2022 Child and Adult Core Set Annual Review:
Meeting to Review Measures for the 2022 Core Sets Day 3 Transcript
May 6, 2021, 11:00 AM – 3:00 PM EST

Hi everyone, and thanks for joining today's event, the 2022 Child and Adult Core Set Annual Review Meeting: Day Three. 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 finish 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'd like to introduce Margo Rosenbach from Mathematica. Margo, you now have the floor.

Thank you, Dayna. Next slide, please. Welcome back to day three of the Stakeholder Review of the 2022 Child and Adult Core Sets. I hope everyone had a nice evening. And now I'd like to review what happened yesterday. So, here's a recap. So, yesterday the Workgroup voted on nine measures, and we had three measures recommended for removal. In the Care of Acute and Chronic Conditions domain, Ambulatory Care: Emergency Department Visits, the AMB-CH measure, was recommended for removal from the Child Core Set. And in the Maternal and Perinatal Health domain, two measures were recommended for removal: Audiological Diagnosis No Later than 3 Months of Age, the AUD-CH measure, and then PC-01: Elective Delivery was recommended for removal as well.

We also had two measures that were recommended for addition in Care of Acute and Chronic Conditions, Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis, and then in Long-Term Services and Supports, Long-Term Services and Supports Comprehensive Care Plan and Update. I want to thank the Workgroup members for such a robust conversation yesterday, both about the measures and also about the gaps in each of the domains. We're looking forward to another day of insightful discussions about updates to the Child and Adult Core Sets, but before we begin, I wanted to turn to Shevaun Harris and David Kelley, our two co-chairs, for brief welcome remarks. David?

Good morning everyone, and welcome to day three. And I just want to thank everyone for the great discussions that we had yesterday and the ongoing participation. Hopefully we'll have good engaging conversation as well today, and I encourage folks to really participate as much as possible so thanks again, for all the hard work. Shevaun?

Thanks, David. I want to echo your comments. This has been another fantastic event or Workgroup produced by Mathematica. I think there's been a lot of great conversations, and discussions, and recommendations made, and look forward to our last and final day. And so, thank you all, and thank you, Mathematica team.

Thanks, David and Shevaun. And I'd like to echo thanks to the Mathematica team who are working diligently behind the scenes to make this happen, particularly with the voting. And thanks to the Workgroup members for all their efforts yesterday to become very proficient with voting. So, we're looking forward to another day of great conversation and very insightful discussion, particularly about gaps at the end. So, next slide, please. So, now we'll conduct a roll call of the Workgroup members. Next slide. 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 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 again, and we'll unmute you. Next slide. So, in the next few slides, we've listed the Workgroup members in alphabetical order by their last name. When I call your name, please raise your hand and we'll unmute you, and you can indicate whether you're here, and remember to mute yourself in WebEx when you're done. So, we've already heard from Shevaun and David. Next, Richard Antonelli. Richard, are you in here? Okay. Let's move on. Lowell Arye.

Hi, it’s Lowell, good morning.

Good morning, Tricia Brooks.

Good morning everyone.

Welcome. Laura Chaise.

Good morning.

Morning. Lindsay Cogan.

Good morning, this is Lindsay.

And Rich Antonelli were you able to join? There you go. Rich? Can you unmute yourself, Rich, and say hello?

There we go. Good morning, I'm here.

Good morning. All right. Is Jim Crall on today? I think Jim may be out again today.

Amanda Dumas?

Good morning. I'm here.

Anne Edwards.

Good morning.

Kim Elliott.

Good morning.

Good morning. And Tricia Elliott is not able to join today. Karen George.

Good morning. This is Karen George.

Lisa Glenn.

Good morning.

Steve Groff. Steve? Okay.

Good morning.

Good morning. Next slide, please. Tracy Johnson. Is Tracy on?

Hi, I'm here. Tracy Johnson, Colorado Medicaid Director.

Hey, welcome, Diana Jolles.

Good morning.

David Kroll.

Hi, good morning.

Hey, Carolyn Langer.

Good morning, everyone.

Jill Morrow-Gorton. Is Jill on?

Hi.

Okay. Welcome. Amy Mullins.

I'm here.

Fred Oraene.

Good morning, all.

Lisa Patton.

Good morning. Hi, there.

Sara Salek.

Good morning. Good morning.

Good morning. Linette Scott.

Good morning.

Jennifer Tracey.

Good morning.

Michelle Tyra. Michelle, you should be unmuted now.

Good morning.

Morning. Ann Zerr.

Good morning. Good morning, Ann's here.

Bonnie Zima.

Morning.

Morning. And just a reminder after you have done your introduction, please remember to lower your hand.

I can see my hand, but I think it's lowered.

You see how to lower your hand? And, and Jill can you try to speak to unmute yourself?

Ah, there we go. I'm now, I'm now unmuted, and I can mute myself. Thank you.

Terrific. We want everybody to have a voice. All right, so next slide, please.

Okay. So, as you can see here, we've listed the federal liaisons who are non-voting members, and federal liaisons, if you have questions or contributions during the Workgroup discussion just raise your hand and we will unmute you. And I'd also like, once again, to take the opportunity to thank our colleagues in the Division of Quality in the Center for Medicaid and CHIP Services, and also all the measure stewards who are attending, and are available to answer questions about their measures.

Next slide. So, once again, we're going to do an icebreaker before we begin our conversation. So, Dayna, can you load up the Menti Poll? Okay. So, we've been enjoying starting off our days looking forward to warm weather activities, and here is, here is how the poll works. On your screen there are instructions to go to www.menti.com and enter the poll number which you can see on the top [redacted]. And our poll question for today is, what are your favorite picnic foods? And please enter a short response and press submit. You can also be thinking about cookouts, barbecues. We know there are regional differences in how these terms are used. And feel free to enter multiple responses. Looking like potato salad is a clear winner here so far.

All right, we'll give it another few seconds. All right, seeing potato salad, watermelon, beer, some hotdogs. All right, thank you everyone for playing along, and for launching our day today with an icebreaker, and we hope everyone enjoyed that. So, Dayna, let's switch back to the slides. And you can tell we're all excited for summer, so thanks everyone for participating. And now I'd like to turn it over to Alli Steiner, she'll lead the discussion of measures in the Primary Care Access and Preventive Care domain. Alli.

All right. Thank you, Margo. Next slide. So, this is a pretty big domain. I'm going to give a quick overview of the current measures in the 2021 Child and Adult Core Sets. So, first for the Child Core Set, the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents measure in the Child Core Set previously only included the BMI percentile documentation component, which is reflected in the 2019 data on this slide. And the counseling for nutrition and counseling for physical activity components were added to the 2020 Core Set in response to stakeholder input.

Next, we have measures of Chlamydia Screening in Women Ages 16 to 20, Childhood Immunization Status, and Screening for Depression and Follow-Up Plan: Ages 12 to 17. We also have Well-Child Visits in the First 30 Months of age, sorry the First 30 Months of Life, which is an updated version of an earlier measure that focused on the first 15 months of life. The number of states reporting on the slide is for the previous version of the measure. Next slide. The other Child Core Set measures in this domain are Immunizations for Adolescents, Developmental Screening in the First Three Years of Life, and Child and Adolescent Well-Care Visits. This third measure is a combination of two previous measures, namely Well-Child Visits in the Third, Fourth, Fifth, and Sixth years of Life, and Adolescent Well-Care Visits. And these are among the most frequently reported measures in the Child Core Set.

Next slide. Okay. And we'll move on to the measures in the Adult Core Set. So, this includes Cervical Cancer Screening and Chlamydia Screening in Women Ages 21 to 24. Next, Flu Vaccinations for Adults Ages 18 to 64, which has been suggested for removal, so we'll go over that in more depth shortly. The Screening for Depression and Follow-Up Plan: Ages 18 and Older is the same as a child measure, but with a different age range. And lastly, Breast Cancer Screening. And those are the existing Primary Care Access and Preventive Care Measures in the Core Sets, and so with that framing in mind let's dive into measures suggested for addition or removal.

Next slide, please. So, we'll start off with Flu Vaccinations for Adults Ages 18 to 64, which was suggested for removal. This measure is derived from the CAHPS 5.0H/5.1H Adult Medicaid Survey. The measure is defined as the percentage of beneficiaries ages 18 to 64 who received a flu vaccination between July 1st of the measurement year, and the date when the CAHPS survey was completed. The measure steward is NCQA, and it is NQF endorsed. The Preventive Care and Screening: Influenza Immunization measure was suggested as a replacement for this measure, and I'll - I'll present that measure shortly.

Twenty-five states reported this measure for FFY 2019; however, the measure was not publicly reported due to concerns about data quality. We also wanted to mention that preliminary results for FFY 2020 Core Set reporting, which is currently underway, suggest that this measure may have reached the public reporting threshold for FFY 2020. We also wanted to note that additional states or their managed care plans may be submitting CAHPS data to the AHRQ

CAHPS database. As Margo mentioned earlier, CMS is currently conducting a pilot to use results from the AHRQ CAHPS database for Core Set reporting.

This measure was suggested for removal for a couple of reasons, the first is feasibility. The Workgroup member who suggested the measure for removal noted that, although CMS's pilot has shown it is feasible to calculate the measure using data from the AHRQ CAHPS database, the data are incomplete due to lack of submissions for some states or plans. They also noted that responses and completion rates vary widely across demographics, and therefore it does not allow for consistent calculations across counties and states. And second, the Workgroup member recommended a replacement measure that is used by other CMS programs. We'll turn to that measure now. Next slide.

So as just noted, the Preventive Care and Screening: Influenza Immunization measure is suggested for addition and is proposed to replace the flu vaccination measure in the Adult Core Set. This measure is defined as the percentage of patients six months and older seen for a visit between October 1 and March 31 who received an influenza immunization or reported previous receipt of an influenza immunization during the flu season. The measure steward is NCQA, and it is NQF endorsed. The data collection method is electronic health records or clinical registry.

The Workgroup member that suggested adding this measure to the Core Set noted that the measure had been tested at the provider level using Medicare data. In addition, the measure is currently in use in selected Medicaid and CHIP value-based purchasing programs in their state, but has not been used statewide in Medicaid and CHIP. The Workgroup member also noted that the flu vaccine is important for reducing morbidity and mortality in Medicaid and CHIP, and that the measure could be stratified to perform comparative analysis. Additionally, the Workgroup member noted that the measure could be calculated using immunization registries, and that states could benefit from assistance in this area which would also benefit other immunization measurement efforts. And next slide. And I'll pass it back to Margo to facilitate Workgroup discussion.

