2025 Child and Adult Core Set Annual Review: Meeting to Review Measures for the 2025 Core Sets, Day 3 Transcript

April 27, 2023, 11:00 AM – 4:00 PM EST

Talia Parker:

Good morning, everyone. My name is Talia Parker, and I'm pleased to welcome you to the 2025 Child and Adult Core Sets Annual Review meeting to review measures for the 2025 Core Sets, Day 3. Before we get started today, we wanted to cover a few technical instructions. If you have any technical issues during today's meeting, please send a message to all panelists through the Q&A function located on the bottom right corner of your screen. If you are having issues speaking during Workgroup or public comments, please make sure you are not also muted on your headset or phone. Connecting to audio using computer audio or the call me feature in WebEx are the most reliable options.

Please note that call-in only users cannot make comments. If you wish to make comments, please make sure that your audio is associated with your name in the platform. All attendees have entered the meeting muted. There will be opportunities during the meeting for Workgroup members and 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. You will be unmuted in the order in which your hand was raised. Please wait for your cue to speak, and remember to lower your hand when you have finished speaking by following the same process you used to raise your hand. Note that the chat is disabled for this meeting. Please use the Q&A feature if you need support. Finally, closed captioning is available in the WebEx platform. To enable closed captioning, click on the CC icon in the lower left corner of your screen. You can also click Ctrl+Shift+A on your keyboard to enable closed captioning.

With that, I will hand it over to Margo to get us started.

Margo Rosenbach:

Thank you, Talia. Welcome back to Day 3 of the Meeting to Review Measures for the 2025 Child and Adult Core Sets. I hope everyone had a nice evening. We had a very productive day yesterday, and I'll provide a very brief recap before we get started with Day 3. First, the workgroup considered two measures related to Opioids, Use of Opioids at High Dosage in Persons Without Cancer, and Concurrent Use of Opioids and Benzodiazepines. These measures had been suggested by Workgroup members for removal, but they were not recommended for removal by the Workgroup. I did want to clarify, however, a point that came up during yesterday's Workgroup discussion, that CDC has decided to discontinue production of the codes that would be required for calculating this measure; and, as the measure steward reported, they will likely be retiring the measure because those codes will no longer be available. The next measure considered was Statin Therapy for the Prevention and Treatment of Cardiovascular Disease, and that was suggested for addition; but it was not recommended by the Workgroup. Primarily, because of reasons of feasibility and also because it is not widely used or tested in Medicaid and CHIP. Next, the Workgroup considered two measures for removal, Screening for Depression and Follow-up Plan in Ages 12 to 17 in the Child Core Set and Screening for Depression and Follow-up Plan Age 18 and Older in the Adult Core Set. Those had been suggested for removal but were not recommended by the Workgroup for removal. Primarily because of the importance of those measures even though they are hard to produce because of the coding issues; but they were not recommended for removal because of their extreme importance in Medicaid and CHIP population. I am hoping that during today's discussion on technical assistance that the Workgroup will be able to follow up on some of the

conversations yesterday about ways the measure could be considered more feasible for production by Medicaid and CHIP agencies. Then lastly, we considered two CAHPS measures, one in the Child Core Set and one in the Adult Core Set. Those too had been suggested for removal, but were not recommended for removal, primarily because of the importance of the consumer voice in understanding experience of care. Again, there were suggestions on how to make those measures more usable and possibly even considering options for the future in getting consumer voice.

I'll also very briefly recap our first day since some of you might not have been here. On the first day, we considered four measures; the first, Oral Evaluation During Pregnancy, which had been suggested for addition; and the Workgroup did indeed recommend it for addition to the Core Sets. Then we discussed two measures related to Topical Fluoride for Children; the current measure, which is the Dental Quality Alliance measure, and a possible replacement, which is the NCQA measure. The Workgroup voted not to replace the measure and to retain the DQA measure of Topical Fluoride for Children. Then finally, Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults. That had been suggested for addition, and it too was recommended for addition by the Workgroup. So, as we discussed yesterday, that was a fairly major milestone in the Workgroup's discussion of oral health measures with the addition of two adult measures recommended for addition to the Core Sets.

So with that, we are ready for Day 3 and lots of other exciting conversations. I would like to now turn it over to Kim Elliott and Rachel La Croix, our two Co-Chairs for their brief welcome remarks.

Kim and Rachel?

Kim Elliott:

Can you hear me today?

