2022 Child and Adult Core Set Annual Review:
Meeting to Review Measures for the 2022 Core Sets Day 2 Transcript
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Good morning, everyone. And thank you for attending today's event, the 2022 Child and Adult Core Set Annual Review Meeting, Day Two. 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 participants 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 the public comment period, and the audience is unable to hear you, please ensure you are 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 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. And with that, I will hand things over to Margo Rosenbach.

Thanks, Dayna. And hi everyone. Welcome back to Day Two of the stakeholder review of the 2022 Child and Adult Core Sets. I hope everyone had a nice evening. We had a very productive day yesterday. We voted on nine measures, had a very robust discussion on every one of them. Five of the measures were recommended for addition and one recommended for removal. I'll give a brief recap for those of you who were not here yesterday. We had two measures in the Behavioral Health Care Domain that were recommended for addition to the Child Core Set, Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence and Follow-Up After Emergency Department Visit for Mental Illness. Both of these measures are already in the Adult Core Set, so this is to promote alignment between Child and Adult Core Set.

In the Dental and Oral Health Services Domain, we had three measures that were recommended - two for addition and one for removal. The two measures suggested or recommended for addition are Oral Evaluation, Dental Services, and Prevention: Topical Fluoride for Children at Elevated Caries Risk. And the measure recommended for removal is the PDENT measure - Percentage of Eligibles Who Received Preventive Dental Services. So, thank you Workgroup members for all of your discussion, for your voting. We definitely had some challenges with voting yesterday, and we appreciate all the troubleshooting that has occurred overnight, and all of the test polls that were done this morning, so thank you for really working with us to try and make the voting go more smoothly today. So, we're looking forward to another day of discussions about updates to the Child and Adult Core Sets. Before we begin, I'd like to turn to Shevaun Harris and David Kelley, our two co-chairs, for brief welcome remarks. Shevaun and David.

Thank you, Margo. Just I'll be brief. As Margo said, had a great day yesterday looking forward to today's discussion, I think it'll be just as robust. And yeah, that's it. Thank you.

Morning, everyone. And thanks again for all the hard work yesterday and the perseverance to get through that agenda in a very efficient way and coming up with some, I think, some great recommendations. So put our thinking caps on for today and be ready to cover again a lot of territory so, Margo, back to you. Thanks.

Thanks, Shevaun and David. And as they've mentioned, we have a long agenda today. So, with that, I'd like to turn to the Workgroup member roll call. So next slide, please.

And we will now conduct a roll call of the Workgroup members. We ask that Workgroup members raise their hand when their name is called, and we'll unmute you and you can say hello. After you're done, 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. And just as a reminder, 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.

So, on the next two slides, we've listed the Workgroup members in alphabetical order by their last name. When I call your name, please raise your hand and then we'll unmute you and you can indicate whether you are here and remember to remute, to mute, when you are done. So, we've already heard from Shevaun and David next Richard Antonelli.

I'm here.

Welcome. Lowell Arye.

Hello.

Hi. We can hear you. Tricia Brooks.

Good morning everyone.

Laura Chaise.

Hi, good morning.

Great. Lindsay Cogan. Lindsay you’re on mute.

Good morning this is Lindsay Cogan.

Good morning. And Jim Crall is unable to attend today. Amanda Dumas.

Hi, I'm present.

Good morning. Anne Edwards.

Good morning.

Kim Elliott.

Good morning.

Tricia Elliott.

Good morning.

Karen George.

Good morning.

Morning. Welcome.

Thank you.

Lisa Glenn.

Good morning.

Steve Groff. Steve, are you here? Well, we'll come back to Steve later see if he's arrived. Next slide, please. Tracy Johnson. Tracy, I believe you're unmuted.

Now I'm unmuted, thank you. Tracy Johnson, Colorado Medicaid director.

Thank you. Welcome. Diana Jolles.

Hello, I'm here. Good morning.

Great. And just a reminder, everyone, please lower your hand after you have spoken. And this is going really well today very smooth. David Kroll.

Hi, everyone. Good morning.

Carolyn Langer.

Good morning.

Good morning. Jill Morrow-Gorton.

Good morning, everyone.

Amy Mullins.

I'm here.

Fred Oraene.

Good morning I'm here.

Good morning. Lisa Patton.

Hi everyone.

Sara Salek. Is Sara here?

Good morning, I'm here.

Good. Welcome. Linette Scott.

Hello, I'm here.

Jennifer Tracey.

Good morning.

Michelle Tyra.

Hello, I'm here.

Ann Zerr. Is Ann here?

Good morning.

Morning. Bonnie Zima.

Morning.

Good morning. And has Steve Groff arrived?

I don't believe so, Margo.

Okay, well, we will hope he can join later. Well, thank you Workgroup members for being here. And also, for those of you who tested out the voting this morning, thank you for that as well. Next slide, please.

We're also joined by federal liaisons who are non-voting members. Federal liaisons, if you have questions or contributions during the Workgroup discussion, just raise your hand and we'll unmute you. And I'd also like to acknowledge 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.

Well, before we begin the actual formal discussion of measures, we're going to do another icebreaker like we did yesterday. Before, we thought we would -- it worked so well, we're going to do a Menti Poll, and all attendees are welcome to participate. So, whether you're a Workgroup member, federal liaison, please join in. Dayna, you can go ahead and share the poll. And here's how it works. On your screen, there are instructions to go to www.menti.com and enter the poll number [redacted]. And our poll question for today is what's your favorite flavor of ice cream? And please enter a short

response and press submit. And if you can't pick just one flavor, feel free to enter multiple responses, and watch the screen for real time results of everyone's favorite flavors. Good choices. Just give it a few more seconds. All right, Dayna, can you close out the poll?

Well, it's looking like chocolate, and cookies and cream, and vanilla, we've got some real good flavors here, looking forward to the summer. So, thanks, everyone, for playing along. And now we will go back to the slides. And just to let everyone know, we're planning one more icebreaker for tomorrow, so be thinking about your favorite picnic foods. So now I'd like to turn it over to Dayna Gallagher to lead the discussion of measures in the Care of Acute and Chronic Conditions Domain. Dayna?

Thanks, Margo. And hi everyone. There are currently 11 measures in the Care of Acute and Chronic Conditions Domain, and today we'll be discussing one measure that was suggested for removal and five measures that were suggested for addition to the 2022 Core Sets. And we'll be breaking this up into two discussions today. Next slide.

So, the 2021 Child Core Set contains two measures in this domain, the first is the Asthma Medication Ratio for Ages 5 to 18, and the second is the Ambulatory Care: Emergency Department Visits measure, which is highlighted here as it's suggested for removal this year. The Adult Core Set contains nine measures in this domain, Controlling High Blood Pressure, Comprehensive Diabetes Care, Hemoglobin A1c Poor Control, PQI 01: Diabetes Short Term Complications Admission Rate, PQI 05: COPD or Asthma in Older Adults Admission Rate. Next slide.

We also have PQI 08: Heart Failure Admission Rate, PQI 15: Asthma in Younger Adults Admission Rate, Plan All-Cause Readmissions measure, the Asthma Medication Ratio measure for Ages 19 to 64 and finally, the HIV Viral Load Suppression measure. Next slide.

So, the first measure we'll discuss is the Ambulatory Care: Emergency Department Visits, which has been suggested for removal. NCQA is the steward for this measure, which is not endorsed by NQF. The measure uses administrative data and 47 states reported the measure for FFY 2019. The Workgroup member who suggested this measure for removal noted that the two emergency department follow-up measures suggested within the Behavioral Health Domain for the child age ranges could serve as a substitute for this measure. And as Margo mentioned earlier, both of those measures were recommended by the Workgroup for addition to the Child Core Set yesterday.

The primary reason the Workgroup members suggested the Ambulatory Care ED visits measure for removal was that specific measures around ED use for high cost and highly prevalent conditions are preferred over a general measure of all ED usage. In terms of actionability, they noted that a measure of overall ED use is not particularly useful for quality improvement initiatives. And as a final note, this measure was suggested for retirement by the measure steward for measurement year 2020. The measure was retired from the Medicare and commercial lines of business, but was retained for Medicaid, at least temporarily, because of its inclusion in the Child Core Set. Next slide.

Next up, we have a measure suggested for addition, Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis. This measures the percentage of episodes for

members ages three months and older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event. The measure steward is NCQA, the measure is NQF endorsed, with the caveat that the latest revisions, which expanded the age range to start at three months, are still under consideration for endorsement, the data collection method is administrative. The Workgroup member who suggested this measure indicated that states can and have used this measure to promote appropriate outpatient antibiotic prescribing. They noted that there is significant room for improvement on this measure with a bronchitis diagnosis resulting in antibiotic prescriptions in almost half of adult cases and 60 percent of child cases in Medicaid. The Workgroup member noted that the data should be universally available for states to calculate this measure. Next slide.

Finally, we have the Appropriate Treatment for Upper Respiratory Infection, which measures the percentage of episodes for members three months of age and older with a diagnosis of upper respiratory infection that did not result in an antibiotic dispensing event. The measure steward is NCQA. The measure is NQF endorsed with the same caveat we gave for the bronchitis measure that the expansion of the age range is still under consideration for endorsement. And finally, the data collection method is administrative. The reasons for suggesting this measure are similar to those for the bronchitis measure, including that there is substantial room for improvement on the upper respiratory infection measure. I will also add that one in eight adults has reported a diagnosis of rhinosinusitis in the last year, making it a common condition among Medicaid beneficiaries. Next slide. So, I'll now pass it back to Margo to facilitate the discussion.

Thanks, Dayna. We'd like to start with the Ambulatory ED Visit measure and take some Workgroup member comments or questions about this measure. So, if you have a comment, please raise your hand and we'll call on you in turn. Kim and Linette, you have hands raised, is that from the previous discussion, roll call?

Apologies I hadn't lowered my hand yet. But I can go ahead and comment that the fact that the measure is only being retained by the measure steward for Medicaid means -- does seem like it, it takes it away from the alignment that we've been trying to do with various performance measures, so that does seem like a reason to perhaps remove it. And certainly, whether something's on the Core Set measure set or not, doesn't mean states can't do it. So, I suspect most states are going to be reporting on ED utilization just in the course of things because it's a common utilization measure, as opposed to a performance outcome measure. So, thank you.

Thanks Linette. Lindsay.

I think Linette really covered what I was going to say, in the spirit of really looking close at this sets and understanding that as we add measures we need to look to take away as well. I support the removal of this measure.

Thanks, Lindsay. Jill.

So, I struggle with this. I don't think that this measure is- I don't think that the behavioral health ones replace this measure because behavioral health is excluded from the measure, and perhaps moving to a disease specific measure would be helpful. I struggle

because I think it leaves a gap in looking at urgent care for children, in a group of children for whom urgent care and ED use is often used inappropriately in terms of conditions that maybe could have been seen in another environment. But that said, I agree that if the measure is being retired and removed from the other measure sets that we certainly have to take that into consideration.

Thanks, Jill. Kim, did you have a comment?

No, I did not. Thank you.

Carolyn.

Yeah, I'm kind of torn as Jill is. I agree with Jill, the two follow-up measures are not a complete substitute. On the other hand, I don't believe that the current measure really distinguishes between true ambulatory sensitive or avoidable ED visits, compared to those that are truly medically necessary. So, it's of really limited value in that respect.

Thanks, Carolyn. David Kelley.

I'm also torn with this measure because it is somewhat of a - I'll say a blunt instrument, but it is a useful instrument to look at what's happening within your program especially if there's not good access to ambulatory care and primary care. So, it is a good blunt instrument to measure what's happening within the Medicaid program and we use it and we actually stratify also by race and ethnicity. I think NCQA retired this and replaced it with a risk adjusted measure, I think and I'm just wondering, would it behoove us to keep this for another year and then think in terms of looking at whether or not there is a better measure, that looks at ED across all diagnoses and all age bands, but is I'll say less blunt and risk adjusted that allows -- that's more actionable.

David, you're correct. We have been communicating with NCQA about the future of this measure and potential replacement measures. And there is currently not a plan to test those measures in Medicaid, but it is under consideration. I see that Sepheen has raised her hand. Derek, can you unmute Sepheen?

Actually, Margo I think we want to call on Rachel Harrington.

I don't see Rachel. Oh, there she is. Okay, Rachel -- Derek, can you unmute Rachel and Rachel, you should be able to speak now.

Thank you. Hi, everybody. This is Rachel Harrington from NCQA. So that is correct, the risk adjusted sort of companion to this measure, which is our Emergency Department Utilization measure, uses a similar outcome on the ED side, so they just a non-condition specific emergency department utilization, but it is risk adjusted as David and Margo you mentioned. It is not currently specified for the Medicaid product line, that is something that is under consideration, as you said, and I think it's something we're very sensitive to understanding that this is a potential gap in the measurement space, but we don't have a specific timeline that we can share at this point in time as to when that would be available.

Thank you, Rachel, that's really helpful. Carolyn do you still have a comment or is that your hand raised from before? Okay. Other Workgroup comments? Why don't we move on now to the two Avoidance of Antibiotic Treatment measures and take comments from the Workgroup on these two measures? So just a reminder, one is Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis, and the other is Appropriate Treatment for Upper Respiratory Infection. And both of these have been suggested for addition. Amy Mullins.

Yeah, so in the spirit of alignment, just to know the Avoidance of Antibiotic Treatment for Acute Bronchitis is in the Core Quality Measure Collaborative, ACO PCMH Core Set and the Appropriate Treatment for Upper Respiratory is in the CQMC Pediatric Core Set. So, it would be nice to have these in the Medicaid set as a method of aligning across programs and across Core Sets. So, I would support including these.

Thanks, Amy. Lindsay Cogan.