Thanks, Alli. So, now we will invite Workgroup members to discuss these two measures. And please remember to raise your hand. Lisa Glenn.

A point of clarification. Is the flu vaccine in part of the, the bundle for the childhood vaccines already or not?

You're talking about the Childhood Immunization Status measure?

Right.

So, I believe that it is not part of the combo three that we are currently reporting.

Thank you. Thank you.

Sure.

And then just difficulties, right. I know that in our state, the childhood immunization registry is fairly robust. It's been fairly recently that the adults have come online, and it's still an opt-in in Texas. So, some difficulties collecting this measure if we add it, and it's done on registry or EHR data.

Thanks, Lisa. Jill?

Yeah. Flu vaccine is so important, but the, the - the sort of heterogeneity in the ways that people get their flu vaccine is somewhat problematic in terms of being able to gather it. Not all states have a really strong registry, and - and I would agree the registry for children tends to be much stronger than for adults, the, the - the kids are more likely to get theirs in their primary care office than the adults are, because not all states allow pharmacies and other ways to - to get your flu vaccine. And I know that this, that the proposed measure is a mix of EHR and reported, although you would have to have a way in your EHR to report that you'd gotten it, and the CAHPS is just reported.

I think, I don't know, I think both of these are problematic in terms of being able to capture flu vaccination, we have a horrible time trying to capture it and we use every source that we can, that you can imagine to try to get it. The other concern I have is that the current measure sounds like it is progressing, and - and becoming more mature. And, and I just worry about the sort of starting again, kind of thing.

Thanks, Jill. I did want to add one point of clarification about the two measures, going back to Lisa's comment about the age range for the flu vaccinations measures. So, the one that's in CAHPS is Flu Vaccinations for Adults Ages 18 to 64, and that's in the adult CAHPS. And as Jill mentioned, we are indeed making progress in terms of having more states reporting the measure. So, it does look like it could possibly be publicly reported this year through the CAHPS data submitted into the web-based reporting system. The Preventive Care and Screening: Influenza Immunization measure that actually does include a wider age range, and I believe it's six months and older. So, so they're a little bit different in terms of the capture both in terms of the age ranges, but then also in terms of the data source, one being self-reported through CAHPS, and the other being through a variety of data systems that would be pulled together electronically. Lowell? Lowell, I think you're next.

Yeah. Thanks. So, that was, that clarification was very helpful about age, but I do wonder, did they break it out all the way to, you know, in different age frames from I'll say like 60s, 65, 70, 75, 80, 85, and things like that, because especially for the geriatric population influenza is definitely a very significant issue, and wanting to be able to track that by age group I think is an important big piece and specifically, I had concerns about the adult CAHPS, because it, as you said, it only goes 18 to 64 and it doesn't go any higher. So, I actually like the addition, specifically, and I know in the states I've worked in they, they've - they've been able to track that fairly well.

Thanks, Lowell. Kim Elliott.

Good morning. So, my concern with the CAHPS measure that's currently in place with the flu is the declining participation in response rates across many, many states. And states are working really hard to try and improve their response rate to the CAHPS, but it still remains low and in many states it's still declining. So, how valid and reliable that data really is, is a little bit of concern or representative of who is really getting flu vaccinations is a little concerning to me, just because of the - the data that's being received. Regarding the new measure, I think that that shows a lot of potential when I looked at managed care organizations and states and HEDIS reporting, and performance measure reporting, the EHR, and supplemental data from EHR is expanding tremendously year after year. And although it's still a struggle to get some of

that data I think there's great potential in the next year or two to have that be a much more valid and reliable data source. Thank you.

Thank you. Lindsay Cogan.

I wish there was a way we could think about a glide path to these different sources of data reporting. So, if we, my concern is if we, if we change the modality now, what's going to happen is you will not have any insight or public reporting into the flu vaccine information coming up this year. So, if we make the switch, we remove, we then start from scratch. And we have to make sure we have enough states report before that information goes out. So, I wonder if there's a way we can think about some of these glide paths right into new modalities, and not lose insight into the - the data that sounds like it's ready to be reported, right? And so, I mean, I know that's not an exact answer, but - but we as a state in New York, are trying to move over to - to new ways of collecting information. So, this is the first year we're going to look at vaccinations not using the measure that was proposed, but a different measure, and then compare it with our CAHPS.

And so ideally, when we're looking to switch over, you know, it's hard for me to say if only one state is doing it this way, and we switch over, but if we, if we saw that, you know, this has taken off in states and, you know, 15 to 20 states have already moved over to this new modality, then yeah, I would be totally comfortable swapping that out, but right now, currently states have to complete the CAHPS, the information is there and there's been nothing that has said to me that the information we're getting yet is drastically under report - it doesn't really represent what we think it does. Everything that I see is the CAHPS rate still benchmarks quite well with what we see in other reporting mechanisms that are not specific to Medicaid, but maybe through the CDC or other - other ways that we see reporting of influenza information in our state.

So, nothing has concerned me that has said, you know, this is drastically different, you know, our rate of 40 percent of adults getting influenza vaccine coverage at a certain age range. Nothing has said to me, “Oh, this is so grossly misrepresenting where we are,” I think it's showing us we have lots of room for improvement, but that's what we see with other data sources as well, we kind of triangulate. So, I don't know if we could think about that. I think the Medicare Star Ratings does do a preview where they say, you know, coming - coming soon, it's not this year, but maybe next year or the year after is this measure. And maybe we could think about that in the, in the context of the Core Set, because I think we're going to have this discussion over and over again as - as new ways of capturing and collecting information come forward.

Lindsay, thanks for those comments. I suggest that you bring that back up when we talk later about gaps and future directions. I think that's a really helpful thing to think about as a Workgroup. Linette, you're next.

Thank you. I, I completely echo what Lindsay just said, around needing a glide path. I was thinking about this over the last couple days as well, because I feel like in attending the - the quality meeting over the last several years, I feel like CMS has been very clear, the expectation is that states are to start linking with their registries, starting to work towards the EHRs. We know we have a long path to go, but that's the direction we are to go. So, I feel like I have heard that as a state Medicaid person from CMS very clearly, and yet I get to this point where we're looking at these measures and - and to the - the comments people made, it's a sudden switch. So, what does that sudden switch look like? In terms of the - the CAHPS measure, I was pulling

up the numbers on NCQA, that report for the commercial HMO, PPO, Medicaid HMO. And, and one of the things that was interesting to me though was - was looking back to - to 2009 and earlier. 2009 was still only about 50 percent, and - and it stayed pretty constant, it's 50 plus or minus 2 percent for this on the CAHPS survey. Yet, in 2009 we had a flu pandemic, and we did a mass vaccination effort, and we kept the second round of the, the pandemic from coming back.

So, I would have expected if the survey was representing the activity that there should have been a bump in that year, because there was such a push around flu vaccine. So, so that makes me makes me wonder, but so there's, there's this aspect of when do we make the switch? How do we make the switch? The other thing I think that flavors the current environment right now, is that in this experience with COVID over this last year there's been a couple things.

One, flu, because of all the prevention we did for COVID, we didn't see flu. So, so that was an interesting dichotomy, right? And then the second part of it though, is - is with COVID we now have another mass vaccination event. And the only way to know who's getting vaccinated is to connect with the public health immunization registry. And the COVID vaccine is capturing all ages, and it's being required from the federal side as part of the COVID vaccine distribution, but I know for California, because of the way it's being delivered if we were to look at our claims data, we'd see a couple 100,000 vaccinations. If we look at the COVID vaccine data from public health, we see a couple million people getting vaccinated.

So, we have, I mean, it's clear to me that our connection to our immunization registries are probably the best way to do this. And with the work that's been done under the COVID response, I think there's a huge opportunity to leverage that for flu as well. And I would, I would be very surprised if we don't have some sort of measure coming up related to COVID vaccinations in the future that would perhaps be a combination COVID/flu. So, just looking towards the future, and thinking about that. Thank you.

Thanks Linette. And just a reminder, when you are finished making your comment to please lower your hand. Are there other Workgroup members with comments? Or questions? Lowell, did you have another comment?

Sorry.

Other Workgroup member comments, questions? Are we ready to move to public comment? Last call for Workgroup members to make comments or ask questions about these measures. All right. Well, with that, we'd now like to provide an opportunity for public comment. 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 again, a reminder to lower your hand when you're done. Do we have any public comments? And a last call for public comments? All right, so I think then we're ready to turn it over to Dayna and Alli for voting.

All right. Thanks, Margo. Just give us one second as we get the vote pulled up on the screen. Okay. So, for our first vote, should the Preventive Care and Screening: Influenza Immunization measure be added to the Core Set? Voting is now open, if the question does not appear on your voting page, please refresh your browser. We're waiting for just one more vote, so if everyone could take a look at their screen and just make sure their response has gone through. Shevaun, I think we might be missing your vote if you’re having any trouble, you can submit it over Q&A.

Yes. I am getting, I will send it in, in a moment.

Okay, thank you.

Okay. All the results are in.

Okay. And for the results, so 56 percent of Workgroup members voted yes, and that does not meet the threshold for recommendation. The Preventive Care and Screening: Influenza Immunization measure is not recommended by the Workgroup for addition to the 2022 Core Set. We'll move on to the next vote. So, the next question is, should the Flu Vaccinations for Adults Ages 18 to 64 (FVA-AD) measure be removed from the Core Set? Voting is now open?

Okay. We have 27 in, that's how many we're expecting.

Okay. And for the results, 33 percent of Workgroup members voted yes, that does not meet the threshold for recommendation. The Flu Vaccinations for Adults Ages 18 to 64 measure is not recommended by the Workgroup for removal from the 2022 Core Set. Next slide.

All right. Thank you, Dayna and Alli, and thank you Workgroup members for voting on these two measures. So, we have planned a 10-minute break, but we're a little bit ahead of schedule so what I'd like to do is have us reconvene at 12 noon, and then we will turn back to the final measure to be voted on and discussed today which is Colorectal Cancer Screening. So, everybody, enjoy your break and please be back by 12 o'clock noon.

BREAK

Hi, everyone, and welcome back from the break. We are now going to discuss one other measure suggested for addition in the Primary Care Access and Preventive Care domain, and I will now turn it back to Alli.

All right, thank you, Margo. Next slide please. The Colorectal Cancer Screening measure assesses the percentage of patients ages 50 to 75, who had appropriate screening for colorectal cancer. The measure steward is NCQA, and it is NQF endorsed. Currently the measure is specified for administrative, hybrid, and HEDIS Electronic Clinical Data Systems or ECDS reporting. Currently, NCQA is considering whether to transition the measure to ECDS-only reporting starting with measurement year 2024, which would correspond to the 2025 Core Set. Next slide please.