Margo Rosenbach:

Yes, very well.

Kim Elliott:

Wonderful.

It is hard to believe that we're already in Day 3 of the Core Set Workgroup. I really do want to thank everyone again for their active participation. It really makes for an excellent discussion, excellent meeting, and a real valuable part of our day and time. I'm looking forward to another productive day discussing the ECDS measures, and I'm also really looking forward to informed, and most likely very passionate, discussions regarding how to use the Core Set measures to drive quality improvement.

As you all know, the measure rates are really just numbers unless we're able to use the results for purposes of quality improvement to drive change and have an overall impact on the quality of care and services delivered through Medicaid. Across the country, we see states and health plans doing great work focused on the Core Set priorities, including using the core measure set in value-based purchasing initiatives, as a measure of success for performance improvement projects, and allocating member assignments, and also in evaluating MCO RFP decisions; and

that list just could go on and on. Over the last few several years, the Workgroup has done a lot of work at identifying potential gaps in the core measure sets; and I'm looking forward to today's gap discussions, particularly in relation to the cross-cutting schemes and how our discussion may influence developers in refining existing measures to better represent the Medicaid population and of course testing the measures in the Medicaid programs. That hopefully will help us address some of the gaps that we're going to be discussing today.

Finally, I'm also looking forward to more of the thoughtful, informed discussion that we have all participated in during the last two days. Thanks.

Rachel La Croix:

Good morning, everyone.

This is Rachel, and I echo everything that Kim and Margo already mentioned about the two prior days of meetings. These have been really great discussions, and I really appreciate everyone's feedback and sharing experiences when concerned with the different measures. I know that our conversation so far has been much more specifically focused on individual measures that were suggested for removal or addition to the Core Sets. So, I look forward to today's conversation being broader and thinking more generally about the Core Sets as a whole and how they can be used to help drive quality improvement and move performance of the Medicaid and CHIP programs forward over time and how we can address gaps and try to look for measures moving forward to cover some of those areas that we haven't really been able to measure as well thus far. So, thank you, everyone. Definitely looking forward to more in-depth conversations during our meeting today.

Margo Rosenbach:

Thank you, Kim and Rachel. All right, so next slide, please. We're going to conduct a roll call of Workgroup members. As we have done the last few days, we ask that Workgroup members raise their hand when their name is called. We'll unmute you and you can say hello. Can we go to the next slide, please?

After you are 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 discussion. I just want to note that we have noticed that sometimes there is a little bit of a lag in the unmuting. So please, if you think you might not be heard, just ask if we can hear you. Also, if you leave and reenter the platform or find you've been muted by the host due to background noise, just raise your hand and we'll unmute you. Next slide, please.

On the next three slides, we've listed the Workgroup members in alphabetical order by their last name. When I call your name, please raise your hand. We'll unmute you; you can indicate whether you are here. But also remember to mute when you are done and also to lower your hand.

So, we've already heard from Kim and Rachel. Next is Ben.

Benjamin Anderson:

Present, and I just want to mention that I feel like I've learned so much these past couple days, particularly from our partners on this call from the states. So, I want to thank you for all the work

you do in this area and for pointing out, I think, some really important issues; and I look forward to the discussion today. Thank you.

Margo Rosenbach:

Thank you. Rich?

Richard Antonelli:

[Inaudible] …So far and going back to the icebreaker, that was one of my first objectives. The second one was the hummingbirds have arrived here in Cape Cod, so I wanted to share that we had a very productive week there as well. Thank you.

Margo Rosenbach:

Well, that's very exciting! Thank you for sharing that. Stacey?

Stacey Bartell:

Hi, I'm Stacey Bartell. I'm from the American Academy of Family Physicians. Glad to be here, thanks.

Margo Rosenbach:

Tricia?

Tricia Brooks:

Can you hear me now?

Margo Rosenbach:

Not very well, it might be a microphone issue.

Tricia Brooks:

Okay, well, I'm here so we'll leave it at that.

Margo Rosenbach:

Okay, glad to have you. Emily?

Emily Brown:

Present and looking forward to the discussion today.

Margo Rosenbach:

Joy?

Joy Burkhard:

Hi, everyone. Joy Burkhard from the Policy Center for Maternal Mental Health. Glad to be back for a third day.

Margo Rosenbach:

Do we have Karly today? I'm not seeing Karly. Stacey?

Stacey Carpenter:

Thank you so much. This has been quite an interesting process. I'm happy to be here.