I've struggled with this one across the set. So what we found in New York, and I don't know if we have any performance data to share, what we found in New York was lots of room for improvement across adult antibiotic use, but in the pediatric space, our performance is very high on the appropriateness of antibiotics. So, I can't remember if this is a lower is better measure, I don't think it is, I think it's reversed to indicate the appropriateness of the antibiotics. So that's where we struggle, whereas we have very good performance in pediatrics, and lots of room for improvement in adults. So, I don't know if we could think about -- I know that we like to have alignment, and it's good to have measures across. But if we could understand if that's -- I don't know if New York State is an outlier, or if others find that as well like, if the performance is very high, I mean, like the high 90s in New York for the children, lots of rooms not anywhere near close to that in adult. So, I don't know if others can add perspective there.

Thanks, Lindsay. Rich Antonelli.

So, Margo, I don't know whether - I'm happy to hold my question, if somebody wanted to respond to Lindsay's query about other experience. I was going to make a point about both measures, but it wasn't going to be based on current state level experience. So, should I proceed, or should I hold?

You should proceed, and others who want to speak to Lindsay's point can just reference Lindsay's point. Thank you. That's great.

Yeah, so the acute bronchitis one is interesting. And for me, and I think as we, Dayna, I think teed it up for us is bringing the age level down, introduces some concerns about whether it's really ready to be out there. For those of you that are not clinicians, bronchitis in children is very ill defined clinically. As an entity, bronchiolitis is much more common under 12 months of age and the need for antibiotics in bronchiolitis is questionable, at best. So, there is some underlying reason to think that there's merit to considering that, however, I would be really interested to hear a little bit about experience in the field. I do have a fair amount of experience with the URI one and for the non-clinical people on the committee, you might think, well, gee, that makes a lot of sense if you don't have a bacterial infection in the upper airway URI, upper respiratory

infection, or a sore throat pharyngitis, if the throat culture didn't reveal a bacteria, strep, for example, why would we use an antibiotic.

But the problem with the measure is that it's not difficult to game, and so there are ways around getting outcomes that obviate the intent of the measure. So, if somebody is coded as a sinus infection, for example, it may actually be an underlying upper respiratory infection, and so just being mindful that the coding issue here could subvert the intent of the measure. So, in general, I'm not a big fan of this measure for that reason.

So Rich, and just to be clear, your comments are about the URI measure and more support for the acute bronchitis measure was that?

Yeah, I'm intrigued by the bronchitis measure, but need to know more about the experience in the younger population, because of some of the questions that I have about the clinical ramifications around diagnosis and treatment. So, I guess I'm saying Margo, I'm on the fence and intrigued, but I need more information on the younger side. And the URI measure I'm not in favor of because it's easy to game.

Okay, that's great. Thank you. Jill.

So, I wanted, Lindsay, your numbers in the 90s is like wonderful for pediatricians, yay. This is an issue that people have been working on for many years to get to right sizing antibiotic use. And so, I mean, I think from a clinical standpoint, and from a sort of country standpoint, this is really an important issue. I understand that you can game it, there are lots of things you can game, but I do think that this is an important thing to measure. I think the two measures are a little bit different because they're measuring different things. I don't know whether just having one would be sufficient for being able to kind of measure antibiotic stewardship and Lindsay, I think that New York's experience is probably not paralleled across the country, although I would not be surprised that pediatrics would perform better than the adults, just because there's been a really big push in pediatrics to avoid unnecessary antibiotic use.

Thanks, Jill. Tracy Johnson.

Tracy Johnson, Colorado Medicaid, I'm also responding to Lindsay's comments and in Colorado, our performance is relatively good on this measure, sort of consistent with the New York experience, so just trying to address her question. Thank you.

Thanks Tracy. David Kelley.

Likewise, just wanted to -- in Pennsylvania, our rates for the pediatric measure have been as high as 91 percent it has slipped a little bit to 89 percent last year. However, and again, I'm an internist, I will say that on the adult side, plenty of room for improvement, we're at 56 percent right now, and had been at 36 percent two years ago, so we've seen some improvement. I'm assuming higher is better, I hope I'm right on that, on the adult one. But there is a, there's a gap in performance and our performance in the pediatric measure because again, I believe my pediatric colleagues and family medicine colleagues have always done a better job than I think internists in being antibiotic stewards. I think it is an important issue though, as we want to prevent ongoing

resistance, antimicrobial resistance, and obviously, don't want to subject kids and adults to unnecessary antibiotics.

Thanks, David. Kim Elliott.

Thank you. The only thing that gives me a little bit of pause on this one is that the measure specifications were recently revised in 2019, so I don't know that we have a lot of comparable data. But we do have, in the revision they did expand the age group down to three months and made it episode-based versus population or member-based as a measure, but we do have three states that are reporting. So, I think that would really be a value add from the perspective adding this particular measure.

Thanks, Kim. And Lindsay, did you want to offer any clarification about what your experience has been in New York?

Oh, I just put it in the Q&A, just to clarify I think I had misspoke, so it was the upper respiratory infection where our rates are in the high 90s not the bronchitis measure, so I just wanted to clarify that because I think I had misspoke and said it backwards. Okay.

Great, thank you. Linette you're next.

Thank you. Yeah. I just want to double check, are both measures being proposed for both child and adults? And then I have a follow-on comment.

Yeah, that's a good question Linette. So, as we've mentioned, during this Workgroup meeting, we do not make recommendations about which Core Set the measures are added to, that is a decision that CMS makes. I think to the point that these measures now start at three months of age, they would span across both Core Sets. I think this conversation will be very helpful to CMS to better understand what the experiences have been between the pediatric experience and also the adult experience, so that could inform a final decision, but when you vote on the measure, we will be voting on the measure for age three months and older, regardless of whether there's a recommendation for it to go for Child or Adult, but this conversation is very, very helpful and I know CMS is listening closely, and would consider that as well in final decisions.

Okay, thank you. That's helpful. Yeah, that's helpful. So, I mean, I guess a couple of comments. I agree with what folks have said about a focus on antibiotics and appropriate use of antibiotics, I think would be a really good addition to the Core Set. It's a struggle often because sometimes parents or people come in, and they're determined that they need an antibiotic, when it's not clinically indicated, so you're balancing your patient satisfaction score against the clinically appropriate treatment. So, having a measure that focuses on the fact that antibiotics are not correct all the time, especially when it's a viral infection, I completely support that. I do wonder though, about having both measures, and I don't necessarily have a sense of which one would be better, and given some of the comments today so far, I'm not sure that's helped me figure out which one would be better. Upper respiratory illness is very general, it is a common diagnosis and yes, definitely, you just change the diagnosis to game it, so to speak. But they're both upper respiratory, they both are commonly virally the URI and the bronchitis/bronchiolitis common viral etiology. So, if they're both going to be running the full age ranges, I would encourage CMS to think about whether or not we need to have

both measures. But I would strongly support having at least one of the measures. Thanks.

Thanks, Linette. Carolyn Langer.

I just wanted to build on one thing that Linette mentioned, she mentioned the pressure when parents come into the office. And I don't have good data on this yet, but I am concerned about with the widespread adoption of telehealth, not just directly with one's own treating providers, but also with the national telehealth vendors, I do wonder if over this past year, we're going to see an increased use -- inappropriate use -- of antibiotics for viral conditions. So that that may also weigh in as Linette was saying to including at least one of these measures and I do think that telehealth is here to stay as well.

Thank you. We still have a bit of time for more Workgroup conversation. I think what I'm hearing is some questions about picking one versus another versus both measures, and so if there are any further comments that might help the Workgroup decide on which of these two measures, both measures, the complementarity of them, that would be great. David, it looks like you have your hand raised David Kelley.

I have again, a technical question around both these specifications and maybe NCQA can answer. So right now, these measures when I was looking at our reporting for HEDIS 2020 measurement year 2019, there wasn't -- these measures didn't go across the entire age band. For measurement year 2020 is that the first year that these are going across all of the age bands for both URI and acute bronchitis, and if so, do we have any idea of how that's going to affect results either in 2020 or moving forward?

Thanks, David. That's a great question Sepheen is that something you can comment on or is there someone else from NCQA that can comment? It looks like Deidre we have you here from NCQA. Derek, can you unmute Deidre? Okay.

Deidre Washington from NCQA. Can you hear me?

Yes, we can. Thank you.

Great. Thank you for the question. So, in response, yes, measurement year 2020 was the year that we expanded the age ranges to make them identical for both measures, whereas prior URI was focused on children and AAB, antibiotics, I'm sorry bronchitis was focused on adults. And as far as how that may impact performance going forward, I'm really not sure I have a good sense of that right now with bringing children and adults into measures where they were not before. It may be that they tend to come down a little bit. Like as people have noted the bronchitis measure has not performed as well as respiratory, so respiratory your numbers may come down, whereas for URI it may go up, but that is just a hypothesis, and I'm not sure we have a good sense of which way that performance will start trending from this point forward. Sepheen, I don't know if you had any thoughts you wanted to add on to that.

Hi, am I unmuted?

Yes, you are.

Great. Thank you. Yeah, I think it's a little hard to say, and as David noted, I think that in addition we changed it to an episode-based measure, so it was member-based prior, we revised it to episode based so that we could target every opportunity there was to ensure that antibiotic stewardship principles can be applied although in testing we didn't see too big of a change between how the two measures were structured. Bronchitis, I think has typically been lower, poorer performer, and we expect that will continue, and somehow, we've been making better headway with the URI measure, so it remains to be seen. I think the telehealth is another good point to bring up and we did make sure that the measures also addressed telehealth settings. So, given the huge increase in that, because of the pandemic, there could be an increase in inappropriate antibiotic use, I know, studies have borne that out and so, we think it's important to keep an eye on this particularly now after the pandemic, or during the pandemic.

Thanks, Sepheen. Lindsay, did you have another comment? Are there any other --

Sorry, that was my hand, my hand was still up, I apologize. I'll take it down.

No problem. Thank you. Are there any other Workgroup member comments? Kim.

I think again, piggybacking on what I said earlier, and then what David Kelley has said, I don't know that it's been tested enough yet in state Medicaid programs, with it being a measure that the new specifications are just being measured for measurement year 2020. So, I'd like to see a little bit more particularly with the pandemic and the addition of telemedicine and telehealth, I think those are pretty important things from a consideration standpoint.

Thanks, Kim. Linette.

Just going back, so it sounds like I mean, historically, I was just looking at the NCQA website around the performance and there's commercial and Medicaid HMO data showing there. So, for the adult with acute bronchitis, those numbers are ranging in the 30 to 40 percent, it looks like generally in terms of performance, whereas the URI in children is up in the 70 to 90 percent. So, from that perspective, the acute bronchitis definitely seems like it has a lot more room for improvement. And I'm kind of echoing David's comment earlier and wanting to make sure I understand sort of that shift to episode-based. I mean, the acute bronchitis, if it's truly acute bronchitis, we're assuming that we would not use antibiotics, so would the goal actually be 100 percent or is this one of those where we would expect it to be 70 to 80 percent type things? So I guess that's sort of another question.

But in any case, in terms of choosing between the two, doing the -- just looking at the historical, the acute bronchitis for adults, so even though the measure has been extended to do a longer age range, if CMS were to choose to apply it to the age range that it has been used in, that would add it to the Core Set, and then they could consider expanding it after the expanded age ranges have had more time to be used or observed with the updated measure specifications, so I just want to put that idea out there. Thanks.

Thanks Linette. Rich Antonelli I saw your hand raised before. Do you have a comment?

No, it was just touched on, so I'm all set.

Okay, very good. Any other Workgroup member comments? And before we move to public comment and voting, any further comments on the Ambulatory Care: Emergency Department Visits measure suggested for removal from the Child Core Set? Okay. Well, Workgroup members, thank you for such a robust conversation. So next slide, please.

Okay. So 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 lower your hand when you're done, and we'll let you know when you've been unmuted. Do we have any public comments? It does not look like we have any public comments, so let's proceed to voting. And now I'm going to turn it over to Alli and Dayna to get us ready for the voting. Thank you.

Great, thank you, Margo. And Dayna will get the vote pulled up.

Yes, one second. Sorry, I'm some having some issues with the platform. There we go. Looks like a couple people have already gotten their votes in.

Great. So, for our first vote the question is, should the Ambulatory Care: Emergency Department Visits measure be removed from the Core Set? And voting is open. If the question does not appear on your page, please refresh your browser.

We're looking for about four more votes. So, we'll hang on for just another moment. Thanks for hanging with us folks. First vote of the day is always hard, but it looks like we do have 28 votes in now, which is correct.

All right, great. And now for the results: 71 percent of Workgroup members voted yes. That does meet the threshold for recommendation. The Ambulatory Care: Emergency Department Visits measure is recommended by the Workgroup for removal from the 2022 Core Set. Next vote.

So, the next question is, should the Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis measure be added to the Core Set? And voting is now open.

We have 25 results we're looking for just three more. Looks like we're missing Karen George's vote. Karen, if you haven't submitted yours through the Q&A, if you could submit that to all panelists. Thank you. Okay. And it looks like all results are in. So, I will go ahead and close.

Okay. And now for the results: 71 percent of Workgroup members voted yes. That does meet the threshold for recommendation. And so, the Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis measure is recommended by the Workgroup for addition to the 2022 Core Set.

And moving on to the next vote. All right. And so, the third vote is, should the Appropriate Treatment for Upper Respiratory Infection measure be added to the Core Set. And voting is open.

Okay. And we have 28 results in I think that's record time. So, thank you everyone.

All right. And now for the results: 54 percent of Workgroup members voted yes. That does not meet the threshold for recommendation. The Appropriate Treatment for Upper Respiratory Infection measure is not recommended by the Workgroup for addition to the 2022 Core Set. Next slide, please.

