2022 Child and Adult Core Set Annual Review: Meeting to Review Measures for the 2022 Core Sets Day 1 Transcript May 4, 2021, 11:00 AM – 4:00 PM EST

Hello everyone and thank you for attending today's event: The 2022 Child and Adult Core Set Annual Review Meeting, Day One. Before we begin, we want to cover a few housekeeping items. Next slide.

All attendees of today's webinar have entered the meeting muted. There will be opportunities during the webinar for members of the public to make comments. To make a comment, please use the raise hand feature in the lower right corner of the participant panel. A hand icon will appear next to your name in the attendee list. Those who have joined us today using the mobile app will need to open the participant panel by tapping the participant icon. The raise hand icon will appear at the bottom of your screen. You will be unmuted in the order in which your hand was raised. Please wait for your cue to speak and remember to lower your hand when you have finished speaking. Next slide.

If you have any technical issues during today's webinar, please send the event producer a message through the Q&A function. If the host has unmuted your line during public comment and the audience is unable to hear you, please ensure you're not muted locally on your headset or phone.

If the issue persists, we recommend reconnecting to audio using the call me feature in audio settings. Audio settings can be accessed by clicking the arrow next to the mute button at the bottom of your screen. Please note that call-in only users cannot make comments. To make sure that your audio is associated with your name in the WebEx platform, look for the headset or phone icon next to your name in the attendees list. With that, I'd like to introduce Margo Rosenbach from Mathematica. Margo, you now have the floor.

Thank you, Dayna. Next slide, please.

Hi, everyone, and welcome to the virtual meeting of the 2022 Core Set Annual Review Workgroup. Thank you to our Workgroup members, federal colleagues, and members of the public for joining us for this virtual meeting. Next slide.

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

We have a full agenda, and important objectives to accomplish over the next three days. And here you can see our four meeting objectives listed on this slide. First, the Workgroup will review the seven existing measures that were suggested for removal, and the 14 measures suggested for addition, to the Child and Adult Core Sets. Second, the Workgroup will vote on the measures suggested for removal or addition and make recommendations for updates to the 2022 Core Sets.

Third, we'll discuss gaps in the Core Sets, and areas for future measure development. We will invite Workgroup members to identify gaps as part of each domain discussion, and on the last day, we'll provide an opportunity for Workgroup members to reflect on cross cutting gaps and areas for future measure development. And finally, we'll provide

multiple opportunities for public comment, to inform the Workgroup discussion about the measures. I'd like to pause for a moment, and note that we are committed to a robust, rigorous, and transparent meeting process, despite the virtual format.

That said, we acknowledge that attendees may continue to face challenges working from home, and our team is still 100 percent remote. I hope everyone will be patient, as we all do our best to adhere to the agenda and fulfil the objectives of this meeting. Some of you may be wondering why we are not using video for this meeting. We found that some of us do not have enough internet, or Wi-Fi bandwidth to support video. We're also keeping our fingers crossed that there are no storms, or high winds this year that can cause outages that disrupt the meeting.

I also wanted to remind the Workgroup members of a few ground rules for participation today. First, we acknowledge that everyone brings a point of view based on your individual or organizational perspectives. And as a Workgroup, you're charged with recommending Core Set updates as stewards of the Medicaid and CHIP program as a whole, and not from your own individual or organizational perspectives. Please keep this in mind during the discussion and voting.

We also know that spending five hours a day in a virtual meeting can be challenging, for all of us. We ask that you be punctual in returning from breaks, so that we can have everyone present for the discussion and voting on a portfolio of 21 measures before us the next three days. And related to that, we want to make sure that all Workgroup members who wish to speak may do so. We're using a new platform this year that will enable you to unmute yourself when you want to make a comment or ask a question.

If you find that you're unable to jump into the conversation, please raise your hand, or contact us through the Q&A feature. And we'll make sure you have a chance to speak before we move on. Finally, we encourage Workgroup members to not repeat comments made by other Workgroup members, and instead to build on the discussion with new comments.

Now, I would like to turn to our co-chairs, Shevaun Harris and David Kelley, to offer their welcome remarks.

Thank you, Margo, and good morning, everyone. It is such an honor and privilege to be able to be a part of today's meeting, and to especially serve as a co-chair. I think this is such an exciting opportunity. I've had the pleasure of participating in this Workgroup. I think this is my third or fourth time, and I always find it equally enlightening, the ability to share, but to learn from all of you. And so, I think, what comes to mind immediately, as we begin to embark on this is the tumultuous year that many of us have had, related to the pandemic.

And when I think about that, I think about in the healthcare space, what it has meant for individuals, in their ability to continue to access care. Medicaid and CHIP programs have moved mountains, to be able to ensure that their recipients, or beneficiaries have been able to continue to have access to the same level of care that they were receiving pre-pandemic. But we know that that has been challenging. And so, as we think about measures that will help us be able to tell how our systems are performing, it seems most critical in my mind that these types of measures will help us see, not only the impacts

from the pandemic, but help us as we try to steer the ship and move forward. It's critically important in helping us to see from a pre-perspective to post-perspective, on where we need to be going. I also love that we have the ability to focus on measures that are generally applicable across the nation. We know that no one Medicaid program looks exactly the same. But the measures that we will focus on and pick, whether it's for deletion or addition, will really have - give us insight, across our entire nation.

And then, it also gives us the ability to focus, which I think as someone who used to be a part of a Medicaid program, I think it's so critically important, given all of the competing priorities that we have. So, with all of that, just super excited to engage with all of you, share knowledge, and come out with the best product that we can put forward to our federal partners. I want to thank all of you, thank Mathematica, and thank our federal partners for giving us this opportunity. Thank you.

Thanks, Shevaun, and this is Dave Kelley. It's a privilege to be a co-chair along with you, Shevaun. And I just want to start by also thanking the entire Mathematica team, and our federal partners. But also, want to thank the entire Workgroup for all the suggestions, and all the work that you've put in, prior to this meeting. Hopefully, we'll be able to efficiently move through the 14 additions, and seven removal suggested measures. So, we do have our work cut out for us over the next several days, again, keeping in mind, that we want these measures to be actionable, feasible. They need to be strategic priorities within the Medicaid and CHIP populations. And we need to try to align them as much as we can, with other programs. So, I know that we have a lot of work ahead of us, and really look forward to working with each and every one of you. And hopefully, we can have some great robust discussion, and come to consensus. Thanks so much.

Thanks Shevaun and David for your comments. Next slide, please.

Now, we'll introduce the Workgroup members and any disclosures of interest. Next slide.

To ensure the integrity of the review process, we asked all Workgroup members to submit a form that discloses any interests, relationships, or circumstances over the past four years, that could give rise to a potential conflict of interest, or the appearance of a conflict related to the current Child and Adult Core Set measures, or new measures that will be reviewed by the Workgroup. Members deemed to have an interest in a measure suggested for removal or addition will be recused from voting on that measure. During introductions, members are asked to disclose any interest, related to the existing or new measures that will be reviewed by the Workgroup. Next slide.

When we go through the roll call, we ask that Workgroup members raise their hand when their name is called. We will unmute you, and you can say hello. Share any disclosures you may have or indicate that you have nothing to disclose. When you're done with your disclosure, please mute yourself in the platform, and lower your hand. This will allow you to unmute yourself when you would like to speak during the measure discussions. If you leave and re-enter the platform, or find you've been muted by the host due to background noise, just raise your hand, and we'll unmute you. Next slide.

On the next two slides, we have listed the Workgroup members in alphabetical order by their last name. When I call your name, please raise your hand. We'll unmute your line. You can indicate whether you are here, and whether you have anything to disclose. If

you've also muted yourself on your headset or phone, please remember to unmute your own line, to avoid the dreaded double mute. If you have any technical issues, please use the Q&A function for assistance. So Shevaun, starting with you, please indicate whether you have a disclosure.

I do not. Thank you.

David?

Good morning. Yes. I sit on the CPM for NCQA, which is the Committee for Performance Measurement, and formerly was part of the NQF CSAC committee, but no longer serve. So, I have no really direct conflicts with any of the measures that are being discussed today. Thanks.

Thanks, David. Richard Antonelli.

Yes. I think I'm unmuted. This is Richard Antonelli. I have no conflicts to disclose.

Great. Thank you, Rich. Lowell Arye? Lowell, are you there?

Can you hear me?

We can hear you. Thank you.

Okay. Yes. Thank you. I'm sorry. I have no conflicts. Thank you. And I'm very happy to be here.

Welcome. Tricia Brooks?

Can you hear me?

We can.

Oh, sorry. You guys are unmuting this automatically. No wonder, I couldn't find the button. Tricia Brooks, from the Georgetown Center for Children and Families, and I have nothing to disclose.

Thank you. Laura Chaise.

Hi, this is Laura Chaise. My conflict is just that, because I am an employee and a shareholder of a managed care plan, certainly, we may have financial incentives tied to different measures, but no specific interest on any specific measures. Thank you.

Thank you. Lindsay Cogan?

Good morning. My name is Lindsay Cogan, and I have no conflicts to disclose.

Thank you. Jim Crall?

Hello. Can you hear me?

We can.

Thanks Margo. Hello, everyone. Jim Crall. I'm a professor and Chair of the Division of Public Health and Community Dentistry, at UCLA. I have no conflicts. I did disclose that I have worked as a consultant for the previous two years for Centene Corporation. Basically, giving general policy advice, nothing that relates to any of the measures we're discussing today. I also have worked as a consultant and lead a quality indicator advisory team for a center that's based at Georgetown University, and funded by HRSA, Maternal and Child Health Bureau, or Oral Health Systems Integration group. Thank you.

Thanks, Jim. And just a reminder to Workgroup members, please re-mute yourself in the platform when you're done. Amanda Dumas?

Good morning. I have nothing to disclose.

Thank you. Anne Edwards?

Good morning. I have nothing to disclose.

Kim Elliott?

Morning. I've got nothing to disclose.

Tricia Elliott?

I believe Tricia is having some trouble joining and will be with us soon.

Okay, great. And Tricia Elliott actually does have a disclosure. So, we will come back to her when she has joined. Karen George? Is Karen here? Why don't we move on? Lisa Glenn?

Good morning. I have nothing to disclose.

Thanks, Lisa. It's a little hard to hear you, for when you want to make a comment. Steve Groff?

Good morning. I have nothing to disclose.

Thank you. Next slide, please. Tracy Johnson. Tracy?

Can you hear…

Yes. Now, I can hear you.

Okay. Thank you. My name is Tracy Johnson. I'm the director of the Medicaid program in Colorado. And in that role, of course, we use Child and Adult Core Set measures. And in a prior role, I worked for a large safety net health delivery system, that also use these measures. So, that would be my conflict.

Right. Thank you, but nothing that would preclude you from discussing, or voting on measures?

No.

Great. Diana Jolles?

Can you hear me?

Yes, we can.

Okay. Good. I said, good morning, and I have nothing to disclose.

Thank you. David Kroll?

Hi, everyone. So, my spouse has done some consulting work for some pharmaceutical companies, including Celgene, Genentech, Astra-Zeneca, BeiGene, Incyte, C4, and Chimera. None of this work pertains to any of the measures we're going to be discussing today.

Thank you, David. Carolyn Langer?

Good morning. Can you hear me?

We can.

Oh, great. Good morning. This is Carolyn Langer. I'm the Chief Medical Officer at Fallon Health. Fallon Health is a nonprofit health plan. I have no conflicts to disclose. Thank you.

Thank you. Jill Morrow-Gorton?

Good morning, everyone. I have no conflicts to disclose.

Thank you. Amy Mullins?

Hi. This is Amy Mullins. My only disclosure is that I was the Co-Chair for the PCMH and ACO Workgroup at the Core Quality Measures Collaborative, but nothing that would preclude me from voting on any measures.

Thank you. Fred Oraene?

Good morning, everybody. Can you hear me?

Yes, we can. Thank you.

Okay, great. Thank you. Fred Oraene, nothing to disclose. Thank you.

Lisa Patton?

Good morning. Hi everyone. Nothing to disclose, thank you.

Sara Salek?

Good morning, nothing to disclose.

Linette Scott?

Good morning. Linette Scott. I have nothing to disclose. Thank you.

Jennifer Tracey?

Good morning, nothing to disclose.

Michelle Tyra? Is Michelle here?

Can you hear me?

Yes, we can.

Hi, good morning. I have nothing to disclose.

Ann Zerr?

I'm an internist from Indiana. I have nothing to disclose.

Thank you. Bonnie Zima? Bonnie, are you here?

Good morning, nothing to disclose.

Thank you. And I believe that Tricia Elliott is still having a technology issue with connecting. We will continue to troubleshoot and help her get on. And then, come back when she is on. So, thank you everyone for your introductions, and disclosures. Next slide, please.

And just a reminder, Workgroup members, please do, lower your hand when you're done speaking, put yourself on mute. We're also joined by federal liaisons, who are nonvoting members. I will read the name of the agencies, but not do an individual roll call. Center for Clinical Standards and Quality, Centers for Disease Control and Prevention, Agency for Healthcare Research and Quality, Health Resources and Services Administration, Office of the Assistant Secretary for Planning and Evaluation, US Department of Veteran Affairs, Office of Disease Prevention and Health Promotion, Substance Abuse and Mental Health Services Administration.

Federal liaisons, if you have questions or contributions during the Workgroup discussion, just raise your hand, and we'll unmute you. I'd also like to take the opportunity to thank our colleagues in the Division of Quality in the Center for Medicaid and CHIP services, and also, the measure stewards who are attending, and available to answer questions about their measures. Next slide.

This year, we're going to do something different for an icebreaker. We're going to do a Menti Poll. And all attendees are welcome to participate. So, that means, regardless of whether you're a Workgroup member, federal liaison, member of the public, please join in. Dayna, you can go ahead and share the poll. And here's how it works. On your screen, you will see instructions to go to, www.menti.com, and enter the code [redacted]. Our poll question for today is, what are you looking forward to this summer?

Please enter a short response, and press submit. You can enter multiple responses and watch the screen for real-time results of what all of you are looking forward to this summer. We'll allow about a minute, and give you a 15 second warning, before the poll closes. So, let's see. Okay, another 15 seconds, some great answers here. All right, last call. Dayna, can you close the poll? Okay. Voting is now closed. So, thank you, everyone. It looks like beach, vacation, family, travel, swimming, sun, friends, these are great responses.

And just so you know, we're going to be planning icebreakers for tomorrow, and Thursday. So, be thinking about your favorite ice cream flavors, and picnic foods. And back to the slides. Okay, next slide. So, thanks everyone, back to the business at hand. Before we review the measures, we wanted to provide some context for the Core Set measure review. I'm going to go rather quickly through this recap. And please note that the slides and other background materials are available on our website. Next slide.

So, this slide is a recap of material presented at the April 8th webinar. A few key points I want to emphasize here. The purpose of the measures is to estimate the national quality of care for Medicaid and CHIP beneficiaries. And these measures can be used to monitor program performance and drive improvements in care delivery and health outcomes. Improvement on the measures should be actionable by state Medicaid and CHIP programs. I think David summarized that well, in his remarks too. We asked the Workgroup to review the measures from the lens of the purpose and uses of the Core Sets. While there are many quality measures, not all will be a good fit for the Core Sets. And that's the charge to the Workgroup members, to recommend measures that are a good fit for the Core Sets, and also to know which measures may not be a good fit for the Core Sets, but could be used for other purposes by Medicaid and CHIP agencies. Next slide.

This slide also provides a recap of material presented at the April 8th webinar. The Workgroup should seek to optimize the desirability, feasibility, and viability of measures, by recommending measures for addition that are desirable, that is they're actionable, and aligned with strategic priorities, and that are feasible and viable for states to implement. And conversely, the Workgroup should recommend measures for removal that are no longer considered desirable, feasible, or viable for state level reporting in the Core Sets. Next slide.

