficiary months among children up to age 19.

The Adult Core Set contains nine measures in this domain. The first is the Controlling High Blood Pressure or CBP measure. CBP measures the percentage of beneficiaries ages 18 to 65 who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year.

The second measure is the Comprehensive Diabetes Care: Hemoglobin A1c Poor Control measure or HPC. This measure captures the percentage of beneficiaries ages 18 to 75 with diabetes who had Hemoglobin A1c in poor control (greater than 9%).

Next is the PQI 01, Diabetes Short-Term Complications Admissions Rate or PQI 01 measure. This measures the number of inpatient hospital admissions for diabetes short-term complications per 100,000 beneficiary months for beneficiaries age 18 and older.

And the last measure on this slide is PQI 05: COPD or Asthma in Older Adults Admission Rate. PQI 05 measures the number of inpatient hospital admissions for COPD or asthma per 100,000 beneficiary months for beneficiaries age 40 and older. Next slide.

Next is PQI 08: Heart Failure Admission Rate. This measures the number of inpatient hospital admissions for heart failure per 100,000 beneficiary months for beneficiaries age 18 and older.

PQI 15: Asthma in Younger Adults Admission Rate, which measures the number of inpatient hospital admissions for asthma per 100,000 beneficiary months for beneficiaries age 18 to 39.

Next is the Plan All-Cause Readmissions measure or PCR. PCR measures the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission for beneficiaries 18 to 64.

The Asthma Medication Ratio measure is similar to the child measure and is for beneficiaries ages 19 to 64.

And the last measure on this slide is the HIV Viral Load Suppression measure. And this is highlighted on the slide, because it has been suggested for removal. HVL measures the percentage of beneficiaries ages 18 an older with a diagnosis of HIV, who had an

HIV viral load less than 200 copies per milliliter at last HIV viral load test during the measurement year. Next slide.

So, we'll now discuss the HVL measure in further detail. This slide has summary information about the measure. The Health Resources and Services Administration is the steward for this measure, which is endorsed by NQF. This measure uses administrative or EHR data. Six states reported the measure for FFY 2018. I want to note that a replacement measure has been suggested for this measure, which is the Proportion of Days Covered - Antiretroviral Medication measure, which we will discuss next.

The primary reason a Workgroup member suggested this measure for removal is due to barriers that states experience in reporting the measure, which have not resolved over time. Namely, very strict confidentiality and privacy laws about sharing data on individuals with HIV. This makes obtaining the required lab results difficult for most states. The Workgroup member noted that these policy barriers have existed for decades. In addition, the Workgroup member noted that the available data source does not allow for the consistent calculation across states. Next slide.

Moving onto the next measure, the Proportion of Days Covered - Antiretroviral Medications measure was suggested for addition as a replacement for the HIV Viral Load Suppression measure that I just mentioned. This measures the percentage of individuals 18 years and older who met the proportion of days covered threshold of 90% for three or more antiretroviral medications during the measurement year.

The Pharmacy Quality Alliance is the steward for this measure, which is not NQF endorsed. This measure uses Medicaid pharmacy and medical claims and eligibility files as the data source. The denominator is individuals who filled a prescription for three or more distinct antiretroviral medications, each with two different dates of service during the measurement year. The numerator is individuals from the denominator who meet the threshold of 90% of days covered by antiretroviral medications during the measurement year. The Workgroup member who suggested this measure for addition indicated that the measure is a proxy for viral load suppression; a medication adherence ratio of 90% correlates with viral load suppression for individuals with HIV.

The Workgroup member also noted that there are multiple interventions that can increase medication adherence, such as medication therapy management programs and wraparound services provided by specialty pharmacies to encourage ongoing patient engagement. The Workgroup member noted that this measure might not present the same barriers to reporting that states have experienced with the existing HVL measure. This measure is used by New Hampshire Medicaid and Pennsylvania Medicaid programs. New Hampshire publicly reports the measure and Pennsylvania requests that its managed care organizations submit an HIV dashboard that includes this measure. The rates are about 53% to 56% in New Hampshire and Pennsylvania, suggesting that there's room for improvements.

Before we move onto the next addition, I'd like to pause here to discuss the two HIV measures together. I'll pass it back to Margo to facilitate the Workgroup discussion.

Okay. Thank you, Tricia. So, I'll open it up for Workgroup discussion at this point. We're going to discuss the two measures related to HIV first, as Tricia said. And we welcome your comments.

Hello. This is Fred in Oklahoma. So, the measure that is recommended for removal, as a state and as a Medicaid agency, last year we were hopeful and looking forward to start being able to report this, but then ran into the issue with the LOINC codes that we do not essentially have right now in our system. So, the one that is recommended for addition and just we didn't do the information that is available right now and what we've been able to lay our eyes on - it does seem like from a feasibility standpoint that this would be a lot easier for us as a state to be able to report moving forward. So, yes, I think we'll probably be in support of this one. I did not recommend this one, but I was excited to see it up here as potentially something that could replace what we currently have. Thank you.

This is Lindsay from New York. Go ahead, Jill.

Go ahead, Lindsay.

I think I brought this up again last year. This is the ultimate outcome measure that we have our hands around. It's being reported by five states. Here in New York, we do a match to our viral load registry, so we don't get back individual level information and we're fine with that. We're able to partner with public health and send them our Medicaid IDs to match. They send us back the aggregate information. Ultimately, they're the ones that are working with our managed care plans and we have a strong partnership. It's definitely one of the measures that falls under the hard to do, but I don't know why we would back away from the ultimate outcome measure. We do have some concerns with the measure that's being proposed, and I have shared those with PQA.

They've been kind enough to reach out to us and we've been working through some of their questions with them, especially with the PrEP and the expansion of treatments for HIV, for folks who maybe are not positive yet. The way to kind of tease those folks out of this measure is incredibly difficult to do. And so, we are not going to invest our time in this when we have a clear task to work on viral load. I understand that not all states have a cooperative agreement or the opportunity to work with their public health. And I would ask CDC to help facilitate that wherever possible. I don't know why we haven't been able to share those lessons learned across states, because it can be done. And all the data that you need to calculate viral load suppression is stored in the viral load registry. It's clear. Its definition is the same, and the information is standardized. And once you have that match completed, getting the information on the viral load registry is not the issue.

So, this is Shevaun with Florida. I would just offer - I think I was pretty vocal last year on this one. I agree with everything that Lindsay just said in terms of it being the ultimate outcome measure, but the states are not able to get to that point where they can report on it. It diminishes its utility being included the Core Set drastically. And so, I think until we can get to a place where states can really overcome those barriers and we're making significant strides, its placement on the Core Set just doesn't seem as valuable other than to signal that this is important, which we all know it's important.

Shevaun, can you say a little bit more about the barriers in Florida?

Yes. So really, it's getting our health department to work with us to get the data that we need. We have made some strides in that regard, but with administration changes and some other confounding factors that have come up, it's just been hard to get the agreements in place that we need to have to access the data needed to be able to really report on this, so - and that data that we have in hand, and requires collaboration and cooperation from another entity. So, that just makes it that much more challenging.

So, this is Jill Morrow.

Are there other states - go ahead, Jill.

I was just going to add that when I was in Massachusetts, trying to get these collaborative data exchange agreements between department of public health and Medicaid were difficult.

Yeah, and I agree. This is worthwhile to continue behind the scenes, working to get to a place where nationwide we're in a better place. Just given the real estate of the Core Sets, it's not helpful to be able to do any comparison from state-to-state with so few states reporting.

I'm wondering if there are other states on the line that have had success in doing the kind of matching that Lindsay has described.

This is Linette from California. Yeah, we've been reporting this measure for a few years. And similarly, we share the patient level data with the HIV registry, AIDS registry. They're able to do the linkage. They give us back summarized data that we can then use for reporting. I think one of the things in particular in our state, whether this measure stays on or off, we'll continue to do that. We have very strong stakeholder interest in this area -- the Getting to Zero initiative has been very strong. So, we do some additional reporting by plan. And that is done either by our public health colleagues or within our Medicaid program in terms of public reporting around this measure. So, we have an engagement that's broader and that helps support the data sharing activities as well, but if it does not necessarily happening in your state, then it would be probably harder to get the initiative behind it, because as was noted, sometimes developing and sharing agreements can be rather challenging, but it can be done. It takes time.