Three Workgroup members suggested the measure for addition. Regarding feasibility, they noted that although the measure is currently specified for Medicare and commercial plans, several states are already using the measure for their Medicaid programs, and that the required data elements are available in Medicaid claims. Regarding actionability and strategic priority, Workgroup members noted that colorectal cancer is the second leading cause of cancer death in the United States. And that screening effectively identifies precancerous lesions and reduces mortality. Additionally, they noted that there are currently inequities in screening rates by payer. The Workgroup members indicated that there is substantial, substantial room for improvement in screening rates, and that there are evidence-based quality improvement strategies in this area. These interventions are further described in the measure information sheets.

Finally, Workgroup members noted that the main technical challenge is a 10-year look-back period for colonoscopy. They noted that some states have been able to overcome this challenge by using EHR data. And they also noted that fecal testing, which has a shorter look-back period is increasingly being offered as a screening method. And now I'll pass it back to Margo to facilitate Workgroup discussion. Next slide, please.

Thanks, Alli. So, as always, if Workgroup members have a comment, please raise your hand. Rich Antonelli. Rich, you are muted. Can you unmute? There you go.

Yeah. Thank you, Margo. Margo, I, I don't appear to be able to unmute myself. So, I don't know whether there is a something wrong with my connection, but I'm glad to hear. So, I'm actually really excited to see this measure come forward. I've got two questions. One is I am a bit concerned that fecal occult blood testing meets the criteria. While that is important, in my view, there is not enough evidence to show that that would be equivalent to the other tests that that are listed there. So, I'd be concerned that the measure, just looked at bluntly, may not actually be promoting what is the evidence-based intervention. And then the second question that I have Margo, and fellow committee members is, is that has there been any look at the implementation of this measure stratifying by race, ethnicity, or language?

Thanks, Rich. So, for that I'd like to call on Sepheen Byron from NCQA to answer the question.

Hi, can you all hear me?

Yes, we can.

Oh, great. Thank you. Thanks so much. So, thanks for that question. So, first, let me respond to the FOBT. This, this is, this measure is based on a recommendation from the U.S. Preventive Services Task Force. And as they continue to recommend FOBT as it's an adequate method of screening, you know, we don't think that it makes sense for us to not have it in the measure. So, we include all the different modalities that the task force recommends. To the issue of race/ethnicity, we agree that that's really important. And in fact, we have just finished public comment in recommendation for the next iteration of this measure. And look, this is actually aligned to our work in health equity. And we are proposing to stratify this as one of five other, five measures to have race/ethnicity stratification as part of the measure.

This needs to go to final approval, which will happen around June, but thus far we had strong support from public comment for that. And it was our final recommendation which was approved by our initial voting body. So, it'll, it still needs final approval, but it's looking like that is going to occur. So, you know the other thing I want to mention, because right now this is a commercial and Medicare designated measure. And so another thing that NCQA is looking to do is to expand the measure for Medicaid in light of the U.S. Preventive Services Task Force recommendation that has not been released yet, but we anticipate will be released soon, that lowers the screening age. Thanks.

So that, that's helpful, but I think can you assure me that the U.S. Preventive Services Task Force gives equal evidence to fecal occult blood screening as it does for the other screening methods? And, and remember, I'm fully in support of - of colon cancer screening, but I'm not aware that those carry equal evidence. And we could be celebrating a somewhat hollow victory if the country moves toward fecal occult blood, because to my knowledge, and I'm just a pediatrician I apologize for that. I actually don't apologize for that, but I don't think that they have

equal evidence, but I could be wrong. So, if NCQA could address that, or maybe one of our internal medicine folks?

Yeah. So, it is included as part of an “A Recommendation,” so the task force does note that, you know, there are different risks and benefits to the different screening methods, but as of right now, you know, unless that changes which we don't anticipate it will in the new recommendation that's slated to be released, it is in there as meeting the evidence threshold that the task force uses. And that I think as we know, the task force has really the gold standard in terms of basing their recommendations on evidence. So, we feel pretty confident that, you know, this should be in the measure if the taskforce is recommending it. I think it would be hard to go out there, and you know, have a measure that doesn't have this method given that primary care physicians are being given this guidance to allow for FOBT. There are also issues with, you know, access to all the different screening methods, and so that's another consideration if you're looking across the country. If FOBT is the primary method that's available, I don't think we want to have a measure out there that's discouraging its use.

Thanks, Sepheen. Lindsay, you're next.

Thank you. You know, I think it's well past time that we have included this measure in the Core Set. It's clearly identified as a measure where there are disparities between Medicaid and commercial enrollees. And I think it really gets at to some of the social determinants of health, and you know getting time off from work, transportation, social support, all of those things that we really want to support in the Medicaid program. We see almost a 20-point difference between our commercial members, and our Medicaid members, and we've been measuring this for over, 2011, so this is 10 years now that we've been looking at this. And while we've made - made great strides in our Medicaid population we have not closed the gap between Medicaid and commercial. And also, it’s a screening measure that covers men and women, we have several screening measures in the Core Set already that really only address women, not very many that address men. So, I think - I think we should take a real serious look at this. And, you know, I'm excited to hear NCQA suggest interest in, in making this a Medicaid measure. And I think we'd be sending a clear message by putting this on the Core Set that we want it to be specified for the Medicaid product line.

Thanks, Lindsay. Amy Mullins, you’re next.

Yeah. Lindsay just said everything that I was going to say, so I don't want to repeat all that, but I agree with everything she just said, I completely support this measure being added to the Core Set, I'm kind of surprised that it's not already there. I think it, it is a way to help with the disparity issue. It is a USPSTF. I mean, colon cancer screening is a, is an A recommendation from the USPSTF. And I think that, and I really agree with the men and women, this you know, one measure covering both men and women for screening. It's really a good cross cutting kind of measure for that too. So, I'm fully supportive of this being added to the Core Set.

Thanks, Amy. Laura Chaise.

Hi, and so I agree. I'm really glad we're talking about this measure. Just a question about reporting relative to dually-eligible individuals, so it looks like the exclusions would remove Medicare folks that are living in institutions or in I-SNP plans, but I, A) just want to confirm that I'm understanding correctly that it would continue to include the majority of dually eligible individuals who are in the community, and also would be curious just how Medicaid entities that

have been reporting on this measure have - have gotten over any challenges with regard to getting this data for dually eligible individuals?

Thanks, Laura. Why don't we move on to Kim Elliott, and then Linette Scott? Kim you are muted.

Thanks, I couldn't unmute it, you had me muted. I just wanted to say, because we've been adding so many adults to the Medicaid program particularly through Medicaid expansion in many states, adding another measure that can really capture some quality and health indicators, particularly screening for men and women in that age category I think is really important for us to think about as we develop the core measure sets.

Thanks, Kim. Linette?

So, I echo what my colleagues have said, the - agree with adding this to the, the reporting. I would just add that in California we've been using this measure in a couple of our program areas within the Medicaid program, although we haven't done it for the whole Medicaid program yet, in terms of running the measure. And it is a measure, though, that we're talking about alignment with our other public programs, our Covered California, and our CalPERS programs. So, so having this would definitely be a good alignment from that perspective.

With respect to the question around the - the dually eligible, we've, we've been working with our, our CMS colleagues around data for the, the people who are dually eligible. And we've received fee-for-service data, but not managed care data for those folks from CMS. So, it's not something we can really run unless we have both the fee-for-service and managed care. We're a very managed care-oriented state overall. So, on the one hand there's a possibility, on the other hand it may not be possible at the present time depending on current data sharing. Thank you.

Thanks Linette. And I wanted to follow back with Sepheen or any other state partner about the inclusion of dual eligibles, given that the measure is not currently specified for Medicaid, right? I think that's a future direction, but wondering Sepheen if you have any insights about that, as it would pertain to use in the Medicaid population?

Right. Can you all hear me?

We can, thank you.

Okay, great. Yes, I, you're correct, that it's not because it's not part of Medicaid, yet we would have to look into that, but we do include dual eligibles in other measures, and we have guidelines around how to count that if you have, you know, Medicare and Medicaid. And so, they are not excluded, and so I don't imagine we'll have issues with that. So, but it is something we'll explore as we explore putting Medicaid into the measure.

Are there any other states that have experiences related to dually eligibles for this measure? Are there any other Workgroup member comments on this measure or questions? Jill?

Yeah. Margo, I was just wondering if one of the states that has used this could speak to the 10-year look-back period.

Thanks, Jill. That's a good Question. David…

I can, I can speak to that Margo.

Right? Go ahead, Lindsay.

Yeah. So, in the beginning people were very concerned about the 10-year look back. You always care about, you know, how much people churn in Medicaid and, and so I would say in 2011 when we started, I quantified this. So, what we did to kind of bridge that worry was we said, okay, so as the Medicaid program you send us the list of the people that are in your measure denominator, and we'll bump it up against our Medicaid claims and encounter system, and we'll look to see who, who's had a screening, maybe they were on another plan, maybe they were fee-for-service. And if we can find evidence of one, we'll give you credit for it.

And so, we, that was the agreement to kind of get us kicked off and started, and kind of alleviate that concern, right? So when we started doing it, we would find about 1,000 extra hits in our data out of the 10,000 people in the denominator, because this is a hybrid measure, and we had a sample of 411 across, you know, 18 or 19 plans I think. So, we would find about 1,000 extra hits. Now we're finding less than 300 when we do kind of this longer look back. So, that speaks to a couple different things. It speaks to you know, there's much less of this idea of churn, churning in and churning out, churning off. We see much more continuity in our population now because of expanded Medicaid eligibility and other things we've implemented in our state. Two, is the ability to access data in other ways. So, being able to access information on a patient's historical information through that provider, through using our HIEs, as well as we've also engaged in much more claim sharing information when a member comes into a plan, and we try to give them some of that historical information, so that the plan knows when they need to do outreach.

So, the numbers of those extra, sort of the extra credit we've been giving have gone down each year. So, it's not un-surmountable, it's about one to three percentage points we see on average per plan that if we didn't give them the extra credit, they would look maybe three points lower. In my mind, that's not enough to justify not doing the measure if it was, you know, 10-to-15-to-20-point differential here then yeah, that that's a little bit misleading, but we're talking about really a small margin when we sort of go back that long, which tells us we're not meeting the needs of this population. So, we want to try to sort of dispel this myth that there's a bunch of information hiding out somewhere that you just can't see, because of the 10-year look back.