This is a new graphic that shows the concept of multilevel alignment of quality measures. At the bottom, we have measures at the clinician or practice level, which feed into measures at the program, health plan, health system, or community level. As many of you know, we recently launched a multi-stakeholder review of the Medicaid Health Home Core Set. These measures are at the program level because they are for distinct subpopulations within a state's Medicaid program. The Child and Adult Core Set

measures are considered state level measures, because they are intended to capture all Medicaid and CHIP beneficiaries within the state. State level measures can then be aggregated to the national level for monitoring the Medicaid and CHIP program as a whole. CMS values alignment of quality measures across programs and levels because it can help drive quality improvement by addressing each level of care, so that improvement at one level may lead to improvement at other levels. Moreover, alignment is intended to streamline data collection, and reporting burden. We ask the Workgroup to consider how the measures under discussion may help facilitate quality improvement, both within and across levels. Next slide, please.

Now, for a bit of level setting about the Core Sets. Currently the Child Core Set includes 23 measures, and the Adult Core Set includes 32 measures. As we discussed previously, CMS does not have a target number of Core Set measures, either minimum or maximum. We encourage the Workgroup members to consider each measure on its own merits, according to the criteria that Dayna will discuss shortly. Next, we wanted to note how frequently states report measures in the two Core Sets, to give a sense of the feasibility of the current measures.

For FFY 2019, which is the most recent cycle for which data are available, states reported a median of 20 out of 26 measures in the Child Core Set, and 22.5 out of 33 measures in the Adult Core Set. As you would expect, the most frequently reported measures are those that states can calculate accurately using claims and encounter data. And those less frequently reported required other data sources and methods to produce accurate results, such as medical record extraction, electronic health records, or survey data collection. And perhaps not surprisingly, it often takes a year or two for states to ramp up for reporting new measures. Next slide, please.

This slide lists the seven Core Set domains. We want you to keep in mind that CMS will assign the domains when updating the Core Sets for 2022. And we will not be focusing on domain assignments during the meeting. And we also wanted to note that some measures cut across the Child and Adult Core Sets, and CMS decides which Core Set to assign the measures to. Next slide.

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

My final introductory slide is about the current context for the 2022 Core Set Review. We wanted to mention a few factors that Workgroup members may want to consider as part of their discussion and voting. First, as I mentioned briefly during the April 8th webinar, CMS is actively exploring the use of alternate data sources to support calculation and public reporting of several current measures. The goals are to reduce state burden and improve the completeness, consistency, and transparency of measures.

Examples include the use of T-MSIS for calculation of the preventive dental measure in the Child Core Set, known as PDENT. The use of the AHRQ CAHPS database to report

CAHPS measures, and the use of CDC WONDER for two measures based on vital records, namely low birth weight rates and low risk C-section rates.

The next factor acknowledges the increasing use of digital measures and electronic data sources. As we discussed last year, this reflects an important future direction for quality measurement, and states are in different stages of readiness.

This review is also taking place as CMS and states actively prepare for mandatory reporting of all the Child Core Set measures and behavioral health measures in the Adult Core Set in 2024. These measures will need to be reported by all states, for all their Medicaid and CHIP populations. This includes managed care and fee-for-service beneficiaries, as well as dually eligible beneficiaries. So, measure feasibility is a key consideration for the 2022 Core Set Review, as we move one year closer to mandatory reporting.

And the final contextual factor, of course, is the implications of COVID-19 for quality measurement. One consideration here is the feasibility of data collection, such as through medical chart review.

And before we move on, I wanted to acknowledge that Tricia Elliott is on. Tricia, can you please unmute yourself. Please raise your hand, and we'll unmute you. And then you can also give your disclosure.

Great. I think I've been unmuted. Can you hear me?

We can. Welcome.

Excellent. Thank you. Sorry for the delay. I was able to hear everything, just couldn't see the slides. So yes, I do have a disclosure. I work at the Joint Commission. We are a measure developer. And I will be recusing myself from voting on our measure, which is the PC-01: Elective Delivery measure, as we are the measure steward for that. Other than that, that is my only disclosure. Thank you.

Great. Thank you. And just to check, is Karen George on? All right, if you're here, please raise your hand.

I don't believe so, Margo.

Okay. Well, let's continue. So, next slide, please.

And now I'd like to turn it over to Dayna, to talk about the criteria for reviewing measures, and to share the voting logistics. Thanks, Dayna.

Thanks, Margo. So, before I get started, I do want to remind Workgroup members, to just make sure you're signed into the voting app, so you'll be ready to practice voting in just a few minutes. Next slide.

So, for most audience members, these criteria are nothing new, but I will quickly walk through them just to keep them top of mind, and for any public attendees who might be seeing these for the first time. The first category of criteria for suggesting measures for

addition are minimum technical feasibility requirements. All suggested measures must meet these requirements. So, the measures we'll discuss today have passed through Mathematica's initial screen, based on these criteria. This means that the measures up for discussion: should be fully developed and have detailed technical specifications for producing the measure at the state level; have been tested or used by at least one Medicaid or CHIP program; have an available data source or validated survey that includes an identifier for Medicaid and CHIP beneficiaries; and should allow for consistent calculations across states. CMS also requires that the measure must include technical specifications, including code sets, that are provided free of charge for state use, but Workgroup members don't need to consider this criterion. Next slide.

So, the second category is actionability and strategic priority. Measures that are recommended for addition to the Core Set should be useful for estimating the overall national quality of health care in Medicaid and CHIP. Address a strategic priority in improving health care delivery and outcomes and can be used to assess state progress improving healthcare delivery and outcomes in Medicaid and CHIP. Next slide.

So finally, a few other criteria to consider: is the prevalence of this condition or outcome sufficient to produce reliable and meaningful results across states? Is this measure aligned with those used in other CMS programs? And will all states be able to produce this measure by 2024 for all populations? Next slide.

So, when Workgroup members are considering measures for removal, we ask them to consider whether the measure no longer meets the criteria for addition. So, for example, we ask the Workgroup to consider, is the measure no longer making a significant contribution to the Core Sets purpose of estimating the national quality of healthcare? Are states unable to access the data needed to calculate the measure? Or is the data source leading to inconsistency across states? Is the measure unable to be used to assess improvements in state Medicaid and CHIP programs? Is there another measure that's better aligned with other CMS programs? And looking ahead to mandatory reporting, will some states be unable to produce this measure by 2024? And of course, this is not a comprehensive list of all the reasons for removal, but a few key considerations. Next slide.

And so, now with those criteria in mind, here's an overview of the voting process. Voting will take place by domain, after both Workgroup discussion and public comment, and will be for Workgroup members only. Federal liaisons are not eligible to vote on measures. Each measure will be voted on in its specified form, and if a measure is considered for removal, a yes vote means, I recommend removing this measure from the Core Set. And if a measure is being considered for addition, a yes vote means, I recommend adding this measure to the Core Set. Measures will be recommended for removal or addition if two-thirds or at least 67 percent of eligible Workgroup members vote yes. Next slide.

So, are there any questions from Workgroup members about the criteria or voting before we move along to a practice vote? You can just speak up if you have been manually unmuted by us before. Okay, hearing none. We will move along. Next slide.

Okay. So, as a reminder for all attendees, voting is for Workgroup members only. Workgroup members, please make sure you're logged into your voting account, and have navigated to the Core Set Review voting page. You can remain on this page for the

duration of the webinar, and new voting questions should appear as we make them available. If you don't see the new question, just refresh your browser page, and it should pop-up for you. If you need any help, please refer to the voting guide, or send us a chat through Q&A. During voting on measures, if for any reason, you're unable to submit your vote after troubleshooting, please send us your vote through the Q&A. Your votes will be visible only to the Mathematica team monitoring the Q&A. Next slide.

So, I will shortly share the first vote. And we pull it up, great. So, the first question is now available, to test things out. And the question is, do you prefer waffles over pancakes? So, the options are, yes, I prefer waffles, or no, I prefer pancakes. Voting is now live. So, I am seeing, we do not have any results in yet, or any Workgroup members - have any Workgroup members been successful in voting? Oh, I'm seeing, we do have votes. It's perhaps just an issue of my screen.

This is Rich. Can you hear me?

I can hear you, Rich.

Yeah, I logged in about an hour ago, it kicked me out and I'm repeating the same password, and it's not taking it. What am I doing wrong?

I have - this is Lowell. I have a similar issue.

This is Diana. Can you hear me?

We can hear you, Diana.

The password that you're using when you ultimately get in is not the same password that you use to get into the beginning of the app. So, you might be entering - we all share the same password ultimately in that section where you're getting the rejection.

So, should we be given an option to create a password, so we can stay logged in, or if you could give us some guidance, please, as to how to get back into the voting platform.

Sure. If you have questions at this point, let's address them through the Q&A. The password should have stayed the same for everyone. Once you logged in, it does prompt you to enter the account that you want to vote under. So, at that point, you would enter Core Set Review. But that is not your password. Go ahead and show the responses that we have. So, for those who are having trouble, let's continue troubleshooting. It looks like a good number of people are able to vote.

So, I will make live the next vote, and then, as we continue to move through, we can resolve any questions that anyone is having. So, the current poll that is live is, would you rather vacation at the beach, or in the mountains? And the current options are at the beach, or in the mountains? Obviously, all of us are looking ahead to the summer. We do have 21 responses from Workgroup members. That's a good number, but looks like we're still getting a couple people up on the voting app.

So, the question didn't load for me in the voting app. This is Shevaun Harris.

Shevaun, did you see the first question?

I did.

Try refreshing your browser, it should come up.

Okay. Thank you.

Yep. That usually resolves the issue, every once in a while, it doesn't come up automatically.

So, this is Carolyn Langer. I did refresh and didn't get the question to come up, and then I logged out, and logged back in. And I'm still not seeing a question appear on the page.

Does it say you're in the Core Set Review waiting room?

Initially, when I logged on, it did. Now, all it says is - it just shows the page. A blank screen actually. It says, responding as Carolyn Langer, and on the left, it has no home history registration, et cetera.

So, if you try going to [redacted] and see if it shows up then.

Okay. You know, it shows up for a fleeting second, and then it disappears, and leaves me with an empty screen, other than those terms I mentioned.

It may be an issue with your browser. Let's take it to Q&A and see if we can get it resolved for you.

Okay. I'll try logging in with a different browser perhaps.

What device were you using?

A PC.

Oh, sorry, as your browser?

Oh, Chrome. I'll try Internet Explorer.

Okay. We haven't had issues with Chrome. So, we'll troubleshoot with you. Okay. So, we will continue to troubleshoot with people in the Q&A. I know it's difficult to conduct this voting process virtually. So, we appreciate everyone's patience, and help getting us up and running. That's why we do these test polls. So, I will go ahead and share the responses. And so, it looks like a majority of people would rather vacation at the beach, though it's not too uneven of a split.

So, with that, I will take us back. And again, if you continue to have issues, please just message us on the Q&A, and we will get you going. Thank you. Okay. So, thank you all for testing the voting. I will now turn it over to Patricia Rowan, to discuss the first domain, Behavioral Health Care.

Thanks, Dayna. We are starting off today with the Behavioral Health Care domain. Please note that the domain discussion and voting are going to be organized in two parts, to allow time for a break in between. Also, this will help to focus discussion, and voting on smaller sets of measures throughout the virtual meeting. Next slide.

I will start with the current 2021 Core Set Measures in this domain. There are four Child Core Set Measures, and 12 Adult Core Set Measures. Note that all of these measures will be subject to mandatory reporting in 2024. I'm just going to read the measure names. These slides also show whether the measure is NQF endorsed, the data collection method, and the number of states reporting the measure for FFY 2019, which is the most recent year of public reporting. More information about the current measures is in the background materials about the Core Sets, available on Medicaid.gov. So, four Child Core Set Measures are Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication, Follow-Up After Hospitalization for Mental Illness: Ages Six to 17, Metabolic Monitoring for Children and Adolescents on Antipsychotics, and Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics. Next slide.

And here we show the Adult Core Set Measures. The first two measures have been suggested for removal: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment, and Medical Assistance with Smoking and Tobacco Use Cessation.

Next, we have, Antidepressant Medication Management, Follow-Up After Hospitalization for Mental Illness: Age 18 and Older, which is the same measure as the one in the Child Core Set described earlier, but with an older age range, Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications, and Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c, Poor Control, greater than 9.0 percent. Next slide.

And here we list another six Adult Behavioral Health Measures: Use of Opioids at High Dosage in Persons Without Cancer, Concurrent Use of Opioids and Benzodiazepines, Use of Pharmacotherapy for Opioid Use Disorder, Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (note that this measure has been suggested for addition to the Child Core Set for ages 13 to 17), Follow-Up After Emergency Department Visit for Mental Illness (note that this measure has been suggested for addition to the Child Core Set for ages six to 17), and finally, Adherence to Antipsychotic Medications for Individuals With Schizophrenia. Next slide.

So now, we'll move on to discussion of the first set of measures suggested for addition or removal. The first measure suggested for removal is Medical Assistance with Smoking and Tobacco Use Cessation. It is an NCQA measure. It is NQF endorsed. And it is calculated using data from the CAHPS 5.0H/5.1H Adult Medicaid survey. Next slide.

This slide contains information about the denominator for this measure. The measure has three components, and the denominator for all three is the number of beneficiaries who indicated in the survey that they were current smokers or tobacco users and who responded to the individual survey questions about each component. Next slide.

This slide contains information on the numerator for each of the three components of the measure, based on responses to questions in the survey. As you can see, the numerators are related to the number of beneficiaries who reported their providers advised them to quit, discussed cessation medications, and discussed cessation strategies. Next slide.

A measure has been proposed for replacement: Preventive Care and Screening Tobacco Use: Screening and Cessation Intervention. Twenty-three states reported the measure for FFY 2019. We also wanted to mention that preliminary results for FFY 2020 Core Set reporting, which is currently underway, suggests that this measure may have reached the public reporting threshold for FFY 2020. I also want to note that additional states or their managed care plans may be submitting CAHPS data to the AHRQ CAHPS database. As Margo mentioned earlier, CMS is currently conducting a pilot to use the results from the AHRQ CAHPS database for Core Set reporting.

Now turning to the reason that this measure was suggested for removal, the Workgroup member who suggested the measure for removal noted that, although CMS's pilot has shown it is feasible to calculate the measure using data from the AHRQ CAHPS database, that data are incomplete due to lack of submissions for some states or plans.

Additionally, the Workgroup member indicated that, with only 23 states reporting the measure for FFY 2019, it is unclear whether it will be possible for all states to produce the measure by FFY 2024. The Workgroup member acknowledged that removing this measure would leave a gap in the Core Set, which could be filled by using another tobacco measure used by other CMS programs, which we'll discuss next. Next slide.

Turning now to the measure suggested to replace the Medical Assistance with Smoking and Tobacco Use Cessation measure. The name of this measure is Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention. This measure has three rates, including the percentage of beneficiaries screened for tobacco use one or more times within 24 months. Of those who were screened and identified as a tobacco user, the percentage who received a cessation intervention, and the percentage who were both screened and received a cessation intervention if identified as a tobacco user. This is an NCQA measure, but was formerly stewarded by PCPI. It is NQF endorsed, and can be calculated using the administrative method, electronic health records, or registry data. Next slide.

This slide contains information about the denominator and numerator for the three rates that make up this measure. I want to point out that tobacco use for the purposes of this measure is defined as any type of tobacco, including e-cigarettes and vaping. Cessation interventions can include counseling and/or pharmacotherapy. The measure is being used in California for its Medicaid population, as well as part of value-based purchasing programs. The measure can be calculated using claims, electronic health records, paper medical records, or registry data. However, testing results from the measure developer suggests that performance rates may vary based on the data collection method used. The mean and median performance rates were higher when calculated using claims data than the mean and median rates calculated using clinical registry data or EHR data. Next slide.