This is Gretchen. I have a question for both California and New York. If the data is reported back to you in aggregate, how does that drive clinical performance? It may be an interesting piece of information, but if you can't put a payment incentive around it or a visible dashboard, how are you able to translate that into clinical decision making or changes in clinical behavior?

So, in New York…

Go ahead.

So, in New York, we publish rates at a health plan level and statewide. And then through - so, that's step one, because we only get it back in the aggregate, we're able to display rates at various units to show where the opportunities for improvement are. We roll up to

geographic regions as well to point to particular areas. And then we do have an additional data use agreement between managed care organizations and public health. But it takes us out of the loop as the department of Medicaid. There's a data sharing agreement between the folks who oversee the viral load history and the plan, and they send them the non-suppressed individuals. So, they send them individuals who are not currently suppressed, so that they can engage them in care, and get them back to care. So, there are specific rules about how they can use that that they get to the numerator non-compliant folks based on a list. And so, that took a lot of effort to get there, but I think that's that next step of, "Okay, so here's my rate. And who do I need to actually target and get engaged and back in care?"

Is there somebody? Jennifer, is that you trying to speak?

Hi. Yes, sorry. I'm trying to wait my turn. This is Jennifer Fuld from CDC. And I just wanted to add in a few points. So, CDC strongly opposes removal of this measure and I'll give some reasons for that, and then also second, we don't think that the proposed replacement measure is really equivalent. So, as you all know during the 2019 State of the Union Address, the administration announced a new initiative, ending the HIV epidemic, A Plan for America. And this is a 10-year geographically targeted initiative, which began in fiscal year 2020, with the important goal of reducing new HIV infections in the United States to less than 3,000 per year by 2030. And this initiative has four pillars: diagnose, treat, prevent, and respond. And increasing the percentage of persons with diagnosed HIV infection who are virally suppressed is a key outcome of this federal initiative.

As part of this initiative, through HRSA's Ending the Epidemic: A Plan for America funding, grant recipients are able to support infrastructure costs associated with the development and expansion of data systems. It may include technical assistance on the type, design, and building of new data systems, bridging existing systems to achieve data integration, improving data entry to decrease burden, and increase accuracy, training of staff and providers on collecting and using data, as well as employing experts to provide accurate and in-depth data analysis. So, there may be some possibility to use some of those funds to be able to address some of the challenges with reporting for this measure. In addition,

Jennifer, this is Gretchen. Can I ask a question about that?

Sure. And as you know, I'm not from HRSA, so yeah.

That's fine. I guess I respect the position of the CDC. However, I think you've heard both last year and this year that there are state public health departments and or statutory barriers to sharing this information. So, what actions have CDC taken to engage state health departments on this issue?

So, first, I do want to see if there are any CDC HIV staff on the line. Otherwise, I can certainly give I would say more of a partial answer. But I don't know, Margo, if that's possible to see or not.

Yeah. We're not seeing that. And I think in the interest of time, I prefer if you could respond. And I also want to make sure we leave time for the other measure. Thanks.

Sure. And so, this will be I would say more of a partial answer. But CDC has done a lot of work over the past several years to work with state health departments around data sharing, both within health departments across infectious disease, and with health care facilities. And of course, since HIPAA, the HIPAA rules, there had been at times different policies on using public health data. But a lot of it has been more around interpretation. And so, New York State, New York City are really good examples of localities that have made really good strides in data sharing. So, CDC also, through the funded cooperative agreements in the Division of HIV Prevention, works to facilitate peer-to-peer sharing in order to share a lot of those lessons.

So, it may not be as far along as everyone would like, but there have been a lot of successes in improving data sharing that could help with supporting this measure. And if I could just add one more thing - I'm sorry.

I was just going to say I think that makes sense. I think if you're going to come out with a strong opposition statement, maybe also being willing to continue to lean in, if we've got multiple state Medicaid agencies who are saying they have not been able to break through on this issue, maybe just a recognition that there may be further action taken by the CDC to help support progress.

Yeah, thank you. And I'll definitely give that feedback to the Division of HIV Prevention. And the last thing I would just say, in terms of the proposed new measure, one concern is that it could overestimate viral load suppression, because as we know and many of us sometimes do, persons may pick up a prescribed medication, but may not always take the medication as prescribed. And then just I think that Lindsay's point is very important. Viral suppression is one of the key outcome measures in order to really be able to reduce rates of HIV. And as we know, if someone is virally suppressed, then they're not able to transmit. So, again, we would ask for this measure to be kept in or not removed. Thank you.

Thanks, Jennifer. Why don't we turn to the Proportion of Days Covered measure, the antiretroviral medication measure. Before we move on, any comments about that?

This is Dave Kelley. I'll confess, I was the one who started this discussion again from last year. So, again I'm proposing this measure primarily, because for many years the State of Pennsylvania, we have just been unable to report this in any way, shape, or form, even though we've tried various avenues. Our Philadelphia Department of Health, I believe, is able to report at least globally for Medicaid. Quite honestly though, and I think Gretchen asked a great question, how actionable is that global reporting for Philadelphia when we can't get down to individual intervention? And I think it's great - I'm jealous with what New York has been able to do. I think that's great. That's one state out of 50 plus territories. And so, I'm looking at the numbers for the viral load suppression. And believe me that I think it's a great measure. It is the ultimate outcome.

This measure, looking again the PQA measure, gives managed care plans the ability to look at what is happening at pharmacy level. It's not perfect. It gives them ways to intervene with either individuals or clinical sites. It's actionable. Pharmacy data comes in relatively quickly and it allows for quality improvement activities. And I'll just say that unfortunately within Pennsylvania, we not only have HIPAA, but we have a very

antiquated law that is very prohibitive about sharing HIV, and I really fully understand where that law came from. So, it's a challenge for us obviously. It's a challenge for other states because of viral load suppression information. So, I am proposing this as a reasonable alternative or even a companion measure.

Thanks, David. But why don't I turn it back over to Tricia to walk through the last measure in this domain? And then we'll have some time for further Workgroup discussion after that. Tricia?

Thanks, Margo. Next slide. The final measure suggested for addition to the FFY 2021 Adult Core Set is PQI 92: Prevention Quality Chronic Composite. PQI 92 measures the number of inpatient hospital admission for ambulatory care sensitive chronic conditions per 100,000 population age 18 years and older. This composite measure includes admission for several chronic conditions that are listed on the slide here. The Agency for Healthcare Research and Quality is the steward for this measure, which is not NQF endorsed. Like the PQI measures that are currently in the Adult Core Set, this measure uses administrative claims as its data source. The denominator for this measure is the population age 18 years and older. Note that discharges are identified based on the patient's residence and not the location of the hospital where the discharge occurred. Next slide.

This slide describes the numerator for PQI 92. It includes discharges for patients age 18 years and older that meet the inclusion and exclusion criteria of the prevention quality indicators that make up this composite measure. I will note that four components of this measure are already included in the Adult Core Set, and they are PQI 01, PQI 05, PQI 08, and PQI 15. PQI 92 is included in the Health Home Core Set and 23 Medicaid health home programs reported the measure for FFY 2018.

The Workgroup member who suggested this measure for addition indicated that this measure identifies hospitalizations that might be prevented with more timely or appropriate outpatient care. Therefore, it is sensitive to the quality and accessibility of ambulatory care in an area. The Workgroup member noted that the measure could be used to improve access to appropriate care for a set of common conditions that are prevalent in the adult Medicaid population such as hypertension, diabetes, and asthma. Next slide.

Okay, now I'll pass it back to Margo to facilitate the Workgroup discussion on this measure.

All right. Let us know what you think. Remember to unmute your line if you wish to speak.