Thanks, Lindsay. David Kelley.

Being the general internist, I had to, Rich, I had to answer your question. So, I went onto UpToDate about the fecal occult blood testing, and according to UpToDate, the sensitivity is about 70 percent. Its specificity ranges between 87 percent and 98 percent. And that compares to a sensitivity of colonoscopy every 10 years of 95 percent, CT scanning of 84 percent. The fecal immune testing ranges between 73 percent, and up to 92 percent for the DNA-FIT testing. So, it is lower, but it is still within that acceptable range. And there's a fair amount of specificity to the test. So, not perfect, but the U.S. Health Preventive Task Force does still include that in their recommendation, so just wanted to provide that information.

Thank you.

Thanks, David. Any other Workgroup member comments or questions about the measure? We will have public comment when we are done with Workgroup discussion. Rich, did you have any other questions or comments that you wanted to make? Carolyn Langer?

Yes, I was wondering if I could ask a question of our guests from NCQA. I know that a lot of health plans will send out the FIT DNA tests directly to their members. I'm just wondering if NCQA has thought about putting in place some sort of guardrails, so that, first of all, the health plan gets an order from the PCP before they do that. And secondly, ensuring that the results do get sent back to the PCP. I've heard of some health plans that actually have one of their medical directors write the order, and the health plan ships it out, which isn't, isn't very good medicine.

Sepheen, is this something you can speak to? Derek, can you unmute Sepheen in case she's re-muted?

Thank you. Yeah, I was talking on mute. So, thanks for that question. So, yeah, that's interesting. FIT DNA, as you know is a - is a newer modality that we had added relatively recently. And so, it is interesting to hear sort of how it's being put out in the field. We do look to see that the results occurred. I have to look to see exactly how it's specified in terms of this particular one, but in the hybrid discussion, we are - we are looking for results, and so that would speak to a guardrail in terms of making sure it's not just that the test was ordered. I need to see how the codes work around the administrative specification for that.

Yeah. I would highly encourage you to think about adding into the standard that if a health plan is going to ship out these FIT DNA tests, they must obtain a PCP or other treating physician order to do so. And that the results must go back to the PCP or other ordering physician.

Right? Yeah, and I've got the spec open, I'm just looking at it. It definitely requires that the FIT Test was done, so not just shipped out you know, for most of these we are looking for something that goes beyond somebody simply sending out a test. So, yeah, and you know, that would also be part of our, NCQA's audit.

Yeah, I mean, the claims come in, so the test is done, and health plans can easily provide evidence of that. My concern though is that I think, some health plans are gaming the system, if you will, and sending them out on their own without a PCP order. I don't think it's a lot. It's definitely not the majority, but I just think it's an important guardrail to include in the standard, that a, that a PCP order must be obtained, and the results must be sent back to the PCP or other ordering provider. I mean, it may not necessarily be the PCP, but it should be the - the patient's own treating clinicians. You know, it's just a more holistic approach that way. And frankly, I'm surprised any health plans would take this on themselves, to write an order. It's a liability issue for them as well, but I have heard out in the field that that does happen occasionally.

Thanks, Carolyn. Ann Zerr.

One is with FIT testing and Cologuard testing, a positive result then flips the colonoscopy from a screening to a diagnostic. And in Medicaid, for most of us that doesn't change the patient's out of pocket expense, but it does in commercial insurance, because screening tests according to the Affordable Care Act are covered at 100 percent by the insurer, so that's one issue. The second is that with Medicaid being a lower payer, many gastroenterologists in Indiana at least

don't accept Medicaid, and so, I - I'm totally on board with this measure. I love it. And I think it's incredibly important. It's challenging, but incredibly important, but I do worry that gastroenterology, that Medicaid members may only be eligible in some areas for stool tests rather than colonoscopies. And so, it's just, it's sort of channeling my colleague's equity thing. And so, I do think that the race and gender of people who are screened is an important thing for all of us to keep an eye on.

Thanks Ann. Just to clarify, are these implications for the re-specification of this measure for Medicaid or are you concerned about alignment between commercial and Medicaid, and comparability of results? Could you maybe clarify a little bit what your concerns are?

So, I think it's all of those things. One is the out-of-pocket expenses for diagnostic tests for all people are very significant when you're talking about a colonoscopy. And so, you know, you're, you've been ordered, you've been offered a stool test, and which was positive, it's sort - it's the same thing as a diagnostic mammogram for an abnormal mammogram. Now, suddenly the diagnostic results in a lot of out-of-pocket expenses for the woman or - or in the colonoscopy whichever person had the test. And then my other concern is that I know that the American Gastroenterology Association or whoever that they are, they're looking for, for encouraging more stool tests, which I think is good, but we want to make sure that patients who really should have colonoscopies as their diagnosis–as their screening measure because of their higher risk, if they are lower income and insured by Medicaid–we'd like to make sure that they still have access to colonoscopies.

Thank Ann. Carolyn Langer?

Yeah. I just wanted to address your concern, Ann, we did see that early on. And I work both as you know, Ann, at our state Medicaid program, as well as at a few of our commercial payers in my state. So, - so at least in our state, most payers have changed their policies for exactly that reason. You had patients going in for what they thought for example, was a screening colon, colonoscopy, the gastroenterologist did a biopsy and then suddenly billed it as a diagnostic. And the reason most health plans changed that and made sure that particularly for commercial and Medicare members who might have some cost sharing is A) because of the member abrasion, a member going and thinking they were having a screening test to end up with a bill for cost sharing for a diagnostic. And the other reason is also, because of HEDIS, and the desire to ensure that they could encourage their members to comply and to remove you know, one more obstacle or barrier to members going and getting their screening colonoscopies. I can't speak for other regions of the country, but in my state anyhow, that issue seems to have resolved. Thanks.

Thanks, Carolyn. Ann, I see you have your hand raised still. Is that from before, or do you have another comment? Okay, thank you.

It won't go down. I'm very sorry.

No problem. No problem. So, I don't see any other Workgroup members with comments or questions. This is the last call for Workgroup members before we move on to public comment. Any other Workgroup members that wanted to make a comment or ask a question? Okay. So, with that, we will move into our public comment period. 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. We'll let you know when you've been unmuted, and

please remember to introduce yourself by name and also give your affiliation. So, Derek, can you please unmute Courtney Moreno?

Hi, good afternoon. Can you hear me?

We can.

Wonderful. My name is Dr. Courtney Moreno. I am a radiologist at Emory Healthcare in Atlanta, Georgia, and speaking on behalf of the American College of Radiology Colon Cancer Committee. The American College of Radiology supports the Colorectal Cancer Screening measure. The ACR is a professional organization representing nearly 40,000 radiologists, radiation oncologists, interventional radiologists, and nuclear medicine physicians and medical physicists. The ACR also supports the positions at the American Cancer Society, and the USPSTF, that the best colorectal cancer screening test is the test that gets completed, and that patients should be given the option of stool-based tests, optical colonoscopy, and CT colonography, also known as virtual colonoscopy. CTC has also been given an A grade from the United States Preventive Services Task Force. Thank you.

Thank you. Next up is Samir. Derek, can you please unmute Samir?

Hello, good afternoon, everyone. My name is Samir Gupta. I'm a professor of medicine at UC San Diego, and a member of the California Colorectal Cancer Coalition. I strongly support this measure. I think that this is the single biggest policy move that can be made to address the persistent disparities that exist in colon cancer screening and outcomes among underserved populations. I think this will really bring Medicaid plans to put a lot of attention to doing the things that need to be done to get screening rates up for this population. And it will make a world of difference. I really think it's the single most important thing.

I want to just briefly mention that the Preventive Services Task Force in their modeling studies have demonstrated that a program of stool-based testing can achieve similar outcomes to a program of colonoscopy. And that in fact, is one of the reasons why they have continued to include stool-based testing on their list of recommended tests. And I just want to thank you all for taking this very seriously and considering the measure, and I hope you all will vote for it. Thank you.

Thank you so much. Daniel Anderson. Derek, can you unmute Daniel?

Hi, I hope you can hear me this time.

We can.

I just wanted to, can you hear me?

Yes, we can. Thank you.

Great. Thank you so much. I'm Daniel S. Anderson. I'm a gastroenterologist. I'm the President of the California Colorectal Cancer Coalition. And I want to thank Samir and other people on the call that are supporting this, and also the voting member participants for supporting. I second words Samir said that programmatic stool testing is probably equivalent to colonoscopy. And in fact, randomized control trials have been done in stool testing, but haven't been done in

colonoscopy. And there are presently three randomized controlled trials comparing colonoscopy and stool testing. And it'll be interesting to see which is actually the best; I suspect they'll continue to be equivalent. So, I think that problem is one you don't have to worry about.

Stool testing, I won't say what I prepared to say, because most people have already talked about it, but I think it's important to know that a program of stool testing with a mail-out stool testing from Northern California Kaiser increased their screening rate about 43 percent. And over that time, they saw a decrease in their instance of colon cancer of about 30 percent and a 54 percent decrease in their colorectal cancer mortality. And when we were writing the cancer plan for California for 2021 to 2025, we were looking at disparities, and we were surprised to see that our biggest disparity was in the insurance type people had. And if you had Medicaid, which we call Medi-Cal, you had a 71 percent late-stage diagnosis compared to 64 percent in Medicare and commercial.

And oddly enough, the late-stage diagnosis in our Medicaid population was the same as in our uninsured population. And this has, this trend remained through 2018. We just got that data. So, adding this to screening, because of course we report Colorectal Cancer Screening in our commercial and Medicare population, will be extremely important. And if you add this to the CMS Medicaid Adult Core Set, California will adopt it. That's our stance we're, we're looking at the Medicaid Adult Core Set as our set of quality measures. So, I strongly encourage you to vote for this. And thank you so much for all the comments, and the comments to come. Thank you.

Thank you so much. And I just want to mention that we have a lot of people queued up for public comment. So, I'd like to encourage you to keep your comments brief, and so we can be sure to hear from everyone. So, next up is Rachel. Derek, can you unmute Rachel, please?

Good morning, or afternoon and thank you so much. I'm so pleased to see this measure up for discussion. And I do hope that the committee members vote for it. I'm a gastroenterologist and a health services researcher at the Fred Hutchinson Cancer Research Center at the University of Washington. And we know that quality performance measures are used by multiple entities to improve quality of care. We know that CMS has adult set performance measures, and that currently include breast and cervical and don't include colorectal even though the death, and overall impact of colorectal cancer in this country are greater.