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

Thanks, Tricia. We're now inviting comments and questions from Workgroup members. You may unmute your line if you wish to speak, and please remember to say your name, before making your comment. So, feel free to unmute and jump in. Why don't we start with Linette Scott, who can speak a little bit more to the use of the measure suggested for addition in California, in a couple of its programs? Linette, did you want to speak up here?

Sure. Can you hear me okay?

Yes.

Okay. Good. So, we are still relatively early in the use of this measure, in that we have included in our value based payment program. We will be calculating the measure statewide, to look at the use. Unfortunately, during the COVID pandemic, we were not able to do some of the work that we expected to do with that this year. So, it is still early in the use. It does depend on there being - as noted, there's different ways of collecting it, and depending on the way it's collected, may impact the responses. So, we will be collecting it using administrative data that comes through on the claims and encounters in terms of assessing the value based payment program that we are running.

Great. Thank you, Linette. And then also, in terms of statewide calculation, is that something that is in the future?

Yes. So, when we do the measures, part of the value based payment assessment, we'll be running it for the full state. So, the value based payment program in California is providing additional incentive payments for providers in our managed care plans. So, the incentives are only going to those in the managed care plans. They aren't going to the fee-for-service side. But we will run it for the full state as well as looking at its various stratifications.

And what is the timeframe for that?

I had hoped we would be doing that this year, but due to the impact of COVID, we would expect to be doing an initial run of that later this year. But the full evaluation of the program is after the three-year program for CMS. But we plan to run it throughout the program, to see how things are going.

Great. Thank you so much. We wanted to provide a little bit more background information on the use of this measure in California since it has not been widely used in Medicaid or CHIP and thought that background information might be useful to Workgroup members to better understand. So, let's open it up to other Workgroup members. Please feel free to unmute yourself and speak up. And just a reminder that we're talking about two measures, both the measure suggested for removal, and the measure suggested for addition.

Hi. I would just ask if this meets the threshold for having been tested then? I'm a little unclear as to whether the measure suggested for addition has qualified under those standards.

Can you introduce yourself?

Yes. Sorry. Hi, this is Amanda from Louisiana.

Amanda, thank you. Yes, that's actually a great point. And that's largely one of the reasons why I wanted Linette to speak to this, to be able to talk about their plans in California. So, it is being used in California, but at the program level at this point, and not yet statewide. And so, I think that it met our threshold for being discussed today. And this also will apply to another measure being discussed later on, the flu measure.

So, these are measures that are being used at the program level, but not yet at the state level. And so, we thought it was worth bringing it to the Workgroup as measures that are available for important topics that are currently being measured through CAHPS. And Linette had offered these as alternative measures to the two CAHPS measures. And so, specifically the smoking cessation measure MSC, that's currently being collected through CAHPS, that this would be an alternative. I will also say to echo something that Tricia said earlier that we are very encouraged about the states' reporting of the MSC measure through CAHPS. So, it does look like - it's very promising that we'll be able to publicly report that measure for the first time through CAHPS. So, kind of balancing this measure suggested for addition against the MSC measure based on CAHPS suggested for removal.

Amanda, does that answer your question, or did you want to follow-up, or offer some other remarks?

That's helpful. Thank you.

Thanks for your question. That was great. Lindsay, it looks like you might have your hand raised. Did you want to say something?

Sure. So, I think, and I was just going to echo what I think you just brought up, Margo, was that, from a workload perspective. Strategically, we all have to complete the CAHPS survey. So, it's not a, we're all putting that measure in our current CAHPS survey, and able to report it right now, so, to make that pivot, and switch. Well, I agree the information is much more actionable at this level. I don't think it yet meets that criteria of being tested at the state level. And since we have to do this CAHPS survey anyway, and are doing it, I think that is at this point, a more feasible measure for us to be able to collect and report out on at this time. Not to say that there's nothing wrong with the merit of the measure. I understand the move. And then, maybe we could have California come back and talk to us in the next cycle, once they've implemented this at the state level, to let us know some of the challenges or successes that they've had implementing that measure of at a statewide level.

Thanks, Lindsay. And just a reminder, when you're done speaking, please remember to lower your hand. David Kroll, you have your hand raised. Do you still have a comment, or was that from earlier?

I think that I may have never lowered my hand from when I did my disclosures.

Okay. So, if you could lower your hand that would be great. And Jill, looks like you have your hand raised.

I just had a quick question for Linette. Linette, can you describe the rationale for moving from the CAHPS, to the - or adding this measure, whichever way that happened? Was it the data source and where it comes from, that it's administrative, versus recall on the part of the participant? Was it that it gives you a larger sample than the CAHPS would? I'd just be interested in hearing the rationale behind using this one, instead of, or with the CAHPS measure.

Yeah. Thank you so much. And actually, I think it's all of the above. The CAHPS survey got a less than 20 percent response rate. So, it starts as a survey, it has a low response rate. It's not necessarily done for the entire Medicaid program in all states and may be done just for managed care plan participants. The chance to do it administratively would mean that we would have a lot more opportunity around some of the stratifications, in terms of looking at disparity, race, ethnicity, et cetera, in some of those respects. So, a variety of reasons for looking at it as an alternative to the survey. I sit with a number of different survey conversations, and response rates on surveys are just getting worse and worse. So, National Center for Health Statistics, in California, we have our CHIS survey, California Health Interview Survey. And consistently whenever we talk about surveys, response rates are declining, in general.

And so, thinking about things like true representativeness and the coverage of a survey, I think as we go forward is becoming more problematic. So, looking to alternatives that can replace surveys, at least in the traditional sense, I think it's something that's important for us to do.

Thanks Jill, and thanks Linette. I will point out one thing about mandatory reporting, when that goes into effect in 2024. It will be required for CAHPS to include all populations. Both managed care and fee-for-service. So, I think that one consideration will evolve over time as we move toward mandatory, but I appreciate all the comments that you've just made. We do have a question, or a comment from Joe Francis. Joe, could you unmute yourself, or Derek, unmute Joe, and also introduce yourself.

Hi. Dr. Joe Francis from the Department of Veterans Affairs, I had a question in the Q&A box, which I think was partly answered just a moment ago. And I had an observation. We're heavy users of CAHPS, both on the hospital side for Hospital Compare Reporting, as well on our Community Care and In-house Primary Care, and Specialty Care programs. We have included some of these prevention and screening indicators in the CAHPS survey, as well as use a shortened version. And I will just say that, when we add the extra questions in the CAHPS survey, our response rates do fall dramatically.

You can get a higher response rate with a shorter survey. If anybody's curious for follow-up, I can get that information to you. My question was partly answered. We were concerned about the lack of standardization on how outside of the hospital setting, CAHPS surveys are used, which makes it difficult to trend and benchmark. But it sounds like in 2024, if with mandatory reporting the administration protocols would be standardized. Thank you.

Thank you. And Joe is a federal liaison. So, thank you for being part of this meeting. I will mention that in the Child and Adult Core Sets, we utilize the health plan survey. We've used 5.0H and 5.1H this year, which now adds telehealth. And those are standardized protocols. Be happy to share with you our resource manual, which includes the questionnaires, and the protocols that are utilized. So, in fact, I think there is quite a robust protocol, both for the sampling, and for the administration of the CAHPS surveys in the Core Sets. And we are pleased to see how many states are collecting the data, and the plans, and then how many now are submitting to the AHRQ CAHPS database. We've seen quite an increase, and we're hoping to see even more, going forward. So, I think that has been good news over time. But thank you for your comment.

I'd love to see that if you have a chance to email that to me separately. Thank you.

We sure will. Thank you. Jennifer Tracey, it looks like you have your hand raised.

I do. Thank you, Margo. Hi, this is Jennifer Tracey, from Zero to Three. Quick question on the proposed new metric, Linette, I know you mentioned that California is using claims data, and that that's probably the best source to calculate this metric. I was wondering if this metric was to be adopted, if states dictated the data source differently, maybe it's claims for some, EHR for others, would the variation in the reliability of the data sources be a concern, as we try to generalize across states? And Margo wasn't sure if there are examples of other metrics, where that variation exists, right now, with some of the Core Measures or if it's just something that comes up with a lot of these metrics.

So, this is Linette. And in terms of the data that we would be using, we would be using claims data. And I'm not saying it's the best data source per se, but it has a number of advantages, and it's one that is available to us. And we're using it as part of our value based payment program. So, that's why we're using that. The other thing I would just call out again is because electronic health records are an option for this measure, I think one of the things we'll probably talk about a couple times over the next few days is what does it look like to shift from claims data to electronic health record data?

So, on the on the Medicare side, obviously, there's been a lot of work in terms of going to the e-clinical quality measures. Our state Medicaid programs are not ready to do that yet, but we're certainly getting signaling that's the direction we need to be working towards, and with the implementation of the interoperability rules that have been coming out lately. Well, the one last May, and then the one that's on hold that was released in January. The Medicaid programs are going to be building infrastructure that is going to be able to connect to EHRs.

So, I think it's important for us to be thinking about what it will mean to move in that direction as well. And so, at some point in the future, and I'm sure at some point in the future, it will happen. We will be universally receiving EHR data into Medicaid programs, then that would become a consistent data source for Medicaid programs for this measure. So, I know some of this is in the future state. But one of the things that we've talked about this in the past is, both how do we signal for what's coming to be able to work towards this? As well as, what can we do today?

So, today, the survey is probably the most consistent method, although it also has issues. It's definitely not perfect. And so, this is an alternative measure, though, to be thinking about, and it is where moving forward with all the various changes that are going on in the healthcare environment, in terms of data and data flow.

Thank you, Linette. That's super helpful.

Joe, it looks like you still have your hand raised. Do you have another comment?

No. Sorry.

Okay. Thank you. Other comments? And Workgroup members, remember, you can just take yourself off mute, and speak up, or you can raise your hands. All right, going once, going twice, and then we'll move to public comment. Any other comments? All right, thank you, everyone. Next slide, please.

So now, we'd like to provide an opportunity for public comment. If you'd like to make a comment, please use the raise hand feature in the bottom right of the participant panel to join the queue. And lower your hand when you're done. And we'll let you know when you've been unmuted. Do we have any public comments? Last call for public comments or any other Workgroup comments before we move on to voting. All right, well, we're going to move on to voting. And we are going to try again to help Workgroup members with another practice session. So, I'm going to turn it back to Dayna, to help us all troubleshoot. We're way ahead of schedule. And we knew that voting could be a little bit of a challenge with the platform, and with Poll Everywhere. So, bear with us, everyone, while we continue to troubleshoot. So, back to you, Dayna.

Great. I am just going to reopen a test poll and see if everyone can see this. So, I have reactivated it. I'm seeing some results come in already. And just for the audience's sake, I am not sharing this result as we're test shooting, but we will share this visually for the actual votes. Okay. We have 25 responses. We're just going to do a quick check to see who is missing. If you know you're missing, please let us know in the chat, and we will get you going. And thank you for bearing with us everyone. We're just troubleshooting behind the scenes, with individuals who aren't able to vote. And the vote just for everyone who does know, we have reactivated the waffles versus pancakes question. So, if you're seeing that one, you're seeing the right thing.

And just for those who are still on with us, we are still troubleshooting. And so, if you think you've lost audio, we're just really frantically working behind the scenes to get all of our Workgroup members able to vote. Maybe we can use this time, if anyone has a comment, public comment, or Workgroup comment on the two measures while we're getting ready to vote, feel free to speak up. Ifeoma, I think if you can unmute Ifeoma, Derek. I think Ifeoma had a comment.

I'm on mute. Okay.

We can hear you.

Hi. Can you hear me now?

Yes, we can.

Okay. So, I was just thinking that, since the proposed measure cannot be validated at this time, we might as well retain the old measure, because tobacco use cessation is still a challenge to most of us.

Thanks, Ifeoma.

Thank you.

All right. We're very close. I think we're only missing one person from voting. And in that case, if you are unable to vote, please send your vote confidentially through the Q&A. And our team will pick it up and put it into the polling platform. So, I think we are going to move forward. And please bear with us for these first couple of votes, while we're continuing to troubleshoot. And make sure that everybody's vote is getting counted. So, thank you everyone, for bearing with us. So, with that, are we ready, Dayna to move on to the voting?

Sure. We can move on. Let’s see how it goes. Okay. So, the question is now live. And the question is, should the Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention measure be added to the Core Set? The options are, yes, I recommend adding this measure, or no, I do not. Okay. We have 26 in. It looks like we're missing just - oh, 27, just one individual.

So, let's go through the list. If you know it's you who have not voted yet, let us know in the Q&A. Otherwise, we will identify who's missing, and we can put in your vote for you. Ann Zerr, it looks like you are our individual who's missing. So, if you could let us know your vote in the Q&A. We will add that, and then we can share the results. And again, we are just waiting on one vote. Ann Zerr, if you can - oh, it looks like you sent your vote to the mailbox.

I'm so sorry. The Q&A function is not working on my computer. So, I don't know how else to communicate with you. I'm very, very sorry.

No. We completely understand. Technology issues happen to us all. Clearly, they're happening to us. So, we will put your vote in, and then we can share the results.

I appreciate it. Thank you. I apologize.

No problem. We have all the results in. So, I will go ahead and close voting, and share the responses. So, the results were 18 percent of Workgroup members voted yes. That does not meet the threshold for recommendation. So, the Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention measure, is not recommended by the Workgroup for addition to the 2022 Core Sets. So, we move on to our next vote.

For our next vote, the question is, should the Medical Assistance with Tobacco and - with Smoking and Tobacco Use Cessation measure be removed from the Core Set? And voting is now open. Again, if you don't see it, please refresh your page. We are waiting on just two more, two more individuals. So, if you haven't received that

confirmation on your voting page. Looks like we just have one more; Ann I assume you're voting through the mailbox again.

I am. I sent it.

Right. Thank you. We are just waiting for that email to come in through our mailbox. So, hold with us for just one more moment. Ann, can you confirm that the email sent?

I did confirm, but I bet - I'll try again. I'll send it again.

Was it sent to me, or the mailbox?

Oh, to you, but…

Okay. Let me check. And then, I'll put it in our chat for everyone.

And I can change the mailbox.

Okay. We got it now. So, I will go ahead and close voting and show the responses. Lots of suspense today, really building the suspense. Great, so for the results, 21 percent of Workgroup members voted yes. 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 2022 Core Sets. With that, I will stop sharing.

And that - go ahead Margo. That takes us to our break.

Yeah. Well, we had planned a 10-minute break, but I think we're a little bit ahead of schedule. So, let's take a 15-minute break, and be back at 12:45, for the next section. So, thank you everybody for bearing with us through this first set of votes, and first discussion. And we'll be back at 12:45.

BREAK

Hi, everyone and welcome back from the break. Thank you for the robust discussion in our previous discussion of the two tobacco measures. We are now ready to move on to the next slide for the next part of Behavioral Health Care.

So, Tricia, back to you.

Great. Thank you, Margo. Next slide. The next measure we'll be discussing is Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment. This measure was suggested for removal from the Adult Core Set. This is an NCQA measure. It is NQF endorsed. The measure can be calculated using either the administrative or electronic health records data collection method. The slide also contains information on the numerator and denominator for the measure. The measure is stratified into four diagnosis cohorts.

They are alcohol abuse or dependence, opioid abuse or dependence, other drug abuse or dependence, and total alcohol and other drug abuse or dependence. For each of these diagnosis cohorts, two rates are reported: one, assessing initiation of treatment within 14 days of the diagnosis, and the second, assessing engagement with treatment within 34 days of the initiating event. Next slide.

No other measure has been suggested to replace this measure. For FFY 2019, 38 states reported the measure all using Core Set specifications. The measure is also included in the Medicaid and CHIP scorecard, as well as other CMS initiatives, including the Health Home Core Set, MIPS, and the Marketplace Quality Rating System. We included a few upcoming changes that the measure steward will be making to the measure, for measurement year 2022 on the slide.