Margo Rosenbach:

Lindsay?

Lindsay Cogan:

Good morning. This is Lindsay Cogan. I'm here as well.

Margo Rosenbach:

Great. Jim?

James Crall:

I'm learning from all the discussions, and thanks to the MPR Team for all their hard work.

Margo Rosenbach:

Thank you. Next slide, please. Curtis? I'm not sure if Curtis is here.

Curtis Cunningham:

[Inaudible]…For the discussions today.

Margo Rosenbach:

Oh, there you are, okay. Great, glad to have you. Erica?

Erica David Park:

Good morning. Sorry, I think I had a lag there. I'm present. I just want to say I'm a first-timer for the Workgroup. It's been a great experience, so looking forward to more discussion today. Thank you.

Margo Rosenbach:

Amanda? I can see you...there you go.

Amanda Dumas:

Amanda Dumas here, Louisiana Medicaid, thanks.

Margo Rosenbach:

Anne Edwards? Anne, if you're speaking, we can't hear you. Now we can.

Anne Edwards:

Okay, great, hi. Hi, everyone. This is Anne Edwards. Great to be back for the third day.

Margo Rosenbach:

Clara?

Clara Filice:

Nice to be back for today's discussion, thanks.

Margo Rosenbach:

Sara Hackbart?

Sara Hackbart:

Also being new to this Workgroup, this has been a great experience. I'm looking forward to the discussion today. Thank you.

Margo Rosenbach:

All right, is Sarah Johnson here?

Sarah Johnson:

Good morning, everyone. This is Sarah Johnson from IPRO. Looking forward to the discussion today.

Margo Rosenbach:

Great. David Kelley?

David Kelley:

Hi, this is Dave Kelly, Pennsylvania Medicaid. Good morning, everyone. Part of my icebreaker was I wanted to hopefully fill some gaps. I think we've done that, at least within adult dental. My second point was to hopefully move towards measure harmonization and more efficient measurements. So hopefully that will be part of today's discussion. But thanks, as always, to the lots of hard work from the Mathematica team and from our federal partners.

Margo Rosenbach:

Thanks, David. David Kroll?

David Kroll:

Hi, everyone. Dave Kroll from Mass Brigham Healthcare. I'm here, thanks.

Margo Rosenbach:

Thank you. Jakenna?

Jakenna Lebsock:

Looking forward to the discussion today.

Margo Rosenbach:

All right, next slide, please. Lisa Patton? Lisa, there might have been a lag. Can you speak up again?

Lisa Patton:

Oh, yeah, hi, can you hear me, Margo?

Margo Rosenbach:

Very well, thank you.

Lisa Patton:

I'm here, yeah.

Margo Rosenbach:

Great. Laura Pennington? Laura, if you're speaking, we can't hear you.

Laura Pennington:

Oh, I’m sorry, I was waiting for you to call on me. Hi, good morning, this is Laura Pennington from the Washington State Health Care Authority. I appreciate the opportunity to participate. I’m looking forward to the discussion today on gaps and ECDS measures. Thank you.

Margo Rosenbach:

Great. Grant Rich we know cannot attend. Lisa Satterfield?

Lisa Satterfield:

Hi, I'm Lisa Satterfield from the American College of Obstetricians and Gynecologists. I also look forward to the discussion on ECDS measures and maybe discussing some social determinants and how to appropriately measure those.

Margo Rosenbach:

Linette?

Linette Scott:

Present, thank you, and looking forward to the conversation.

Margo Rosenbach:

And Kai is not able to make it today. Mitzi?

Mitzi Wasik:

Hi, good morning, Mitzi Wasik. I'm from OptumRx/United Health Group. I'm looking forward to today.

Margo Rosenbach:

Ann? Ann, I saw your hand raised; but if you're speaking, we can't hear you. You might be having a microphone issue.

Ann Zerr:

Good morning. This is Ann Zerr.

Margo Rosenbach:

Okay, now we heard you, great. Bonnie?

Bonnie Zima:

Good morning.

Margo Rosenbach:

And Sam?

Samuel Zwetchkenbaum:

Good morning, everybody. Looking forward to today. Also, I'm going to take Richard's advice and go to the Cape. I have to visit my sister, which I'm looking forward to; and now I'm looking forward to seeing the hummingbirds.

Margo Rosenbach:

All right, Rich, so we have to ask you...where are you on the Cape?