Okay, thank you so much Dayna and Alli, and thank you Workgroup members, I think we're getting good at this. So now we are ready to take a break, and we're running a little bit early. Why don't we come back at 12:15 from the break? We'll see you at 12:15.

Hello, everyone, and welcome back from the break. I hope everyone had a nice little break. So, we are now moving into the second half of our conversations about Acute and Chronic Conditions measures, and we're going to discuss three medication adherence measures. So now I would like to turn it back to Dayna.

Great, thanks, Margo. Next slide.

So, our first addition is the Proportion of Days Covered: Diabetes All Class measure. This measures the percentage of individuals 18 years and older who met the proportion of days covered threshold of 80 percent for diabetes medications during the measurement year. This is a Pharmacy Quality Alliance measure and is NQF endorsed. The data collection method is administrative. The primary reason the Workgroup member provided for suggesting this measure was that nonadherence to diabetes medications leads to more hospitalizations and an overall cost burden to the health care system. They suggested that adoption of this measure has the potential to drive patient education on the importance of adherence at the health plan, pharmacy, and provider levels, and noted that this measure has demonstrated its effectiveness in the Medicare Part D Star Ratings program. Additionally, adherence rates for diabetes medications are lower in Medicaid compared to the Medicare population. Next slide.

Next up, we have the Proportion of Days Covered: Renin Angiotensin System Antagonists. This measures the percentage of individuals 18 years and older who met the proportions of days covered threshold of 80 percent for renin angiotensin system antagonists during the measurement year. This measure is specified similarly to the previous PDC measure, and is suggested for the same reasons, namely with the intent of using this measure to track and drive quality improvement efforts with adherence to hypertension medications. Next slide.

And finally, we have the Proportion of Days Covered: Statins measure, which is also suggested for addition. This measures the percentage of individuals 18 years or older who met the proportions of days covered thresholds of 80 percent for statins during the measurement year. Again, this is specified the same as the other PDC measures, but with a focus on medication adherence to statins for addressing high cholesterol. High cholesterol along with hypertension and diabetes are all high prevalence conditions within the adult Medicaid population. So now I'll pass back to Margo for the discussion.

Great, thanks, Dayna. So now I'd like to open it up to Workgroup members. I see Lisa Glenn, you're up.

Good morning. So, two questions. These three measures, just measure whether somebody picks up the medicine at the pharmacy, and not necessarily whether this was an appropriate medication for the person to be on, yes or no. And then with the diabetes medication an explanation of why insulin is excluded. Thank you.

Thanks, Lisa. I want to check whether we have anyone from the measure steward? Ben Shirley, Derek, please make sure that Ben is unmuted. And Ben you can speak.

Hey, can you hear me, all right?

We can, thank you.

Great, thank you. Yes. So, to the first question, that is correct, the day supplied field on claims is used to determine whether or not the patient picked up the medication. But using administrative claims, it's not possible to determine directly whether the patient took it, and also these measures do not sort of look at the appropriateness necessarily of the medication for a given patient. To the point of insulin, so individuals on insulin are excluded from the diabetes rate primarily because insulin requires titration and frequent dosage adjustments, which in turn can result in sort of frequent dosage adjustments to other diabetes medications. So, addressing adherence, or persistent to insulin itself, is quite complex since the day supplied field in claims is typically less reliable for injectables as opposed to oral products. To that sort of point PQA actually developed recently a separate measure for persistence to insulin that uses a more sort of complex empirical methodology, but that sort of is captured separately from this more broad oral diabetes measure.

Thank you so much, Ben. Lisa, did that answer your questions?

Yes, it confirmed what I thought I was reading. Thank you very much.

Sure. Shevaun, your turn.

Thank you, Margo. So, with the Proportion of Days covered for the Diabetes All Class. Can anyone just speak to how we see this needing to be added considering we have the Comprehensive Diabetes Care measures, which within that set includes more outcome-focused measures?

That's a great question Shevaun. Ultimately, that would be up to CMS to decide, I think the question before the Workgroup would be whether these are complementary measures, whether having both measures are value add, so I would turn to the Workgroup to talk to that.

Yeah, sorry. I was asking if anyone had for the person that maybe recommended this if they had any thoughts about how they -- why they maybe thought it needed to be supplemental to what is already on the Core Set.

Sure. Thanks, Shevaun. Michelle, are you here? Would you like to speak to that?

Yes. So, I notice that the measure of the diabetes measure that's already part of the Core Set it's also already included in the HIX [Health Insurance Exchange] Quality

Rating System. So, they have both measures together, the Proportion of Days Covered measure along with the diabetes measure, so they're complementing each other. That's really all I can speak to that.

Thanks, Michelle. Shevaun, did you want to ask any further clarifying questions or make any comments?

No, I'm okay. Thank you.

Linette.

Hi, I mean, maybe just on the previous item that was being talked about, and in terms of what we have for diabetes in the Core Set, we have a focus on the poor control measure, and then the Short-Term Complications Admission Rate. So we had previously had the hemoglobin A1c testing, as well as then the poor control measure and a couple years ago, I think the group suggested removing the testing measure and keeping the poor control measure, because the testing was a process measure, as opposed to the poor control being an outcome measure. So, trying to follow the direction that CMS has said in terms of moving towards outcome measures where they're available as opposed to the process measures. So, from that perspective, the medication piece also seems somewhat like a process measure, as opposed to the diabetes care measure that we have on the Core Set related to poor control, which is trying to focus more on the outcome. So, I guess that's just a general comment.

The question I had, because I'm trying to remember, and I don't, I'm hoping somebody else will, so we had - previously had had a set of measures, Annual Monitoring for Patients on Persistent Medications, which was the NCQA measure. And then these three measures are the PQA measures, but it seems really similar to me, and I don't remember why we removed the Annual Monitoring for Patients on Persistent Medications and I don't know whether somebody remembers that. And then two, I'm hoping we can have a discussion as to why we removed that versus why we now need to add this very similar measure back in. Hopefully that makes sense.

Thanks Linette. Other Workgroup members? Lindsay.

The Annual Monitoring for Patients on Persistent Medications was a little bit different than this one. This is really a medication adherence measure that's being proposed. The annual monitoring for medications really, we took that out because it topped out, it was incredibly high. Again, high 90s and across the board there wasn't a lot of room for improvement. There's definitely room for improvement in these measures, but I echo what Linette has brought up, especially in diabetes, we have quite a bit of the real estate already focused on diabetes. I'm not a clinician, so I can't speak to the benefits of adding something around cardiovascular disease. Remind me again, which I always get confused about which measures we're on here. We looked at the diabetes.

There's hypertension.

And then the other two are hypertension and cholesterol.

Yeah.

Okay. Yeah. So, we do have an outcome measure already related to hypertension, we have Controlling High Blood Pressure, so I think, again, in the spirit of moving towards more outcome-based measures, that was where we wanted to look. And then I don't know if anyone with more of a clinical background can speak to sort of the merits of having an additional measure related to med adherence around cardiovascular diseases. But I do echo that we really need a strong rationale as to why we would continue to put in more process measures when we already have sort of the gold standard outcome-based measure on the Core Set.

Thanks Lindsay, Michelle Tyra.

Hi yes, I want to add to it. So, I proposed these measures, these are outcomes-based measures and looking at the data, so I work for a PBM OptumRx, and we're tracking these medication adherence measures for multiple lines of business, Medicare, Medicaid, and even HIX. And what I've seen over the years is that the adherence rates for our Medicare line of business are increasing year over year, because they've implemented multiple strategies, initiatives to improve adherence rates that includes member education, why it's important to take your medications as prescribed, refill reminder programs, whether that's through text or email, or phone calls, even prescriber education. They are sending members who are not adherent, they're sending a list of patients to those prescribers, informing them that your patient is not taking their medication as prescribed. It's an educational tool, so the prescriber can hopefully reach out to their patient and talk to them about the importance of taking this medication, and why it's important down the road to decrease mortality and morbidity.

But anyway, going back to reporting with our Medicare line of business, the adherence rates are in the high 80s for all three medication adherence measures, and for Medicaid, it's in the mid-60s, so there's definitely room for improvement when it comes to medication adherence for both diabetes, hypertension, and statins.

Thanks, Michelle. Ann Zerr.

It's very important, but I would also have to agree with my colleagues that we have true outcome measures, and that is much better. And I think to the point where insulin is not included, because it's adjusted frequently, I adjust other oral and injected diabetes medications and hypertension medicines all the time. And so, I think that the medication adherence is complementary to achieving outcomes, but the medication adherence is not the outcome, particularly not the medication fills.

Thanks, Ann. Amy.

Yeah, I would agree with that. And also when I prescribe medication sometimes, especially to the Medicaid population, in order for them to be able to afford all their medications, I would sometimes say what I'll do is I'll give you a pill that's twice the dose you need and you can break it in half, and that will last you twice as long as you need it. And so the fill rate on that prescription would not necessarily meet the criteria for this measure, and so I think that that happens a lot, and I did that a lot, especially on the statin medications and the blood pressure medications. And I don't think that that's a true

representation of who's taking them. I think filling a prescription isn't necessarily, regardless of that, a true representation of who's taking the medication anyway.

Thanks, Amy. Rich Antonelli.

Yes, thank you, I wanted to weigh in as well. I see these as process measures, but something that really caught my eye and in reviewing the measures, the fact that they've done some testing to stratify in Medicaid beneficiaries with serious mental illness in 14 states, and Margo, I'm very mindful that you told me we'll revisit that cross cutting discussion on day three. But really for me to be thinking about this in a meaningful way, there may actually be implications around equity, and access across race, ethnicity, language, and disability status, so kudos on that. But in general, I'm not sure how I see this would be supplanting anything that's already there, because they really seem more process than outcome to me.

Thanks, Rich. Jill.

I'd like to echo that I think these feel very process-oriented, and just because somebody fills a medication and takes it doesn't mean that it's working to treat their condition or for prevention. And just to get to kind of how you practice in the real world, especially with a population where they may have copays and whatnot, as small as they may be, even a dollar copay, if you take 20 medications is 20 bucks a month, and for some people, that's a lot, so absolutely doing things like giving bigger tablets and splitting them or that kind of thing, and as well, people juggle things to be able to afford to eat and pay their rent and take their meds. And I don't know that this really measures are they taking their meds? And are they getting the benefit from it? There are often frequent changes, and it's not just changing dose in the same medication. So, it's moving from one class of drugs to another that sort of thing, which again, is going to interfere with being able to measure this.

Thanks, Jill. Ben, do you have a clarifying comment about the measure specifications? Okay, Kim Elliott, you're next.

I particularly do like the statins measure, because it's for the general population for people with high cholesterol, which is a good portion of the Medicaid population. But also, because you can do a little bit more focused on individuals with behavioral health conditions so for that reason alone, I think it's a really good general measure, even though it is a process measure.

Thanks Kim. Other comments from Workgroup members? And remember, you can unmute yourself. Are there any comments, like following up on Kim's comment about the relative merits of these three measures? Jill.

Yeah, Kim, I think that's a really good point, and I was sort of thinking about these all three together, but we clearly have the end measurement, at least some end measurement, for diabetes and for hypertension. But you're right we don't have for treatment of high cholesterol, and this is in fact a huge issue especially for people with behavioral health problems on antipsychotics and yeah, maybe this one deserves sort of a separate consideration in terms of thinking about it.

Thanks, Jill. David Kelley.

I think there are other measures. When you look at the cholesterol-related measure, I don't think, at least as I'm reading it, it's not as pinpointed to any various conditions, and I think there are other pinpointed measures from other stewards that I'll say focus on individuals that may be on let's say, antipsychotic medications, and so there are other pinpointed measures, none of which have been recommended for addition, but there are those more pinpointed measures that are potentially available. So it is, that one measure there is a little bit of a gap there, but I think, again, there may be others in the future that might be more pinpointed to our purposes, and more specific to certain populations or pinpointed to certain conditions, clinical conditions.

Thanks, David. Rich, do you have another comment or is your hand raised from before?

Sorry, I was a laggard.

Okay. Other comments from Workgroup members? All right. Well, I think at this point, we can turn to public comment. Next slide, please.

So now we'd like to provide an opportunity for public comment. If you'd like to make a comment, use the raise hand feature, and we'll call on you and then lower your hand when you're done. I think Ifeoma you might have a comment. Derek, can you unmute Ifeoma. I think we can hear you Ifeoma.

Okay, thank you, Margo. I was trying to find how to raise my hand. Even though I'm from the Connecticut Department of Social Services, I want to just speak as the public, as a patient. I think that with the diabetes measure for monitoring the medication adherence, that would kind of detract from the way it is going now that managing diabetes by lifestyle changes is actually working for a lot of people who have diabetes type two. So, I don't know if it can be modified to clearly spell out which group because it might affect providers in managing diabetes type two through lifestyle changes. And I think that's very important because if a medication can be avoided, I think it should be avoided and focus the main lifestyle changes that actually promote diabetes control that you control. Thank you.

Thank you, Ifeoma. Other public comment? Remember to please raise your hand if you have a comment. All right. With that, I think we are ready to move toward voting. So, I will turn it over to Alli and Dayna to manage the voting. Next slide.

All right, great. Thank you, Margo. We'll get the votes up on the screen. Great. So, the first question we'll vote on is should the Proportion of Days Covered: Diabetes All Class measure be added to the Core Set? And voting is now open, if the question does not appear on your voting page, please refresh your browser.

We're waiting on just one more vote. Okay. And I'm seeing 28. So, I will go ahead and close the poll and share the responses.