The Workgroup member, who suggested the measure for removal, felt that it was duplicative of other measures currently in the Core Set. They also indicated that removing it, would not leave a gap in the Adult Core Set, because other measures address several components of this measure, such as the Follow-Up After Emergency Department Visit for Alcohol and Other Abuse - Other Drug Abuse or Dependence measure, and the Use of Pharmacotherapy for Opioid Use Disorder measure. Next slide.

The next measure we'll discuss is Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence. This measure is currently in the Adult Core Set and was suggested for addition to the Child Core Set for ages 13 to 17. This is an NCQA measure, that is NQF endorsed. The measure uses the administrative data collection method, and it was recommended to replace the Ambulatory Care: Emergency Department Visits measure, that is currently in the [Child] Core Set, which we'll be discussing separately, during tomorrow's portion of the meeting. This slide also contains information about the numerator and denominator for the measure. I'll note that the measure is specified for beneficiaries age 13 and older and all other specifications are identical to the version of the measure in the Adult Core Set. Next slide.

The measure is currently being reported as part of the Adult Core Set for beneficiaries 18 and older. It is also reported as part of the Health Home Core Set for beneficiaries age 13 and older. In FFY 2019, 36 states reported the measure for the Adult Core Set. The measure was recommended for addition, to address what the Workgroup member identified as a gap in the quality of care for adolescents diagnosed with substance use disorder, and to allow for comparative analyses across various populations.

The Workgroup member also noted that there is significant room for improvement on the measure. NCQA benchmarks for all ages, indicate the follow-up care within seven days occurred for 13 percent of ED visits. And follow-up within 30 days occurred for 20 percent of ED visits. The Workgroup member acknowledged that the denominator size could be relatively small in some states. Next slide.

The next measure suggested for addition is the Follow-Up After Emergency Department Visit for Mental Illness measure. Similar to the last measure, this measure is currently reported in the Adult Core Set and was suggested for addition to the Child Core Set. This is also an NCQA measure, that is NQF endorsed. The measure uses administrative claims data. Next slide.

Two rates are reported for this measure. A rate of follow-up within 30 days, and a rate of follow-up within seven days of the ED visit. The measure was suggested for addition to the Child Core Set for ages six to 17. It is being reported as part of the Adult Core Set for beneficiaries 18 and older. And in FFY 2019, 26 states reported the measure for the Adult Core Set. The Workgroup member who suggested this measure indicated that emergency departments are frequent sources of care for children with behavioral health issues, and that these visits increased during the pandemic.

The Workgroup member also noted that there is room for improvement on the measure. NCQA benchmarks for all ages show that 41 percent of all ED visits had a follow-up within seven days, and 56 percent of all ED visits had a follow-up within 30 days. The Workgroup member noted that sample size could be a potential barrier in some states, but that the denominator size for this measure should be larger than for the follow-up after hospitalization for mental illness measure, which most states already report as part of the Child Core Set. Next slide.

Okay. Now, I will pass it back to Margo, to facilitate Workgroup discussion for these measures. Margo.

Thanks, Tricia. So, we have three measures to discuss in this block. I thought maybe we would start with the first measure that Tricia mentioned, which is the suggested removal of the Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment measure. And then separately, we can move on to the addition of the other two measures to the Child Core Set. So, why don't we start, like I said, with the IET measure, and Workgroup members, please feel free to unmute yourself and speak up.

So, hi, this is Carolyn Langer. So, I think the whole area around alcohol and other drug misuse is just so important in the Medicaid population. It is one of the most prevalent conditions. And I guess my concern would be that, in removing this, this is a broad measure across multiple settings, compared to the measure that was proposed for addition, which was only with respect to follow-up after an ED visit. So, I'm just concerned that we'll be missing a broad swath of the population.

And I don't know if the individual who proposed removal, and perhaps it was the same individual who proposed addition of the post-ED visit measure, would like to comment, but I just feel that given that BH and SUD really drive so much of the morbidity, and exacerbate medical morbidity as well. I would just be concerned about removing this, and replacing it with something that is potentially narrower, at least in adults.

Thanks, Carolyn. That's really helpful. We have a few hands raised. So, why don't we go in order and start with David Kroll.

Hi. Thanks, Margo. And thanks, Carolyn, for those comments, and I agree with them entirely. I will add that I actually see that while there is some overlap between this measure and the follow-up after emergency department visit, I actually think that they're looking at different gaps. The measure that's looking at follow-up after emergency department visit is really looking at an access to care gap, looking at a fairly specific population, as Carolyn said, of people who end up in the emergency department, as opposed to the patients who end up in general care.

I think that the gap that this measure is looking at is really looking at the problem. Whereas clinicians are not always bad at identifying alcohol use disorders, but we're notoriously bad at actually treating alcohol use disorders. And even when we diagnose them, we often fail to treat them. And in fact, there's this widespread problem within medicine that many clinicians don't see themselves as being responsible for or specialists in addiction disorders. And yet, most patients with substance use disorders end up with general care providers, primary care providers, general psychiatrists, et cetera. And so, I think that the goal of this measure is really to incentivize or steer clinical systems towards ensuring that patients are actually receiving this care when they're identified. Not necessarily just accessing providers after an emergency department visit.

Thanks, David. Lindsay, you're next.

Yep. So, I agree that substance use is an issue that we need to address in this population. We worked extensively in New York State with this measure, as a part of our DSRIP, and received a lot of really great feedback from providers. I think that - I brought this up with NCQA as well. I do think we need to take a closer look at this measure. It does address outpatient care in here, that is something that we don't have a good measure for. But at the same time, it's very muddled. So, it is a measure that looks at the first event in a year. It looks at new substance use, not existing substance use measures.

So, anyone who has an existing substance use event would be disqualified from the denominator. So, while it's important to get people engaged in care right away, it doesn't always align with how we… the principles of care around substance use, which is what I get from my colleagues in the field of substance use, that sometimes it takes more than the first time. And then, we don't give up if someone doesn't go into treatment their very first time engaging with the system. It's more of a stickiness where we're continually working on engaging folks and bringing them into care where needed.

So, I do think that substance use is important. I recommended the addition of the follow-up after emergency department visits in the Child Set. There is a follow-up after emergency department that already exists in the Adult Core Set. And I know, this is a measure that transcends many different programs. So, it makes us a little uncomfortable to think about removing a measure like this, when it is involved in many measure sets. It's one that we all can produce. But I want us to continually challenge ourselves and think, "Is this the best measure? Is there a way for us to think about areas and gaps in the Core Set that really get at what we want to achieve, and the best possible outcome?"

This measure has not moved very much at all in our state over the umpteen many years that we have been working with it. And again, as I mentioned in our DSRIP program, we really tried to work very hard with providers on improving. And what we did, is we increase screening, but the numerator went down, as my colleagues said earlier, it is sometimes very difficult to get folks to not only screen, but take that next step. So, I just want to continually move this conversation forward. I don't think it's the best measure. I think we really need to challenge ourselves to find the right measure in this space.

Thanks, Lindsay. Jill, you're next.

So, I want to echo the importance of looking across the continuum of health care for people with alcohol use disorders and substance use disorders. This is not a perfect measure. It is a new episode. If it expanded and divided, right, so you could assess each of the areas, that would be great down the road. But I do think it's really important to look at more than just ED visits, because people get to the ED because they've hurt themselves or otherwise, but that's a small number of people with alcohol use disorders, and it has an astonishingly bad outcome for people who drink for - and not huge numbers of years. So, when you're seeing people in their 40s and 50s with the consequences of alcohol use disorder, to be able to capture this across a broader set of settings, I think is very useful.

Thanks, Jill. Amy Mullins, you're next.

Yeah. I want to echo what David and Jill said. I like this measure because it does include that treatment piece. And I do think it's probably one of the better measures we have for that, and I don't think this is an either-or discussion as far as removing this and adding the others. I think they're all needed at this point, because I think they all do something different, and something important. And so, I would say, we need to keep this measure because it does focus on the treatment, which we're not terribly good at. And add the other measures, for the reasons stated, because they are important as well. So, I don't think it's one or the other. I think it's an and.

Thanks, Amy. Anne you have your hand raised and wondering if you have a comment or if it's from earlier. Anne Edwards, do you have a comment? David Kelley, you have a hand raised.

Thanks. And really appreciate those comments. The initiation and engagement, we use rather extensively in the state of Pennsylvania, and actually drill it down to the county level, and use it as an incentive for our physical health and behavioral health plans to actually work together. And perhaps there are some changes, I think that were proposed that NCQA put out for public comment that may address some of the concerns that were stated. I do believe that there is a breakdown of looking specifically at alcohol, opioids, and then other substances, and there are several rates that are generated, including the two age bands.

So, I think that measure is, I believe, a good measure. It more broadly, takes a look at what is happening beyond the emergency department. Individuals present elsewhere with a new diagnosis, so I don't think we should be fully dependent on what's happening in the emergency department. I think the follow-up, the two measures I think are being… could be added in the pediatric side of the fence. I think again, these are very good measures.

My concern, I think we've had some issues over the years with, happily, I guess, with lower denominators. But I think it's certainly useful. I think we need to keep in mind that these would become mandatory, I believe, since they're pediatric and they're behavioral health, so, just some food for thought. And I don't know if the measure stewards on to talk about any changes or proposed changes.

Sepheen, would you like to speak? Derek, could you unmute Sepheen, please. Sepheen…

Hi. Actually, if you could unmute Lauren Niles, she can speak to the changes that we are implementing.

Thanks, Sepheen. Derek, can you unmute Lauren Niles, please.

Hi, can you hear me all right?

We can. Thank you.

Am I unmuted? Oh, great. Well, thank you so much. Thanks for having us. I just want to briefly speak to some of the things that I was hearing as well, some of the changes. So, we really do believe that this IET measure does address a unique piece of the care continuum that the follow-up measures and the pharmacotherapy for opioid use disorder measures do not. So, the follow-up measures are more measures of care coordination. The pharmacotherapy measures, both ours and the one that I believe is already in the Core Set from last year, focus on those that have already elected to use medications for the treatment of opioid use disorder in their recovery.

And then, this measure is really more about access and early initiation engagement. And engagement in care especially is found in multiple studies to be related to improved outcomes for individuals with substance use disorder. So, this really does represent, I think, a really important piece of the care continuum. And I think as Lindsay pointed out also, a gap in care that continues to exist, and persist over time. We are making a couple of revisions to the measures as you mentioned on your slide. The first, is that we have lengthened the negative look back period reach, which we think increases the validity of the measure, by really identifying better the folks that are not already receiving long-term treatment, which is something we had heard from a couple of users.

We're also removing individuals that have only had an episode for medically managed withdrawal, or an emergency department visit in that negative look back period, but received no other services. Really trying to remediate the problem of folks that are just kind of routinely pinging the emergency department just for stabilization services, and never actually getting connected to care. So, those folks will now be included in the denominator, and represent a really important population to monitor, and to ensure gets access to care.

We've also changed some of the numerator goals around pharmacotherapy for the treatment of alcohol and opioid use disorder. Guidelines used to suggest that you had to have that therapy in conjunction with psychosocial care. And those guidelines have been updated. So, we updated the measure to take out some of that complexity. And so, those are some of the big changes. Oh, as well as, you are now able to qualify for this measure two times a year, which we think better represents the care trajectory for many patients. We know that on average, patients can take up to five times to successfully initiate care. I think the median is around two, but the average is a little bit higher than that.

And so, we're really trying to take a look at this measure, and both reduce some of the complexity related with reporting it. And also increasing the validity, where we can, and really try to target some of these really high-need populations. So, I just wanted to add

that. Thanks for giving me the stage here for a second. And thank you so much for this conversation.

Lauren, can you clarify when these measure changes will go into effect? Which measurement year?

So, we do still have some… our board of directors does need to approve these changes. But if everything goes well, those would go into effect for measurement year 2022.

Okay. And for everyone listening, that is Core Set year 2023. So, it comes a year after the reporting cycle that we're talking about now. But that's very helpful. Thank you so much, Lauren, for explaining those updates. Lisa Patton, did you have a comment that you wanted to make?

Thanks, Margo. I think it's been covered. Yeah. I think other speakers have hit it. So, I won't repeat. But thank you.

All right. Thank you so much. And Joe Francis, did you have a comment you wanted to make?

I just put this question in the chat, and maybe someone can answer this. And I realize the data may not be available. But one of the concerns for measures that require a diagnosis to be made, in order to activate the measure, particularly in an area where under diagnosis is prevalent, is whether you create perverse incentives, not to report the diagnosis. I realize that, our system is different than private sector. And we measure in VA with a vengeance. And we have sometimes found that, like seven-day follow-up measures, are often hard to meet. And sometimes we see less willingness to call a diagnosis. So, we've been cautious about that. And try not to make the follow-up too tight in terms of timing. Thirty days has less of a problem than meeting a seven or a 14-day window. But I don't know whether this has ever been explored or addressed in the Medicaid population.

Thank you for that comment. That's very helpful. I think right now, maybe we should pivot to the other two measures that were suggested for addition. Now these two measures, just to keep in mind, are already in that the Adult Core Set. So, the IET measure, which we just talked about, these measures are already in the Adult Core Set, along with the IET measure. The conversation right now is about adding the child component to the Child Core Set. So, the age group that corresponds to children, and so, those two measures are Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence. For those keeping score, that's the FUA measure. And the other measure is Follow-Up After Emergency Department Visit for Mental Illness, which is the FUM measure. The way I'd like to structure this conversation, is to hear from people who think that they have some concerns about adding it to the Child Core Set. Again, keeping with the notion of alignment between Child and Adult Core Set, what I'd really like to focus on, is why there might be a case for not aligning, and for not adding to the Child Core Set? Linette, you have your hand raised.

Hi. Thank you, Margo. I guess two quick questions. I mean, extending it to a child set seems like a good idea to me in general, in terms of being consistent with the adult set. It's already going to be required in the adult set. So, having it in the child set doesn't

seem like it would be a significant additional burden. I think the biggest question I have for you, just for clarity, is small cell sizes, obviously get to be a problem with a variety of kinds of measures. And this could be one of them, especially depending on the size of the state. So, how does that work in terms of whether or not there's enough states that it can be reported? Like if the numbers are too small, in over half the states, does that mean it would never be publicly reported? And what are the small cell sizes, that means a measure is not publicly reported? Could you speak to that?

Sure. Those are good questions. So, the first comment I'll make, which has already been mentioned, is that the FUM measure actually tends to have a larger denominator, than the FUH measures. So, the follow-up after hospitalization tends to have a smaller denominator than follow-up after ED visit. And we publicly report that for all states that report the measure in the Child Core Set, and the Adult Core Set. So, I think from the standpoint of that, I would not have any concerns. That is for ages six to 17, I believe. The FUA measure would be for ages 13 to 17.

That I think, we have less evidence of what the cell sizes would be, the sample - but they're not really sample sizes. They're population sizes, since it uses administrative data, and does not take a sample. I think there, your question about what are our reporting requirements, in terms of precision and privacy. So, two things there, we follow the CMS rules, where we do not publicly report any measures that have a numerator or denominator between one and 11 for privacy. And then, for a precision standard, we have adopted a rule that's used in other federal agencies that we would not report a measure that has a denominator of less than 30, but we have very few instances at the state level, where that occurs. Not saying that there's none, but it's very few. I think it is untested, what would happen with the FUA measure in the Child Core Set. But I think that some evidence suggests that we would not have very many states, to which that would apply. So, I'll stop there. But I'd be interested in hearing from other states, whether you have concerns about the sample sizes - or the population sizes for those two measures. Are there other comments or questions about adding these two measures to the Child Core Set, either support or opposed?

This is Carolyn Langer again. I agree with an earlier comment, that it's not either-or for the removal and the addition of these two. And I also share the concern about potential small denominator. But having said that, I think these are two really important areas that we need to address in the pediatric population as well. So, I would be supportive of adding these. Thank you.