Richard Antonelli:

Just so-called the Upper Cape, so just over the Bourne Bridge. But, Sam, they actually have arrived en masse. So wherever your sister is, you will see them. But it's only the males. The females aren't here for two weeks.

Samuel Zwetchkenbaum:

Okay, fine. (laughing). Eastham – Eastham is where she is.

Margo Rosenbach:

Okay, well, that's good to know because Alli Steiner's mom is on the Cape, and she wants to know as well. So, thank you for that information. All right, next slide, please.

So, before we go on, I just want to acknowledge the federal liaisons who are non-voting members. Federal liaisons, if you have questions or contributions during the Workgroup discussion, please raise your hand and we'll unmute you.

I also want to acknowledge again our colleagues in the Division of Quality and the Center for Medicaid and CHIP Services and also all the measure stewards who are attending and available to answer questions about their measures.

I must say that hearing all the voices this morning...it's just so nice to have you all on the Workgroup and have you back for another day. I think the Workgroup conversations have been so rich and really so informative. Thank you for all that you have contributed so far and all that you will continue to contribute today. Next slide, please.

I heard a lot of people looking forward to this conversation on the ECDS measures. We have allotted about 30 minutes for this part of the discussion with not a lot of time for discussion. CMS wanted to bring these measures back to the Workgroup. The Workgroup previously recommended three ECDS measures that they have deferred because of concerns about the feasibility of reporting the measures at the state level and due to the proprietary nature of the technical specifications. These measures are the Prenatal Immunization Status and Postpartum Depression Screening and Follow-Up measures, which were recommended by the Workgroup during their 2021 Core Set Review and the Adult Immunization Status measure that was recommended by the Workgroup in their 2023 Core Set Review. I know in conversation yesterday someone mentioned the depression screening ECDS measure. That one has not been deferred by CMS. That measure because of the CDF measure that we discussed yesterday, for purposes of alignment across programs CMS has not deferred the depression screening measure because of alignment with the CDF measure in other programs.

So I know on Tuesday, the first day, Deirdra had mentioned that CMCS is requesting that the Workgroup reconsider the three measures this year. Next slide, please.

Before we turn to the specific measures, I wanted to mention that Electronic Clinical Data Systems, or ECDS, is a reporting standard for HEDIS that was developed by NCQA. It provides health plans with a standardized method to collect and report structured electronic clinical data for HEDIS. The eligible data sources used for ECDS reporting are administrative claims electronic health records, health information exchanges and clinical registries, and case management systems. Next slide, please. As I mentioned, the Workgroup previously recommended these three ECDS measures for addition to the Core Sets. CMCS has deferred a decision on whether to add these measures to the Core Sets pending further assessment of how the proprietary nature of the ECDS reporting method impacts the feasibility and viability of including these measures in the Core Sets, and now would like the Workgroup to reconsider these measures and vote on whether to recommend them for addition to the Core Sets. Next slide, please.

I'd like to invite Deirdra Stockmann, Acting Director of the Division of Quality and Health Outcomes in CMCS, to provide additional remarks on the context and motivation for reconsidering these three measures. Deirdra?

Derek, can you unmute Deirdra, please?

Deirdra Stockmann:

There we go. Hi, everybody. What a fantastic meeting this has been, and I'm glad to be with you the whole time and for this discussion. So, I don't want to repeat too much of what Margo just said, but let me just take it up a level for a second and share a few thoughts on the transition to digital measurement in general.

I think we all know that the future of quality measurement is increasingly digital and digital measures, and there's really good reasons for that. More and more health care information, quality information, is collected, stored, and shared digitally; and that trend is only going to continue. Moreover, with respect to health care quality in particular, mobilizing other digital sources of data – including EHRs, clinical registries, HIEs, lab values – has the potential to provide much richer quality data and better information about health outcomes, which we all want to see more of in quality measurement as compared with administrative sources alone.

That said, we're very much in the midst and, I would say, still relatively early in the transition to digital measures; and we're not quite sure how long it's going to take to get there. Collecting digital measures at a state level has, of course, added complexities that to be really transparent we're still working on identifying and figuring out how to address. We know states, but also health plans and providers, are in different places with respect to their capacity to collect and report digital measures; and we're very committed to helping everybody get there. We're actively engaged. We've had conversations, I think, with a handful of you just this week in assessing what technical assistance would be beneficial to states regarding the reporting of digital quality measures, including but not limiting to the ECDS ones; and we really encourage states to consider using digital measures, think about how to ingrate them into quality programs, and be in touch with us about how we can support this transition.