Hi. So, this is Lowell Arye. So, this gets back to my issue with regards to aging in the population and questioning as to how this indicator, does this indicator do anything to delineate by age grouping? It’s just that it’s currently age 18 and older. When I did some research, I saw that people 65 and older have the highest percentage of diagnosed diabetes, almost 26% from what I gather. And so, I'm curious if this is something that this measurement does or if there's another measurement that looks into this a little bit more.

Can you clarify what you mean when you say, "looking to this a little bit more," looking into what?

Well, that it allows us to delineate by age. So, are there other measurements that might be used instead if this one does not define by age? Are there other ones that do that could be actually used? I think I'm trying to get people to look at the issue of the aging population and the impact that certain diseases have on an aging population. And specifically, when you look at diabetes, it's clearly a much higher rate in seniors. But then from what this says, there's no delineation. So, I'm just trying to figure that out and understand it better.

Yeah. That's a good question Lowell. Most of the Core Set measures in the Adult Core Set are stratified by ages 18 to 64, and 65 and over. And to some extent, that's also a function of data availability that not all states have complete data for the 65 and older populations. But in general, most of the Core Set measures are stratified. And as you would expect that many of them that are stratified and for which states have complete data, they do show higher utilization. So, that becomes a method and a data issue to some extent when the measures are implemented in the Core Set.

Hi. This is Linette from California. One of the things that we've struggled with a little bit with respect to the PQIs is for those PQIs currently on the list that are more predominantly conditions of individuals who are over 65. And it really is a data completeness issue, because as people are over 65, generally Medicare is their primary payer where a lot of these claims would be. And so, we don't necessarily have that. And while we have done data sharing with CMS related to Medicare data and we've received fee-for-service, we haven't received managed care data. And that still leaves a significant hole for us in California. One of the questions would be our organization that does hospital discharge data, they actually do quite a bit of analysis and reporting related to PQIs.

And so, with the hospital discharge data, they have data for all ages. So, in terms of looking at the PQIs in general especially when they include populations over 65, and this composite one would definitely have this issue as well. Understanding how to get at the data to make the reporting effective and meaningful, recognizing that for the population over 65 where Medicare becomes the primary payer, is an issue, so, just a contextual challenge that we have.

This is Lindsay from New York. Linette, that's a great idea that I haven't really thought about, but most states submit data to their HCUP. So, AHRQ has the HCUP data they collect across states, and they do identify Medicaid. I think they are able to parse out Medicaid. So, I don't know if CMS has thought about that as a way to reduce burden on states and avoid duplication of submission of data. So, if AHRQ is already collecting HCUP data, is there a way that we could tap into that as a data source for the PQI as opposed to asking state Medicaid agencies to duplicate efforts and then now have to run this measure on their own claims? Could be slightly different. I think it's a good one to test and walk through, but that might be a way to reduce burden on state Medicaid agencies, have consistency across data sources, and would allow additional composite or additional information that might rely on Medicare, which I think many states have the same problem California does, is the integration of this data across Medicaid and

Medicare to get a full picture of duals is challenging. So, then I think that's something that I would like to see put in the record, as something to work on or look toward.

Lindsay, that's a great point. And it is something that we have started thinking about. But the other thing that we started thinking about that I'll mention here is the use of T-MSIS. And we have begun an effort to use T-MSIS to calculate the PQI measures and also working with a few states to calculate the PQI measures as well. So, I think T-MSIS is another promising source of information that would be available for all states. I think the issue with the HCUP is that it's not available for all states. But yes, I think that's a really good point that I was hoping could be brought up is the use of alternate data sources to calculate this measure.

And this is Linette again. So, the problem with T-MSIS though is that it still doesn't have that Medicare data for 65 and older. So, it still leaves a major gap in terms of having the measure be meaningful when the conditions are primarily in that population. And I'm not sure which states you're testing that with, but we're always interested in that kind of thing in California, as a separate aside.

That sounds great. We might take you up on it.

This is Richard Antonelli. Are you able to hear me okay?

Yes, we can.

I apologize. I've been struggling with the quality of the audio. I think that I heard Lowell ask about age stratification. I'm wondering, are there any other ways of stratifying this data? I tried to look at some of the information sheets and I couldn't find it. So, for example is housing insecurity captured as a way of looking at these performance measures or are they just crude rates?

So, the data source on which this is specified, which I think has already been mentioned, is hospital discharge data. And I don't believe hospital discharge data has housing insecurity as an example. And so, I think that there would need to be data matches, data linkages which is actually another potential opportunity for future work in extending or enhancing the use of quality measures for quality improvement. So, I think one that's been mentioned is the use of Medicare-Medicaid data linkages that would be one opportunity and then various other cross-sector types of data linkages.

I think another thing that I would just mention is that there are other codes whether it'd be on claims that we've already talked about, G codes for other measures, or ICD10 codes that are not as frequently used. But those also I think that we could talk about when we come back to the wrap up, talking about gaps and future directions in ways to perhaps utilize some of the capabilities within coding systems or data systems that might be underutilized to this point.

So, I would like to go back to a point that Tricia made earlier that this PQI 92 measure has been used. I'm trying to remember, Tricia, what you said, how many states have actually been or state plan amendments, SPAs or some SPAs have been reporting it or is a fair number of states.

Twenty-three.

Twenty-three, right. So, it has been demonstrated to be usable, but I think all of you are highlighting some of the questions about how it does get used and how it does get calculated. Are there other comments in this section whether on this measure or also the other two measures that we previously discussed?

Gretchen or David, anything you wanted to add at this point?

Nothing for me. Thank you for the good conversation.

I have nothing to add.

Okay. So, now I think we're ready for public comments. All right, again, please press star-one to enter the queue, and remember to state your name and affiliation before you make your comments. Operator, is there anybody in the queue?

And yes, we'll go first to Ben Shirley.

Hey. This is Ben. Can you hear me?

Yes, we can.

Hey, everyone, Ben Shirley with the Pharmacy Quality Alliance. I just wanted to give, I think, our perspective and some brief comments on the Proportion of Days Covered measure. So, adherence really has been explored at length in the literature, and there is really a broad body of evidence, I think summarized especially in the recent meta-analysis, that does really show that better adherence is very strongly associated with viral load suppression, improved CD4 counts, outcomes like this. While poor adherence really, we know, does lead to development of drug resistance, to increased risk of transmission, and to other negative outcomes. So, we do feel that while we certainly acknowledge that it is a process measure, and obviously, we all have preference for these outcome measures, it is a very strong proxy for an outcome. And the PDC methodology in these measures, it's very well established. And we think it's very feasible. It's used in the Part C and D Star Ratings and really in a variety of settings. So, really from the perspective of feasibility and aiming to estimate quality across all states - a significant strength of the measure in meeting the needs of the Medicaid Core Set program, so, just wanted to weigh in. Thank you for the good discussion.

Operator, is there anyone else in the queue?

And as another reminder, it is star-one if you'd like to make a public comment at this time. We'll go next to Pedro Carneiro.

Hi. This is Pedro Carneiro from the National Association of Community Health Centers. I would like to oppose the removal of HIV Viral Suppression from the Core Set and substitution for a more not objective measure, which would be the pharmacy claims. I think to the discussion that we had before from the CDC about folks not taking medication as indicated is very valid. As well as viral load suppression is a key indicator of HIV prevention efforts and community viral load is actually a very important peer

review data point. So, I would like to oppose. I would like to thank you, everybody. And I also like to remind that in addition to being a key data point, viral load suppression is also very important to efforts to spread the undetectable equal untransmissible message to communities at risk for HIV. Thank you.

Operator, is there anyone else in the queue?

And yes, we'll go next to Marlene Mitoski.

Hi. This is Marlene Mitoski. I'm from the Health Resources and Services Administration. We are the steward for the Viral Suppression measure. I really appreciate the discussion today. And fully, we are aware, along with our CDC colleagues, of the challenges that the states have had with this measure. We continue to offer support to states to work through these challenges. You may recall that we had an affinity group that was an effort between CDC and then HRSA as well as our colleagues at CMS to offer support to states on overcoming these barriers and challenges. We've seen consistently the same six states reporting the viral suppression measure. But I wanted just to take a moment to highlight what our colleagues in CDC said with the Ending the Epidemic initiative. We know that there's been an infusion of a significant amount of money into the highly disproportionately impacted states and counties.