Thanks, Carolyn. Lindsay, you’re next.

Yeah. I think not having a measure around substance use for adolescence, is a real gap that we need to think about how to close. You have the follow-up after hospitalization right now, in the Core Set for children, which at least you have some. And you have other measures around mental health, but there is currently nothing on substance use, where we know this is a particular issue. So, I get the concern of small sample sizes, but as in other areas, we're sending them a message with the composition of our Core Set.

So, I think we just need to think about, if this isn't the right measure, then what is the right measure for looking at adolescent substance use? Is it more of a screening and referral measure? Is it a treatment measure? I mean, where do we feel like there is

room? And again, you don't have to have a measure for every single condition. We can have measures that address more components of care, right? So, do we have a measure that looks at medication usage? Do we have a measure that looks at follow-up after some sort of acute event? We don't have to have a measure for every single scenario. But it does seem like it's gap area that we've talked about, for as long as I've been involved in the Core Set, it's substance use around adolescence. So, I do think at a certain point, we really have to, have to look deep on this one and see where we have the opportunity to really impact care.

Thanks Lindsay. Richard Antonelli, you're next.

Yeah. Thank you. I absolutely agree that we need to make movement in this area. I have been in multiple conversations in the last couple of years, when discharges from emergency departments that have a mental health, behavioral health, substance abuse component, do not necessarily routinely get sent to the delivery system. Now, just to be clear, I'm not pointing that out as a deficiency in the measure, but in fact, as a gap in care delivery system design. So, to the extent that these measures really send a strong signal about systems thinking in an integrated fashion, identifying patients, making sure that those care transitions are as seamless as possible, then I think that this will send a very, very strong signal to all of the appropriate stakeholders.

Thanks, Rich. And Kim, did you want to make your comment? Kim Elliott? You are muted. There you go.

I don't have anything really unique to say, other than what's already been said. Other than that, I think we really do need to start spending a little bit more time focusing on catching these kids a little bit earlier, and really doing some focus on, not only the identification of the issue, but really the follow-up that needs to occur. So, I do like the follow-up measures. And I do like the treatment measures. And hopefully, at some point, we'll be able to get to more outcomes-based measures, as well as these process measures.

Thank you, Kim. Linette, you have your hand raised, is that a new comment, or from a previous comment?

Sorry. No comment right now.

Okay. Any other comments from Workgroup members? Before we move on to public comment, any comments on three of these measures?

Hi, Margo. This is Shevaun Harris. I'll be brief because I know others have already spoken up. I really think the addition of the follow-up measures is a step in the right direction. Florida has already made that transition. And we found it can be very helpful when you start to think about the readmission rates of individuals. I know when you're going through the emergency department, it doesn't necessarily mean that someone actually gets admitted, but really help put some focus -- and that was one of the comments earlier -- where performance measures can really help a state in focusing on gaps in their system of care. And this ended up being very helpful from a care coordination case management perspective, to really make sure that we were catching this population earlier and making sure that we were not seeing that continuous cycle

that sometimes you can have, with populations that are not intervened, when you don't have early intervention. So, that's all I'll say, because I think others have already weighed in, and commented, and gave some good feedback.

Thanks, Shevaun. That's great. All right, any other comments before we move on now to public comment? All right, next slide, please.

Now, we'd like to provide an opportunity for public comment. If you would like to make a comment, please use the raise hand feature in the bottom right of the participant panel to join the queue. And then, lower your hand when you're done. We'll let you know when you've been unmuted. Are there any public comments? And just a reminder that we have three measures that are open for public comment. The first is the removal of Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment. Next, we have addition Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence, and that would be to add to the Child Core Set. And finally, the addition of Follow-Up After Emergency Department Visit for Mental Illness, also for the Child Core Set. Any public comments before we move on to the votes?

All right, well, I think it's time then to move on to the votes. So, now, I'll pass it along to Dayna.

Thank you, Margo. We'll go ahead and share the first question. Okay. So, the first question we have is, should the Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment measure be removed from the Core Set? And voting is now open. So, if you do not see the poll, refresh your page. Okay. We have 27 votes and we are looking for just one more. So, if everyone could confirm that they have submitted. Bonnie Zima, I think we are missing your vote.

Yes. And I'm having technical difficulties.

No worries. If you could submit it through the Q&A if that's available to you?

Can I give you my cell phone number and text it to you?

Sure. Are you having computer issues?

Yes. It's the internet. It's so -

Sure. If you read out your cell phone number, I will text you and then text me back. How's that? We take votes any way we can get them.

Right. I apologize. Okay. So, I should send it to you Dayna?

You can send it to me. This is Margo. [Redacted]. Want to try that?

Okay.

Okay. So, we do have all the results. And now, I will go ahead and close the poll and share the responses. So, for the results: 11 percent of Workgroup members voted yes, that does not meet the threshold for recommendation. So, the Initiation and Engagement

of Alcohol and Other Drug Abuse or Dependence Treatment measure is not recommended by the Workgroup for removal from the 2022 Core Sets. So, the next question is, should the Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence measure be added to the Child Core Set? Voting is now open.

Okay. Votes are in. We're getting faster every time and I will share the responses. Okay. So, 93 percent of Workgroup members voted yes, that does meet the threshold for recommendation. So, the Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence measure is recommended by the Workgroup for addition to the 2022 Child Core Set. And our last question in this section, the question is, should the Follow-Up After Emergency Department Visit for Mental Illness measure be added to the Child Core Set? And voting is now open. Okay. 28 votes are in. So, for the results, we had 96 percent of Workgroup members voting yes, that does meet the threshold for recommendation. So, the Follow-Up After Emergency Department Visit for Mental Illness measure is recommended by the Workgroup for addition to the 2022 Child Core Set. So, with that, I will turn it back to Margo to facilitate a discussion of gaps in the Behavioral Health Care domain.

All right. Thank you, Dayna. And thanks everyone for voting. Just to recap on the five votes that we've had so far. Related to Behavioral Health, we had two measures related to tobacco use. The first measure, Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention was not recommended for addition. Medical Assistance with Smoking and Tobacco Use Cessation was not recommended for removal, Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment was not recommended for removal. The two Follow Up After Emergency Department Visit measures were recommended for addition to the Child Core Set, that is Follow Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence and Follow-Up After Emergency Department Visit for Mental Illness.

So, thank you everyone for your voting and thank you for accommodating the voting technology and troubleshooting with us. I think mostly we've got it down. So, now, we'd like to hear from Workgroup members about possible gaps in the Behavioral Health Care domain of the Child and Adult Core Sets. Please keep in mind that measures in this domain are subject to mandatory reporting in 2024. So, now, we'd like to hear what suggestions the Workgroup has for further strengthening the Core Sets. What types of measures or measure concepts are missing in the Core Sets? And are there existing measures to fill the gaps or would a new measure need to be developed? And please remember to say your name before making your comment. So, we'll open it up. Jill?

So, I would just like to put a plug in for the concept of the measure that looks across a broad range of settings and that something like that to be expanded to more than just the first episode. Recognizing that substance use is ongoing, persistent and people don't always engage the first, second, third, fifth time.

Thanks, Jill. Joe Francis?

Hi, Joe Francis from VA. One of the things that we have learned over the years is that if you don't address housing instability, it's very hard to address the substance abuse or other mental health problems. And while it may be beyond the purview of Medicaid

programs, I think that at least some assessment of housing needs might be a measure to consider for the future. Thank you.

Thank you. Anne Edwards?

Thank you. I think this has been in some of the earlier comments, is we really look at mental behavioral health and thinking a little bit more upstream. And thinking how we could leverage system change. Since I think about it, I think that the follow up measures get us in that direction, but again, thinking about is this really where we want people to be accessing the care at that point. So, would like to see a little bit more movement in that direction. And then the other thing that I think gets a lot of attention, that I will add just for consideration would be thoughts around suicide and how we might utilize a measure or not, to really address that significant health concern.

Thank you. Carolyn?

Yes. I just think it's really important, and there's no easy way to measure this but I just want to put it out there that I would like to see more work done around behavioral health integration with primary care, and really move the needle on finding a good way to measure that.

Thank you.

Just as we were talking about before the ED is really the tip of the iceberg, and particularly for pediatric population, but for adult population as well. The majority of behavioral healthcare is delivered in the primary care setting. So, I do think that there is a need to really shine a little bit more of a light on the behavioral health integration in the primary care setting. Thanks.

Thanks, Carolyn. Bonnie? Bonnie, you need to unmute.

One possibility to address the issue of suicide is, we could use the child mental health disorder classification system that can translate the ICD 9 and 10 codes. And one of the groups is suicide self-harm and it's validated, and the SAS codes are publicly available on the Children's Hospital Association website.

Thank you. We have a lot of people lined up to make comments. So, next, Linette.

Hi. Thank you. I guess one observation and then comment related to gaps. So, currently under behavioral health, we have 12 measures on the adult side and four—which would go to six if the recommendations from today go forward—on the child side. So, on the one hand, I think there are gaps in some of the measures we have in the behavioral health category. On the other hand, especially on the adult side, if there's more that get added, I think we need to streamline and prioritize the ones that we do have there. Since there are so many measures currently under that category, I mean, from the general perspective, one of the things has been raised before is the - we have a lot related to the substance use and especially mental health and opioids. But depression's being very common, there's the medication management piece, but the broader depression component and anxiety piece is somewhat of a gap.

The issue that the gentleman just raised related to housing, certainly in the category of social determinants of health, there's a lot more focus in that arena and Medicaid programs through whole person care activities, and others are looking at how to help support housing. So, that is a component, and to really take care of folks with multiple conditions, it's hard without doing that. So, it may not fit under behavioral health, but there may be something to think about around some of these social determinants of health and whether that's an additional category or component of some of the other pieces. So, thank you so much.

Thanks, Linette. David Kelley.

Yes. Thanks. Again, I'd like to—on the pediatric side, really—and again, I'm an internist geriatrician, but on the pediatric side, I'd really like to go further upstream into many of the problems and issues and really see work around validating adverse childhood events. And then, actually, either quantifying that and then, linking that with trauma-informed care. I think that's really a vital part of the health delivery system that right now is missing. And all of these other things tend to fall further downstream. So, I'd like to challenge the measure stewards to really think in terms of going very far upstream, early on in that child's existence in life.

Thanks, David. Shevaun?

Oh, I'll be brief. Maybe it's the new role that I have, the new lens I'm looking through things, but as I think about children in the child welfare system and the serious trauma that they generally experience. I think that there's some opportunity there for some at least one nationally recognized measure that might measure or that might help us in assessing and improving behavioral health for that population, in terms of how we're measuring trauma-informed care for that population. Again, could be my new lens, I'm not typically a fan of - or I know that it's hard to hone in on special populations, but given that in this group, I think in most states, they generally are on Medicaid, I think it's an important area for us to hone in on, even if it's just one measure. Thank you.

Thanks, Shevaun. Sara Salek?

Yeah. Hi. Thank you so much. This is Sara Salek, I'm the CMO of the Arizona Medicaid program, I'm also a child and adolescent psychiatrist by training. And so, just wanted to reflect and provide feedback and agree with my colleagues' previous statements on all the aforementioned issues, including looking at primary prevention, and I think that's really where it's at from my perspective. And we know that the different domains within the Child Core Set are not mutually exclusive, right?

So, as we move along to the preventative measures like the Well-Child and Well-Adolescent Visit, that those are cornerstones to early identification and intervention, prior to an issue presenting itself. And so, just wanted to comment and reiterate the importance of those well-child visits, but also noting that Medicaid, we don't operate in silos. And so, a lot of the other programming coming, for example, from SAMHSA to prevent substance use conditions or mental health conditions, that we need to continue to leverage those and understand the applicability within the Medicaid population.

But also, as noted in regards to suicide prevention, which is really critical, just the work that the CDC is doing and our counterparts through our Departments of Health. And so, I think it's looking broader, as far as that broader context that - Again, in Medicaid, we don't function in a bubble. And then, I would just mention that integrated care component is something that we need to continue from a performance measure steward's standpoint, to look at how do we best measure. Thank you so much.

Thank you. Lowell, you're next.

Yeah. Thanks. I also want to talk about the integrative components, both for children with complex medical needs, as well as adults with disabilities and seniors, the issues of both integration of physical, behavioral, as well as long term services, I think are extremely important issues. Social determinants of health, things like looking at social isolation for individuals, depression, et cetera. I don't know the measurements, but I know as a policy wonk, that's what I would like to look at, make sure that that's included in it and we don't have it at this point, unfortunately. And we really should be measuring that. Thank you.

Thanks, Lowell. Tracy Johnson, would you like to make a comment?

Yes. I just wanted to second an earlier comment, about measures that focus on behavioral health integration and primary care seem important. Thank you.

Thank you. Jennifer Tracey?

Thank you, Margo. Jennifer Tracey from Zero to Three and Healthy Steps, love to echo what David and Shevaun both said, around ACEs and child welfare metrics. And add to that, I say this every year, but really feel like we need to be going further upstream and looking at social-emotional screening, especially in the early years. We of course, have a core metric around developmental screening. And I'd love to see something related on social-emotional screening, as we move forward, especially all that we know with COVID and how important stresses on caregivers have impacts to young children and of course, their social-emotional health and well-being. And of course, we know a lot from the research, that what happens in the early years around social-emotional health is a predictor of what happens to children when they get older and something that we need to be paying more attention to in Medicaid. Thanks.

Thank you. Kim Elliott?

I think we're doing a really good job at adding measures or keeping measures that identify, engage, and follow up on all of the different types of behavioral health issues and with the core measures that's really not having a limit. But yet there is a kind of a limit in how much work can be done by states and by managed care organizations to really achieve improvement in any of the core measures. I have to say in almost every call that we have, I really think that we really need to focus and balance across that whole person and put a little bit more emphasis in looking for measures that talk to health equities and disparities, social determinants of health, and of course, the measures that really integrate behavioral, physical health. I think that's really an area that we need to continue to strive to achieve.

Thank you. Lisa Patton?

Yeah. Thanks, Margo. I just wanted to mention that in 2017, 2018, SAMHSA was doing some work on developing a suicide prevention measure. And I'm not quite sure where that work landed, but I believe that the initial focus was on developing a safety plan for those individuals who had screened positive for suicidality. And so, there may be some opportunity there with the folks who were mentioning looking at suicide. And so, there may be some foundational work that's been done in that respect. Also, I really do think the time is ripe for measures to better tackle SDOH, social determinants of health. And we may be able to learn some from the Accountable Health Communities, Medicare and that funding that's gone out and the evaluation that's being conducted on that.

I think there's a lot of public and private sector momentum to look at housing, to look at food insecurity and social isolation. So, a number of those factors that we can get a better handle on measuring and really looking at consistently across populations. So, I think it's a great time for us to be forward thinking about that and really pushing the field in that respect as well. And that holds true for getting to outcome measures, which I know is something that everyone on this panel has been invested in for a while and would really like to see us get to. So, just one more push for outcomes. Thank you.

Thank you. David Kroll?

Hi, there. Thanks. So, the only thing that I would add to these comments is that I also see this as a potential opportunity to do a better job of actually providing some leadership around defining what constitutes a suicide death or suicidal behavior. Where variation within the way that that's characterized and defined, often leads to difficulties in really keeping track of suicide related outcomes and improving them.

Thanks, David. Thank you, everyone, for all of these comments, a lot of gaps, a lot of great comments. We do not have anybody else who's queued up at this point to make a comment. Any other Workgroup members?

Yeah. This is Sara Salek. Sorry to just chime in on one more point, that's come up at the beginning. But just looking forward, just the concern of the impact of the COVID-19 pandemic on children's mental health. And so, this is a very critical topic as we move forward and identify additional measures to add to the Core Set. Thank you.