We also know that in the states that have adopted this, and those include Oregon, New York, and Minnesota, that when you look at colon cancer screening between Medicare and Medicaid, that actually participation of most Medicaid enrollees improved by 10 percent. So, I also echo what Dr. Samir Gupta mentioned, this is one of the most modifiable things we can do to decrease disparities in colorectal cancer. So, thank you so much for your support, and for this opportunity to provide a comment.

Thank you. And I'd just like to remind public commenters to please lower your hand after making your comment. So, I believe next up is Heidi. Derek, please unmute Heidi.

Hi, this is Heidi. Can you hear me?

We can.

Wonderful. Okay. Just briefly, Heidi Bossley on behalf of the American College of Gastroenterology. And we would like to voice our support for inclusion of this measure. Thank you.

Thank you. Next up is Molly. Derek. please unmute Molly.

Hi, thank you. My name is Molly McDonnell, and I'm the Director of Advocacy for Fight Colorectal Cancer, a national patient advocacy organization dedicated to the colorectal cancer community. Fight CRC strongly supports adding colorectal cancer screening as a quality measure. And we're grateful to the Workgroup for considering this addition. And so I just want to quickly echo the remarks of those who've spoken before me, and again reiterate that this is really critical to address the disparities that exist in colorectal cancer screening, and to add this measure would be good for patients and good for the healthcare system. You know, to really ensure that we're doing everything we can to encourage and incentivize colorectal cancer screening so thank you.

Thank you. And Derek, can you please unmute Richard.

Hi, I'm Dr. Richard Wender. I'm chair of the Department of Family Medicine and Community Health at the University of Pennsylvania, and I'm also the chair of the National Colorectal Cancer Roundtable [inaudible] …for considering it.

Thank you for your comments. Next up is Bev Green.

Yes. Hi, I'm Bev Green and I am a senior investigator and a family physician at Kaiser Permanente Washington, and I just work in the area of implementation strategies to increase colorectal cancer screening in diverse populations. And one of the biggest barrier to scaling these up is lack of metric, that very successful programs have decided to not prioritize it, because they have other things they have to measure, even though they've experimented with these and found them to be very successful. I also want to make the point that in most states that Medicaid, at least in our state in Oregon, that Medicaid will pay for all the out-of-pocket costs. So, Medicaid-insured patients, even if the colonoscopy is diagnostic after a positive FIT, the patient experiences no cost, because the insurance plan covers it already.

Thank you. Next up is Heather.

Hi, thank you so much. This is Heather Dacus. I am a preventive medicine public health physician at the New York State Department of Health. I want to voice my support for this measure being added. As a public health practitioner, having New York State measure colorectal cancer screening in the Medicaid population has really allowed us to implement some good programming at the local level, targeted to disparate populations. And so, for that reason I would see that this would be really valuable for other states to have access to. Thank you.

Thank you. And I just wanted to mention, we're coming toward the end of the queue of public comment. If anyone else has a public comment, please raise your hand. Next up, Caroline.

Hi, good afternoon. This is Caroline Powers, Senior Director of Federal Relations for the American Cancer Society, Cancer Action Network or ACS CAN. I'm also the co-chair of the policy task force for the National Colorectal Cancer Roundtable. And as such, I just want to say

thank you for considering the measure today, and that we are extremely supportive. And I want to associate myself with the remarks that were made previously. And again, thank you.

Thank you. And Gloria, you are last public comment.

Hi, my name is Gloria Coronado. I'm an epidemiologist at Kaiser Permanente Center for Health Research, and just want to say yes, all the comments have really been made. And I think it is really important to know that screening saves lives. And we've seen a significant reduction in colorectal cancers in the older population over the last several decades, but as Dr. Wender mentioned, rates are increasing in the 50 to 54 age group. And they're increasing in the younger age population as well. And we know that U.S. Preventive Services Task Force recommendations are about to change. So, I think that the important thing to note is that many of those patients are eligible for Medicaid, and yet we know that the Medicaid screening rates are substantially lower than commercially insured and much lower than Medicare.

We have had success in Oregon of having a reportable Medicaid metric. It has also historically been incentivized here in Oregon, and as Dr. Issaka mentioned, that has resulted in over 10 percentage-point increase in our rates among Medicaid enrollees. So, we're really proud of that accomplishment. So, I give my wholehearted support for this measure. And I applaud the committee's interest in including it as part of a disparity subset, because we also know that there are important and significant disparities in access to colorectal cancer screening.

Thank you. With that, are there any other public comments? Ann Zerr and Gloria, could you please lower your hands if you're done commenting? Thank you. Any other public comments before we move on to a vote? Okay. With that, I would like to turn it over to Alli and Dayna to facilitate the Workgroup vote.

Thanks, Margo. Okay. And so, for our final vote, should the Colorectal Cancer Screening measure be added to the Core Set? And voting is now open, as a reminder if the question does not appear, please refresh your browser. We're at 26 we're looking for one more vote, and there we go everyone is in. Okay. And for the results 100 percent of Workgroup members voted yes. And so that does meet the threshold for recommendation. The Colorectal Cancer Screening measure is recommended by the Workgroup for addition to the 2022 Core Set. And so, I will turn it back to Margo now for a discussion of gaps in the Primary Care Access and Preventive Care domain. Margo.

Thanks, Alli. And thank you to Workgroup members and public commenters for a very informative conversation about the measure, really much appreciated all of the evidence and data to support this conversation. And I think this may be the first I've ever seen a measure be unanimously recommended for addition. So, thank you all. So, as Alli said, we are now going to turn to gaps in the Primary Care Access and Preventive Care domain. So, 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, who would like to go first among Workgroup members? Do we have any suggestions for gaps in this area? Linette?

One of the things I would, I would echo from some of our earlier conversation, I don't know that I have a specific measure in mind per se, but especially on the adult side we do have this opportunity to add things, and so thinking about the use of things like registries, and also EHR data, because the adult measures outside of behavioral health are not going to be required in

2024. There's a little bit more room on the feasibility piece in terms of being able to do something that might take a little bit longer for states to come up to. So, I just wanted to flag that. We'll probably flag it in the general gaps conversation as well, and being able to think about that aspect. Thanks.

Thanks Linette. Lindsay.

I think one thing I really like about some of the measures, especially in the Primary Care Access and Preventive Care domain is that the denominator is population based. So, you can very clearly see when you start to stratify some of these measures, whether or not we're being equitable, and who is actually getting the care they need. So, I think a very, something we already do as states is report stratified measures. It's an optional field at this point, but maybe for a small subset of measures, we make that stratification required. And we actually put out the information. I just think it's important to ensure that we have equitable access to care, and this is one step where we've already been reporting stratifications to CMS. And I'm just asking now that we think about prioritizing some of these population-based measures and really commit to require reporting on behalf of the state. And then I want CMS to turn around and publicly report some of these measures stratified by certain characteristics of our population.

Thanks, Lindsay. I think that is a great topic to pin for the next section where we come back and talk about future directions. And I would definitely encourage Workgroup members to think about which Core Set measures might be part of that prioritized list that Lindsay just referred to. Other Workgroup member comments? Kim Elliott?

One of the things that I keep going back to is that we really are kind of underrepresented on measures for men in the prevention and access to care. So, maybe even considering things like prostate cancer screening would be a potential opportunity for us to really do a little bit better job on measuring care for that population. And the LTSS, I'm still always looking for ways to look at primary care access and preventive care for individuals that are served in the LTSS or MLTSS population. I think it's still a bit underrepresented in the Core Sets.

Thanks, Kim. Rich?

Yeah. I think, what I want to do is actually borrow a quote that I've heard from many, including families, which is behavioral health is primary care. And our group structures our conversations around these various domains. Some of the tension that we've been feeling in the last couple of days, especially during discussions around integration, really gets at that point of tension. So, thinking about social determinants of health, health-related social needs, traditional mental health, behavioral health, developmental support, family support, et cetera.

And so, I guess I just want to call out this idea that we're being asked to think inside some of these boxes, and crossing over is, it creates a little bit of tension for me as I think about health in a comprehensive way. So, the gap here might be thinking about measures that would force integration from sector to sector or setting to setting. This will be especially relevant for persons with complex needs, behavioral and neurodevelopmental disorders, and certainly anybody who has significant social determinant risk factors. So that's, I'll conclude my comment with that, Margo.

Thanks, Rich. Carolyn Langer.

Yeah. So, just following up on two comments, I'll start with Richard's. I think I also made a comment two days ago about the need to really drive more behavioral health integration into primary care, especially given the access issues. It is, short term anyhow, the only way to really improve access is by providing more of these services especially for mild to moderate cases in the primary care setting. So, I definitely support what Richard said. And then I think it was Lindsay who talked about more preventive measures for the LTSS population. And I just wanted to also put in a plug for that. I think in general, there are some real challenges with access to primary care and preventive services, and in particular, in transition age patients. So, those who are transitioning out of pediatrics practices into adult medicine practices, you do get into issues with numerators and denominators, but I would hope we can start thinking about ways to develop measures for the LTSS population. Thank you.

Thanks, Carolyn. Jill.

Great.

We can hear you.

I was, I was unable to unmute myself again, it was grayed out, but anyway, I actually, so as we think about the LTSS population and the population of people with disabilities, I think we should be thinking back to what are general health screenings for people, because that's what tends to get missed, because people are paying attention to the sort of acute problems, the seizures or the arthritis or whatever, and they're not always thinking about the general screenings. And so, you know, things like cholesterol screening, which is really basic, doesn't always happen. And so, I actually like Lindsay's idea about thinking about going back to things that the, essentially the population is the whole population. So, you're looking across the population and then being able to, to sort of slice and dice them based on various groups that they fit into.

Thanks, Jill. Any other Workgroup member comments? All right. Well, I think that concludes this part of the meeting. And we will take another break. I want to thank Workgroup members, measure stewards, public participants for all of your discussion this morning, all your participation. And we will take a break and be back at 1:20 when we will turn to the last part of our meeting to reflect on the last three days and think about some future directions. So, I hope everyone enjoys the break and see you back here at 1:20.

BREAK

Hi, everyone, welcome back from the break. We've come to the reflections part of the meeting where we review the Workgroup recommendations, discuss remaining gaps and future directions, and consider opportunities to support states in reporting the Core Set measures, and also provide feedback on this year's review process. Next slide, please. So, this slide presents a high-level agenda for this part of the meeting. To begin, I'd like to recap the Workgroup's recommendations for updating the Core Sets.