All right. Thank you. And so, for the results: 7 percent of Workgroup members voted yes, and that does not reach the threshold for recommendation. So, the Proportion of Days

Covered: Diabetes All Class measure is not recommended by the Workgroup for addition to the Core Set. Next slide.

So, the next question is, should the Proportion of Days Covered: Renin Angiotensin System Antagonists measure be added to the Core Set? And voting is now open.

Okay. It looks like everyone's in.

All right. Great. And so, for the results: 7 percent of Workgroup members voted yes, and that does not meet the threshold for recommendation. The Proportion of Days Covered: Renin Angiotensin System Antagonists measure is not recommended by the Workgroup for addition to the 2022 Core Set. Next measure.

Right. So, the question is, should the Proportion of Days Covered: Statins measure be added to the Core Set? Voting is now open.

Okay. Everyone’s in. Thank you. That was fast.

And so, the results are that 18 percent of Workgroup members voted yes. Again, that does not meet the threshold for recommendation. The Proportion of Days Covered: Statins measure is not recommended by the Workgroup for addition to the 2022 Core Set.

And now I will turn it back to Margo to facilitate a discussion of gaps in the Care of Acute and Chronic Conditions Domain.

Great. Thank you, Alli and Dayna and thank you Workgroup members. I think we're getting really good at this now, getting the hang of it. So just to recap on the measures that we just reviewed. There were six measures, and actually five measures six measures sorry, and two of them were recommended by the Workgroup, one measure recommended for removal Ambulatory Care: Emergency Department Visits, the AMB measure in the Child Core Set, and one measure recommended for addition, Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis. And then four measures were not recommended for addition. So, with that, we are ready to talk about gap areas. And we'd like to hear from Workgroup members about possible gaps in the Care of Acute and Chronic Conditions Domain. What suggestions does the Workgroup have 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 gap, or would a new measure need to be developed? So, with that, I'd like to open it up for Workgroup members. Rich.

Yeah, thanks, Margo. I was sort of reflect that, but I really want to make a broad statement here. To the extent that we know that there are likely disparities by race, ethnicity, language, disability status, it's so important that we send a clarion message across measure stewards, measure developers, systems, health care providers, Medicaid agencies, and the like, that it would be really nice, especially if we're thinking -- if we're adding to the Core Set, to be able to get a sense for what the testing showed along, RELD lines. Each time we promote a measure and don't have an explicit conversation about was it tested for RELD; I almost feel like we're contributing to an ongoing issue. So I'm just sort of making that broad statement, this is not specific to

acute and chronic domains, it's certainly not specific to behavioral health, or even to social determinants, but I would love to be able to have a standard component of our review, Margo, include has it been tested across those stratifications. And just to be clear, I recognize what it takes to develop risk adjusted measures, but I'm still very much in this space looking nationally that even just looking at stratification, and the implications there too is really important. So that's my comment. Thank you.

Thanks, Rich, that's great. And in fact, the criteria that we indicate for actionability and strategic priority, do reflect an interest in having measures that can allow for comparative analyses. And so, I think it's great that you keep bringing this up, and that you really are heightening that as a conversation cross cutting across all the domains. And I think we can talk more about that, like we said tomorrow, but please do keep bringing it up, and we can talk more tomorrow as well. Kim.

Just to add to what Rich said, when we're thinking about the stratifications, we do need to start keeping in mind the LTSS population as well. I know there are many other issues with that population, other care needs that we need to measure. But focusing still on chronic conditions and acute conditions is important for that stratification of population as well to keep them in the healthiest and most productive manner possible.

Thanks, Kim. Other Workgroup members? Jill.

So, I applaud both of those recommendations. My thoughts are a little more pedantic since that's already been said. I do think that we have a bit of a gap in terms of acute care for children in not having an ED measurement, or potentially not having an ED measurement and potentially there not being a sort of an up to date one. So, I would put out there that we really do need to measure that for this population, so we get a sense of the quality of care in EDs, and also the access to primary care and outpatient care outside of EDs for less urgent conditions.

Thanks, Jill. David Kelley.

Thanks. Again, I think our discussion around the emergency department measure does show that there is a gap and there may be some, as Jill mentioned, for both kids and adults, really an opportunity to have measure stewards work on let's say, either a risk-adjusted ED visit. I know that there's been a fair amount of publications around what's called low-acuity non-emergent visits, and we use that in Pennsylvania with our plans. That looks at what I'll call less than appropriate ED utilization and how to reduce that. So, I know in other lines of business, there are more sophisticated, risk-adjusted measures, and I don't understand why we wouldn't do that in Medicaid.

It took a while for a risk-adjusted Medicaid readmission measure to hit and be used widespread. So I think that's something that we really need to look at is getting a risk-adjusted ED visit or if we want to even drill down more to some sub populations, or conditions, we certainly could, but I see that as a gap in what's happening. I think it is important as a Medicaid program to look at what is happening in the ED, because that may tell you there are problems elsewhere in your program with access to care.

Thanks, David. Linette.

Hi, I'm wondering, especially for the children population, whether I don't know, I was just looking at some measure related to injury. So, when we think about common morbidity in children, there's things we have covered - asthma, infectious disease, we have a lot of stuff under the preventive category - but in terms of injury, and injury prevention, and mitigation, we don't really have something for that. I wonder if that would fit in this category. And I don't know that there's a specific measure, but kind of picking up a little bit on what David was just saying, ED is one way of trying to get at that, but a lot of urgent care goes to primary care or goes to other places. And so, it seems like that's a gap in general, and it may be that there's just a gap in measures available, you know there's more measures of mortality than morbidity, but for childhood issues, injury is a significant one.

Linette, that's a really good point. I think one of the things that when we think about a fit for the Core Sets, we think about what's within the influence of Medicaid programs to prevent or treat or mitigate. And so, I think something I'd open up to the group is where does Medicaid fit in injury prevention?

So, I would piggyback on that and say that, I think, certainly in California and a variety of other Medicaid probably focus on adverse childhood events, how do we intervene in that respect? Thinking about whole person care, what are all of the things that contribute to a person's well-being? I think there's a number of ways in which our Medicaid programs are definitely moving into that space and have been. So, an alternative to an injury measure would be looking at an adverse childhood events measure of some sort. So, I would say that it ties to what we're doing in Medicaid. But I'd love to hear what other people think. Thanks.

Thanks, Linette. Tracy Johnson.

Yes, hi, this is Tracy Johnson, Medicaid Director in Colorado. I just want to underline the several comments around an ED measure that is risk stratified and perhaps more targeted., I don't really have anything new to say except to just underline those points.

Thank you. Rich Antonelli.

Thank you, Margo, for giving me a second chance in the batter's box. Linette, pretty much everything you say I always do a fist bump on this end here in Boston thank you and I really want us to think about the gap about Medicaid, the social aspects, and if we're going to stick in a space with pediatrics, recognize that some really important events and activities, whether it's ACEs or health-related social needs, those data flow to other places. And so, I would like to call out that there is not just a conceptual gap around what's the measure, but in fact, getting things right around where does the data flow? And I know, we're going to be debating, the hearing, screening, and follow up measure during this review conference, but I think there are some really important issues that it's not that we're missing a measure, it's that we're missing a methodology. And so, for child health writ large, we really have to be thinking about that. So my comment, Margo, has to do with from whence the data is drawn, and that's how I would sort of add to what Linette pointed out.

Thanks, Rich. Anne Edwards.

Thanks, I'm going after Rich and he took some of my comments to kind of say I think it's a really interesting discussion and concept to think about how do we understand that that the whole child or whole person and follow those data elements. When you look at, chronic conditions for children and the numbers, it does get complicated in that space especially. I'm intrigued by the injury challenge there and trying to think through that, as well and what role Medicaid has or does not have in that space. The other thing just made me to -- this is maybe just stretching a little bit on what to add to the concept because this theme came up earlier in the discussion, we talked about ED utilization. Individuals raised telehealth, and I think as we kind of look forward and help people intersect with health care and access to health care, and what that looks like, I don't know if COVID-19 has changed that or not, or if it will continue to impact that, whether or not it's actually performance on measures or utilization, and how that actually may create disparities. But just to add that into the mix as we continue to kind of look at these measures as well.

Thank you. Lisa Patton.

Yeah, I wanted to add my virtual fist bump to Linette and Rich and the previous speaker. Part of the concern we've been having is around potentially, or in some cases documented, rates of increases in interpersonal violence. So, in terms of the child injuries, I think that's a critical piece to look at in the ER context, but also interpersonal violence across the age spectrum. And part of what we know is that telehealth can be both a blessing and a curse in these issues because if somebody is coming on for a respiratory infection, you may not notice some signs of violence that are happening or some injuries in that respect. And so, just to note that, I think this is a very important space for us to be thinking about, and sort of how care may have changed during COVID, and even potential for diagnosis and sort of that whole person looking at different aspects that we can touch with some of the messaging of our measures and where we'd like to go in the future.

Thank you. Jill.

So, I have another thought related to that, and then something related to the other measures. This may be an opportunity for Medicaid to partner with some of the other state entities, national entities that look to child welfare, and to kind of think about it as what's good for kids. I actually think the concept of domestic violence in the broad sense of thinking about not just child abuse, child neglect, but spousal abuse and sort of abusive families is a really important aspect that I don't know that we measure, but it has an incredible impact on people's lives, and it also has an incredible impact on their utilization of health care. So, I think that those concepts are really important ones.

I'd like us to sort of think a little more about sort of chronic diseases and treatment of chronic diseases, and it seems like measures are individual condition, individual condition, individual condition, although there are similarities in terms of how one treats conditions, not using the same medications or doing the same labs or anything like that. But just wondering if rather than sort of measures for each individual condition, is there a way to measure how well, in general, chronic conditions are being treated and whether that's medication adherence gives you a little piece of it, although it doesn't necessarily give you whether they're treated well or not, but thinking about is there a more global measure that would get us there, rather than kind of each individual condition. Because

the common conditions will always appear, but there will be other conditions that may not be uncommon, but are not common enough to sort of rise to the top, but the way you think about them and treating them is the same, because they're a chronic condition. I'm just wondering if we should be thinking about a more global measure for treatment of chronic conditions.

Thank you. Tricia Brooks.

Yes, thank you. I just want to raise up one of the things that concerns me about quality measurement in Medicaid is the churn. And we know that people who don't have the periods of continuous eligibility are not included in the quality measure, so they're not necessarily distorting it, but it really interferes with the ability of the Medicaid program to improve health. And we had looked at one measure of continuity of coverage a couple of years ago that didn't gain approval. I think this is an area where I would encourage measure developers to be looking. I think this is much more meaningful for the Medicaid population than other coverage groups. And while I have the floor, I just yesterday, I was having difficulty figuring out how to raise my hand, but I want to echo comments that were previously made about social determinants and ACEs and trauma those are all areas, I think that we need to do more in. Thank you.

Thanks, Tricia. And we're glad you're able to raise your hand today. Other Workgroup member comments? As we've mentioned, we'll have more time to come back and talk about gaps tomorrow. So, with that, if there are no more Workgroup member comments, let's take a break. And we're going to give you a nice long break, and we're going to get back on schedule and resume at 1:40 Eastern, so that's around a 40-minute break. And we will resume with the Long-Term Services and Supports Domain conversation. So, enjoy your time off and take a walk and have lunch, and we'll talk to you soon.

Hi, everyone, and welcome back from the break. I hope everyone had a nice time off. We are now getting ready to proceed with the conversation about the Long-Term Services and Supports, or LTSS, Domain. Before we start, I just wanted to make one point Workgroup members and members of the public that are attending. We do not have a public Q&A or chat function. This is a public meeting, and we would like all Workgroup members and members of the public to make their comments verbally during the meeting. So please feel free to raise your hand and we have plenty of time. As you can tell, we've been running a little bit ahead of schedule the last couple days. So please feel free to make your comments public and we look forward to hearing from you. So, with that I will turn it over to Tricia Rowan to take us through the LTSS Domain. Tricia.

Thanks Margo. So now as Margo said, we'll be discussing the Long-Term Services and Supports, or LTSS, Domain. There is one LTSS measure in the current Core Set, and one measure has been suggested for addition, which we'll discuss. Next slide.

The LTSS measure in the 2021 Adult Core Set is the National Core Indicators Survey or NCI, the NCI measure was added to the Core Set for FFY 2020. Next slide.

One LTSS measure has been suggested for addition to the 2022 Core Set, the LTSS Comprehensive Care Plan and Update measure. This measure assesses the percentage of individuals receiving long-term services and supports who have documentation of a comprehensive care plan within a specified time frame. This is an

NCQA measure that is not NQF endorsed. The measure is calculated using case management records and as noted on this slide, the review is based on a review of records drawn from a systematic sample with a minimum sample size of 96 beneficiaries. Next slide.

Two rates are reported for this measure as documented on the slide, one assessing the documentation of nine core elements in the care plan, and the second assessing documentation of at least four supplemental elements. Care plans can be discussed either during face-to-face, telephone, or video conference encounters. The care plan must be completed within a specified timeframe that varies for new and established members. Next slide.

This slide contains the list of core elements that must be included in the care plan. In order to be numerator compliant, all nine of these elements must be included in the care plan. Next slide.

This slide lists the supplemental elements that can be included in the care plan to be numerator compliant with the supplemental elements rate, and for this rate, at least four of the supplemental elements must be included in the care plan. The measure is currently being used in several states, including Pennsylvania and Florida. The Workgroup member who suggested the measure noted that there are no LTSS measures in the Core Set that measure quality of care management, and that this measure addresses whether beneficiaries are engaged in a care planning process that incorporates person-centered principles, and looks at all of their needs, including physical, behavioral, functional, and social.