Thanks, Sara. Anyone else? Well, there's a lot here for us to consider and for the Workgroup to consider, going forward. So, with that, I think we have arrived at our next break. Why don't we take a 20-minute break? So, come back around 2:10. So, 2:10. Thank you everyone. Enjoy your break.

BREAK

Hi, everyone, welcome back from the break. We'd like to get started again. So, I am going to get started with the Dental and Oral Health Services domain. Next slide.

So, in the 2021 Core Set, there are two measures in the Dental and Oral Health domain, both of which are in the Child Core Set. First, we have Percentage of Eligibles Who Received Preventive Dental Services, which has been suggested for removal, and

Sealant Receipt on Permanent First Molars. Next slide. So, first, we'll start by discussing the measure suggested for removal, which is the Percentage of Eligibles Who Received Preventive Dental Services or PDENT measure. This measure assesses the percentage of children ages 1 to 20, who received at least one preventive dental service during the reporting period. As I mentioned, this measure is reported via Form CMS-416. States do not report this measure to the online reporting system used for other Core Set measures. This measure is not NQF endorsed and is calculated using administrative data. Next slide.

So, two measures have been suggested by Workgroup members as potential replacements for the PDENT measure: Topical Fluoride for Children at Elevated Caries Risk and Oral Evaluation, Dental Services. All 51 states including DC reported the PDENT measure for the FFY 2019 Child Core Set reporting. The PDENT measure was suggested for removal for a few reasons. One Workgroup member expressed concern with the methodology, including inconsistencies in calculations due to the broad set of codes used to calculate the measure, as well as the lack of rigorous testing to establish the reliability and consistency of calculations across states. Two Workgroup members noted that COVID-19 has exacerbated these issues, with dental providers using one of the codes used to calculate this measure for PPE rather than oral health services.

In terms of actionability, one Workgroup member commented that the broad definition of prevention in this measure means that improvement in the measure does not necessarily reflect an increase in evidence-based preventive services. They expressed a preference for measures of specific dental preventive services, like sealants and topical fluoride, which lead to improved quality of care. And to provide some additional background on this measure, this year, CMS gave states the option of having CMS produce the EPSDT Form CMS-416 on their behalf, using T-MSIS data. And we understand that more than 20 states have opted in so far to having CMS calculate the measure on their behalf. Next slide.

And now we'll discuss the two measures suggested for addition to the 2022 Child Core Set. The first measure we will discuss is the Oral Evaluation, Dental Services measure. This measures the percentage of enrolled children under age 21, who received a comprehensive or periodic oral evaluation within the reporting year. The measure steward is the American Dental Association on behalf of the Dental Quality Alliance. The data collection method is administrative, and it is NQF endorsed. One Workgroup member suggested this measure as replacement for the PDENT measure, because PDENT includes codes that would not indicate an evaluation of oral health. They also noted this measure can be used to trend access to care and is currently in use by a number of states including Texas, Florida, and Massachusetts. Next slide.

So, next, we have the Prevention: Topical Fluoride for Children at Elevated Caries Risk measure. This measures the percentage of children, ages one to 21 years, who are at elevated risk who received at least two topical fluoride applications within the reporting year. This measure includes separate rates for first, dental or oral health services, second, dental services, and finally, oral health services. The measure steward is the American Dental Association on behalf of the Dental Quality Alliance. The data collection method is administrative. And one of the rates, dental services only, is NQF endorsed.

The nominating Workgroup member suggested this measure to replace the existing PDENT measure for a few reasons. They noted that dental caries is the most common chronic disease in children in the US, affecting almost half of all children. And topical fluoride is one of the interventions with the strongest evidence base for reducing dental caries.

The Workgroup member suggested that this measure could be used by state Medicaid and CHIP programs as a complement to the existing sealant measure to assess whether children are receiving evidence-based preventive services and target quality improvement. The Workgroup member noted that disparities in the prevalence of caries and untreated caries are significant, and there is significant room for improvement within State Medicaid programs. Finally, a note from the measure steward that changes are under consideration for measurement year 2021. The proposed change would expand the measure denominator beyond those at elevated risk to include all eligible children and add an optional risk stratification. Currently, the measure includes a three-year look-back for risk. The changes would eliminate that look back. Next slide.

So, now I will pass it to Margo to facilitate the Workgroup discussion.

Thank you, Dayna. We now invite comments and questions from Workgroup members. You may unmute your line if you wish to speak and please remember to say your name before making your comment. Jim Crall, you're first.

Thank you, Margo. And thanks for the opportunity to comment. I actually was... I -- recommended replacement of the PDENT measure with the topical fluoride measure. Just to remind the group that last year, we added a new measure, was added to the Child Core Set, a sealant measure that eliminated the risk element, which made it a more population primary prevention measure. So, we start with the new sealant measure and the PDENT measure. But I think people are aware that the PDENT measure - even though it really emphasizes an important aspect of care, preventive services - CMS, and I can't speak on behalf of CMS, but I've been part of some meetings that have been held that CMS has had with the Dental Quality Alliance and other stakeholders about trying to improve PDENT. Basically, it boils down, as you heard, that it's not a precise measure at all, it includes all of the CDT codes that are in the 1000 series.

So, it makes it what I refer to as a salad measure, difficult to interpret. Of the roughly 30 or so codes in that series, about half of them, close to half of them deal with something called space maintainers, which is something that you use when children lose their teeth and we're trying to preserve space or sometimes even in conjunction with orthodontic therapy. And I don't think that's what people really think of when they think about prevention for children, dental prevention. And as mentioned, the two procedures with the strongest evidence base are sealants, which we already have the new measure and topical fluorides. And just to confound things or make it a bit worse in the COVID situation, there's a code D1999 that's included in the PDENT series that was being used by many programs and payers to provide payment for personal protective equipment, which came more to the fore during the COVID situation and clearly is not going to go away.

So, it just added more noise to that measure. And the other aspect of the measure is that, as it's currently used, the PDENT measure, it really only looks at dental services,

which in Medicaid are defined as services provided by or under the supervision of a dentist. And there's growing emphasis on topical fluoride application in particular, by other types of health care providers, primary care providers, pediatricians, nurse practitioners, et cetera. And there's recommendations by the U.S. Preventive Services Task Force for children to have topical fluoride applications. So, in looking at the measures under consideration here, I'll comment first on the topical fluoride measure, which as I noted, does have a strong evidence base, including evidence that two applications within a 12-month period achieves significant reductions in caries experience. I'll have to cite the studies for that.

I'll mention that in California, our most recent 1115 waiver has used two-to-four applications of fluoride per year, depending on caries risk of children. So, that's consistent with what the science and the evidence suggests is appropriate. If we add the topical fluoride measure to the current sealant Core Set measure, I think that really gives us two strong evidence-based dental measures, with plenty of room for improvement by Medicaid and CHIP programs. The proposed measure does allow for stratification by provider type. So, you can look at services provided through dentists or oral health services, which are services provided by or under the supervision of someone other than a dentist. So, community programs or primary care providers. Or a combination of the two, if you want to take a child-centric look. So, I think that's a great strong foundation for QI initiatives going forward, including the current CMS quality improvement learning collaborative.

The DQA has had access to the T-MSIS data and have been analyzing those and has calculated sample rates. So, it's definitely feasible and we're very happy to see the variation that's shown from state to state, particularly with respect to services provided in different age groups, the younger age groups, by primary care providers, as well as dental providers. It was mentioned that this current measure that we propose, and at the time we proposed it, has the elevated risk aspect of it, that's the way that it was actually endorsed by NQF, but I was informed as recently as Friday that the Dental Quality Alliance Measure Development and Maintenance Committee has voted to remove that risk element, which will really strengthen the measure as a population primary prevention measure. And the fact that it can be calculated through T-MSIS certainly helps to reduce the measurement burden.

Now, in thinking about all the three measures that are in play here, I can't predict how the group is going to vote. But I can predict with pretty much 100 percent certainty that we're going to end up with one of four scenarios. We could vote to drop out the PDENT measure, to remove it and not have consensus about either the other measures, in which case we'd be left with the sealant only measure, which to me is like taking a 20-year step backwards, in terms of measurement for kid's dental services. We could end up with the sealant and the PDENT measure, the status quo, which is okay, but all the other issues that have been raised with PDENT are not going to go away. And I think we can do better, in terms of a more precise measure. One option would be to end up with the sealant measure and the oral evaluation measure. I guess that it's better than sealant only.

But I think it would leave us very limited, in terms of our quality measures and evidence-based quality measures in the Core Set, because essentially, we'd have one good prevention measure, the sealant measure, and one other measure, which is essentially a

utilization or an access measure, which won't add much, because it's highly correlated with the CMS-416 Line 12a measure, any dental service that's currently also obtained by CMS in the EPSDT report. Finally, we could end up with a sealant and topical fluoride measure. To me, that's the best-case scenario, taking the risk element out of it, I think really does make it aligned well with the sealant measure, which now, no longer depends on elevate caries risk, it would help to reduce the burden. And therefore, that's my hope that that's the scenario that we end up with. Thank you for the opportunity to comment.

Thanks, Jim. Next up, Tricia Brooks.

Thanks. I have a question about the topical fluoride measure, either as it stands or how it might be changed. But how does fluoridated water come into play in terms of the results of the measure being an accurate assessment of the share of kids who needed fluoride?

Do we have anybody from the Dental Quality Alliance who would like to respond to that? Diptee, or someone else? If you're here and you would like to speak, please raise your hand.

If not, Margo, I'm happy to comment also.

Okay. Why don't you start, Jim, and we can always call in?

Yeah, sure. Yeah. So, what we call prevention or control of a disease clearly depends on a balance of risk factors and protective factors and water fluoridation, as well as other types of fluoride, like fluoridated toothpaste or professional topical applications, like the ones we're talking here. They all provide additive benefits. So, if a community has water fluoridation and another community doesn't have water fluoridation, you're likely to see caries reduction and a few less caries, less severe caries in the fluoridated community. Topical fluoride on top of water fluoridation provides an added benefit.

And so, while water fluoridation provides a certain baseline of preventive or anti caries effect, it is really most effective at the margin. So, if everything is pretty close to being in balance and you've got that water fluoridation in the environment, then that's going to help to tip the balance toward not having disease as opposed to having disease. But water fluoridation in and of itself is not enough to provide high levels of prevention in kids in elevated risk. Hope that helps to explain.

Tricia, did that answer your question?

Yeah, more or less. I do know that there are areas where there's natural fluoride in well water. But I guess with the topical, it's not adding to the intake ingestion of fluoride that some have been concerned about. So, thanks for answering the question.

Sorry, Tricia. I didn't understand the actual nature of the concern right. So, and in recent years, the most popular mode now of applying topical fluoride is through a vehicle called fluoride varnish. And fluoride varnish has been shown to reduce the risk of - I think you're alluding to various forms of dental fluorosis. So, some cosmetic effect that might be, might occur, generally quite mild in a subset of kids. But the fluoride varnish,

because it's a much slower release and results in less peaks in the plasma fluoride. Definitely, it is advantageous from the standpoint of reducing the risk of fluorosis.

Thank you.

Thanks, Jim. Thanks, Tricia. Carolyn Langer?

Yes. I have a somewhat technical question. I don't know if Jim or someone from DQA would like to respond. But on the topical fluoride measure, I noticed that the measure is for 1 to 21 years of age and by “to 21 years,” I interpreted that to mean up to and including 21. I wonder if DQA really meant under age 21, as they indicated on the oral evaluation and that would also be consistent with the population eligible for EPSDT. Thank you.

I'll say that I believe that. Yes, that is the case. Up to 21, I'm not sure if Dr. Diptee Ojha might be…

Do you mean under age 21?

Under age 21. Yes, up to including 20.

And so, you might want to just change the wording to under 21 years of age, like you have on the previous measure with oral evaluation under age 21.

Right. Thank you.

So, there's no confusion. Thank you.

Thanks, Carolyn. Amanda?

Hi, thank you. I wanted to ask a couple of clarifying questions slash suggestions on the proposed addition. I agree that topical fluoride and especially through fluoride varnish is incredibly important and the uptake of this service has not met the needs, especially given the mitigation it can provide for early childhood caries. And so, a couple of comments on this. One is that if you're, we're trying to measure the percentage of children who are receiving topical fluoride, do we want to instead focus on those receiving it as an oral health service? Because to look at it also as receiving it as a dental service, to me, seems a little redundant, where I would typically assume that a child accessing dental care from a dental provider would get exposure to fluoride at that service.

And what we're really more interested in is the mitigating approaches being taken through oral health services, especially for that group of one through five, who are at risk for early childhood caries. My understanding of the evidence is that, that's really where we're targeting fluoride in terms of using fluoride varnish is for those younger groups to prevent early childhood caries. And that ties into my next question, which is, should this be focused then or split into different measures, where you're looking at simply access or receipt of oral health services from a dental provider, versus receipt of oral health services through fluoride varnish application for those five and under in the medical, or sorry, through their medical provider? Because again, seeing age one through 20 and

these different sites being included to me, muddies the water in terms of what our goals are and where our intervention is going to lie, especially when we're focused on fluoride varnish as the intervention.

Yeah. I'll just respond by saying that - I mean, first of all, fluoride varnish is used by both dental providers and oral health care providers. And oral health, again, in the Medicaid context, refers to services provided by someone other than a dentist or not under the supervision of a dentist. So, it tends to include things like community programs, maybe school based or Head Start Center, as well as services that are provided by primary care providers. The reason the measure as it's currently set out, it actually includes stratification by age groups, consistent with the way that reporting is done for the CMS-416. The three different measures that are being proposed in this measure to allow for measurement by dental providers, to allow for measurement by oral health care providers, so, not the dental piece or the combined dental or oral health measure, really I think is the best way to go from having a foundation for improvement.

Because, again, you're absolutely right, there is interest and there are efforts on the part of states and groups like the U.S. Preventive Services Task Force to increase topical fluoride application in younger children by all types of providers. Still we've used the T-MSIS data to analyze this measure on a subset of 20 states and looking at age slices, like one to two-years-old, three- to five-years-old, et cetera. And among those 20 states, we've got one state that really stands out, that I think most people probably are familiar with the literature know. A state that's really been working to involve its primary care providers for many years now and it's reported this in the literature. And we see significant applications there, close to on a par with what you see by the dental providers in that state, but that's one state out of 20.

Most of the rest of the states, the oral health component or the actual percentage of kids that are getting those preventive services, that we know they should be receiving from someone other than a dental provider is very new. That's good news from the standpoint of there's lots of room for improvement. But by being able to look at dental providers in isolation, oral health providers in isolation, or the combined measure centered on the child, you have all the flexibility in the world to be able to use the measure to understand how the various components of your system as well as your system overall is functioning.

Thanks, Jim. Diptee, did you want to say something? Derek, can you unmute Diptee? Diptee, you might be unmuted. Do you want to try speaking? Derek, can you unmute Diptee? Diptee, we'll come back to you. Why don't we move on to Anne Edwards and we'll come back to you?

Thank you. So, I think others have commented on the importance of oral health. And really, I agree with all of that and agree that I think really, it's a system level approach that needs to involve a primary medical home through fluoride varnish application as well as, the dental community. I guess my question and slash comment is, I wonder if we are to drop the PDENT and not adopt the oral health primary care services, if we really do reach that total goal of having support and access to optimal oral health for kids, especially adolescents, as I look at it, a lot of the fluoride varnish work is focused in that younger age group. And then, you have the dental sealants in six- to nine-year-olds. And just wondering if we create a different kind of gap, especially, since what we hear

consistently is a primary care challenge to kind of meet the needs of kids, who need care beyond the medical or health services or community setting. And I know that that's even in prevention too. So, thank you.