The Workgroup considered a total of 21 measures, including seven measures suggested for removal and 14 measures suggested for addition. As a reminder, to be recommended for removal or addition a measure required a yes vote from at least two thirds of the Workgroup members. Thanks to everyone for managing the voting technology in this virtual environment.

So, of the seven measures suggested for removal, the Workgroup voted to recommend four for removal, and those four measures are: Percentage of Eligibles Who Received Preventive Dental Services (the PDENT measure), Ambulatory Care: Emergency Department Visits measure, Audiological Diagnosis No Later Than 3 Months of Age, and PC-01: Elective Delivery.

Of the 14 measures suggested for addition, the Workgroup recommended seven measures for addition, and that includes: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence for the Child Core Set; Follow-Up After Emergency Department Visit for Mental Illness also for the Child Core Set; Oral Evaluation, Dental Services; Prevention: Topical Fluoride for Children at Elevated Caries Risk; Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis; Long-Term Services and Supports Comprehensive Care Plan and Update; and finally Colorectal Cancer Screening.

So reflecting on the Workgroup discussion and recommendations over the past two and a half days, there was considerable discussion across three criteria discussed on the first day, namely: desirability of measures as reflected by their strategic priority and actionability to improve care delivery and outcomes among Medicaid and CHIP beneficiaries. Also, technical feasibility of measures for states to collect the data and calculate the measures for Core Set reporting and finally, financial and operational viability of measures, which relates to state reporting capacity and resources.

And it was very clear during the Workgroup discussions that there was a lot of effort to balance across these three criteria of desirability, feasibility, and viability. And really appreciate the Workgroup members talking about those three different aspects, and really grappling with coming up with recommendations that reflect the intersection and optimization of those criteria.

So, at this point, we'd like to pivot the discussion to future directions for the Core Sets in terms of cross-cutting measure gaps that should be addressed and implications for the development of new quality measures, such as domains for future focus, data sources for state-level reporting, and use of other existing data sources.

And just want to mention a few ground rules for this discussion. We've already had a very rich conversation about specific gaps in the domains, and also some cross-cutting gaps, particularly related to the stratification of measures by race, ethnicity, language, and disability. As well as thinking about future data sources and a glide path toward moving in the direction of emerging data sources. So, I'd like to encourage the Workgroup members to please not repeat gaps that have already been mentioned in the previous discussions, but to build on previous comments to keep the discussion moving forward and offer new insights to help improve the Core Sets and how they can drive quality improvement in Medicaid and CHIP. And now I'd like to open it up to the discussion by Workgroup members. So, if you have a comment, please raise your hand. Actually, maybe I'll turn to our co-chairs, David Kelley and Shevaun Harris for a few words to also kick off this conversation. David, do you want to go first?

Sure. Thanks, Margo. So, I mean, from my standpoint, I think there’re two quick points I'd like to make. One is in the future, we need to continue to move towards electronic capture of quality measures, whether that's through better immunization registries, more health information exchange methods, I think that is the wave of the future. And hopefully, we can continue to work with both state and federal partners as far as electronic measurement. Secondly, I think it's vitally important to stratify many of the current measures by race, ethnicity, as well as regional variances. We have done this for many years. I think we're right now at about 22 or 23

performance measures in Pennsylvania, where we have identified inequities both statewide and regionally. So, I would really encourage CMCS to think in terms of not just adding to the Core Set, or deleting from the Core Set, but thinking in terms of the stratification by race and ethnicity so that state programs can really define where there are inequities. So, I also just want to thank the Workgroup for all the great comments, and robust professional discussion. Thanks.

Thanks, David. Jill?

So, I would like to second what David just said, both of those points. I think electronic captures is the best way to go in terms of work and whatnot. And, the ability to stratify and look for disparities. I'd like us to think about how to address the LTSS population in a way that's not just focusing on LTSS. It's a very varied population of people, they have multiple different needs, but one thing that sort of makes them stand out from some of the other populations is that they tend to have a lot of diagnoses, and a lot of sort of medical complexity. And I would like to see us figure out a way to measure the quality of care for people with multiple complexities. And there are children in this group, there are adults, there are people with behavioral health and physical health problems, people with physical disabilities, but I think that, I think that's a bit of a gap in terms of being able to look more holistically. And I think it's not just the LTSS population that would benefit from that.

Thank you. Lowell.

Yeah. Thank you. To kind of add on to that I mean certainly, my perspective on LTSS I should say that it's difficult in this world of LTSS itself to actually get anything from like the claims data, because in my mind what we truly want to know is, are the services supporting the people, the person living in the most integrated setting appropriate to their need? That's what you need to figure out. And the only, and you can't get that from the claims data. You have to talk to the people, and or their families. And so, using those kinds of things yes, we just recommended putting the care management, but there's more to it than that. There's the person centeredness, there's a difference. And Shevaun I agree with you about - about that more holistic kind of look, see, but there's several components of it. One is the individual LTSS services and supports, and then there's the integration of the physical health, which we have to really focus in on as well as the linkages with behavioral health especially for this population, because of all the issues of social isolation, et cetera, et cetera.

So, I, just focusing, and I really think that that would be to be able to do that, and I don't know, and I can't be sure that CMS is doing this at this point. And it's just unclear, and I would recommend to move forward is to really get CMS to sit down with this Workgroup and actually say, this is what we want to do, and this is how we're doing it, because right now, we've seen the RFI, but that just doesn't quite explain it. So, until that's done, I don't think we can, we need to use that as a way to move forward as a Workgroup so thank you.

Thanks, Lowell. Kim, do you have a comment or is your hand still raised from before? Okay. Lisa Patton you're next.

Thanks, Margo. Yeah. I mean, so taking the long view of the work that this group has engaged in over the past few years, I think it's, you know, I think it was very daunting when we first began discussing the mandatory reporting coming up, and how we would get to a set of core measures that really balances some of those competing factors, and cuts across the population of interest, all age groups, lots of disparities, and data that actually can be collected, and is actionable. And

so, I want to applaud the efforts of the group in moving in those directions. And, as we've talked about quite a bit over the past couple of days, you know kind of forward thinking, the more that we can bring to bear some of those social determinants of health factors that really impact access to care regardless of coverage. You know, and I think the colorectal screening measure that we looked at earlier today and voted on is a great example of the type of measure that can get at those health disparities in some different kinds of ways, and really empower the beneficiaries and the consumers in their own healthcare process. And so I just really want to, you know, say the more we can look at those kinds of access issues and build those into the measures that we're moving forward with, I think the stronger picture we will be able to offer CMS and you know, we'll make much better strides in terms of reaching these vulnerable populations where they live.

Thanks, Lisa. And Linette.

I wanted to pick up on something David said, and I think that we've talked about is, thinking about how we do that transition from claims data to our EHR and registry data. It's an important transition, I know we've talked about it before. So, it's not so much a gap in what a specific measure is per se, but it's how we collect the measures. So, in other parts of our industry right, there's transition to e-measures, e-clinical quality measures that are coming from electronic health records and from registries.

So, making that transition for Medicaid I think is a significant investment. I think the interoperability rules are going to help drive us in that direction. So, thinking through how that works, helping to draw the connection between the interoperability work and Core Set measures is going to be really important. Also, as we move towards having required reporting, I think we need to think about that as well. So, I think Lindsay mentioned it earlier, the idea that the Medicare Star Ratings will signal that a measure is going to be required in "X" timeframe or soon. I think we need to have an opportunity for that with measures that would be added so that it decreases the barrier to adopting new measures or making changes over time in the required setting. So, those would be kind of process things I think that are gaps that we need to look to address. Thank you.

Thanks, Linette. Lindsay? Lindsay you're muted. There you go.

There we go. Okay. To kind of build off of that and something I mentioned earlier, you know, I think leveraging existing data sources would be great. So, rather than having every single state do it a different way, if there is a way we could start to centralize, and I know there's a desire to use T-MSIS data. And I know states have put in a great deal of time and effort to clean up their T-MSIS data where it hasn't been great. I think that similarly, if there are other data sources that are already collecting this information, and they don't have payer, add payer. I mean, to push it out to states in which we are trying to scrape together budgets, and our workforce has been dramatically decreased over the last year in New York, I don't know about in other states, but we've had everything from retirements to people leaving public service, because they're just exhausted.

We're doing much, we're going to have to do much more with much less. So, we really have to find those efficiencies, and hone in on where we can direct resources to improving care. I would hate to see us get into this exercise where we're spending all of our resources to collect the data, but we never get to, and then what do you do with it? I think that is something that I'm always cautious about in the measurement space. Everything's possible, but what are we going

to ultimately be able to use to impact care? And then how much resources are we going to have to expend to actually collect it?

I do think that in looking at future directions having you know, a domain around social factors, is something that I think we should start to really seriously think about. It's something I'm challenged by my advocates on, you know, every single meeting I go to, and I don't blame them, they asked me what have we been doing? What have we been doing? So, I would challenge all of us to think about that space, and how we could get some effort directed towards looking at social factors. And I think that those types of domains would extend across the entire spectrum of the population.

And then my last point is just about duals. So, again, it's getting back to efficiencies. I think that I would really like to challenge CMS to think about how they can help states match Medicare and Medicaid data. In order to report on the quality of our dual members we need that data linked, and it's really just not going to be possible for each state to do it on their own. We've tried, we've thrown a lot of money at it, and that's not been very successful. So, I think that's definitely something that if you want us to be able to report on our dual membership, and then we need a solution, we need some linkages done at the federal level, so I'll stop with that.

Thanks, Lindsay. I wanted to pick up on one thing that Lindsay said when she asked about a domain for social factors. I would love to hear more from Workgroup members about what that domain would look like. Rich.

Yeah. Thank you, I'd like to sort of jump in with that, and actually match that to the point that I raised before about having a domain on primary care, a BH, et cetera. And I think the social domain, but I want to make sure that we put in a note of caution. So in many conversations that I have been part of in the last couple to three years around accountable care organizations, putting in social determinants screening, health related social needs screening, a lot of that maps back to the PCP and you know, when all you have is a hammer, everything looks like a nail. And so, I think to the extent, I absolutely fully embrace that notion of social, I think without adding that we're not going to meaningfully move out of the medical outcome...outcomes anchored to medical services, and into the realm of overall health and productive lives.