As Margo mentioned, over the last few years, the Workgroup has recommended several measures for addition to the Core Sets that rely on the proprietary ECDS, Electronic Clinical Data System's reporting methods; and it has been CMS's intent to add these measures to the Core Sets. However, given concerns as Margo mentioned about the feasibility of reporting the measures at the state level and because CMS has been working with NCQA as to how to navigate the proprietary nature of these measures and facilitate that state-level reporting, we have not yet added them.

As we're on the cusp of mandatory reporting and since it has been a couple of years since the Workgroup voted on these measures, or at the least the first two – that one of the Adult Immunization Status was I think just last year – we just want to take a minute to check in with the Workgroup and confirm continued interest in adding these measures. I would say that the last thing is that I think the earliest they would be added would be the 2025 Core Sets, just for your perspective.

So that's all I have, Margo. I'll hand it back to you to get into the Workgroup discussion and further conversation.

Margo Rosenbach:

Thanks, Deirdra. So now I'll turn it over to Chrissy. She's going to provide a recap of the three ECDS measures under consideration before the Workgroup votes on the measures. When she's done, we'll take a time check; and if there is time for some questions or discussion –

actually, I would just say discussion – we'll allow a few minutes for that before proceeding with the vote. Next slide, please.

Chrissy Fiorentini:

Thanks, Margo.

So, the first ECDS measure the Workgroup will reconsider today is Postpartum Depression Screening and Follow-Up. This measure assesses the percentage of deliveries in which members were screened for clinical depression during the postpartum period and, if screened positive, received follow-up care. Two rates are reported.

First, depression screening. This is the percentage of deliveries in which members were screened for clinical depression using a standardized instrument during the postpartum period; and, second, follow-up on positive screen. This is the percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding. The denominator for the depression screening rate is deliveries during September 8th of the year prior to the measurement period through September 7th of the measurement period, where the member also meets the criteria for participation minus exclusions. The denominator for the follow-up on positive screen rate is all deliveries from the depression screening numerator with a positive finding for depression during the 7 to 84 days following the date of delivery. Next slide.

The numerator for the depression screening rate is deliveries in which members had a documented result for depression screening, using an age-appropriate standardized instrument, performed during the 7 to 84 days following the date of delivery. The numerator for the follow-up on positive screen rate is deliveries in which members received follow-up care on or up to 30 days after the date of the first positive screen. You can see on the slide what qualifies as follow-up care. Next slide.

The next ECDS measure is Prenatal Immunization Status. This measure assesses the percentage of deliveries in the measurement period in which members had received influenza and tetanus, diphtheria toxoids, and acellular pertussis (or Tdap) vaccinations. The denominator includes deliveries during the measurement period where the member also meets the criteria for participation minus exclusions. This measure includes numerators for two individual vaccine rates and a combination rate.

The numerator for the influenza rate is deliveries where members received an adult influenza vaccine on or between July 1st of the year prior to the measurement period and the delivery date or deliveries where members had anaphylaxis due to the influenza vaccine on or before the delivery date. The numerator for the Tdap rate is deliveries where members received at least one Tdap vaccine during the pregnancy, including on the delivery date, or deliveries where members have anaphylaxis or encephalitis due to the Tdap vaccine on or before the delivery date. The numerator for the combination rate includes deliveries that met criteria for both influenza and Tdap numerators. Next slide.

The final ECDS measure the Workgroup will reconsider today is Adult Immunization Status. This measures the percentage of adults 19 years and older who are up-to-date on recommended routine vaccines for influenza; tetanus and diphtheria (Td) or Tdap; zoster; and pneumococcal. The measure is NQF-endorsed, and it was recommended to replace the flu vaccinations for adults ages 18 to 64 or FVA-AD measure in the Adult Core Set. The FVA-AD

measure is included in the 2023 Adult Core Set but will be removed from the 2024 Core Set because it has been retired by the measure steward.

This measure includes denominators for four individual vaccine rates in the age groups included. Each one varies, as shown at the bottom of the slide. Next slide. Here you can see the numerator criteria for each vaccine rate. In the interest of time, I will not read each of the numerators. Next slide. Finally, as shown here, the measure is specified for stratification by age, race, and ethnicity. Next slide.