Margo, if I can just respond to that. So, one of the nice things about being able to use the T-MSIS data and to look across states, so, you can actually look at it in with respect to what the policies in that state are. Some states provide a lot of primary care providers and reimburse primary care providers to provide topical fluoride applications, fluoride varnish to a wide range of children under age 20. Other states have more limited policies that might be under three or under five or six years of age and we can see some differences in states. So, again, that I think really lends itself to quality improvement initiatives and policy initiatives in the states to try to tailor their interventions to target them toward the groups that they think where the greatest gap is. By having the age stratifications built into the measures, you can really start to focus in, and you can also look across your components or your delivery system and see where services are or are not being provided.

Thanks, Jim. Let's see if Diptee is available now. Diptee, can you try unmuting yourself? There you go.

Hi, can you hear me now?

We can.

Okay. Well, thank you so much. And Dr. Crall has already addressed all of the issues. So, the measure currently assesses two topical fluoride applications within the reporting year by all rendering providers as identified as defined by the CMS. So, you will be able to assess if the topical fluoride was rendered by a primary care physician or not under the supervision of a dentist or such as like independently practicing dental hygienists or is it rendered by a dentist or a dental -- under the supervision of a dentist. So, you will be able to evaluate where, how those topical fluorides were rendered. And as Dr. Crall mentioned, we currently have access to the T-MSIS data. And we've been able to assess for more than 25 different states and be able to look at the measure scores by the rendering providers to look at the variation in the measure scores across the different population. And if it is possible to unmute Dr. Jill Herndon, she will be able to summarize the findings that we've seen through the T-MSIS.

Okay. Derek, can you unmute Jill Herndon?

Can you hear me?

We can.

This is Jill. All right, great. Okay, so good afternoon, everyone. So, yeah, actually, I was just looking at some of our data and I think that the question that was raised about the age and as Dr. Crall was saying, the age stratifications can be tremendously useful, because yes, it is the case, though a lot of efforts are focused on the youngest kids, but it's not the case that topical fluoride is only important for the youngest kids. And so, having the age stratifications allows you to see that, for example, when you get to 15 and older, you see lower rates of topical fluoride application. And so, being able to see

that can help spur states to identify that as a gap area and include those populations in their QI initiatives. So, you really can see which kids within that age range, that broad age range, which is very inclusive of all ages, are and are not receiving an acceptable amount of fluoride, getting at least two topical fluorides during the year.

Great. Thank you. Why don't you move on to Richard Antonelli?

Thanks, everybody. Jim, this might be for you, but I'm happy to open it up. And I think we've been touching on it, but I would really like to put this into a package as clearly as possible. Oral versus dental provider. We've talked about primary care providers doing some of the varnish and if you could just be really explicit. It sounds like especially if we're using T-MSIS data, we have the ability to see who is providing those services, in what setting in a given state? Is that correct for what it is we're being asked to evaluate here?

Yeah, Rich. My response is, yes, it is, not only in what setting, but at what age groups.

Okay. And I want to point this as a very, very important point. I've been in Medicaid meetings in the past, where people have said, "Well, let's use this measure and if it's poor, we'll just be able to recruit more pediatric dental providers." And many of us that have been agonizingly advocating for increased Medicaid dental services availability have been saying, "But it's not enough just to show a poor score, there have to be other incentives on the table." So, I am really grateful for the opportunity to really think about this from a dental community health approach. Thank you for that. I mean, actually, one other follow up question. Jim, I know that when the studies were first done out of North Carolina, and then, subsequently the focus was all kids and then increasingly, it was kids in Medicaid, because of the risk factors that are there. I know that today's conversation is all about the Medicaid Core Set. I get that. But are there dental health reasons why this should not be restricted to Medicaid eligible children?

Good point, Rich. And you win the prize for identifying the state that I was not mentioning by name, and absolutely not. There's no reason to limit this just to Medicaid. And in fact, with the DQA, the measure development, I think nearly all of our measures are designed to actually be applied to commercially-insured individuals, as well as Medicaid or CHIP-insured individuals. And if you had a data source, it could be for uninsured individuals, but absolutely. And that there is some work done by the ADA Health Policy Institute, that really does help to identify, on a state-by-state basis, just where you actually see gaps and where, thankfully, after the years and decades of efforts, some states are actually showing parity in use of dental services by Medi-Cal-covered kids and commercially-covered kids. So, it definitely should be looked at across the broad spectrum of kids.

That's great. Thank you very much.

Linette, you're next.

Hi. Quick question and then, a comment for the Topical Fluoride with Elevated Caries Risk, I know you talked about the fact that that elevated caries risk component was going to be removed. And that is a problem for us. So, I would definitely be supportive of

that. But are we voting on the measure that has the component around elevated caries risk or that does not have a component?

Linette, that's a great question. I would like to recommend that we vote on the measure as it has been recommended to be changed. That update, I believe, is very close to being approved and that is then what would be in the Core Set. So, without the elevated caries risk, it will have an optional stratification for those who want to stratify. But it would not be required.

Yeah, Margo. –

That would change my vote.

Yeah, if I could just add, Margo, and Diptee could comment on this from the internal DQA perspective. But the process basically is that as I mentioned, the Measure Development and Maintenance Committee recommended the new measure as you just spoke, Margo, without the risk. The process is that that would then--, that recommendation goes to the DQA Executive Committee, which then would forward it to the full DQA committee for a vote. The meeting's coming up in June and at least, all indications thus far are that things happen within that time.

Okay. So, thank you for confirming that. And then, the other comment is just that, I'm very supportive of removing the PDENT from the measure set. The CMS-416, unfortunately, uses a three months continuous eligibility, but looks at services occurring over one year. So, there's a mismatch between eligibility and service period, in terms of the measure, which is not very helpful for a variety of reasons. So, definitely support that removal. Thank you.

Thanks, Linette. Lindsay, you're next.

Great. Thank you, Margo. And I apologize if I missed this. But we have also been trying to expand the fluoride measure in New York State, but not having a lot of success with feasibility. So, if someone can explain to me how this measure meets the criteria of being implemented at a statewide Medicaid level, that would be great. As far as I understand is, this is not a reliable claims-based measure, this really needs to be an EHR measure. So, that's going to impact how I vote. Although, I think it's the merits of the measure are great. I just don't know that we have it figured out on how to measure this across the state.

Thanks, Lindsay. I think for this, we'd like to call on the measure steward, Jill Herndon or Diptee. Can either of you unmute?

Hi, this is Jill. In terms of the feasibility of the measure, it's quite feasible with the claims data. I'd like to understand a little bit better, what some of the barriers are that you've been facing, because we could certainly provide some technical assistance around that. But you're looking for fluoride CDT codes that are in the claims data and when you're looking for dental services, it's D1206 or D1208. When you include the oral health providers, some states are still reimbursing and including the CDT codes, but there's also the CPT 99188 that can be captured for the non-dental providers, who may be providing fluoride varnish. So, but I know that other states have used this measure

successfully, we've been able to calculate it successfully with the T-MSIS data. So, I guess, I'd really like to understand what the challenges are that you're facing.

So, why don't we move on and ask... I think David Kelley has a comment. And we also have Lisa Glenn from Texas, who I believe also has been using this measure. So, perhaps we could move on to a couple of other states to talk to Lindsay's question.

This is David Kelley. I actually have a slightly different question. But Lindsay, I think from a claims-based standpoint, this should be something that could be done fairly easily based on the dental codes and the one CPT code. In Pennsylvania, we do allow for a whole host of providers to be able to use that CPT code. My question was around the twice a year fluoride service, which I'm a big advocate of. The dental management companies, do they put barriers in place where this really makes it difficult for someone to actually get in twice a year? Just ask that as a rhetorical question. I've heard, and we don't allow it in our system, but we do have limits that we put on fluoride varnish. They're pretty liberal. I'm just wondering, though, if other states have these more draconian edict or limits in place, where if you go in like one day before six months that you're not going to get that service paid. And did you guys notice any of that in the claims? Any concerns around that?

David, thank you for the question. I'll comment and then Jill can go into greater depth if necessary. First of all, the last example you gave, I've heard from plenty of pediatric dental colleagues, who've been audited, and then, some formula applied and clawback payments on kids who are seen within a week of the six months when it should have been put on. I think the state really calls the shots on that. And then, the way they contract with their managed care plans or whoever their administrators are, their benefits. Certainly mentioned. I talked about the dental transformation initiative in California. The 1115 waiver that's been going on for the last four years plus here, and there's anywhere from two to four fluoride applications per year based upon whether the child is deemed to be at low risk, that's two per year, moderate risk, three per year or every four months, and high risk, every three months or four times per year. So, hopefully more states are moving in that direction, because two has been the standard for many, many years with a commercially-insured population. But we know that is a population, which collectively is at significantly less risk of tooth decay than a Medicaid population.

Okay. So, you didn't see that as a big barrier in the T-MSIS data that you guys looked at?

I'll let Jill comment on that.

So, we don't really have information, in terms of the specific benefits coverage. So, I can't answer that. But I mean, the findings were about, what our experience has been and when our initial testing data for states, it did have coverage of topical fluoride. So, the rates that we're finding are consistent with what we were finding based on states where we knew there was the coverage for it. I don't know if that's helpful or not.

Okay. Yeah, that's very helpful. I just have one real brief question on the Oral Evaluation, Dental Services. Again, this is a narrower range of codes. Correct?

Yes. It’s the, 01450/1200-150.

Yeah.

Okay. So, it's a very pinpointed precise measurement versus the PDENT, which is this whole wide range of codes that includes all kinds of interesting things. Okay.

And that oral evaluation measure, it's not in the preventive series at all. It's in the diagnostic series.

Well, that's -

It's precise, but you got an apple and an orange here.

And again, this is the comprehensive periodic evaluation. And is that done by a dentist under the auspices of or under the direction of a dentist?

Generally, yes. And the comprehensive, the 150, typically is the - for a new patient or perhaps a patient who hasn't been seen for quite some time. The periodics are what you'd normally consider a dental checkup, every six months, four months, whatever periodicity is recommended.

Okay. Thank you very much.

So, just to clarify. The codes that are included in oral evaluation, does it include preventive and diagnostic? I’m a little confused.

No. No preventive.

No preventive at all, in Oral Evaluation?

No. It's only comprehensive oral evaluation. And this is a marker that the child was fully evaluated, and diagnosis was recorded, and a treatment plan was developed. So, the activities is much more comprehensive. And again, the denominators again, kids who are in the system for at least six months of - six months and those who went on to get oral evaluation, where a diagnosis was recorded, and a treatment plan was conducted.

Thank you, Diptee. We have…

So, it's like a well-child visit only on the dental side. And I'm still puzzled as to why that's not included in the preventive set of codes. That's a new one for me.

Next up, Amanda.

Hi. Thank you. I just want more clarification around the age stratification there and under the technical specifications. I'm wondering why it starts at one given the recommendations that children start receiving new preventive oral health six months after their first tooth or by 12 months, knowing that some may have had an opportunity to have their first dose of fluoride varnish even before they're one year of age. So, I was wondering if you could speak to that. And then, maybe clarify the breakdown. I

understand, it's important for understanding differences between, for example, the under five groups, the young children adolescence, but there's very specific break down into the two - three-year periods, if that could be spoken to. Thanks.

Yeah. Diptee or Jill, Diptee, you want to speak to the age stratification question? Or do you want me?

Sure, Dr. Crall. So, I can start first and then Jill can please chime in here. But the topical fluoride measures, the specification allows, accesses for continuous enrollment for 12 months. So, even if there was a first tooth interruption, there has to be at least 12 months of enrollment requirement, before the child can be eligible to be in the denominator. And even if there was an initial dental visit that was done, that preventive services are more likely to happen on a later date. So, that was that first startup time from age start at one and then forward until less than 21 years of age. Jill, do we have any explicit data around it, that we did look into during our testing that confirms this?

Well, not with the 12 months, because we know that you have to have the 12 months of enrollment at least. And the reason for that is because of the two fluoride applications being needed, where one really generally isn't sufficient. So, to allow two fluoride applications, you need a year's worth of enrollment. And so, practically speaking, you can't really start the age stratifications, before then.

I would add that clearly our guidelines, as well as many other guidelines that support that application. The first dental visit before age one or at least by age one and the application of fluoride varnish as soon as the teeth erupt. But Jill's right, it's because of the two applications and the practical aspect of that, that it wouldn't be captured in the children under age one. And we've heard plenty of pushback from plans and others before, when we do comment on our measures about that under age one group. But because of two applications, in this case, it's really not likely to yield data.

Thanks, Jim. So, we're almost out of time for Workgroup discussion. I just wanted to check, Lindsay Cogan, do you have one more comment that you wanted to make?

No. I just put it in the chat. That was my last comment. Was just that, it's very difficult to justify, when we have an existing mechanism to collect and report dental information. It just would be a whole lot better, as far as resources, allocating resources, you know, the Child Core Set becomes mandatory, what do we need to do? It'd be great to get CMS and DQA on the same page and reconcile the first two measures and still maintain that reporting mechanism that we currently have in place already, rather than relying on new programming. So, that was just my suggestion.

Thanks, Lindsay. And I just wanted to check, Lisa Glenn, if you're on, did you have any comments about these measures, because I know that they're being used in Texas, and so, anything that you wanted to say before we move to public comment?

I'm muted and unmuting just keeps going on and off. Hi, this is Lisa Glenn. I'm not sure that I have any comments on it, to the question about our difficulty collecting data. I can't speak to it, but when I talk with our quality people, they did not express any concerns about collecting data on any of those measures. We do it and we have fluoride varnishes in our EPSDT program. And we're able to track that because there's an additional

payment when that's done. So, we're using our claims data and don't really have any difficulty collecting it.

Thank you, Lisa. All right, with that, next slide, please.

Thank you all for a very robust conversation and good questions. And thanks to the measure steward and also Jim for all of your responses. So, now, we'd like to provide an opportunity for public comment. If you'd like to make a comment, please use the raise hand feature in the bottom right of the participant panel to join the queue. And then lower your hand when you're done, and we'll let you know when you've been unmuted. Do we have any public comment? And just a reminder, the Workgroup members, please lower your hand when you're done. Rich, Linette, and Amanda, you all have your hands raised. Any public comment? Last call. Okay. Next slide, please. I think now we're ready to vote on the measures. Dayna?

Great. Thanks, Margo. Okay. So, we have our first question, and it is, should the Oral Evaluation, Dental Services measure be added to the Core Set. And voting is now open. If the question has not shown up on your voting page, please refresh your browser. We have 24 and we're looking for about five more. Okay, we have 26. So, I think there's just one or two folks missing. We're going to take a look now and see who's missing, so we can get everyone’s votes in. I think, Tracy Johnson, we might be missing your vote. Karen George, I believe we're missing yours as well. If you're having issues with the platform, feel free to submit via Q&A. So, Tracy Johnson and Karen George, if you can submit your votes via the Q&A, we do not have your votes yet. We'll hold for another minute, but then, we'll go ahead and close things out. Tracy Johnson, are you here? Do you need to unmute and let us know if you're having a problem with voting?

Yes. Hi. I was grayed out, so I could not talk. I am having technical difficulties and the chat – Q&A is not working for me. [Inaudible]

Could you send your response to our mailbox?

What do you mean by your mailbox? Is that an email address?

The MAC Core Set review at Mathematica.

You know what? Tracy, I'll email you directly.

Okay. Did not mean to] do that, sorry. I don't know why the Q&A isn't working.

Tracy, can you let me know when you've sent your vote?

I sent it to you directly, Margo. So, if you check your personal email, you should see it.

Okay. We are at 28 votes. Thank you everyone for holding tight with us, while we get that last vote in. So, I will go ahead and close the polling and share the responses. So, 82 percent of Workgroup members voted yes, that does meet the threshold for recommendation. So, the Oral Evaluation, Dental Services measure is recommended by the Workgroup for addition to the 2022 Core Set.

So, our next question is, should the Prevention: Topical Fluoride for Children at Elevated Caries Risk be added to the Core Set? And voting is now open.

And just to confirm, this is voting without the requirement for the elevated caries risk, correct?