So, I want to make sure that there's a caution in the domain on social, okay, and let's not presume it all falls on the shoulders of the PCP, that's one. Second, I want to - every time a measure goes forward into the Core Set, and/or that we have a conversation about measures that have topped out, and think about either moving them, removing them or in Massachusetts we call it putting into monitor. And we don't look at that data in a stratified fashion, I feel that we've lost an opportunity. Similarly, if we put forward a recommendation for an addition of a measure, and we haven't looked at the ability, the usability, and feasibility of applying a stratified approach to that measure, we're potentially making it more difficult to do meaningful work in this space around equity. What do I mean by that? Many of us have said, and completely appreciate that there's limited real estate in the Core Set, and on the pediatric side, 2024 is a big, a looming opportunity, but also a challenge.

So, to the extent that states are going to be moving forward with mandatory reporting on all child and BH on the adult side, if there isn't a strong commitment to looking at stratification, REL and D, it's going to be hard to backtrack that. So, I want, really wanted to call that out. And then finally I want to bring back this notion of small populations. I wasn't sure how to bring this up, but

my dear friend and colleague, Carolyn Langer, and I have spent literally years thinking about transitioning youth and young adults, and adults with complex needs into adult care.

Many of these folks fall into, quote, small categories on a cohort size basis. And that's often one of the barriers with getting them into high quality, equitable, and even safe adult systems of care. So, we need to think about how we can advance the health and equitable outcomes of all persons, Medicaid beneficiaries, regardless of the size of their cohort. This is going to be especially important for patients with neurodevelopmental disabilities, that a 23-year-old with autism may not have a deep claims experience. And, so therefore, they don't really hit the payers' rolls. Nonetheless, there's a significant need for services so that they have dignified productive lives ahead of them. So, I do think we have to consider approaches to these small populations as a component of the broader one, especially when we factor in some of the social needs and supports that that these folks need.

Thanks, Rich. Other Workgroup member comments?

Margo, can I go?

Sure. Thanks, Shevaun.

I don't want to repeat anything that other Workgroup members have stated, but rather just wanted to thank everybody for the tremendous amount of work that has been done during this Core Set review. I think that everyone really worked hard to really focus on alignment and priorities. And I think that that's evidenced in a lot of the ways that the votes ended up being or resulting. And so, I think that that's fantastic, and I'm really excited to see where we go, where CMS goes, related to Medicaid and CHIP around performance measurement and improvement.

I think that there are a lot of opportunities around how the federal government can continue to help and support states in going beyond using just admin level data like claims and encounters. I know we're not there yet, but as we think about measure development and strategies for improving, having a more comprehensive view of what's happening in terms of health outcomes. I know oftentimes when you talk about health outcomes you have to go beyond claims and encounter data. And I think that that's where most states are trying to go. And so having access, when we think about interoperable systems and moving in the direction where an electronic health record when we start thinking about that, and talking about that, I'm really excited at the possibility of seeing measures, and developments in that area that will help us be able to pull in those pieces of information.

Thanks, Shevaun. Linette?

Thank you. The one other piece I'd add, in thinking about the CAHPS survey, because I know we talked about some of the strengths and weaknesses of that overall, would be just like, you know, just really thinking about what does it mean to have representative samples that can be used for various kinds of stratification? I know there's a lot of work going on in this area. And so, I really applaud and appreciate that, in terms of thinking about it, recognizing the changes in survey response rates.

I actually was just having the conversation with my daughter, she got it flagged to respond to one of these surveys. I'm like, “No, really, please do it.” But there's no social consciousness I don't think around understanding the importance of the surveys. It's something that comes from

your health plan that says, please do this, please do this, please do this? How does that response then really help inform? I mean, what is the credibility of the data depending, you know, in terms of how people are responding? So, continuing to think about how can we understand patient experience to the best of our ability, addressing the response rates, addressing cultural sensitivity? The different ways people respond, making sure it's available in enough languages to support the diversity that we have in our Medicaid programs to get good responses.

And, and really, what are the sample sizes we may need to make definitive understanding? I mean, do you, when you're talking about statewide reporting, is the sample size the same whether it's Rhode Island or California, or are there differences in sample size that we should be looking at, and how do we convey that? So, I've just encouraged and continued thought around the CAHPS survey and how it supports the Medicaid population. And also thank you and applaud the work that's been done today and is ongoing. Thank you.

Thanks, Linette. Ann?

Thank you. So, I will try not to duplicate, but maybe just reinforce or kind of echo some of my colleagues a little bit. I mean, as I think about this, I think it is really important that we look at efficiencies, and how we look at other data sources, and really understand the role of Medicaid within the larger health system, and certainly thinking about the pediatric space, but also the adult space, other outcomes of health measures and productive, and what it means to be healthy? So, I think that necessarily will require us to, as we move to electronic measurements or other how we can, how we can actually reach that looking forward?

My comment as we were talking, and I think it was just to say that you know, how do we really understand, and how can we use this space and bring patients and families to ensure that the measures that we're prioritizing, promoting, that land on these sets truly are then reflecting what those enrolled in Medicaid might see as important health outcomes as well. So, to align that thinking, I think is something that will be important, especially as we think about disparities in how we respond, avoiding any unintended consequences as we look forward to, and measure to assure that the new measurements and rules that we don't unintentionally create different disparities or different priorities that might create those disparities. Thanks.

Thank you. Other comments about gaps, and future directions before we move on to technical assistance needs? Well, why don't we move on, we can always come back if you think of anything else related to gaps, and domains, and data sources, and other existing data sources, that would be great. So, now we'd like to hear some constructive and creative suggestions for technical assistance to help states prepare for mandatory reporting. As others have said the Child Core Set measures and behavioral health measures in the Adult Core Set become mandatory in 2024.

So, we're interested in your suggestions about how to build state capacity for calculating, and reporting these measures as we move toward 2024. I think we heard Lindsay say earlier about help with dual eligibles, and doing the data linkages. What other comments and suggestions do people have? Jill.

So, I'm just wondering if there's some way to harness the highway for exchange of some of this information which may be, I think, maybe happening in some places and may not be happening

in others. But just wondering if that's a way to kind of get all of this data together in one place coming from different sources.

That's a great suggestion. And as we talk to additional states in thinking about state specific TA plans, we are hearing about a lot of progress that they're making with data warehouses that are bringing data sources together, whether it's claims and encounter registries that might include immunization data, vital records in the HIEs. So that we know there's a lot of effort going on in states, so we don't know it for all, but we know it for a number of them. So, I think that's a really interesting idea. And maybe thinking about how some of those emerging data warehouses, data systems can be tapped into, and making sure that we've made the right connections between people that are working on those new data warehouses, and those that are familiar with Core Set reporting so that we can make sure that those dots are getting connected, and there aren't as many silos within states. David?

Thanks. Just to add to Jill's comment, I think it's important to, from a technical assistance standpoint, to have a better understanding from a health information exchange standpoint, where our federal partners are heading and how they can help us. And there are some new regulations around health information exchange, but I think having like the ONC interact, even more so with Medicaid agencies so that we can work together to figure out how we can move more and more towards electronic measurement, I think would be really, really helpful.

I think also, we've heard this along the way that various state immunization registries are in array or disarray, depending on the funding over the years. I think Pennsylvania, we're in half decent shape, even though we have older antiquated systems, but I think technical assistance, and how to fully leverage immunization registries coming from our, again from our federal partners would really, I think, be very helpful. And then I think the last thing around technical assistance is working with state programs, and their managed care plans and fee-for-service programs, to be able to, I'll say, accurately have individuals' race and ethnicity accurately portrayed.

And I know that in stratification efforts that we've done over the years we've made changes to our systems, and we're, you know, over a decade in. I know that some state programs very much so struggle with this. And I think, I think NCQA mentioned earlier that they have several measures that they are going to be, you know, working and pushing to, to have them stratified by race and ethnicity. And I think that's another area of technical assistance that state programs could use. I think state programs are probably ahead of maybe commercial health plans, but I think that's an area where technical assistance would be very helpful. Thanks.

Thanks, David. Tricia Brooks.

Yes, thank you, Margo. Again, I just want to commend Mathematica for a really well-organized event. A couple of things I wanted to note, I won't go into any detail, because a lot has been said about social determinants, but moving upstream particularly as it relates to kids, because if we don't start investing in kids' healthy outcomes and educational outcomes, then we're just going to continue to deal with multiple chronic conditions and all the things that we have to do to manage care. I also want to encourage the state folks, you know, that are on the Workgroup, and in the audience perhaps, to be more proactive in engaging advocates and providers and stakeholders in the whole quality strategies spectrum.

I think advocates can be particularly helpful in advocating for resources for states that need them in order to do a better job of quality measurement and improvement. And I just feel like sometimes we have a very hard time finding EQRO reports, finding the quality strategy, knowing when the quality strategy is being reviewed, and I just think it's really important that just like this particular group represents various sectors that states engage in that way as well.

I also want to talk about stratification at the plan level. We know that some plans do a better job than others. And in order for states to be doing diligence, being good stewards for the money that is spent on managed care, really not keeping that information private, being able to have the stakeholder community be aware of who's doing a good job and who's not doing a good job in the managed care arena, because we're spending a lot of money on managed care. And then lastly, I just have to say that we need guidance from CMS as soon as possible on the mandatory reporting of the Core Set. It may seem like it's straightforward that here's the Core Set, you need to report on it in 2024. But I think it's more complicated than that, and the sooner CMS can provide that guidance to states and stakeholders is really important. Thank you.

Thanks, Tricia. Other Workgroup member comments about technical assistance to prepare for mandatory reporting? Other suggestions on how to build state capacity for calculating and reporting these measures? Okay. Well, why don't we move on to the next and last bullet on the slide. So, in the spirit of continuous quality improvement, we'd like to hear from Workgroup members on ways that we can improve the review process for next year. We definitely have had a lot of interesting challenges these last two years being in a virtual environment. We don't know next year whether we'll be face-to-face again or whether it will still be virtual, but we'd love to hear your feedback on what we've done well, or really, more importantly, what we can do better. Lindsay?

I just really have appreciated the triaging and all of the pre-work that you do before it comes to the Workgroup. That has been incredibly helpful to know that you've curated and really, really done a thorough review to ensure that measures meet the criteria before it comes to us, has really helped us have rich discussion, because we're not trying to do a review on too many measures. In the past it has felt overwhelming to try to really have that rich robust discussion, because we've had to review, you know, upwards of 40, or 50 measures. So, really appreciate the work that goes into sort of getting that list pared down to really have this ability to have a really robust discussion.

Thanks, Lindsay. And I also want to acknowledge all the folks who are working behind the scenes on this, because it is a lot of work to work through the measure specifications. And I also want to acknowledge the measure stewards, because we've gone back to some of them two and three times for information, and also asking them to be here to help with the discussion of their measures. So, thanks both to the Mathematica team, and to all the measures stewards for your help with that. Lisa?