Now I will turn it back over to Margo.

Margo Rosenbach:

Thanks, Chrissy. As you were going through each of the measures, I was reflecting back over the last few years and thinking back to 2021 when the Prenatal Immunization Status and the Postpartum Depression Screening and Follow-Up measures were recommended by the Workgroup.

Not to take too much of a trip down memory lane but because we have so many new members, I'll just reflect that took place in April of 2020, so literally one month after the pandemic hit. We all had just literally transitioned to work from home. We were supposed to meet in-person, but we met virtually; and it was really an incredible experience, I think, with everybody coming together and voting on these measures and particularly based on desirability. At that point, there was not really a lot of conversation about mandatory reporting; but there was a very strong sense of the desirability of these two measures thinking about maternal and infant health and well-being – so again, most of the focus being on the desirability and importance of these measures.

Then last year with Adult Immunization Status, again, a reflection of a gap that would have been created with the retirement of the Flu Vaccinations for Adults Ages 18 to 64, the FVA measure in the Adult Core Set, and wanting to fill a gap and thinking, again, more about desirability than feasibility. But as Deirdra reflected, there's very much a focus on considering the feasibility for states and the viability for states and what types of technical assistance or capacity building would be required for these measures.

So, I think the context for these both is really thinking through again the future of the Core Sets, the drive toward digital, and thinking about balancing all of these considerations about desirability, feasibility, and viability. With that, we have maybe a couple minutes, a few minutes, for comments from Workgroup members.

Lisa Satterfield, you're up first.

Lisa Satterfield:

Thank you. I have a question. I understand that obviously feasibility is paramount to the success of the measures. Have we determined that they *are* feasible, or are they not yet feasible but maybe they will be in 2025? Can you clarify that, please?

Margo Rosenbach:

I think that's a great question. I would turn to – I would like our State partners to address that. I think currently the focus has been on health plan reporting and plan-level and not state-level, per se. So, I do think it's a very good question and one that is certainly a question for states to address. We do have some folks queued up here. So why don't we keep going with some comments. It probably will move our agenda a little bit behind schedule but realizing that before the Workgroup can vote, we need to have a little more conversation about it.

If you do want to make a comment, please raise your hand, get in the queue. That will help us move this along. Also, please keep your comments relatively brief if you can. David Kelley, you're next. Derek, can you unmute David?

David Kelley:

Thanks, just got unmuted. So, in Pennsylvania, we actually require our MCOs to report various ECDS measures; and we've done that for a number of years. So feasibility for some of them has actually been pretty good, especially where there have been preliminary preexisting measures.

I would say that the two immunization measures from my standpoint are – I'm not really sure that -- most of what happens comes from administrative claims data, which states and MCOs should readily have on hand and should be highly feasible, and we supplement that with immunization registries at the state level. So, I think those two measures are clearly, in my mind, quite feasible and important.

The Postpartum Depression Screening and Follow-Up – I talked about this the other day. We actually have reported – and I believe this is from the ECDS measure – we reported a rate of screening of 22 percent and that follow-up treatment was at 48 percent. I mentioned that we have for many years, probably over a decade, have required chart reviews for the same measures and have found that 77 percent on chart review are being screened -- postpartum are being screened for depression – and 87 percent of those that screened positive are getting treatment, so big discrepancy between the ECDS and actual chart review.

I think this was part of the discussion around – in general the measure of both adults and kids for depression screening and follow-up. So, I would highly I'm a big advocate of ECDS measures. I think these immunization ones are, in my mind, clearly feasible. The Postpartum Depression and Follow-Up – I think there are still going to be some challenges there, but certainly would advocate that we continue to try to move forward measuring things electronically.

Margo Rosenbach:

Thanks, David. Next up, Curtis?

Curtis Cunningham:

Hi, I guess what I'm struggling with – and it comes back to the conversation yesterday – is the Core Set measures as we talked mandatory and we talked in regard to the messaging. I feel like we're kind of flying blind right now without knowing what the CMS requirements are because although we talk about mandatory reporting, there is no way states are going to be in a position to report these things for all programs and services come next year. So, I look forward to next year when the rule is out and we really have to reconcile the difference between what we think are important measures versus what states can actually do.

Medicaid is a very diverse program. We have everything from county-based mental health to our large HMO for moms/kids/families to long-term care. So, if we're going to apply Core Sets across, we have a variety of entities that are nowhere near. If we apply it just to HMO, then I think that's a different conversation. We also have numerous EHRs. We do not have a requirement for providers to report, and states that have an all-payer requirement to report make it quite a bit easier.