Because this is a relatively new measure, the Workgroup member suggested that technical assistance may be needed to ensure consistency of measurement, and to help states aggregate data across plans and other entities to report at the state level. We wanted to mention that there is a similar version of this measure included in CMS's Request for Information for a recommended measure set for Medicaid-funded home- and community-based services. NCQA adapted the CMS version of the measure for inclusion in HEDIS. NCQA has indicated that this measure can be used in both managed LTSS and fee-for-service systems. The measure specifications refer to LTSS organizations to denote the broader applicability of this measure. Next slide. So now I will pass back to Margo to facilitate a Workgroup member discussion.

Thanks, Tricia. We now invite Workgroup members to raise their hand and participate in the discussion. Tracy and Tricia, I see you still have your hands raised are those new comments or from previous? All right. Jill Morrow-Gorton.

So, we use this measure. I think they are a lot of work, so this one and the assessment one, because there are a lot of pieces that have to happen. But I think in particular the care plan, I'm putting that in quotes, you all can't see that, or what I've thought about things more being a person-centered service or supports plan, I think that this gets to the elements that are used across home and community-based services, but also sort of across all LTSS in some manner or another. . People talk about behavioral health, behavioral health is usually part of someone's plan, even if you're not providing those services. I know that the people that I work with like this measure, as a way to sort of look at quality in a more standard fashion and given that there are not a lot of real LTSS

quality measures out there, this one, I think people like this one, despite the amount of work that it is to do.

Thanks Jill. Lisa.

Hi. So, we've been doing the NCI measures. We only do them in Texas every other year, so we've been doing those for a good number of years and have good response or experience up here, the things that they measure. We are working on implementing this measure in Texas. We have both fee-for-service and managed care LTSS waivers that are in Texas, we have a lot of them, we have like seven total but our area that's working on pulling out the pieces to look at this measure are very encouraged. We also have a lot of stakeholder requests for us to be looking at, especially in the managed care sites, are the MCOs really doing what they're supposed to be doing around developing a plan, making it person-centered, all those kinds of things that this would measure. I just want to say that I support this as closing a gap that we have.

Thank you, Lisa. Laura Chaise. Laura, you are muted. There you go.

Oh, there we go. Thank you. I was hoping you guys would unmute me. Thanks. Okay. So, a few things. So, agree with the points made. If we really zoom out here, and I know, those of us who've been on the Workgroup for multiple years, we've had a really robust conversation about LTSS each year. I think zooming out, right, LTSS is about a third of all Medicaid spend, and to speak very candidly, the care planning process is literally where like the Medicaid checkbook is open, right. And so if what we want to do is make sure that people are getting the services that they need in a cost effective manner, and taking into account what those people's needs are, and how to keep them in place, in their home or in their setting of their choosing. I mean, I think a measure of care planning is really a core measure for this program.

And I think it pairs nicely with the member experience measure, as an opportunity to get farther upstream to figure out sort of what could be going well, or not going well, in the process of care management. I like that this one does work across both managed care and fee-for-service. It is hard, it is a hard measure. As a managed care entity, I can say it's not easy for us to figure out how to report and track this, but I think it's worth the effort. And I think to the extent that states have difficulty or plans have difficulty reporting on this, I think that then can open up some really productive questions about whether there are improvement opportunities within a state's care management infrastructure, or whether there are gaps in the elements of that service or care plan that that state is using.

And then lastly, folks may have seen in the measure information sheet, there's a citation for a study around person-centered planning and talks about some equity issues with regard to different LTSS populations who don't feel like they're getting a person-centered experience. And so I think that this, while the measure is not necessarily stratified again, I think that's an important area to drill down in terms of starting from whether the processes is working and measurable, and then be able to drill down to what elements of the process are not working for different populations.

Thank you so much, Laura. We have a request that, Lisa Glenn, it was a little hard to hear you. I would like to request that if you could repeat what you said before, and

maybe get closer to your speaker or move your headset closer we'd appreciate and I'm sorry to do this, but it was a little hard to hear.

That's okay. I'll speak a little louder because I tend to not speak very loudly. I'll try to remember what I said. Texas has been reporting the NCI measures for a while. We report them every couple of years. And we see this -- I see this as a compliment to both measures. We are working on implementing this for ourselves in Texas right now, and our quality area feels very strongly that this is a good way to go. We have both fee-for-service and managed care waivers, implementation of these waivers in Texas, and our stakeholders in Texas are always asking us how are we measuring that the managed care organizations are doing a good job to write good plans, to make sure they're implemented, and do it in a person-centered way. I think that's it. Thank you.

Thank you so much. Kim Elliott, you're next.

Thank you, Margo. We have really been challenged over the last several years in finding really good long-term services and supports measures, and this is one that crosses and checks a lot of boxes for us as a committee to find measures that will represent the long-term services and supports programs. What I really like about it from a quality perspective it really does strengthen the person and family engagement aspects of care, and there are so many opportunities to really improve care and outcomes for LTSS members by simply measuring the types of things that this particular measure does include. So, I think that this is an opportunity where we can have not only a good measure for LTSS, but a really good opportunity to improve care and service delivery and outcomes for those enrolled in LTSS. It's not a perfect measure, but it does have all of the core components, and will also help with implementation and measuring the HCBS rule as well. So, I think it crosses many different things that are really important to a Medicaid program, particularly those with HCBS waivers.

Thank you. Lowell, you're next.

Thank you, I don't want to repeat what's already been said. So, I really just want to say thank you to everybody for saying all that. I do want to just, in case anybody has any questions, even before managed care in HCBS waivers absolutely, this is required by State Units on Aging as well as the disability folks and then to the care management organizations. So, this can be utilized in any situation whatsoever under either managed care or fee-for-service. And other than that, I just want to say that I would love to see another measurement for LTSS. Thank you.

Thanks Lowell. Rich Antonelli.

Yeah, thank you. Just a couple of observations on this, this care plan measure is, one could argue, it's a structural measure, but I want us to think about it as a process. It's easy to think about paying for a thing, and the thing is the outcome. But after literally listening to families for decades, and both with children, youth, young adults, and adults with complex needs with pediatric onset, families like having a roadmap from point A to point B that is multidisciplinary, touches each of the domains of what is their health, not just their medical management. So, the concept of this is really, really important, but I do really want to point out that it would be -- we would be -- I think under-serving our LTSS fellow men, women, as well as children and families, if this simply turns into a check box

opportunity. So, a care plan measure that is coupled with a patient-reported experience measure is a powerful combination, so I do feel strongly that the single measure on LTSS that's in the Core Set now is absolutely not sufficient. Adding this one in but capturing the outcome of this, and the outcome here isn't, does a care plan exist? The outcome could be captured with a prompt in the space of, were you fully engaged, were your goals prioritized, did you achieve your goals, etc.? So, I just want to call that out. I think that there is enough in the bones of this measure to move us forward, but I for one won't feel like we've really achieved victory for our LTSS colleagues until we've got the ability to say, so what are the impacts?

Thanks Rich. Tracy Johnson.

Hi, thank you, Tracy Johnson, Medicaid Director in Colorado. We too are very interested in this measure and echo all the sentiments voiced by others. The unique thing I'd like to add is that it will be important to get additional guidance from CMS on what exactly are these core elements and supplemental elements, both to avoid the check the box concern voiced by the prior speaker, but also to ensure comparability across states. So just really, underline that additional information would be really helpful. The other reason it would be helpful is to make sure assessment tools are collecting the information that would need to be reported on this measure, so just ask that for your consideration.

Thank you. That's helpful. David Kelley.

Thanks, and appreciate the conversation. I do support this measure. We use it in our managed care program. We know that there are some challenges. I think NCQA reduced the number of individuals that need to be, I guess, in the denominator, because there were issues around the collective information gathering that’s required. To Rich's point, I believe, I think it is important to also capture the participant’s experience and one of the questions that we, in our program, use is the home and community-based CAHPS. There is a question that's very specific about whether or not your person-centered plan is meeting your needs, and we look at that very carefully in conjunction with this particular measure. So, I think this is a gap that needs to be filled, and even though it is somewhat of a process measure, it's an extensive process measure, and is very close to kind of the waiver assurances that CMS has required even before managed care. Thanks.

Thanks, David. Linette.

Thanks, I think I have a logistic sort of question. So, in looking at the description, it is a sampling methodology, so in the description, it says that the minimum required sample size is 96 members, but it also looks like it was structured around health plans. So, I was just wondering, in terms of trying to get a sense of the workload associated with the measure. How does that then apply? So, if we have 26 plans is it 96 people per plan? Is fee-for-service treated as another plan? How do we deal with all of that, and I guess I raise this partly for CMS that if they move forward with this, then there's probably a lot of technical assistance that would need to be understood around how to deal with that, and to make sure it's truly a representative sample size.

The other thing I would flag around all of these measures that have these sampling conditions is that folks have been bringing up various kinds of demographic

stratifications, race, ethnicity, and others, which absolutely agree is important for looking at equity and disparity. The challenge though, on some of the surveys is if you don't have a high enough sample size, you just can't do that because you lose representativeness when you get into that. So, I would be interested if somebody could talk a little bit more about the logistics of what this measure would mean from an implementation perspective. Thanks.

Thanks Linette. Do we have anyone from NCQA? Sepheen, is there anyone on that can speak to this? Derek, can you unmute Lindsay Roth, please?

Hey, are you able to hear me?

We can, thanks.

Okay, great. Thanks. So, I can respond to the question and just clarify some things around the sampling for this measure. So, for HEDIS measures, we do typically require a sample size of 411 members for reporting measures that use sampling, because this number allows us to make statistically-significant comparisons across organizations. So when this measure was implemented into HEDIS we had that 411 sample size requirement, but just noting some of the challenges that others have brought up with reporting the measure, the fact that there's really no information that you can get easily from administrative claims, it's mostly manual abstraction from case management records, we did decide to temporarily reduce the sample size requirement to 96, and this was to relieve the high level of burden in the manual data abstraction and help to build momentum for plans and community-based organizations to start reporting the measures and sort of lower the entry barrier to reporting. But we are meaning for this to be a temporary reduction in sample size, and we're hoping to eventually raise that back up to 411, so that we can make the statistically-significant comparisons in the future.

Thank you, Lindsay that was helpful. Linette, did that answer your question? Linette you're muted.

I was having trouble seeing the mute button. I think sort of, I guess the call out that the sample size was reduced because of the workload involved, I think if I understood that correctly, it goes to I think this would probably land in the adult measure set, so it would not be required in 2024. But just the logistics of doing this measure and doing those case reviews, and as somebody else commented, making sure that there's a standardized data collection process so that you actually have compatibility across states, I think will be important factors. Thank you.

Thanks Linette. Do we have other Workgroup members with comments or questions? David, do you have another comment? Your hand is still raised?

Yes. Just an additional comment. So, in Pennsylvania, we have three LTSS plans. So, if we reported this, we would usually we do a weighted methodology, we would probably blend in the rates for all three of those plans to pump up that denominator. So that's how Pennsylvania would handle it and report it.

Thank you. Rich Antonelli.

Yeah, I wanted to circle back I think my colleague Jill Morrow-Gorton might have been the first commenter and Jill you use the pronoun that I want to press you a little bit, “they” like it. Who was “they?” Was that the health plans? Was it the providers? Was it the LTSS beneficiaries themselves? Was it all of them together? And is there any comparative data you have on that?

Guilty. So, by “they,” I really mean, my colleagues in the quality department at the health plan that I work with. I don't have any experience with this outside of that, I think it's really a relatively new measure. And so people are just trying to figure out how to do it, as opposed to being comfortable with it, and have it be a solid, they sort of -- now you're going to have to lean to improving the quality of what goes into it, as opposed to just making sure you have all of the stuff, if that makes sense just because it's so new. But Rich, it's really the people that I worked with, and it was an unofficial poll.

Okay. And then, so, Margo, if I could have the floor for 30 seconds more, so I'll ping from the beginning, Jill you to David, when you look at your patient-reported measure, the CAHPS data that you suggested, what is the patient experience like, and can you anchor it specifically to the use of this tool as a performance measure?

So Rich, I think that's a really interesting question. The LTSS MLTSS in Pennsylvania is pretty new so I mean, my experience in the past was with the Intellectual Disability and Autism office, and so this measure didn't exist when I was there. I don't know that we know the answer to that in terms of matching those up. I think the other difficulty is the samples are pretty small actually, even in the CAHPS, and so I think it's hard when you're combining multiple plans, and it's hard to know, how significant your weighted number in that sample is in terms of the actual participants that you're working with. So, I would say, I don't know that I know the answer to that, and I don't know that, David, maybe you do, but it's an interesting question.

Yeah, David, I'd love to hear but let me just tell, I want to make sure that I'm being fully transparent as somebody who lives and breathes professionally all things care coordination. I'm recognizing that there is a significant amount of work attached to meeting this measure. I would certainly feel better if I had the voice of the patient saying the juice is worth the squeeze. So, David, can you shed any light even with small numbers? Is the juice worth the squeeze through the lens of your beneficiaries?

I would say the juice is worth the squeeze, and I was trying to find a PowerPoint that I had put together, I can't find it right now. But we've looked at this particular -- we look at all four of the LTSS measures, we've looked at this one though, in conjunction with several CAHPS questions around person-centered care planning. And I believe that our three plans where there's a higher mark on this particular measure, I think there's some better responses in the CAHPS survey. But don't quote me on that, I'm looking for some of our actual data. And there are several CAHPS questions that actually look at this, so it's not just, there is several there are two or three that we actually look at, and we do think that they go hand in hand. So, I think this is worth the work that goes into it.

Thank you.

David and Rich. How about Laura Chaise?