Yeah. I just wanted to second on what Lindsay said, and note that, you know, I just felt like the discussion gets more and more robust with each year, and you all pivoted so masterfully to the virtual format. You know, these are very rich discussions in person. And I really feel like we, you know, we have been able to engage so well in these virtual meetings this year, and last year, and you know, the pre-work is just instrumental for that, and really being able to look at the nuances of the measures well in advance and think through a lot of where we want to go with the discussion. I just think you all are doing an excellent job with all of that so thank you.

Thanks, Lisa. Carolyn.

Yeah. I definitely want to second to all the previous comments, and your team did a great job with the technology. When I think about how it's evolved compared to a year ago, everybody just seemed a lot more comfortable, and the discussion certainly was much richer. I do want to put in a plug, because I know a lot of organizations are talking about continuing to do things remotely, but I would like to put in a plug when it's safe to do so to reconvene in person, and it would be interesting to know if the preference of most folks is to continue remotely or to offer a kind of hybrid model where some could come in person, and others could connect remotely? Thank you.

Thanks, Carolyn. Rich?

Yeah. I also want to commend the MPR staff, you guys are wonderful. I'd like to make a very tactical request though, in terms of the prep. I would love to have an explicit component of your soliciting information about measures, whether for addition or for removal, to explicitly ask the measure developer and or measure users about the ability to use RELD data for stratification. I'd like to see that as a standard element that can inform our deliberations for either removal or addition.

I think we have a long way to go, and just to be clear I'm not thinking about risk adjustment over time, but just stratification. So, if the team could consider that, CMCS if you could consider that, that would really help me feel much better, that we're putting things in the Core Set that are going to enable active stewardship of equity going forward. And then again, just the staff you guys have been absolutely terrific in general. My voice might be in the minority, but I do feel a need to share. A virtual meeting, especially one that doesn't have the video. It's really challenging to not have the chat function. And what I mean by that is I'm not going to ask, Jill Morrow, did you see that TV show last night?

But sometimes we're going to ask each other questions like, did we try that measure, et cetera. And so, I really felt a lot of constraints with some of the spontaneity. I totally appreciate MPR's preference to have all comments be made in the Q&A, but I really felt personally speaking for myself, I felt pretty constrained to be able to do some on-the-fly organic thinking, and then certainly anything that would be important wouldn't be in the chat, it would be brought into the Q&A so that I just think it would be more organically that way and I wanted to share that.

Thanks Rich, I think what we're trying to do is have you think organically out loud, so that it can be part of a public meeting in the same way that if you were sitting around a conference room in our DC office, you'd be talking out loud and sharing ideas organically, but we definitely understand that there's constraints of a virtual environment.

Yeah. And actually I think that's it Margo, I think it is because of the virtual connection that makes it otherwise, you know, everything that we could say in a live environment, and possibly even could be mitigated if there was a video component as well, but it's pretty brutal when you're trying to think on-the-fly, to not be able to just sort of vet an idea with somebody, because I do think that would get in the way, but yeah, that was the point that I wanted to raise. Thank you.

Well, thank you. And I think we've heard you loud and clear, all of the Workgroup members about wanting more attention to race, ethnicity, language, and disability stratifications. And we

will certainly look at our criteria for next year and elevate that to an actual criterion as opposed to being embedded within the first strategic priority and actionability criterion. And certainly, as part of the call for measures we will ask you to comment on that. And then we also will ask the measure stewards to reflect on what they know, what they've done, and what's feasible. So, thank you for moving our conversation forward this year, we really appreciate it.

If I have the ability to share a smile emoji, I would be doing it now. So, I'm giving you a Linette Scott fist pump, thank you.

From coast to coast. Thank you. Linette, did you have a comment?

Yeah. And, fist bump back, thank you. I echo what folks have said. Certainly, without the video, you do lose something. I think the virtual with video is really pretty good. I certainly have mixed feelings just in terms of the day; two days' worth of travel to get there from the West Coast, but miss the in-person interaction. The thing I was going to comment on other than echoing what everyone else has said is, as we go into the process of submitting measures for addition, or deletion, really appreciate that you've given the opportunity to look at things from a replacement perspective, but I, you know I keep going back to how do we bring things online? And how do we get there, because I know one of the interactions has been, if something's on the list, then there's the ability to put resources against it to help.

So, I mean, I think you know, I've had the conversation with several folks around this and that you know, if something gets removed, well then, we can't put resources against it anymore. So, the flip side though, is how do we get something ready to add, if we can't put resources against it? And so it feels like there's some of the conversations that we are sort of having year after year of, well, a few states have used it, or a few states have tried to use it, but in the, you know in the world of constrained resources if it doesn't go on the list in some sort of formal way, then we states and our federal partners may not really get a chance to do the work to get it there. And I'm really worried about how we get to the e-clinical quality measures and the registry data, and some of the other things that are more robust than we can get from claims data itself. So, I'm not sure exactly what the suggestion is, but in terms of thinking about it from a process perspective, if there's a way to help call that out or have a criteria or something that allows to speak to what would be a potential timeline trajectory or requirements necessary to get it ready, so that we can say, yes, in two, three years we expect states to be ready, and we CMS and states are going to put resources against it. So, that'd be the one suggestion I can think of. Thank you.

Thanks Linette. That's really helpful. Jill, did you have another comment?

Yeah. I actually wanted to speak a little to what Linette should have just brought up, and what Lindsay talked about in the last session. And that is, I really appreciated being able to look at measures that are topically similar together to be able to compare them one to another. I think that is very helpful, because it's a balance between what the population is and what the measure is. I think the concept of how we have a glide path towards moving to new measures, moving to measures that have been modified, moving from one measure in a topic to a different measure, especially as reporting becomes mandatory. I think that it's just not turning on an office switch, it definitely requires some ramp up. And what I wouldn't want to see is losing that data from the old measure in the time that the other one is ramping up, or not putting the other one into the set until, you know, the old measure has been gone. So, finding some way to make that a more seamless process.

Thanks, that's really helpful. I did want to read out a comment that we got from Tracy Johnson, who is the Colorado Medicaid Director and is in a place that's loud and was not able to make her comment. And I thought I would just read out her comment, because she said it's difficult to come off mute. She said she wanted to second, third, fourth, the recommendations to stratify measures by various demographic and eligibility groups. So, thank you Tracy, for sending in your comment.

Other comments for this part of the agenda? Any final reflections from the Workgroup before we move into public comment? Further thoughts about gaps, future directions, technical assistance needs, future of the Core Sets? Okay, with that next slide please. So, we have one last opportunity for public comment. So, if you would like to make a comment, please use the raise hand feature in the bottom right of the participant panel to join the queue. And then lower your hand when you're done. And we'll let you know when you've been unmuted. So, do we have any public comments at this point? Well, seeing no public comments. Next slide please.

So, as we begin to wrap up, I wanted to thank our Workgroup members, and especially our co-chairs for your flexibility and patience in conducting this meeting virtually. I know it wasn't easy to spend three days on the phone with us. And now I'd like to call on Shevaun and David for any final remarks they would like to make.

Thank you, Margo I'll start. Just again, thanking you and the rest of the Mathematica team, I really don't think any other organization does it as well as you all do in terms of just organizing Workgroups virtually, and in person when you have to vote on items of this complexity, and that requires a certain level of stimulating discussion to go along with the technical pieces of the process. So, you all do a fantastic job, and I just want to commend you for another successful meeting. It's been my honor and my pleasure to serve as co-chair for this event. I say all the time, every time I have an opportunity to say so, I love being a part of this process. And there's so many bright and talented Workgroup participants who participate every single year. And I always walk away from these meetings learning so much, thinking differently at times about certain measures than where I started. And so, I really appreciate all of the hard work that the Workgroup members put into making this meeting a success. So, I wish you all great luck and success as we wrap up today's meeting. David, I turn it over to you.

Thanks, Margo. I just thank all the committee members for all the work over the last few months, but especially over the last three days. I think this was excellent discussion. I think in my tally, I think we ended up with a net of three more measures after you take away what we voted off. Final determinations there, but I think we've done our due diligence, and I really want to thank our federal partner for the opportunity to provide this feedback and likewise to [inaudible] their hard work, and pre-work that goes into making this happen. I really do [inaudible] have to be virtual and we can meet because it is a lot more fun. And that's something we all miss. I really again, do appreciate all the efforts that [inaudible] and diligently having a good discussion intelligently. So, thanks again for all this, back to you.

Well, David, your audio was breaking up quite a bit, I think we got the gist of what you had to say. And I'm just very relieved that it's happening in the last little bit of the meeting and not at the beginning of the meeting. So, thank you both, David and Shevaun, I know that in leading up to this meeting we've had some connectivity and audio issues, and all of that. And I'm just very relieved that we didn't have it during the meeting until the very end. So, thank you for being part of this journey with us. Next slide please.

Okay. So, by now this slide should look very familiar. It lays out the key milestones for the 2022 Core Set Annual Review process. As you may recall our journey began on December 17th and continued with the April 8th webinar to get organized for this week's meeting. We're really grateful for all the time you've taken to prepare for this meeting. We know it's a lot of work, and we also appreciate that you spent the better part of the three days with us. So, our next step is to review and synthesize the discussion that occurred over the last three days and prepare a draft report.

The draft report will be made available for public comment in July. And in addition, Workgroup members will have an opportunity to review and comment on the report. Our team will then review all the public comments and will finalize the report which will be released in August. And from there, CMS will review the final report and obtain additional stakeholder input from other federal agencies and from state Medicaid and CHIP quality leaders. And CMS will release the updates for the 2022 Core Sets by December 31st. We also wanted to mention that over this summer we'll be following up with Workgroup members about the 2023 Core Set Annual Review Workgroup nomination process.

So next slide. If anyone has any questions about the Child and Adult Core Set Annual Review, please email the Mathematica Core Set team, at the email addresses here. Next slide, and finally, one last thank you to Workgroup members, federal liaisons, measure stewards, and public attendees for your contributions. And we also want to express our appreciation to staff in the Division of Quality and CMCS for your guidance in planning the meeting. We know you have been listening, and I think we all agree that this has been an incredibly rich and insightful conversation. And so, it will give CMCS a lot of food for thought in thinking about the recommendations for 2022, and also in thinking about preparing for mandatory reporting.

And again, a special shout out to the Mathematica Core Set team. This meeting would not have been possible without everyone's help. So, we wish everyone well, stay healthy, stay safe. And this concludes the 2022 Child and Adult Core Set Annual Review Workgroup Meeting. Thank you, everyone.