So, I just maybe – I want to provide that in the context that it makes it very hard for me to vote on these important measures without knowing what the operational implications are in the future. So that's just something I'm very much struggling with and maybe a conversation I would like to have in the future as we get more information on what is actually going to be required because the diversity of programs of states and requirements – if we're going to make this a success, we need to have some rigor to making sure it's feasible for the states to collect these measures. Thank you.

Margo Rosenbach:

Thanks, Curtis. Lindsay? Derek, can you unmute Lindsay?

Lindsay Cogan:

I'm unmuted, thank you. And, Curtis, I think I will tag onto what you have mentioned. I just want to address sort of some of the feasibility concerns. So here in New York State, we also have had a lot of success with the ECDS measures. I too, like David mentioned, am a big fan of looking across multiple data sources; and it also allows states who maybe don't have access to electronic data yet but have access to claims to still run a version of that measure. I've brought up in the past sort of strategies we can think about for public reporting.

I think this is a good time to get some feedback from CMS on – I really want to make a distinction between mandatory reporting to CMS and then CMS's public reporting back out. So, I really see those as two separate and distinct activities. I may submit a screening for clinical depression and follow-up results to CMS as a part of mandatory core set reporting that as a state we feel is being under captured right now because of whatever reason, right? That was brought up yesterday – a concern with that.

I, as a state, feel comfortable submitting that information as a part of mandatory reporting but want to be involved in the decision about what then gets publicly released, right? So typically, in the past, CMCS has relied on sort of the number of states that have been able to report a measure as a guide or a flip-the-switch kind of activity. So, it's more than – and I forget the exact number. You can correct me, Margo. If 27 states report a measure, then it becomes into that public reporting. Now that we're in this mandatory reporting period, you can no longer kind of rely on that gate any longer. So, what will be the gate, and how will you gather state input before deciding what ultimately gets publicly released on a more public-facing dashboard?

I think it's an important discussion to have in light of some of these more challenging measures but measures which we do want to move towards – have the opportunity for states to work towards them. Maybe we can think about some further clarity around whether these measures get put into an interim, not mandatorily reported or kind of a third tier really of like new, innovative, this is where we want to go. But the rigor in mandatory reporting, I think there needs to be more clarity around the implications for not only if a state is unable to report -- which is going to happen, it's just inevitable -- and then what happens if we do report, but we feel like we

need to flag for you that this should not be then turned around and reported on a public dashboard?

Margo Rosenbach:

Thanks, Lindsay. I will clarify the criteria for public reporting are twofold. One is 25 or more states reporting, but then also the data have to meet CMS's standards for data quality. So we have in a couple of situations that I can recall held measures because they did not meet standardize of data quality. Some of you may remember the AMB measure. Well, it's still on the Core Set; but at one point that measure did not meet criteria for data quality. And for a number of years, we also had issues with the PQI measures. It mainly had to do with the unit of measurement and ratios that were being calculated. So, I will say that it has not historically always been the case that when we hit a threshold of 25 that the measures were publicly reported. But I think, Lindsay and Curtis, you make important points about the ramp up to mandatory reporting and also the difference between mandatory reporting to CMS and public reporting.

So, with that, I'll turn now to Laura Pennington.

Laura Pennington:

Thanks, Margo, I'll keep this super brief. I'm echoing a lot of things that have been said already, including David Kelley. In Washington State, although these aren't yet required reporting measures to NCQA, we've required our MCOs to report these for a few years with varying degrees of success. I feel like we need to continue heading in this direction and start somewhere. But I also agree with Lindsay that if there's an opportunity to really promote the use of these measures in a way that's not punitive or required until states can get this built into their reporting system, I think that would be something that we would be in support of. Thank you.

Margo Rosenbach:

Thank you. Joy Burkhard?

Joy Burkhard:

Great, hi, everyone. I really appreciate this conversation as well. Again, I'm from the Policy Center for Maternal Mental Health. We're a 12-year-old nonprofit organization working to close gaps in maternal mental health care. We were really pleased, as you can imagine, with the development of the new HEDIS measure around maternal mental health disorders; and I just wanted to call out a couple things.