Just to add on to that, and when we get to a gaps conversation, I think we can talk about -- I'd like to talk about how we fill in some of the gaps around experience of care. But yes, I mean, there is a pairing, so if you look also at the NCI-AD, which some states use the NCI-AD, some states use the HCBS CAHPS survey to measure beneficiary experience, the NCI-AD asks beneficiaries questions about do you feel that you receive the services that you need? Do you feel like your care manager takes your preferences into account? And so you could see a nice tight way that you could sort of be able to link those member experience outcomes with the process measure to see well where are things falling apart or has this become a box checking exercise in which case, then the experience piece kind of would couple nicely with that to really capture whether the spirit of the process is really still intact. So, I think in an ideal world, you'd have both and I think they would work very nicely together.

Thanks, Laura. Other comments from Workgroup members before we move on to public comment. Lowell. Lowell you're muted. There you go.

Yeah, thank you. Sorry about that. So I just wanted to say that, as Jill said, and a lot of other people, when New Jersey stood up their MLTSS back in 2014, this was actually required, not just it was required first by CMS in our terms and conditions for the 1115 waiver that we actually do this and then therefore we then included it in our contract with the MCOs and so this was one of the process-oriented outcome measurements we did. And Laura, thank you for saying, for explaining about the NCI-AD because that's what we ended up using to take a look at that, and to make sure that was actually -- people were actually getting served by rather than just check the box. So, I just wanted to say that.

Thanks Lowell. Other comments from Workgroup members? All right then I think we are ready to move to public comment. Thank you. Next slide.

Okay. So, 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. We'll let you know when you've been unmuted. So, Lisa Alecxih. Derek, could you unmute Lisa?

Hi, good afternoon. I have a question regarding the characterization as both managed long-term services and supports and fee-for-service use. It was originally developed and tested with managed care plans. So just general question about fee-for-service use.

Lindsay or Sepheen from NCQA. Can you speak to that of how you define an LTSS organization?

Sure, yes. Hi, this is Lindsay from NCQA. So, any type of organization that provides or coordinates Medicaid-covered LTSS is eligible to report the HEDIS measure. So obviously, that would be managed health plans, as well as we include a list of examples in the HEDIS volume- community-based organizations, Area Agencies on Aging, ADRCs etc. So, it's a pretty wide group of organizations that can report the measures for HEDIS.

Thanks Lindsay. Other public comment? Other questions from the public? And again, if you have a question or a comment, please use the raise hand feature, which is in the bottom right of the participant panel. Okay. I guess we have no other public comments.

So now it's time to turn to voting. So, I'll turn it over to Alli and Dayna, for voting on this suggested LTSS measure.

Great, thank you, Margo. All right. And the question that is being voted on is should the Long-Term Services and Supports Comprehensive Care Plan and Update measure be added to the Core Set? And voting is now open. If the question does not appear, please refresh your browser.

We're just expecting one or two more folks, so if everyone could take a look at their device, and just make sure they have submitted. Thank you. I believe we're missing Bonnie Zima. So, Bonnie if you're having any trouble feel free to submit over Q&A. Okay. We have everyone and I will go ahead and close the poll and share the responses.

All right, great. And for the results: 78 percent of Workgroup members voted yes, and so that does meet the threshold for recommending this measure. The Long-Term Services and Supports Comprehensive Care Plan and Update measure is recommended by the Workgroup for addition to the 2022 Core Set. Next slide.

And at this point, I will turn it back to Margo to facilitate a discussion of gaps in the LTSS Domain.

Thanks, Alli and Dayna, thank you Workgroup members, that definitely was a little bit of suspense while waiting for the votes to come in. So now, as Alli said, we're going to talk about gaps in the LTSS Domain. What suggestions do you have for further strengthening the Core Sets? What types of measures or measure concepts are missing in the Core Sets? And what types of measures or measure concepts might be available to fill the gap or would a new measure need to be developed? So, with that, open it up to Workgroup members. Lowell, do you have a comment? Lowell, I see your hand is raised. Do you have -- there you go.

Yeah, I guess I just wanted to say, I'd like to hear from CMS, what it is that they are looking for? I mean, now this is now the third year that we've talked about LTSS in this committee, and we're still waiting on the HCBS measurements, that based upon the RFI, and it's just not clear to myself, at least, I'll just speak for myself on this one on, exactly what it is, this is a long time coming, I mean, we're talking about that, I've had conversations with folks at CMS since 2013 at least about creating measurements, and we put forward several of them, and now we have -- and so I'm just kind of wondering if at some point, we could hear from CMS kind of what they're thinking and all of that. I think there are, we've discussed over these three years what these gaps are and laid them out and we've had CMS listen to them, and I'm just at this point, I'm hopeful, but I'm also cynical.

And so certainly, I think we definitely need, we need measurements that are based upon, that go beyond the health and safety, go beyond the process. I'm glad we got this last one put in this one put in, but it's a process-oriented type of measurement tool that we just passed to get put in and we need outcome measurements, things that address social community, person-centered planning. I mean, certainly that, from my perspective, the plan of care that they did is person-centered, and that's wonderful. But there's a lot more that needs to be done, and we've discussed this in the past. So, I'm just putting it out there, and I'd love to hear any comments back. Thank you.

Thanks Lowell, and for others as well. If there are specific measures, measure concepts, we'd like to hear those as well. Jill Morrow-Gorton.

Yeah, I'd like to just kind of echo the need for outcomes. We have experience, if this one goes through, we have a structured way to look at person-centered planning. What we don't really have is how do we measure what the services are doing and are they getting to the goals of the program? And I think that's a gap, I think it's a gap sort of individually for people, I think it's a gap in aggregate, and I don't have any measures that I know of that would do that.

Thanks, Jill. Laura.

Oops. Can you guys hear me now?

We can.

Okay, perfect. So, I agree with what's been said. The gaps that I would like to see filled in, one is on the experience piece. I think it's important to continue to note that the NCI survey that is on the Core Set is only one of several major survey tools that are used, the other two that are most popular are the HCBS CAHPS, as well as the NCI-AD. And so, I would like us to sort of fill in that experience bucket in a way that makes sure that we are both including representation from all LTSS populations, stakeholders, as well as honoring the fact that states have chosen different tools. So that's one piece. I think, agree that this is sort of a key cornerstone of measuring the process. And then the outcome piece that I would like to see that for me would make this sort of a nice trifecta here would be a measure around rebalancing at the state level, I think, if you could pair those three things together, I think that would give you a sense of how the system is operating from a state-level perspective.

Thanks, Laura. Lindsay Cogan.

I just wanted to acknowledge here, especially with this population, in the last year with COVID has been disrupted in so many different ways and in ways that we are just beginning to truly understand the impact on. So I think, thinking about this population and thinking about I mean, hopefully, we won't continue to have a pandemic every year, but what if we do and how can we ensure that members who are homebound or members who are in these more vulnerable populations are able to get the care they need? So, I just think that it's something that we need to think about. There's obviously lots of services available, it's just a matter of whether folks are assessed for a need and whether that need is met. Again, I don't have a great measure, but just wanted to acknowledge that particularly in this population, this has been just a year that will never be forgotten.

Thanks, Lindsay. Rich Antonelli.

Yeah, thank you. I am very excited and grateful to the committee for its deliberation on this and the recommendation, but let me go right to the gaps. And occasionally, I'll actually wear my pediatric hat and now I am. So LTSS, certainly there are pediatric LTSS, but more broadly, we call these children and youth and young adults with

complex needs. They're responsible for a significant amount of the Medicaid spend across the country. And part of the tension for child health LTSS if you will, is for those that have medical and behavioral and developmental needs, and then some of the social supports, those are once again in different buckets. And so, integration in things that are meaningful for taking a child turning them from a diagnostic entity into a child with needs is important, so the whole child's health LTSS piece.

Second, Lindsay, this sort of builds off your remark. A lot of my experience in the last year or so has been looking at the impact of virtual care, and a fair amount of the evidence that we've been gathering is that for patients with complex needs - complexity, broadly defined, social, behavioral, developmental, and medical - we're identifying that virtual care is actually value added, eliminating challenges around transportation and the like. And so, I'm hopeful and hoping that as this measure the care plan measure goes forward, that we not create a gap, because we are on the back side of the pandemic. To the contrary, I think maybe Carolyn Langer said this, and I wholeheartedly agree, virtual care is here to stay, but under which circumstances are they so I don't want to create a gap.

And then finally, I'll mention it again, no discussion in the last 30 minutes about race, ethnicity, language, disability status, although disability is sort of a given in the LTSS population. So, I just want us to be mindful of that as we go forward. And then finally, point of accountability. To the extent that these- our LTSS beneficiaries across the age spectrum need care integration, from medical, developmental, behavioral, social providers, the locus of accountability, is that going to be the ACO? And how do we meaningfully engage the other components of the health delivery system, that should be complimentary to the medical delivery system? So for me, outlining what is the point of accountability, how will each of those entities be held accountable, will be a critical piece going forward as we track the provision of needs for these patients.

Thank you, Rich. Laura, you still have your hand raised. Do you have another comment?

Sorry about that. Nope.

Okay. Are there any other Workgroup members with comments? Lowell.

So, I just ask, at some point, and I really would love it if CMS would let us know what they're thinking. But I also would like, and I guess we could also talk about this tomorrow as well, but it would be helpful to know given that the NCI has been included into the Core Set, wondering if CMS would also kind of let us know how that has been going, how incorporating it into the Core Set has been going and the like. So, if we could have that from people, I would appreciate that.

Lowell, I can give a quick update on that.

Okay, great.

So, as you know, this was a tough year for surveys, and particularly for NCI, NCI-AD, and HCBS CAHPS, given the fact that they are face-to-face. So, we have been working very closely with NASDDDS and HSRI on bringing the NCI into the Core Set for 2021 Core Set reporting, or sorry, 2020 Core Set reporting. And I am happy to say that it

appears that we will have sufficient data from states to be able to publicly report the measure. There are not nearly as many states for 2020, which is really considered the 2020 reporting cycle, the data collection ended a little bit prematurely in many states, as you can imagine, but we do have enough states, probably around 26, to be able to publicly report. So, it will be probably around three or so core measures that will be publicly reported, assuming all goes well, and we'll be doing a state preview fairly soon. So, I hope that helps in terms of understanding where things are, and so we're very excited to see this moving forward.

Thank you. I appreciate that update.

Sure. Yeah, and just a reflection on where we started a few years ago, when you think that we now have two measures in the LTSS Domain, we didn't even have an LTSS Domain when we started this process, so a little progress, at least. Jill, did you have a comment or just saying very cool, thank you for the update.

I just said very cool, thank you for the update, but I'll say it publicly.

Okay. Other comments about gaps before we move on to the next domain?

Margo this is Dave Kelley, just a quick comment, and I think we covered this a little bit earlier on the pediatric side. But one of the things that we need to think of in terms of protective services for adults and being able to develop quality measures that might be predictors or indicators of elder or adult abuse or misuse, so just some food for thought there. I think there are some gaps there. I think there are a lot of folks actually working in that area or that domain. But I think that's another vitally component area of working with this very vulnerable population.

Thanks, David. Ifeoma you have your hand raised.

Yes, Margo, thank you. I just wanted to say that Connecticut submits HCBS CAHPS data to the AHRQ database, I don't know what other states do because CMS normally uses that to assess nationally, the CAHPS data so I don't know if they're willing to do that for what 2020 with this data we submitted, don’t know if other states submitted to that.

Thanks, Ifeoma. Jill.

I just wanted to echo what David said about sort of adult protective services and older adult protective services, and to echo back to our conversation about domestic violence and child abuse, as I see them and have seen them over the years. There are huge linkages between them, and I think that is a really important area for us to be addressing.

Thanks Jill. Any other comments? Well, with that, I think it's time to move on to Maternal and Perinatal Health. So next slide, please. And I'd like to turn it over to Chrissy to talk about the Maternal and Perinatal Health Domain.

Thanks Margo. And hi everyone. We are moving now to the Maternal and Perinatal Health Domain. I'm going to start with a brief overview of the current 2021 Core Set

measures. There are six Child Core Set measures and four Adult Core Set measures. Next slide.

So, starting with the Child Core Set, the first measure is Audiological Diagnosis No Later Than 3 Months of Age or AUD-CH. This measure has been suggested for removal, so we'll discuss it in more detail shortly. The other five measures are Live Births Weighing Less Than 2,500 Grams, Prenatal and Postpartum Care: Timeliness of Prenatal Care, Contraceptive Care – Postpartum Women Ages 15 to 20, Contraceptive Care – All Women Ages 15 to 20, and Low-Risk Cesarean Delivery. Note that beginning with FFY 2021 Core Set reporting, CMS will calculate the Low Birth Weight and Low-Risk Cesarean Delivery measures on state's behalf using CDC WONDER which contains vital records data submitted by states to NCHS. Next slide.

Turning now to the Adult Core Set the first measure is PC-01: Elective Delivery. This measure has also been suggested for removal. The other three measures are Prenatal and Postpartum Care: Postpartum Care, and then the two contraceptive care measures are the same as those in the Child Core Set, but with an older age range of 21 to 44. Next slide.

So, our first measure suggested for removal is Audiological Diagnosis No Later Than 3 Months of Age. It assesses the percentage of newborns who did not pass hearing screening and have an audiological diagnosis no later than three months of age. It is a CDC measure, it is NQF endorsed, and it is calculated using EHR data. No new measure has been proposed for substitution.