And they are able to use those funds to support these data infrastructure efforts that we're talking about here today. Those funds were just released about six or eight weeks ago. So, the jurisdictions are just putting their plans together now. I completely understand that six is not a large number of recipients or sorry, states to be reporting this measure. But I do think that it is an outcome measure. I do appreciate the Pharmacy Alliance measure as a proxy, but I would encourage, because it is an outcome measure and also, it's a very important outcome measure and quite frankly the most important outcome measure in HIV that you consider keeping it on the Core Set. Thank you.

Thank you. Operator, anyone else in the queue?

And yes, we'll go next to Ifeoma Nwankwo.

Hi, Ifeoma.

Hello. Yeah, good day everybody. And this is Ifeoma. This is Ifeoma from the Connecticut Department of Social Services. I just want to say that I appreciate the discussions for today, and want to congratulate the Workgroup and CMS and Mathematica for a job well done, and also to say that Connecticut Medicaid has collaborated with other state departments on CDC initiatives, specifically the 6|18 initiative, but we have yet to receive any assistance to break through the data sharing issues, which continue to mitigate against state reporting of some of the measures, particularly the maternal and infant health care measures, as well as the HIV Viral Load measure. But it is good that regarding now in the states and then perhaps the Workgroup can push a CDC intervention on this. Thank you.

Thank you, Ifeoma. Operator, any other people in the queue?

And we do not have anyone else in the queue. As a reminder, it is star-one if you'd like to make a public comment, star-one.

Jennifer, I think while we're waiting, do you have a comment?

Yes. Hi. Can you hear me?

Yes, we can.

Great. Thank you. So, again this is Jennifer Fuld from CDC. And I'm glad HRSA was on the phone. That was the point that I did not make and wanted to make in response particularly to Gretchen's question. So, in 2016, HRSA, CDC, and CMS developed an affinity group to increase state level interagency collaboration for improved data sharing, specifically to be able to increase reporting of HIV Viral Load Suppression. And so, among the 19 states that participated, at the end of the one year period, 13 states had established or refined their data sharing agreements between state Medicaid agencies and public health departments. And then of the 12 states that successfully matched the data or streamlined the data matching process, eight (or 67%) generated an HIV care continuum for state Medicaid beneficiaries, including estimating viral suppression rates and identifying targets with performance improvement. So, again, here are examples. And certainly, there's more work to be done to strengthen the relationship between the state Medicaid and state health department, those are important points. So, just wanted to add that and reiterate what HRSA mentioned. Thank you.

Thanks, Jennifer. Operator, anyone else in the queue?

And we do not currently have anyone in the queue. As a reminder, star one if you'd like to make a public comment.

Okay. I think if we have no one else to public comment. Thank you all for your comments. It was great to hear from so many people. And now I think we're ready for voting. Dayna, all yours.

Thanks, Margo. Next slide. Okay, so for our first vote, the question is should the HIV Viral Load Suppression measure be removed from the Core Set? And the options are yes, I recommend removing this measure, or no, I do not recommend removing this measure. And voting is now open. Okay, waiting on just one more vote. We'll give it another few seconds. Okay and all the votes are now in. So, I will go ahead and close polling. And voting is now closed. So, for the results, the two-thirds threshold for this measure is 18 yes votes to pass. We received eight yes votes. That does not meet the threshold for recommendation. So, the HIV Viral Load Suppression measure is not recommended by the Workgroup for removal from the 2021 Core Set. Next slide.

The next question is should the Proportion of Days Covered - Antiretroviral Medications 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. And voting is now open. Okay, so all the votes are in. I will go ahead and close polling. And voting is now closed. For the results, the two-thirds threshold for this measure is 18 yes votes to pass. We received 10 yes votes. That does not meet the threshold for recommendation. So, the

Proportion of Days Covered - Antiretroviral Medications measure is not recommended by the Workgroup for addition to the 2021 Core Set. Next slide.

Okay and for our final question, should the prevention quality indicators or PQI 92: Prevention Quality Chronic Composite 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. And voting is now open. Okay, waiting on just one more response. Shevaun, I believe this one might be you. Could you just confirm that your vote has gone through? It's possible that Shevaun may have needed to step away. Shevaun, if you are on the phone, please do message Q&A with your response. Thank you. We'll give it just another couple seconds.

Hi. I tried to submit it via the Q&A. Let me know if you didn't get it. My computer's acting a little strange.

No problem. We did receive your vote. So, I will go ahead and close polling. Okay, voting is now closed. As a reminder, the two-thirds threshold for this measure is 18 yes votes to pass. We received three yes votes. That does not meet the threshold for recommendation. So, the PQI 92: Prevention Quality Chronic Composite measure is not recommended by the Workgroup for addition to the 2021 Core Set. Okay and that was our last vote of the day. I will turn it back over to Margo to facilitate a discussion of gaps in the Care of Acute and Chronic Conditions domain.

So, thanks everyone. Twenty five votes, so I think we finally got the hang of how to vote. So, thank you for all of your attention to the voting. And it's exciting to have finished up the voting. But now, turning to the gaps, possible gaps in the Care of Acute and Chronic Conditions area, again 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? And I'll open it up for the Workgroup.

This is Linette.

Go ahead, Linette.

Okay. I just wanted to follow-up on a little bit of the conversation we were having earlier related to the different age group populations and some of the challenges with data in each of those. We have long-term support services as a separate category that's outside of chronic disease. But there's also perhaps some intersection between those two. The difference is with long-term support services, Medicaid’s often our significant payer. Whereas, most of the chronic diseases, Medicare may be the first payer. And I don't have a specific solution, but I wonder if there's something to look at in that arena in terms of how those are grouped together. And maybe in the context as well, of the COVID outbreak, where we see that folks that have diabetes, hypertension, lung disease are at much higher risk of more severe illness that there's something there. I'm not sure what the something is, but it seems like there's an opportunity maybe to think about how we're looking at the Core Set measures that perhaps can get a handle on some of that.

And this is Gretchen. I was just going to raise up COVID-19 as a potential place where we may need some data development, given that the likelihood that the Medicaid programs across the nation are going to play a significant role in the testing, diagnosis,

and treatment for individuals who are impacted by the coronavirus. So, just something, I don't know what that looks like. I know we're all rushing and trying to even understand what is impacting folks, changes from the CDC on what are common symptoms, really an active conversation. So, I know this isn't a federal issue, but it would seem as if this may be a new area for development.

So, this is Jill Morrow. I wanted to go back to what Linette said around we have a lot of individual disease condition measures, which is where measures seem to fall. And just wondering is there a way to look a little more globally as the function and the success or lack of success in the Medicaid program? I think sometimes the PQIs will get you there, but not always. I don't know that there are measures that look more globally at treatment outcomes, grouping treatments or whatever. But just thinking, is there a way to get a little more global picture rather than each of the individual conditions?

Are there comments on gaps in this area?

This is Lowell. I kind of want to both talk about the question about the chronic care and LTSS, but also LTSS as a whole. LTSS is a very different component in chronic care. And I think that the importance and what I appreciated about the conversation about age stratification is there has been over the years a lack of capacity to really look at Medicare and Medicaid integration, both from a service/reimbursement situation, but also with regards to looking at data in general. And I think that that's something that I would hope that CMS probably could really take more of a look at, especially given the population that is coming up. With regards to LTSS, just for everybody to remember, 70% of all spending for LTSS is done by Medicaid. That is a huge component, the reimbursement of all of Medicaid expenditures are LTSS.

Last year, we recommended two measurements for LTSS, both the NCI, which was approved by CMS and the NCI-AD. What's really interesting about that from my perspective is that the NCI, which only works for people with IDDs, LTSS for people with DD only comprises 28% of the expenditures in the LTSS sphere. But for aging with disability, people with physical disabilities, that's 61% of all LTSS expenditures. And that we don't have and we, for some reason, which I still can’t understand, did not approve it this year, is beyond me. We approved it last year. There was no difference in what did - nothing's changed that I can see, but for some reason, it was not approved. And it's unfortunate, and I really would hope that we really look at that both now as to why that was the case as well as for the future.