That's correct.

Thank you.

Okay, we have 25 responses, we're looking for just three more, we have a couple that have come in over the Q&A. So, we are just putting in those votes now. Okay, great. Thank you everyone. We have all our responses. Okay. So, we have 79 percent of Workgroup members voting yes, that does meet the threshold for recommendation. So, the Prevention: Topical Fluoride for Children at Elevated Caries Risk measure is recommended by the Workgroup for addition to the 2022 Core Set.

So, our final measure here, we have, should the Percentage of Eligibles Who Received Preventive Dental Services, also known as the PDENT measure, be removed from the Core Set? And voting is open. Okay. We're waiting on just one more vote. So, if everyone could confirm their vote has gone through, we are checking who we're waiting for on the back end. Shevaun, I think we may actually be waiting on your vote. We are just waiting on Shevaun. Shevaun, if you're having any issues, if you could just unmute and let us know, looks like we may have lost Shevaun.

Let's move on, let's take the votes as we have them with the attendees we have. So, I'll go ahead and close polling. And it looks like it wasn't close. So, for the PDENT measure, we have 89% of Workgroup members voting yes, that does meet the threshold for recommendation. So, the Percentage of Eligibles Who Received Preventive Dental Services measure is recommended by the Workgroup for removal from the 2022 Core Set. Thank you all for voting. So, I will shortly walk us through the next section of the Dental and Oral Health Services.

Great. Jessica, can you take us to the next slide? Wonderful. So, the next measure we'll discuss is the Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults measure. This measure assesses the number of emergency department visits for ambulatory care sensitive non-traumatic dental conditions per 100,000 beneficiary months for adults ages 18 and older. This measure is stewarded by the American Dental Association, on behalf of the Dental Quality Alliance, is not NQF endorsed, and can be calculated using administrative data. Importantly, the measure can be calculated with enrollment and medical claims data, it does not require dental visit data. The Workgroup member that suggested this measure noted that the measure would address a significant gap in the Adult Core Set, as there are currently no measures related to adult oral health.

They also suggested the measure can serve as a broad indicator of the performance of state Medicaid programs with respect to their impact on minimizing acute dental conditions in adults. Furthermore, low-income individuals are at greater risk of having non-traumatic dental ED visits. And that Medicaid is a primary payer of dental-related ED visits. And finally, the Workgroup member noted that improvement strategies for this

measure are available and provided examples of dental access programs and their impact on averting ED visits. Next slide.

So, now, I'll pass it back to Margo to facilitate the Workgroup discussion.

All right. Thank you. So, do we have any Workgroup members who have any comments or questions? Jim.

Thank you, Margo. Yeah, just comments on this measure. Clearly noted, we have no measures in the Adult Core Set that relate to dental. This measure or a measure like it had been discussed before, but just as background, various publications note over 2 million visits a year to EDs for non-traumatic dental conditions in adult, over $7 billion. And maybe billions of dollars are not consequences anymore in the discussions of the U.S. health care system, but let's hope they still are. And that's money that is paying for services, where really preventive care is not being provided at all. Most likely, pain meds, which includes the risk of opioid issues downstream or antibiotics, is typically what is provided in an ED setting. I know that in some of the discussions previously, we've got - I think people are aware, a wide range across states, in terms of what type of adult dental benefits they actually provide, in terms of scope of services. So, most recent information I've seen suggests about 18 states now provide what we would consider, or at least the ADA Health Policy Institute considers, extensive or a decent set of dental benefits for routine dental care. Another 16 states providing some more limited scope of benefits for adults, in terms of dental services, three states having emergency-only coverage, and three states with no coverage at all.

So, again, with the T-MSIS data, Dr. Herndon and on behalf of the DQA has done some analysis and had some data for not all states, time didn't allow for that. But at least a group of five states she looked at, where states that had extensive dental benefits for adults were - and another five states where there was only limited or emergency. I'll just comment that in the states that had extensive dental services, of the five the maximum rate was 223 visits for dental conditions per 100,000, visit months, where and a low of 84. So, a range of 84 to 223. On the five states with more limited dental emergency, limited or emergency coverage for adult dental benefits, the range goes from 101 up to 314 and three of the five states have at least 240, a rate of at least 245. So, exceeding the other sample altogether. So, again, we think this is an important measure. We think that it is an ambulatory care sensitive measure. We have an ED follow-up measure, but we chose not to recommend it at this time, simply because of some of the difficulty we've had in the past of convincing the group to support an adult measure, an adult ED measure.

So, we decided to start slow with just the ED use measure. Clearly having an adult dental ED measure would be a start, or at least a small step towards supporting, I think better integration of dental and medical care, which hopefully would drive efforts at more upstream initiatives to reduce the occurrence of these ED visits. And as mentioned, we do have evidence from several states and local programs, where you can significantly reduce the rate of ED use for dental issues if so-called dental diversion programs are set up so that individuals have other places to access care short of the emergency room. So, those are my comments. Having had the pleasure of spending seven hours in the university ED room recently, I'll have to say that I know this is not going to answer all the

issues related to adult dental care, but do believe it's a start and encourage people to support this measure.

Thanks, Jim. Next up, Richard Antonelli.

Yeah. Thank you. Jim, you use the phrase that I wanted to lead with and that is - this is about as far downstream as you can get. And I struggle with that, because I am mindful that the real estate in those Core Sets is actually pretty precious. And just to be clear, I am completely in support of equitable access to dental health care for adults. But I guess I'm just struggling with the issue of - Is the juice worth the squeeze here? Is there something in the pipeline that could get us a little bit upstream, if not far upstream?

Well, I'll mention and then - if available, maybe Dr. Ojha could comment as well, in terms of other adult measures that the DQA has developed. Sure, you can look at a measure of whether an adult in Medicaid has had an oral eval visit. But what are you going to do for the 20, 15 or so or, 15 to 18 states that don't even have a benefit? And they're going to come in, as zeros. You could look at whether or not patients who have already in the system now, who have diabetes, have had a periodontal evaluation. And I tell you a whole lot evidence suggests that there's certainly a connection between periodontal disease and diabetes. But what's that measure going to really tell you particularly within the overall context and array of what's in the Core Set?

So, everybody, I think, would love to be working upstream. But as I mentioned, I think that this is the measure we feel is the starting place to at least start to point out variability, gaps, and disparities. And for states to start to focus on ways to improve that, that's clearly going to involve the adoption of some strategy to get to, to allow these adults to have services short of pain meds and antibiotics un an ED. So, very good point, Rich, about it being downstream, but I think, given the state of the landscape, the policy landscape out there. I think that this is the place to start.

Thank you.

Okay. We have several people in the queue. And I'm mindful of the time of day. So, next up, Amy Mullins.

Yeah. So, I just wanted to speak to some of the disparity that you just talked about. I mean, are we trying to use this measure to change Medicaid payment policy? I don't know that that's the lever we want to pull, is to put a measure on the Core Set that many states can't reach, because their Medicaid benefits don't extend this service to their adults. We know what the disparity is, that many states don't offer the routine coverage that is needed to keep their adults out of the ED for these ambulatory sensitive conditions. We need to change that. I don't know that adding this measure to the Core Set is the lever to pull to change it. Thank you.

Thanks, Amy.

I'll say, Margo if I can, that's not necessarily the intent of the measure. And I would mention that there are only three states that don't have any coverage for adult dental services, that would at least cover emergencies and things that are could be dealt with outside of the emergency room.

Thanks, Jim. Let's move on. We have Lowell, then Kim and then Lisa. So, Lowell, you're next.

Thank you. So, I just wanted to focus in - I actually think it is the lever to pull. And I'm speaking both politically as well. Medicare currently doesn't have dental care for older Americans, and that's being discussed nationally. And I think it is outrageous that we don't have something like this, to at least say this is a problem and just lay it out that way. We discussed this last year and the specific issue that we didn't have a particular way to do this. This particular addition, I think, actually fills the quote gap unquote that we had identified last year. So, that's all I have to say. Thank you.

Thanks, Lowell. Kim Elliott?

Hi. Yes, I want to reiterate what they are saying, that I do think it is important benefit for all age groups, whether they're Medicaid or non-Medicaid. However, when I'm thinking about a core measure perspective and how we're trying to show the quality of care being provided across all states. I think that what we should be really thinking about for inclusion in core measure sets are things that are benefits across all of the states or at least similar benefits across states. Otherwise, we're really not comparing apples to apples in quality of care.

Thanks, Kim. Lisa Glenn?

My comment was very similar to the fact that it's very difficult to have a core measure, when some states like Texas, we have very limited coverage for adults in the dental services and any of these inappropriate emergency department visits are covered on our medical side for the most part. We would end up with a core measure that would not really be actionable on our end, as much as we would like it to be. There are not dental benefits. Thanks.

Thanks, Lisa. Do we have any Workgroup members who want to speak before we turn to public comment?

Margo, can I add one thing?

Sure, Jim.

I think those are, those comments are more germane if you're talking about a follow up measure. I can't see why we're just going to literally turn our back on this, because we've got, apparently, three states with no coverage for emergency services. Yes, it's going to be captured on the medical side, that's exactly where it's intended to be captured. Those costs are incurred on the medical side. The additional burden on EDs occurs on the medical side. That's exactly where the measure should be focused.

Thanks, Jim. Any other Workgroup comments, before we move on to public comment? Okay. Well, we're in the homestretch. We'd like to provide an opportunity for public comment at this point. If you'd like to make a comment, please use the raise hand feature in the bottom right of the participant panel to join the queue and lower your hand when you're done. And we'll let you know when you've been unmuted. Do we have any

public comments? All right, well, let's move on. I think now it's time to take a vote. Dayna?

Thanks, Margo. I will take us to a vote. Okay. So, the first question we have is, should the Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults measure be added to the Core Set? And voting is now open. Okay. We have almost everyone already. I think we might be missing one. So, we'll check the Q&A. Okay. Votes are in. I'll go ahead and close and share the responses. Okay. For the results, 32 percent of Workgroup members voted yes, that does not meet the threshold for recommendation. So, the Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults measure is not recommended by the Workgroup for addition to the 2022 Core Set. And I will now turn it back over to Margo, to facilitate a discussion of gaps in the Dental and Oral Health Services domain.

Thank you, Dayna. And thank you Workgroup members for such a robust conversation about all the dental measures that we considered today. Next slide, please. Okay. Next slide.

Alright, so, here, we want to talk about the gaps, what suggestions the Workgroup has for further strengthening the Core Sets. What types of measures or measure concepts are missing in the Core Sets and whether there are any existing measures to fill the gap or would a new measure need to be developed? And please remember again, to state your name before making your comment. Lisa Glenn, do you have a comment?

I apologize. I forgot to put my hand down.

Okay. Thank you. Linette.

I think, the conversation we just had about the adult measure actually is one of the gaps, obviously. So, there's no dental oral component on the adult side, especially with the conversation we just had for the children measures, it seems like we're probably in pretty good shape there for now, at least. But the dental side is definitely - I mean, the adult side is where there's I think more opportunity and to the conversation we had earlier, there's the aspect where it lands in the emergency space, and so, and mainly on the medical side, as opposed to the dental side. Obviously, we want to get upstream, but that'll take time as well. So, sometimes, we have to start somewhere, sometimes we start with a process measure as opposed to an outcome measure. So, thank you.

Thanks, Linette. Lowell?

Thanks. I don't want to repeat what was just said. I appreciate exactly what Linette was saying. Well, what you're saying. So, that was basically what I was going to say. I was also going to say that I think it's important that even if we should know, and we should push everyone, dental care is important in social determinants of health, integration of physical health, as well as behavioral health, people. And we really should have done that and it's unfortunate that we didn't vote for it. That is clearly a gap that needs to be found. Thanks.

Thanks, Lowell. Rich?

Yeah. Thank you. Margo and my colleagues, I purposely didn't make the following comment in the gaps discussion on behavioral health, because I didn't want to just leave it there. So, the comments that I'm going to make now are not specific to dental, but they actually do connect with behavioral health and some of the social risk. I'm still struggling with having a really robust view of many of these measures with respect to race, ethnicity, language, and disability status. Some of the most complicated patients that I care for and that I'm sure that are Medicaid beneficiaries have many of these aspects and especially with the dental health, I'm thinking about LTSS beneficiaries, children with complex needs, et cetera. We need to be thinking about these not in this piecemeal fashion and not really that far downstream, but upstream full assessments across the age spectrum, and in particular, looking at the REL and D aspects. And for those persons that have a high-risk trigger, just by virtue of their poverty status, housing insecurity et cetera. These measures should be flagging those opportunities for improvement.

Thanks, Rich. And that's also a great comment to bring back on the last day when we talk about cross cutting gaps. So, thanks for that comment. Other comments about gaps in dental and oral health services? All right, well, hearing none, I will do the preview of day two and the wrap up. So, next slide, please.

Okay. So, that brings us to the end of our measure discussion today. Thanks everyone for hanging in there and helping to troubleshoot on the voting process. I think we got really pretty good by the end of the day. So, hopefully, it will go more smoothly again tomorrow. We really appreciate everyone's contributions today, all the comments that were made. And also keeping to the time, we really appreciate that. I wanted to also do a recap on the votes from today. In Behavioral Health Care, as we talked about earlier, we had a measure for addition Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention, which was not recommended for addition. Medical Assistance with Smoking and Tobacco Use Cessation, which was not recommended for removal. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment was not recommended for removal. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence was recommended for addition to the Child Core Set. Follow-Up After Emergency Department Visit for Mental Illness was recommended for addition to the Child Core Set. In the Dental and Oral Health Services domain, Oral Evaluation, Dental Services was recommended for addition to the Child Core Set. Prevention: Topical Fluoride for Children at Elevated Caries Risk was also recommended for addition. Percentage of Eligibles who Received Preventive Dental Services was recommended for removal.

And the final vote for today, Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults was not recommended for addition. So, thank you, everyone, for all of your votes and all of your discussion. And so, now I'd like to preview the agenda for tomorrow. Next slide, please.

So, tomorrow, we'll discuss measures for removal and addition in three domains. Care of Acute and Chronic Conditions, with one measure suggested for removal and five measures suggested for addition. Long-Term Services and Supports, with one measure suggested for addition. Maternal and Perinatal Health, with two measures suggested for removal. And we will begin promptly tomorrow at 11:00 AM, eastern. And we ask

Workgroup members to sign in about 10 minutes early. And before we break, Shevaun and David, do you have any final remarks to close out the meeting today?

Hi, this is Dave Kelly. I just want to thank everybody for their due diligence today, really great robust discussion. And very, very pleased with where we're at and we're able to really have a good discussion as well on some of the gaps, especially within behavioral health. I think the dental discussion I was actually looking at last year's document about some of the gaps that were still there in dental health and I think some of our recommendations actually helped to fill some of those old gaps that we identified last year. I think these recommendations are much more pinpointed, focused on prevention. And again, to echo the adult dental is still concerning, there's still a gap that exists there. And part of that is also driven by the fact that the dental, adult dental benefit is not a mandatory benefit. And so, that in and of itself is a challenge. So, but I want to thank Mathematica for their due diligence in keeping things on time. And I'll turn it over to Shevaun.

Thanks, David. So, I echo everything he said. Thank you all for your engagement throughout today's meeting. I think we had productive conversation on a number of topics, really excited to see the recommendations coming out of the behavioral health area on the agenda and looking forward to tomorrow's discussion. Thank you to the Mathematica team, as always, for making this be as organized as possible and making it very easy for us, as Workgroup members to be able to digest the recommendations and the recommendations for additions and removals and to make the best selections possible that we think we can make. So, again, thank you all and look forward to tomorrow.

Thanks, Shevaun and David. And thanks to everyone who's stuck with us till the end. We wish everyone a nice rest of the day. This concludes day one of the 2022 Child and Adult Core Set Annual Review Meeting. Take care, everyone. Bye.