Only two states reported the measure for FFY 2019, and both of these indicated substantial deviations from Core Set specifications. Neither of these states reported using EHR data for measure calculations. This measure was suggested for removal by three Workgroup members. The first reason was due to feasibility concerns. The Workgroup members cited state's challenges with accessing EHR data and the fact that only two states were able to report the measure for FFY 2019. Workgroup members noted that challenges with accessing EHR data may lead to inconsistent calculations across states and questioned whether all states would be able to report the measure when mandatory reporting goes into effect in 2024. Workgroup members also identified actionability and strategic priority concerns with this measure. One Workgroup member explained that their state has tried to use administrative claims data to track those who have not received follow up. However, because data are transmitted to EHDI by facility or provider and not billed to Medicaid, the state has had challenges identifying gaps in care with this measure. Workgroup members also commented that the prevalence of this condition - that failed hearing screenings is very low - and achieving meaningful state level variance will be difficult. This measure was discussed by the Workgroup last year and one of the Workgroup members who suggested it for removal this year, noted that reconsideration of the measures should take into account CMS’s progress in working to identify an alternate data source.

Over the past year, CMS has met with CDC several times to discuss alternate data sources; it has determined that an alternate data source is not available for this measure other than EHR. Thus, states will be responsible for reporting this measure if it remains part of the Child Core Set. Next slide.

The other measures suggested for removal is PC-01: Elective Delivery. It measures the percentage of women with elective vaginal deliveries or elective cesarean sections at 37 or greater and less than 39 weeks of gestation completed. It is a Joint Commission measure, it is NQF endorsed, and it can be calculated using EHR data or the hybrid methodology. No new measure has been proposed for substitution.

Nine states reported the measure for FFY 2019, and five of the nine reported substantial deviations from Core Set specifications. These states indicated that they did not conduct chart reviews to capture required data elements. It was suggested for removal first due to feasibility concerns. The Workgroup member who suggested this measure for removal noted that the measure requires chart review to identify if the delivery was elective. However, many states do not conduct chart reviews for Core Set reporting. The Workgroup member also referenced data from the measure steward for calendar year 2019 that indicated a median rate of 0 percent and a mean rate of 1.83 percent among 2,005 hospitals reporting. The measure steward indicated that data are not available by payer. According to the Workgroup member, these performance rates indicate that either providers have identified coding and charting to justify deliveries, or elective deliveries are not being performed. Next slide.

So, with that, I'll pass it back to Margo to facilitate the Workgroup discussion around these measures. Margo.

Thanks, Chrissy. And this year, we'd like to discuss each measure in turn, so starting with the AUD audiological diagnosis measure, like to open that one up for conversation. Are there any Workgroup member comments or questions about this? Rich.

Yeah, thank you. Actually, Margo, this is a question and I don't know whether anybody from CMCS would be able to answer it. But I'm intrigued, I think that the tee up was that CMS has had conversations with CDC about this, but I know that Title V these kids are so -- when they're screened in the newborn nursery, and they screen positive or they screen questionable, that information flows to Title V. So, I'm just wondering, when CMS was reaching out to other agencies if Title V was included, and if I can't get that answer now, I will actually make my comment to the group. But let me hold on making my comment. Can we get some clarity as to whether Title V was queried or not?

So, my understanding is that the primary focus was on looking at implementing the measure as specified. This is a CDC measure, as you know, and it is specified for EHR. There was an effort to see whether it could be specified for administrative calculation using claims and encounter data, and that was not able to be pursued. So the avenue that was primarily pursued for this specific measure, which is what is under consideration here, and I know you're focused on flow of data, but for this particular measure, the first focus was on whether data would be available for all states through the EHDI system where data are being submitted to CDC, with Medicaid being identified, so not all payer, but specifically looking at Medicaid. And then if that was not available, then whether an administrative specification could be developed. So, both of those paths have been explored in multiple meetings over the past year, and none of that bore fruit. So, I think that was the charge over the past year to determine whether this measure as specified could be calculated using an alternate data source, either through the EHDI system or through administrative data specifications.

Okay. That's at least is partially helpful. I just wanted to again call out for the group here that it is disheartening for me to think about, we have a responsibility for children and families and adults, and while I can appreciate the comment about it's a small population or the prevalence is low, imagine if this is your baby, and screens positive and you get lost. And so, this is where I feel the tension between, are we doing the right thing for the children and the families or are we saying well, we'd like to do that, but the system won't allow it, so there's a gap. So, I think my comment is this. On a feasibility basis, as the measure is currently specified and the data sources are there, the fact that only two states are doing it, is really, really compelling information. But I do not want to stop the advocacy for this population, or other populations, in fact, that are low prevalence. In fact, about six years ago, I was in a different forum, not with Mathematica, not even the Core Set, I had raised the issue about sickle cell disease, and one of the committee members said to me, there aren't enough people with sickle cell disease that's not that important for us. And I was devastated and still remember that pain to this day. So, I'll end my comments to this committee, and MPR team, and CMS, we have to find a way, even for low-prevalence conditions, to assure that there is equitable, safe outcome of care, and if we need to figure out how to connect the Title V community with this reporting stream, we need to be able to do that.

And Rich, I do have one point of clarification that I should have said before, and that is that Title V reports into the EHDI system to CDC, so that is being taken into account in consideration of whether this measure is feasible for reporting at the state level for Medicaid and CHIP programs. So that was considered and part of this, just in terms of the availability of EHDI data to report at the state level for Medicaid and CHIP programs. So, I think all your points are very well taken in general, but I did want to make that point of clarification that I think there has genuinely been a lot of effort over the past year to look into this through various meetings and conversations. I also want to put in a plug, I think I've shared this with you, that our team, working with CMS with Shondelle and others, has put together a sickle cell report and infographic using TMSIS data to be able to get at some of the things that you're talking about, at the state level doing stratifications because of the recognition that this is a very important population, that it's hard to do at the individual state level potentially. So, I think, I just want to put in a plug that that has not gone unnoticed, or unheard so a lot of work went into that and in fact, there was a White House roundtable around this as well.

And thank you for both the clarification on the EHDI data with Title V and that and absolutely that sickle cell report that you shared and for the rest of the committee, it is related, not the same, but it is related, and that was absolutely wonderful. And so, if this measure gets voted out of the Core Set, if anything, we have to redouble our efforts to figure out how else are we going to be able to do this work, not to dismiss it because it's low prevalence or anything like that, so Margo, thank you for a really thorough explication.

Sure. Thank you. Lindsay.

Thanks Margo. I had tried to dig in a little bit to the data on the CDC site, just to see if I could ascertain where the loss to follow up was. Was it largely in Medicaid, was it largely in certain populations that are more likely to be in Medicaid and I couldn't really drill in further to find out that small portion of the population who does not pass the hearing screen. And I couldn't really dig in any further, so that was my suspicion was they

probably just don't capture payer when they submit the data. And while, I'm not saying that it's not an important condition and Medicaid does cover half of the births in New York State. So, it's not to say that anything related to child health isn't a Medicaid problem, but we have to look at where you want states to be focusing their resources. So, we can spend a lot of money and time on how to measure something and not have any resources to actually do something about the problem. So that's my fear with some of these measures that are that are really -- that we just can't find a way to kind of cross reference data that's already being collected.

I mean, there's a lot of effort that goes into the early intervention data and it'd be great if we could leverage an already existing data system, so that we as states could put our resources towards impacting care, and not towards developing an entire data system that’s going to replicate something that already exists. So I think that is where I get a little bit frustrated with some of these measures, when I would like to see us really partner with other agencies too, if you can't tell us which of these kids are on Medicaid, then it's up to you to figure it out. They need to change their system, and it would be much more beneficial for them to change the system and then we would have the information actually to act on. So that is kind of where I always come back to with this particular measure.

Yeah, Lindsay, thank you, I think that's a very important point is that currently the EHDI data system does not capture payer, there is no field to capture that. And that's what would be required to be able to use that as an alternate data source in the future. Thank you. Jill.

So as the other pediatrician on the group, and the developmental pediatrician, I will tell you that we are notoriously bad at identifying hearing impairments in children in general. That universal hearing assessment has made an amazing difference in not only early identification, but being able to address it early, and to really help kids be able to communicate better because the average age and I don't know -- I don't think the average age of identifying a hearing impairment without using universal screening changed for years and years and years, and it was really late.

So, I think while this is a not hugely prevalent problem, the impact is in fact huge. And Medicaid does cover in many states 40 percent, 50 percent, 60 percent of the births, so I think this really is an important issue. I think the hearing screening in the office as part of well-child care does not take the place of this in fact, it's largely ineffective in early identification in infants and very young children. So, I think that that this issue in particular is really important. And it's very disappointing that the data sources can't do this in a way to facilitate being able to find these children who fail their screen and who need to be rescreened with a different mechanism or just rescreened in general. So, I have to say, yeah, the data doesn't work, but it's a really important issue.

Thanks Jill. Anne Edwards.

Thank you. And so, another pediatrician on the call. I'll keep my comments briefer because they echo a lot of what has previously been said. I struggle with this because I entirely appreciate the feasibility issues around this and where we are today and yet, this really points to an issue with a system not connecting with another system and really thinking about this from the child and family perspective that what are those

opportunities to bring us together, and while we're talking about hearing screening now, I think that this actually happens quite a bit in the pediatric space where we have great opportunity to make improved connections. And then I do think just to underscore this really is not related to the hearing screening because that has its own issues that would be done in a well exam, but certainly would not be done in an infant stage in a usual clinical setting. So just from that point, there would be a gap if that was considered.

Thanks Anne. Linette.

Thank you. Yeah, I don't think there's any disagreement about the importance of this measure, and I know we talked about it a lot last year too. However, this will be required in 2024, and to Lindsay's point, and certainly coming from California, that's another large state, have a lot of concerns about ability to do this. The data just isn't there, and that's why there's only a couple of states reporting. And so, from a stewardship of the Core Set measures being feasible, and all the different criteria we look at. I mean, I really think that this should be removed from the Core Set. That being said, it doesn't mean it's not an important issue, and the data linkage between public health and Medi-Cal and Medicaid is also very important. So, I know our department is doing a lot of work with our public health agency, doing data linkage on a variety of kinds of datasets. So vital records, blood lead screening, HIV, vaccines, and now COVID and COVID vaccines and COVID cases.

And certainly, a lot of the infrastructure we're putting in place to respond to the COVID pandemic and doing linkage around COVID vaccines is laying the groundwork for more linkage that will support Core Set measures in the future. So, I think that's certainly a possibility, but some of these linkages have been slow to come about in different states. So, HIV is another measure, it wasn't suggested for removal this year, it's one we've talked about before, it also has very few states reporting. And for us in California to report it, we have to send data to our public health department, they have to do the linkage, and then we have to get the summarized results back to submit it.

So it's not something we can do alone it requires resources on the public health side, so it's not just thinking about how to bring the data together, but it's also the resourcing the staffing, how do we do that in a shared way between our Medicaid and public health programs? So I think there's a very strong commitment around that, and definitely around the importance of the audiologic screen, it's just that for the Core Set measures, we have demonstrated as state Medicaid agencies that this is not something that we can do, and if it becomes required in a couple years, then to Lindsay's point, we're going to have to invest a whole lot of money in trying to figure out how to do it. And I don't know that that's the right way to direct resources at this point in time. Thank you so much.

Thanks Linette. Any other Workgroup comments on this measure before we move on to elective delivery? All right, well, why don't we move along and change topics here, and talk about the elective delivery measure. Do we have any Workgroup member comments about the measure? Linette.

This is Linette. Sorry. I think in some ways, it's a similar conversation to the one we just had about the previous measure and that we don't have very many states that are reporting it and that there are some issues again, around the underlying data and being able to get at it because it's elective. So how do you know it's elective unless you do a

chart review essentially? And also, it's interesting, we had a conversation earlier on the antibiotic measures, and the issue was raised that providers will figure out how to code it so that it doesn't show as a problem, and so whether that's what's happened with this measure or just that there's been huge improvements, when the data reporting shows that there's not a whole lot of room for improvement at this point because folks are doing really well. So, I think, in terms of just thinking about the real estate that we have on the Core Set measures, this would be one that would be appropriate to remove. Thanks.

Thanks. Karen George.

Hi. Yeah, I agree that those are really valid points. I think that there are problems with data collection, and that the measure is topped out by payment policies. But I think that we have to be considerate that taking this measure off would really leave a large gap in this aspect of maternal care, so we need to really think about how we're going to measure the quality of maternal care in some other way.

Thanks Karen. Lindsay.

I think that this was one that was perhaps on the list where we could leverage some data from the CDC, same with the cesarean section, which I think was another one that we had teed up to possibly use vital statistics data that was submitted to the CDC. I will tell you though, when you look at these measure results, using vital statistics as your primary data source versus using the medical record as your primary data source, the answers are quite different. So, if you look at in New York State, we're right around 2 percent maybe even lower, if you do the true Joint Commission using medical records. If you do a proxy measure using vital records, we're at about 12 percent. So again, it's missing that medical documentation using vital statistics, it's very difficult to ascertain the medical reasons for it, whether it's appropriately coded or not is beside the point, so it becomes a difficult measure to work with, when depending on what data source you use, you get a very different answer. And the last thing you want to do is go back to a provider or hospital system and say, here's what we want you to work on, only to have them come back at you and say what are you talking about my rate is one and a half percent.

So it gets to be we've worked with it in several perinatal health regionalization forums, where we pull hospitals together to share best practices, we've made great strides and improvement, and as someone else mentioned there's a great deal of payment reform that's been spurred as a result of that. It might be a measure with which we put a pause on it, and either continue to monitor through the back end either through some sort of CDC just keeping an eye on it to make sure it's not going back up, once we take it off the Core Set. I mean, that is something we're going to have to think about. We just can't keep adding, and not taking away. So I just want to think about that balance perspective of we don't have unending resources to do everything although everything is important, we have to kind of think about all right, so if we've made great strides in this area, where is it that we could maybe direct some additional resources?