Thanks, Lowell. Other comments about this area?

Hi. This is Carolyn Langer. I just wanted to add to the previous set of comments. I do see this area of LTSS as being a gap. And I wonder if there is some opportunity to find some commonality, some cross-cutting measures between LTSS and chronic conditions such as something like transitions of care or having a shared plan of care. And the challenge with that of course is the feasibility of measuring those. Those are largely process measures. And while I acknowledge that that could be a bit off in the future, you did mention earlier that that alone should not be a barrier to measure developments. How we get there, I'm not clear I have the answers, but it's definitely a big void, I think.

And I think also with many more state Medicaid programs, moving to these alternative payment models and care delivery systems where they're really trying to promote integration between physical medicine and behavioral health and LTSS, it might behoove us to think long term about some measurement development that's capturing how well these individuals in particular are serviced by these integrated service systems. Thank you.

Thanks, Carolyn.

This is Richard Antonelli. Can you hear me?

Yes, we can.

Great. Thank you for the opportunity to comment. When we think about acute and chronic conditions, and thinking about gaps, I'd really like to call out this notion of, I think, of poverty for example as being a chronic condition. And to the extent that either existing measures, or measures under development, or even the formulation of measure concepts, I think we have a collective obligation to be thinking about those other chronic conditions that aren't necessarily the ones that we think of traditionally medical. And fortunately, in the last decade or so, we've been able to bring behavioral chronic conditions there, so, whether that is an approach to measurement that focuses on things like poverty or race, or whether in fact if the ability to stratify and then eventually to risk adjust.

David Kelley said something a few minutes ago that I'd like to pick up on in this notion of adverse childhood events, ACEs. These are significant risk factors that aren't simply medical or behavioral but have profound life course implications. And so, I just would like to send a message to the measure development community, to be thinking about poverty and race along with more traditional thoughts about quote “chronic conditions.” Thank you.

Any other comments?

This is Ann. Yeah, this is Ann Edwards. Maybe I'll pick up on a few themes that, as we think about the larger issues of health equity, that are being described and how we look at this as we consider measures, I think it’s an important concept. ACEs, which I think it is important to note that adverse experience in childhood has an impact on health immediately and not just behavioral but physical health in the long term. I think that in the measurement space, to consider that in the context of some issues that's strength-based resilience, I think someone mentioned trauma-informed care’s importance to avoid maybe some unintended consequences that might further lead to increased health equity issues. So, important concepts, I don't know that I have any answers, but I think as we start to think about the future in the space is really, really important to consider. Thank you.

Thank you, any other comments? Gretchen and David, do you have anything to add before we break?

No, nothing to add.

Just I appreciate the robust discussion. Thanks.

Okay, so now we'll take a 10-minute break and please be back at 2:05. And we will do a recap and future directions conversation. We are already off on a good start in that direction. So, as a reminder, please do not disconnect your phone line during the break and we'll see you back in about 10 minutes. Thank you.

BREAK

Okay, everyone. Welcome back from the break. We're in the home stretch. We've come to the reflection part of the meeting where we review the Workgroup recommendations, discussion, gaps and future directions, and consider opportunities to support states in reporting the Core Set measures. I'd also like to remind everyone that we also will have one more public comment period, sometime around 3 o'clock. And so, we hope to have comments from the public at that point. Next slide.

This slide presents a high level agenda for this part of the meeting. And to begin, I'd like to recap the Workgroup recommendations for updating the Core Sets. The Workgroup considered a total of 25 measures, including 13 measures suggested for removal and 12 measures suggested for addition. As a reminder, to be recommended for removal or addition, a measure required a yes vote from at least two-thirds of the Workgroup members. And thanks to everyone for managing the voting technology in this virtual environment, despite some technical difficulties with home internet and Wi-Fi. So, of the 13 measures suggested for removal, so the Workgroup voted to recommend one measure for removal and that was this morning, the Diabetes Care for People with Serious Mental Illness: HbA1c Poor Control.

And of the 12 measures suggested for addition, the Workgroup recommended three measures for addition, Prenatal Immunization Status, Sealant Receipt on Permanent 1st Molars, and Postpartum Depression Screening and Follow-Up. And reflecting on the Workgroup discussion and recommendations over the past two and a half days, there was considerable discussion across the three criteria that we discussed on the first day, mainly the desirability of measures as reflected by their strategic priority and actionability to improve care delivery and outcomes among Medicaid and CHIP beneficiaries, technical feasibility of measures for states to collect the data and calculate the measures for Core Set recording, and then, financial and operational viability of measures, which relates in part to state reporting capacity. So, the three measures that were recommended for addition to the Core Sets reflect the emphasis among Workgroup members to address strategic priorities related to maternal and infant health, and preventive dental care. And the Workgroup members also considered feasibility and viability in reviewing measures for addition and removal and acknowledged challenges state by state in calculating the measures. In many cases, however, there is reluctance to recommend measures for removal without a suitable replacement.

So, at this point, we'd like to pivot the discussion to discussing future directions for the Core Sets in terms of measure gaps that should be addressed and implications for the development of new quality measures such as domains for future focus, data sources for state-level reporting, and use of other existing data sources. And we've already begun a lot of this conversation. So, I'd just like to mention a few ground rules for this discussion. So, please don't repeat gaps that were already mentioned in the previous discussions.

We have them as a matter of public record through the transcripts, and we'll certainly be simplifying and redoing those as part of the report. Please build on previous comments to keep the discussion moving forward and offer new insights to help improve the Core Sets in how they can drive quality improvement in Medicaid and CHIP. So now, I'd like to open it up for a Workgroup discussion to come back to the issue of gaps and future directions.

Go ahead.

Sorry. This is Laura Chaise. So, I'm trying to figure out how to go back a little bit on the LTSS, and I will be mindful of not repeating ground that we've already tread. But I continue to find it, as I think some other Workgroup members do, to be a very egregious gap, just given the amount of Medicaid spend that is happening in this realm and with this population, and just how important as an area it is as the overall population continues to age. And so, I'd love thoughts from Workgroup members about how we can move forward in this area. I think that the national measure landscape is of course not as developed perhaps as we would like it to be. But I want to urge us to just find a place to start. And I think that if we continue to hold the bar that's too high around trying to find measures that will work in all 50 states across both managed care and non-managed care, I think we're going to have a pretty difficult time - excuse the toddler screaming in the background - we're going to have a pretty difficult time getting somewhere. And so, anyway, I'd love feedback personally on where we might go from here and how we might put a better foot forward as we go into this process again next year. Because I do think that this is such an important area and we've got to just find a way to get started. Thank you.

This is Linette from California. Maybe just to piggyback on that, I mean, the thought I have around so many gaps, and we've talked about it some, is that it seems like there's several things that we've identified over the last few days that need some work and probably more work than I think can be done by just having Workgroup members suggest things for addition or deletion each year. So, there may be some topic areas that would be good for having some interaction, whether it's a focused workgroup or what have you. I mean, so like this one that was just given, that's the example on LTSS, we identified several, I think, and so, the ask that Mathematica, CMS sort of look at where those gaps that we identified that need technical assistance, whether it's integration with EHRs, specific population areas, data to have enough data completeness to support different kinds of measures. There are some concrete areas that could use assistance if we want to move the bar on some of these things.

This is Jill Morrow. Another gap that I see is we don't really measure disparities in health and health care. And we know that the Medicaid population is a subset of the general population and many of the people that fit into that fit into a group that there are disparities. But that might be another element to add to this, how well states are doing around fixing those to help disparities in the Medicaid population.

Hi, this is Jennifer Tracey. I think another gap that I see pretty glaringly is just the lack of measures to greater integration between behavioral health and physical health. And I think encompassing not only prevention but diagnosis and treatment. And I think that the postpartum, maternal depression screening and follow-up measure, is definitely a huge step forward. But I think we all can agree that behavioral health needs are going to be

increasing as we move forward, especially in light of COVID. All of the increases in social determinants of health needs that individuals and families are going to be facing, and we know they are facing, and having some measures that speak to integration between physical health, behavioral health, a no wrong door approach, is going to be critical as we move forward, and again, especially a unique emphasis on prevention of behavioral health and in trying to adjust that one to the primary care setting.

This is Gretchen. I would also just re-raise, although gently of course so as not to repeat, I think that we have talked a lot about in the past chart reviews and onsite reviews, are troublesome and problematic for state Medicaid agencies that can be expensive, et cetera, but it does give us a level of specificity of understanding what's going on. Given the move to, at this point in time, nearly 100% of most practices not having folks in the office but doing a telehealth visit or other things and how that might change in the future. Some of the underlying methodologies that we've used through these measures may be in question. And I think we talked a little bit about that, but I just think we did what we were supposed to do. We voted on the measures as they were currently constructed. But we also recognize with things like CAHPS and others, there are already concerns about the underlying structure of the way the measure is being collected, and that may just extend to some additional ones. So, again, to the call that I think Linette made about, can we innovate between now and next year in the areas where we've expressed frustrations? We may want to add not only in content but in process for that request for innovation.

And hi, this is Tricia Brooks from Georgetown. I wanted to know, I think the first person that spoke about opportunities between now and when we start getting geared up for the next year's review. I just think waiting until Workgroup members are making recommendations where some collaborative work and some educational work in between might really facilitate our thoughtful deliberation on the measures, would be good. The other thing I think would be helpful is CMS does not always take the recommendations directly, and they make decisions on their own. It would be I think helpful to hear from CMS when they choose to not accept one of the recommendations so that we better understand what their thought process is in making the final determination. And if I can just say one more word since no one is jumping in, I just really want to congratulate the Mathematica team for doing an excellent job here. Last year was my first year on the Workgroup, and I was thoroughly impressed. I've been in person and I miss being in person, but I thought this went really well overall despite a few little glitches here and there.

Thanks, Tricia. And I'll just add that we have time for feedback later as well. So, we'd like to keep going on the gaps as well. But thank you so much, Tricia, for that vote of confidence.

This is David Kelley. Couple of comments, on the LTSS measures, it could be really - I know this is the challenge, but I know that NCQA has queued up four LTSS measures, which I believe many of the managed care plans and the LTSS here have taken upon themselves. Perhaps after a year or two in, that would be nice to think in terms of maybe one of those measures. They are more process measures. And they are more MCO-related and not necessarily requiring chart review, there's one that may require potentially some chart review. It would also be nice for NCQA to maybe look at the LTSS measure that was turned down to see whether or not that - I view that measure as kind

of a partial rebalancing measure - and whether or not that could be something for NCQA to consider doing it up for at least the managed care component of LTSS. I think in the future, we do need to come to grips with the fact that it sounds like half of the states have managed care, half are still in fee-for-service, and we need to figure that out. We've done that for all the other core measures.

I think another area that was brought up was around looking at in LTSS world, the older population, where there are the disabilities or multiple medical conditions, to really be able to marry up the Medicare and Medicaid data for LTSS. But looking at those two data sets and being able to understand even within some of the current core measures what's actually happening to that population and specific to that population. I think there's still a huge gap in the LTSS world. Likewise, there's a huge gap in the adult dental world. We continue to have no measures that address adult dental care, the lack thereof. So, that's I think something we need to - before we get the measure stewards to continue to work on. I like Jill's comment about the health equity. I think it should be a focus. Some states have been looking at this for many years. Pennsylvania is one of them. They have clearly defined inequities in blood pressure control, diabetes, prenatal and postpartum visits, and well-child visits in the first 15 months, and really have encouraged our managed care plans to focus.

But sometimes it's not just adding or subtracting measures, but actually being able to parse out those measures. Discussions could be added to looking at current measures. I'm looking at that from a behavioral health subset. And then lastly, one of the areas that perhaps we need to think in terms of, and I know HIV is extremely important, but likewise, I think there's a lot of effort nationally to identify and treat hepatitis C. So, it would be really nice to see measurements around looking at identifying individuals with hep C but looking beyond that and looking to see that they have been treated, and then actually have been cured. So, I think that's a huge issue within Medicaid. It certainly has been a huge financial issue. But as those medications become cheaper, I think there's a huge opportunity from a public health standpoint to really take a look at combating hepatitis C, really helping to treat those that already have the chronic condition and think in terms of prevention. Thank you.

Hi, this is Lowell. I just want to respond a little bit to David on LTSS. I agree with you in some regards, but I should say that the NCI-AD is used by states both in managed care and fee-for-service. Certainly, the managed care, the MLTSS states have used it and actually over weighted it so that they could actually look by plans. But there are a number of states who are using it as well who are doing it for fee-for-service. I think it would be wonderful if NCQA or someone would look further into it as a measurement tool. I think ADvancing States and HSRI put it together using the NCI, which is now being utilized throughout the country, and it's part of the Core Set and ADvancing States. As I said a couple of days ago, currently, 24 states are using it or are in the midst of ready to be using it. But I think it focuses specifically on patient-centered planning. It focuses on all of the issues and is more outcome-based and not process-based. Certainly, when I was creating MLTSS in New Jersey, we had measurements for the MCOs that were about process-oriented and outcome-oriented, but we felt very strongly that we needed an outcome-oriented playbook system to really look at it, which is why we picked the NCI-AD. So, I just wanted to throw that out.

Yeah. Thanks, Lowell. My comments were more around, not the NCI-AD, but around conversation we had in MLTSS 6 and how there were concerns of not being able to be applied to both managed care and fee-for-service. I appreciate your comments.

Got it.

This is Kim. One of the things that I think we should also consider as we think about different measures and measure sets is the availability of all of the information to be able to actually calculate the measures. Some of the measures that we recommend are proprietary measures. And sometimes, it is a bit challenging to get some of the value sets that are needed to calculate the measures. So, not even just calculating them but to be able to know what to look for and what needs to be improved. So, just being aware of that and making sure that if these measures do make it into the Core Set that there's an ability to know the content and the background, and different value sets in order to be able to implement the measures.

This is Margo. Building on Kim's comment, I'll just draw out another question. We can keep going on gaps and future directions, but I also was hoping that we could hear some constructive and creative suggestions for technical assistance to help states prepare for mandatory reporting of the Child Core Set measures and behavioral health measures in the Adult Core Set, and thinking about ways to build state capacity for calculating and reporting the measures, and also ways as we've also started talking about to think about the use of alternate data sources to reduce state burden. So, I think, Kim, your comment is very much aligned with that to be able to support states and yourself, an EQRO, and others. So, I'll just throw that out as another topic that we'd love to hear about this afternoon.

So, Margo, this is Jill Morrow. I know that the Medicaid Medical Directors Network has worked with - they work with AcademyHealth and PCORI and have worked with some other groups around coding or/and software for measures, so developing one set of software that then gets supplied in multiple places. And David, you know more than I do about this now, but last I knew, there were 9 or 11 states, and they were all working on a big set of SUD measures. The other thing that is interesting that has been happening is some work around using the highway to gather health care data across states. And at the CMS Quality Conference, and I apologize, I forget the name of the person that spoke, but I believe from the University of Oklahoma, and if I got that wrong, I apologize, but he talked about how they have developed relationships there and coding, and a way to reach regions in terms of the highways as another way to streamline data gathering.

Well, those are great comments. I think you're referring to David Kendrick from Oklahoma, who was incredibly impressive. And I think there are efforts underway to try and figure out how he is connecting the dots and how that can be replicated for Medicaid in multiple states. So, I think putting that in the record as something that is a future direction is a great suggestion. The other thing that you're referring to, there's been a number of initiatives, but one that we have currently going on is what we're calling the State Testing Collaborative. And a number of states are a part of that in testing out currently two measures, the PDENT measure and the PQI 01 measure, and possibly looking to expand that to other measures in more states. So, I think that strategy of pushing out standardized code, particularly for very complicated measures, it builds capacity and standardizes, and has a lot of benefits. So, yeah, but those are underway.