Thanks, Lindsay. I wanted to just update on the Low-Risk Cesarean Delivery measure. That one will be calculated through CDC WONDER, so we're very excited about that because we will have that one and a Low Birth Weight measure for all states and the District of Columbia, so we're very excited about that. I think from what we have learned,

it's not possible to use the vital records data through CDC WONDER for the reasons that you mentioned is that it's not possible to subset on clinical criteria that would determine appropriateness of the elective delivery. So I think that while that would be desirable to be able to do, it's not real feasible given the data in vital records, but we do still have the NTSV or the Low-Risk Cesarean Delivery measure in the Core Set and we will have that for all states along with Low Birth Weight. Rich Antonelli.

Yeah, thank you. I wanted to find out if we removed this line of sight to what we know is a pretty flagrant gap around perinatal outcomes for women of color compared to white women. So I guess the first part of this question is, is this data stratified currently at the state level, and if the answer is no but we still think it could be removed, do any of the other measures give us the comparison between women of color and white women?

And you're talking specifically within the Core Set whether we could use for example CDC WONDER data.

Yes, exactly.

Okay. Chrissy, can you speak up to that about the ability to do stratifications with the CDC WONDER data?

I'm sorry, regarding the Low Birth Weight and LRCD measures or the elective delivery?

Yes, those two.

Yeah. So using CDC WONDER you can stratify by race, ethnicity, maternal education, other maternal demographics, also by paternal demographics, although that's missing for maybe like 20 to 30 percent of births, and you can stratify by rural/urban, and you can get down I think, as low as the county level, you can't get any lower than that.

Okay. So, we'll still have some way of tracking disparities by race, ethnicity.

Yes.

Okay. Thank you.

Linette.

And just to piggyback on that, the measure being proposed for removal, because so few states are reporting it and the challenges in reporting, we don't have the ability to do the stratification. In contrast, the two that Chrissy was just talking about, that are leveraging the CDC WONDER, that absolutely has the ability. So, thank you.

Yeah, thanks to both of you for those comments. Other Workgroup member comments? If there are no further comments, we'll move to public comment. Last call for Workgroup member comments. All right. So, with that, I'd like to provide an opportunity for public comment. Oh, Diana, you have your hand raised? Before we move on.

Can you hear me?

Oh. Huge echo, Diana. You must have multiple sounds on, can you mute one of them?

Can you hear me now?

Much better. Thank you.

Okay. Sorry. I was really having technical issues unmuting. It just wanted to comment on what Dr. Antonelli just said --

It's a little bit hard to hear you. Can you move closer to a mic? Sorry. If you're speaking, we can't hear you. Diana, we can't hear you. Are you on a headset?

Can you hear me now?

Yes, we can. Thank you.

Okay, sorry. I've got multiple devices. I just wanted to comment on what Dr. Antonelli just said, just to clarify that the currently endorsed measures do not have race built within the metric, so we aren't currently including in the measure specification race. And I think this committee needs to make a profound statement when it comes to barriers and gaps and future recommendations that with our current maternal mortality crisis in this country, there's no reason why we shouldn't be stratifying by race in the measure specification. That's neither here nor there for the mandatory Core Set, but I think it should be made a note.

Diana, thank you for that comment. I will add that all states are able and encouraged to stratify when they report all of their measures into the web-based reporting system, regardless of whether it's in the specifications or not, it is something that they are encouraged to do through the web-based reporting system. But I appreciate as we're moving more toward the use of alternative data sources, that it's also something that we can do, as we were just discussing with Chrissy's comment about using the CDC WONDER to take a look at various stratifications. So, thank you for making that explicit and certainly, we'll note that in the report as well. Other Workgroup member comments before we move on to public comment. Alright. Well, with that, now we're ready for public comment. So, if you would like to make a public comment, please use the raise hand feature in the bottom right of the participant panel to join the queue. Do we have any public comments on these two measures? So, with that, let's move to voting. Turn it over to Alli and Dayna.

All right, thank you Margo. We will get the vote up on the screen. Okay, great. So, for our first vote, the question is, should the Audiological Diagnosis No Later Than 3 Months of Age measure be removed from the Core Set? And voting is now open.

We have 26. I believe we might be waiting for one more individual. And we have 27 that's the number we're expecting. So, I'll go ahead and close the poll and share the responses.

All right. And for the results: 85 percent of Workgroup members voted yes, and so that does meet the threshold for recommendation. The Audiological Diagnosis No Later Than

3 Months of Age measure is recommended by the Workgroup for removal from the 2022 Core Set. And then moving on to the next vote.

All right. And so, the next question is should the PC-01: Elective Delivery measure be removed from the Core Set? And voting is now open.

We are just waiting on one more individual if everyone could confirm that their vote has been submitted. There we have it.

All right. And for the results: 73 percent of Workgroup members voted yes, and that does meet the threshold for recommendation. The PC-01: Elective Delivery measure is recommended by the Workgroup for removal from the 2022 Core Set. And now I will turn it back to Margo to facilitate a discussion of gaps in the Maternal and Perinatal Health Domain, Margo.

Thank you so much. So now to talk about gaps for Maternal and Perinatal Health. Diana, do you have your hand raised for this or is that from the previous. Okay. So, Workgroup members, do you have comments about gaps in the Maternal and Perinatal Health Domain? Jill.

So I think that, sort of pursuant to our conversation about the universal hearing screening, I think that all of the screenings that occur and they occur -- there are some that occur in every state and some that occur in just some of the states, but that whole process is a really important process, and I feel like this should be, there have been great efforts to collaborate between CDC and Medicaid programs, and I just see this as an opportunity not only to kind of do that collaboration, but also to sort of harness the health care system and the plans in terms of being a part of this whole process, and I think it's an opportunity.

Thank you, Jill. Tricia Brooks. Tricia you're muted. There you go.

Okay, thank you. I just want to talk about postpartum measures. The Timeliness of Prenatal and Postpartum Care, the measure in and of itself, measures both, but the postpartum portion of that is not required in the Child Core Set. But now that Congress has approved a state plan option to extend postpartum coverage to a year, I guess I'm curious about whether, since the measure is already part of the Core Set, we will open up the other half of that measure, so we can start to get a better handle on what's happening postpartum. If not, we need to continue to look for ways to measure postpartum health because we know that about a third of maternal deaths occur post pregnancy.

Thanks, Tricia. Other comments about gaps? Oh, Lindsay?

Yes. So, we in New York are trying to think about more multi-generational measurement. So, think about the mother while she's pregnant, and then also the child, thinking about how to ensure that the family unit has what they need. It's a difficult concept to operationalize, but we are trying to get our feet wet in this space. So it'd be great to continue to think about, especially in the maternal and child health domains, how we can kind of bridge these two worlds. And I don't have a great answer for the measure or how to do this, but I do think it's a gap area that we should keep an eye on. I don't want us to

fall behind, I feel like we've fallen so far behind in the social determinants of health measurement space, that I just want us to keep tabs on some of these more emerging spaces now, because I think that's the social determinants of health and being able to measure health equity is really an area where I think we as measure stewards, measure developers, and all have really -- we failed, we have failed miserably. We have known that the social determinants of health has impacted health forever and yet, here we are not able to really put in something that helps us to really get at and improve care in a particular area. So, I just want us to not fall behind in the area of this multi-generational or two-generational measurement.

Thanks, Lindsay. And I'd like to charge the Workgroup with thinking about this overnight as we prepare for the gaps conversation tomorrow. I think we've heard a lot about this over the last couple days in terms of social determinants and disparities and health equity, and so it would be good to have some real concrete suggestions on specific measures or areas for measure development, so hopefully people can think about that a little bit more this evening. Anne Edwards.

Thank you. Yeah, I want to lend my support for, kind of, thinking about the fact that there's at least two individuals in this space, a mother and one or more infants and to think about the opportunities to not delink that is really important, so thanks for those comments. Maybe something a little bit more specific, which isn't entirely dissimilar from some of the comments around postpartum care, potential opportunities to really look at the site of the delivery and really kind of knowing what we know about morbidity and mortality, and what support we give mom around that prenatal period and giving to her to the right point of care and impact on the outcome both for mother and infant in that same space. I think that that could be something that would be important and helpful and really align with some of the work in public health as well.

Thanks Anne. Rich.

Yeah, it's interesting, Anne, this is going to really harmonize so with what you just said. So a few years ago, I was asked to be on a panel at AcademyHealth talking about ACEs, and I am bringing you to this conversation now because ACEs have come up several times today, it came up a year ago when we were in the same discussion here. And as I was preparing that discussion about ACEs, which at that point was very much at the level of the child and the family, families themselves said, we already have such a burden on us, and now you're going to lay on the fact that my son or daughter comes in for their four-year checkup, that they don't have a good outcome. And so, I want to call out this idea that many ACEs in fact, are viewed across a community. So an opportunity going forward, we can define it as a gap, I prefer to be more positive and thinking about it as an opportunity, is really the alignment for those data that are in that community, public health sector, and those that are in the medical sector.

So, if a year from now, we're debating an ACEs screen, for example, the level of individual patients, that's not going to be sufficient. Hope I'm not insulting anybody, or undoing years of your personal research. But I do think if we really mean it, that multi-generational approach to health, wellness, safety, and equity has to take into account alignment between resources and performance in the community, public health, and the medical space. So, I just wanted to give -- thank you for letting me make that statement.

Thanks Rich. Jill.

So, Rich to kind of piggyback on that, I think there is another piece of maternal sort of prenatal, perinatal, postnatal risks and needs that we might have not captured and that is the overlap of behavioral health and substance use and mothers. Both from the vantage point -- I mean, a lot of the maternal morbidity occurs in moms that are substance users, but also suicide with postnatal depression and I think we have not captured that, and that might be -- I know that a lot of Medicaid programs have put a lot of effort into that as well as public health, and I think that may be a gap in our current menu.

Thanks Jill. I see a couple hands raised. Tricia and Anne are these new comments or from previous comments?

From previous.

Okay. Other Workgroup comments about gaps? Lisa.

Yeah, and I'll just say, Margo, a lot of a what's bubbling for me are these cross-cutting issues that I know we're going to discuss tomorrow, but I will just mention kind of along the lines of Jill and Rich's comments, I mean, there are in looking at the hospitalization data, and as well as looking at a lot of medication assisted treatment, that goes out to pregnant and parenting women, there's a lot of treatment for opioid use disorder, that is not diagnosed as opioid use disorder treatment. And so, we find a lot of hospital stays associated with tobacco cessation and prevention, and otherwise diagnosed. So, it just kind of made me think some about our elective delivery conversation and how what we're trying to get out is reflected in the actual data that we can collect, or that we're seeing. And so, I just wanted to put that out there.

I mean, the behavioral health issues are tremendous in terms of that postpartum morbidity and mortality rate that we're seeing. And again, I know, we can discuss this more during the cross-cutting portion of the meeting, but just kind of trying to pull some of these threads together, some of these systems-level issues and some of the stigma associated with these issues are going to be real barriers to get at.

Thanks, Lisa. Other comments? David Kelley.

Thanks Margo. Couple of comments about again, looking at mom during pregnancy and thinking in terms of immunizations, diagnosis and treatment of substance use and opiate use disorder certainly is important, and I think there are some quality measures that get to that, same thing with prenatal and postpartum depression. There are measures there, some of them are e-measures, maybe not quite ready for primetime, and then also, I think there's still some literature to support ongoing dental care for pregnant women. So those are some areas that I think we need to still think about. And then just to add to the comments about the mom, child, dyad, or even the family unit, is developing measures or bundling measures, and we do this in some of our programs where we bundle the postpartum measure, prenatal, the postpartum measure to the Well-Child Visits in the First 15 Months.

And we've started a new program where we do visits to mom, evidence-informed visits to mom, high risk mom and new mom, and we ask for four to six visits in the postpartum era, focused on not just mom but the baby as well on the entire family and those social determinants. And we actually developed a way to track that it's not perfect, but we also then link that to the Well-Child Visits in the First 15 Months, and we're actually incenting our managed care plans. So, there are ways to get to seeing things getting done postpartum, so that you're addressing mom, baby, the entire family, and social determinants that may prohibit them from getting all of the services they need.

Thanks David. Other comments from Workgroup members. Okay. With that, I think we should move on to the next slide.

And here we are in the home stretch on day two of the stakeholder review of the 2022 Child and Adult Core Sets. Thanks everyone for such a robust discussion today about the measures, about gaps. And thank you for powering through the voting, I think we really got the hang of it at the end. So, we appreciate everyone's contributions today. I'll just do a quick recap on the outcomes today, we had nine votes. Three of the measures were recommended for removal, and that would be Ambulatory Care: Emergency Department (ED) Visits, which is in the Child Core Set, Audiological Diagnosis No Later Than 3 Months of Age, also in the Child Core Set, and then PC-01: Elective Delivery in the Adult Core Set.

And then two measures were suggested or recommended for addition, the first one Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis, and also Long-Term Services and Supports Comprehensive Care Plan and Update. So, thank you Workgroup members for all your efforts to discuss the measures and then to vote. So just a quick preview for day three. Next slide, please.

So tomorrow, we'll discuss measures for removal and addition in one remaining domain, and that's Primary Care Access and Preventive Care, where we have one measure suggested for removal and two measures suggested for addition. We'll also provide a recap of the meeting and discuss future directions including further discussion of gaps and areas for measure development. And we'll also discuss next steps in the stakeholder review process and have an opportunity for one last public comment. So, we'll begin promptly at 11 am Eastern again tomorrow, and we ask Workgroup members to sign in about 10 minutes early. And we wish everyone a nice rest of the day. So, this concludes day two of the 2022 Child and Adult Core Set Annual Review meeting. Thanks everyone. Have a great evening.

Thank you.