And then, I think we also mentioned our replication of the 416 using T-MSIS, so it's another strategy. So, thank you for those suggestions.

And this is Linette. Maybe to piggyback on that a little bit, one of the things that came out this year that nobody's had time to talk about because of the COVID response, is the new interoperability rules that put a lot of requirements around how data should be exchanged and the format of data exchange, the use of FHIR APIs, particular standards for patient data. Some of that is really what we need in the Medicaid program to be able to integrate with each EHRs and HIEs to support some of the measures that we've talked about. So, some focused guidance and assistance around how the interoperability rule perhaps coincides in terms of building out the infrastructure necessary for Core Set measures for the future would be great. And it's been quiet around the interoperability world because they literally released that in the same time that everybody was going full force COVID. And yet, there are some very aggressive and aspirational goals in it, but that would align with this piece around, where do we start to look for data that we don't have to go and do a chart review and get a piece of paper from somebody to do so?

Yeah. This is David Kelley. Two points around building infrastructure to help states collect and report the Core Set. Jill Morrow mentioned that many states, I think there are 26 states or 27 states, have academic relationships with their key academic partners within the state, sometimes several partners within each state. And there's been a lot of efforts to - many times, these institutions are doing things like waiver assessments and other data runs. So, really, helping those relationships to continue to expand so that there is a better understanding on how to operationalize and code up the Core Sets as we move to 2024. I think that's helpful. I also think that we need to think in terms of, how do we look at the interoperability rule and on how the state Medicaid programs think in terms of leveraging and working with the health information organizations within their state or health information exchanges within their state? And again, that might be an opportunity for a greater collaboration. And sometimes, collaboration starts when there is grant opportunities available.

I'll say that within Pennsylvania, we require our managed care plans to join - we have five health information organizations, and our plans must join at least one of them. And we're really pushing our plans and our HIOs to think in terms of electronic data extraction and reporting. So, I think these academic partnerships and the partnerships with health information organizations, I think those are two areas that I think state Medicaid programs need to partner with and leverage as much as possible to advance, really being able to report as many of the core measures as possible.

Any comments, other comments from the Workgroup before we move to public comment? Gretchen or David, anything to add before public comment?

No, nothing to add. I mean, I would reflect that we had a lot of these gaps conversations and raised up the need for state technical assistance and other issues throughout the course of the day or throughout the course of the last three days. So, I think as you noted, Margo, those are all part of the public record and in the final report will be consolidated and reflected. So, I think we're ready to move to public comment.

I have nothing else to add. Thanks.

Great. So, we would like to provide one final opportunity for public comment about any aspect of the 2021 Core Set Annual Review. If you'd like to make a comment or ask a question, please press star-one to enter the queue. Operator, do we have anybody in the queue?

And we'll go first to Daniel Anderson.

Yes, hello. This is Daniel Anderson. I'm with the California Colorectal Cancer Coalition. And I enjoyed listening to your debate over the past three days, but I hope here in the next Annual Review, you'll add Colorectal Cancer Screening to the Adult Core Set under Primary Care Access and Prevention. The reasons are, it's the second leading cause of cancer death, and your cancer screening Core Set measures are actually lower cancers. And in California and with the Medicaid expansion, there are many more adults now in Medicaid. And in California, the Medicaid expansion, about a third of the Californians are insured with Medicaid which we call Medi-Cal. And we have some hard data that we just recently asked the California Cancer Registry to report late stage diagnosis by insured population status. And in the Medicaid population, it was 71%, which was exactly the same as being uninsured in California as far as late stage diagnosis. By comparison, Medicare was 64%. We don't know what our screening rate in our Medi-Cal population is, but the last time it was measured, it was around 20%, but that was years ago. We're hoping it's 40% or 50% because in the rest of our population, we're up at about 72% statewide. But we really need to make sure this is a reported measure, so we'll know where we are. I hope it could - can be added during the next Annual Review. Thank you.

Daniel, before you go, I have a question for you.

Sure.

One of the things I understand about the measure is that it has a ten-year look-back, is that correct?

The measures usually look at the US Preventive Services Task Force Grade A recommended screening test. And one of those is the colonoscopy, which does have a ten-year look-back, but the measurement is not impossible. It's being done today in our Medicare population, and it's also being done in our commercial population. It's Medi-Cal or Medicaid is the outlier as far as doing this measure.

No, that's helpful. I think one of the issues is Medicaid, and I'm sure our state partners could speak to this much better than I, is that there is a lot of turnover in Medicaid over time that to find a population that stays on for 10 years, particularly in the adult population, it's rather unusual. So, I think maybe if anybody on the Workgroup wants to speak to that, we could do that as well. But that is very helpful to hear your comment. And it is something that we struggled with in various other meetings, talking about that measure.

Yeah, I know it's a difficult measure. And I've worked for Kaiser Permanente. And fortunately, our screening rates are very high. But we've been able to do this by being very careful in coding when we find out if someone had had colonoscopy prior to joining our group. And there's a code for that. So, it can be overcome, and it is being overcome in our other measures sets in Medicare and commercial insurance, and it's important.

Most people that find out that we don't measure it in our Medicaid population are amazed. They're so used to seeing it measured in commercial and Medicare.

Thank you for your comment. Operator, do we have anyone else on the queue?

And as another reminder, it is star one if you'd like to make public comment. Star-one.

While we're waiting, is there anyone on the Workgroup that wanted to comment on the Colorectal Cancer Screening measure?

This is Lindsay from New York. I think this came up last year. We in New York actually do ask Medicaid plans to report on the colorectal screening, the issue here being that the measure steward does not have specifications for Medicaid plans at this point. I think it was brought up for addition last year, but that is why we did not put it on, is because the measure steward currently does not extend this measure to the Medicaid population. But we in New York State have had great success. We pay on this measure. We've measured it for years. We actually don't find that the change in plans really burdens or really changes significantly, because it is a medical record review measure where you can go and then look, but our administrative rate for this measure is actually pretty high. And I think we report administratively in different places. So, it's definitely possible. It's something that could be done, but I think we have to point back to, again, the measure steward has not made this a Medicaid measure at this point.

Yeah. This is Dave Kelley. It's great to hear that you guys were successful in measuring that, Lindsay, in New York. I think I opposed to add it last year. It was pretty close, but it was not added. And I know that something that NCQA has at least looked at and it has thought about in terms of doing, I know that we have, in Pennsylvania, we currently do not measure it. We actually had, again, one of our university partners actually run some administrative data. And I'll just say that there's a huge opportunity for improvement. Again, that was just off of administrative data runs. But I think with the chart abstraction you enhance your rate. It's done in Medicare. It's done in the commercial world. It really should be done in the Medicaid. And I think yesterday, I may have commented that it's an area or whatever day it was we did the preventive services, I recommended that it was a gap, and it continues to be a gap. So, I really appreciate the public commenter's comment.

Thanks, David. All the days are blending together. Any others?

This is Gretchen. The only other thing I would add in reflection of that is I think Rich, at one point in the conversation, just referenced that we need some more measures that get at the experience of men in their care through the Medicaid program. And I get the colorectal screening can and should happen with both men and women. But to the extent that many of our measures, because of the traditional populations that were covered by Medicaid, relate to women or to children and adolescents, I think it's just an opportunity, raising it up just one level whether or not the colorectal cancer screening or others that can give us some glimpse into the experience of male beneficiaries.

Thanks, everyone. Operator, is there anyone else in the queue?

No, we currently have no one in queue. As another reminder, star-one if you'd like to make a public comment. Star one.

Are there any other reflections from Workgroup members? Well, Gretchen and David, do you think we should move on to the next step and wrap up?

This is Rich Antonelli. Can you hear?

Go ahead, Rich. Yes, go ahead.

Okay, thank you. I want to try to address directly the issue that Margo mentioned about, what do we need to do to prepare for mandatory reporting on the child health side? One of the things that I've struggled with in the last couple of days is when we are presented the measure, and then what comes back is a fairly anecdotal set of reporting on, some states are having some luck. Some are having frustration. Others aren't reporting. And so, to the extent that this deliberation will extend next year, it would be great if there could be a bit of a more structured approach to how the states are bearing with attempting to hit these core measures. So, I was so glad on the first day with the depression screen and follow-up that we left it to leave it in because it's vitally important that we need to keep pushing that. But I also want to make sure that for those states that are trying, and they are hitting the proverbial wall. So, I don't know if there's a way of categorizing, let's call it the feasibility of those measures that are in the existing Core Set, because this feels very anecdotal to me going forward. And so, that set the stage for the deliberations for next year's Core Set in prep for 2024.

Rich, that's great feedback, and we can certainly work on that. And I think there's lots of different ways we can approach that. So, that is great feedback. Thank you. Why don't we move on to the next steps? Next slide, Lindsay, because I think as we begin to wrap up, we wanted to get exactly that feedback that Rich just gave us. We definitely appreciate all of the efforts of our Workgroup members, especially our co-chairs, for your flexibility and patience in adapting to this virtual meeting format. And so, in the spirit of continuous quality improvement, we'd like to give you opportunity to suggest ways that we can improve the review process for next year. So, Rich, that was a great segue into this part of the conversation. So, other feedback on how we can improve the process, to give you better or more information, do more preparation, have more consistent meetings perhaps throughout, subgroups we've heard, we'd love to hear some feedback on that.

Hi, this is Laura Chaise. I really like Linette's suggestion before about having workgroups particularly in areas where we have defined it to be a priority area and a tough nut to crack based on how prior years' discussions have gone. I think that would be great. And then, I would say another thing that may be helpful for consideration would be perhaps offering few webinars as maybe primers on topic areas. So that if there's an area where you don't have expertise such as behavioral health or LTSS, or any particular niche area that you may be able to get at least a one-on-one, perhaps from a fellow Workgroup member, prior to the process. I do realize that all of these things will require more time and cognizant of that. But it may be helpful to some of the Workgroup members to be able to participate more fully.

Great, thank you.

Hi, Margo. This is -

Margo, this is -

Go ahead.

This is Carolyn Langer. First of all, I want to applaud you and your team for pivoting so quickly to this virtual meeting. I know this was not easy. And I've been participating in a lot of virtual meetings over the last several weeks, so I really applaud your ability to be nimble. Just a quick comment, I'm just wondering, even when we've had our midyear meetings, I wonder, now that people are getting more experience with GoToMeeting and Zoom, and all that, if there's a way to add a video component so we can all see each other? And then, I just want -

Good suggestion.

Yeah. No, I just want to second what the others have said about having some smaller subgroups throughout the year but thank you for really doing what I think is really a Herculean effort to shepherd all of this.

Thanks, Carolyn.

Margo, this is Jill Morrow. I have a couple of suggestions which, one, is that when we sit down to think about potential measures, it would be helpful to have what we had considered the year before. I know we can find it somewhere but having it all in one place to be able to ponder that. The other thing and this would be - I don't know how you would do this to make it manageable, but it might be helpful to have outside input in terms of potential measures. And I say that with a little trepidation, because you could end up with 10,000, and nobody could manage 10,000. And maybe it's areas and thinking about areas or something like that as we sit down to think about what to recommend.

Jill, this is Gretchen. I appreciate that conversation or that suggestion. And perhaps there's a way to just get some input into Mathematica, not through this formal process, but to potentially inform some of the Workgroup activities if we go that route, because I agree with you that someone who is no longer directly involved in the day-to-day management of a Medicaid program. I have a sense of the gaps, but it would be nice to hear from broader voices in the community about where they see gaps. Again, not maybe through that formal submission process, because I felt like we did a better job debating this year with fewer measures. Quantity can be a limiting factor, but a chance for us to explore measures or learn more about them before we get to the formal submission process feels like it would be useful. Again, we can do that on our own and keep our eye on the landscape, but some mechanism for that to be shared with Mathematica in a systematic way might be helpful as well.

So, the other thing that I was thinking of as you were talking was a way to look at similar measures together so that we are aware - I mean, today, a couple of things got brought up, "Oh, there's this other measure, and of course we can't consider it because it's not on the list," but if there are two or three measures that are similar, it would be helpful to

know that to be able to think about those and think about them from the standpoint of how would a Medicaid program or a CHIP program, how would they apply and which one is the best match.

Other suggestions?

This is Lowell. I just want to reiterate what someone else said, it may have been David who said it, that it would be really useful to learn from CMS firsthand why they decided not to choose something that was recommended. It would be that kind of a discussion, and I really think that it needs to be colleague-to-colleague like, what was it that we missed that you guys didn't - did we miss something or did you not get what we were trying to put forward? Why? I think that would be a very useful conversation.

This is Rich Antonelli again. Margo, as often happens is when you say something, it makes my synapse fire in my brain. And I'm wondering if part of some longitudinality with this Workgroup and others on an as-needed basis would be to track between the meetings the progress on both the areas that we've recommended for prioritization for gaps, as well as progress on mitigating issues related to current measures in the Core Set. So that by the time we have this meeting 12 months from now, we had the ability, or the staff has had the ability to track progress, report it back to us. I think it's that kind of a structured approach to thinking about, "Okay, does this measure truly meet the bar for feasibility and implementation so we can move forward in 2024?"

So, I would really like to endorse that notion of being able to keep the committee and Workgroup engaged with tracking progress and some of the things that we have highlighted. I'd feel much more prepared 12 months from now to make those kinds of recommendations at that time. And then it's related to what Jill Morrow had mentioned of, what about other measures? It could be great if we're able to promulgate that information broadly. We're looking for a measure that would get at equitable outcomes on cancer screening, just as an example. That could then be brought up for consideration rather than feeling that in the moment we're making those decisions in the Workgroup. So, I for one would be happy to stay engaged with that workflow with Mathematica.

Thanks, Rich. Other comments? David and Gretchen, any further comments before we move on?

None for me, just an appreciation of gratitude for everyone participating and keeping our eyes both on our current task as well as thinking about ways to improve it, and to Mathematica for opening up the conversation around continuous quality improvement. I really appreciate your willingness to help make this process as effective as possible.

No. Likewise, I appreciate all the comments.

Okay. So, next slide. So, by now, this slide should look familiar. It lays out the key milestones for the 2021 Core Set Annual Review process. As you may recall our journey began on December 13th. It seems like a very long time ago, different world, and continued on March 19th. We had two webinars to get organized for this week’s meeting. We're grateful for all the time you've taken to prepare for this meeting and that you've spent the better part of the past three days with us.

So, our next step is to review and synthesize the discussion that occurred over the last three days and prepare a draft report. The draft report will be made available for public comment in July. And also, the Workgroup members will have an opportunity to review and comment on the report. The team will then review all the public comments, and we'll finalize the report, which will be released in August. And from there, CMS will review the final report and obtain addition stakeholder input from other federal agencies and from state Medicaid and CHIP quality leaders. And CMS will release the updates for the 2021 Core Sets by December 31st. We also wanted to mention that we will be issuing a call for nominations for the 2022 Core Set Annual Review Workgroup. Current members may opt-in if they wish to continue or opt-out if they do not wish to continue. And we expect to release the call for nominations in the fall. Next slide.

So, if you have questions about the Child and Adult Core Set Annual Review, please email the Mathematica Core Set team at the email address listed here. Next slide.

And finally, one last thank you to the Workgroup members, federal liaisons, measure stewards, public attendees for our contributions. We also want to express our appreciation to staff in the Division of Quality at CMCS for your guidance and planning the meeting with us, and a special shout-out to the Mathematica Core Set team. This meeting would not have been possible without everyone's help. We wish everyone well. Stay healthy. Stay safe. And this concludes the 2021 Child and Adult Core Set Annual Review Workgroup Meeting. Thank you, everyone.

Thank you so much.

Thank you. Take care, everybody.

Take care.

Thanks.