David, I thought it was really interesting that you pointed out there's mismatch even with the ECDS -- am I saying that right -- yes, ECDS measures, the electronic measures -- and a disjoint in the rates that you saw, which was part of depression screening in Pennsylvania. What we've seen states do thus far is focus only on the postpartum period and only within sort of pediatric settings. There's been a movement – which we applaud by the way -- but there's also been a movement to look upstream and look at screening in pregnancy, which of course the HEDIS measure now addresses, which is critical given the rates of postpartum depression. If you have depression of course in pregnancy that goes undetected, you're likely to have postpartum depression as well; and also, the link to preterm and lower birth weight deliveries, which we all know are very costly to payers.

So, I wanted to flag that looking at the obstetric medical home for screening is critical. I know the electronic measure looks at various inputs. So we are very supportive of adoption. There are some statistics that I wanted to share with the group, but just to recognize that these disorders impact not only the mother but the developing child. The Harvard Center for the Developing Child was one of the first organizations to call that out. So we're talking about two lives here at stake, and early intervention and detection is critical. Also, researchers have called out that the cost of untreated and undetected maternal depression is over $14 billion a year in the U.S. because of this two-gen impact. So I really believe it's time to measure what we treasure. One final comment is that the CDC has also shared that it's the leading cause of maternal mental health conditions inclusive, according to the CDC, of SUD as well; but suicide and overdose, the leading cause of preventable pregnancy-related death. Thank you.

Margo Rosenbach:

Thank you, Joy.

So we have four people in the queue, and then I am going to cut it off after that for a vote – Jakenna, Tricia, Linette, and Ben. Jakenna, you are next.

Jakenna Lebsock:

Thank you. I want to echo a lot of the comments of what's already been said from the states. But I think generally all states would agree that any way that we can build efficiency and get information in the most readily available format possible with the least administrative burden is ideal in terms of how we approach measurement and getting at that information that's really important to drive how we build our programs and how we address opportunities.

With that said, I don't think we are anywhere near a ready state. We do not have a solid foundation in place. I think if these were to be mandatory any time in the next few years, the data is going to be questionable at best *if* you can even get data from all of the states. I think knowing that and the concerns associated with that, plus the concern around mandatory reporting and the implications if we're not able to meet that, I think it's too much right now. While I think it's critically important and I think we're working diligently to try and make it a reality, we are not there yet; and we are not prepared to be responsive in that way, to have any kind of meaningful outcome from mandatory reporting for ECDS measures at this time.

Margo Rosenbach:

Thanks, Jakenna. Just a reminder to the Workgroup, CMS is still in the middle of rulemaking; so we do not know whether these measures would be subject to mandatory reporting. I know we'll be moving toward a vote very soon, and it might be hard to make a decision; but there is not information at this point about whether these measures would be subject to mandatory reporting or not.

Next up, Tricia. Rich Antonelli, I saw you had raised your hand as well. You will have the last word. Tricia Brooks.

Tricia Brooks:

Yes, thank you. I made some of these comments about the rulemaking and mandatory reporting on our prep call a few weeks ago. I'm certainly sensitive to how complex this is for states; but I

think we have to keep in mind that ultimately CMS makes the determination as to whether they add something we recommend to the Core Set, which means the Secretary has the latitude to delay things that maybe they will add at some point in the future but not going to do it when state readiness is in question.

While at least our read of the Proposed Rule is that all measures are mandatory, that the Secretary doesn't have discretion in regard to, if it's on the Core Set, whether it will or will not be mandatory but has a lot of discretion, I think, around when the measures will be reported. So some of the other speakers have noted this. I will say that my experience with CMS – and I've been doing this for close to 30 years now – I look at the unwinding of the continuous coverage requirement. I look at the fact that not all states are in full compliance with renewal regulations that have been in place since 2014. And I think CMS is always sensitive to state challenges and working with states so that they can be in compliance with whatever the rules and the law says. So I will vote based on whether I think a measure is ready for the Core Set without necessarily worrying too much about what CMS is going to do and when they're going to do it. Thank you.

Margo Rosenbach:

Thanks, Tricia. Linette? Derek, can you unmute Linette?

Linette Scott:

Thank you, can you hear me all right?

Margo Rosenbach:

Yes.

Linette Scott:

Okay, thanks. Echoing the comments, and definitely Jakenna and Lindsay's comments around feasibility and some of those issues, I know when we vote on this we can't specify where on the Core Set it would land. These measures I think if I were choosing would land on the Adult Core Set under Maternal Perinatal Health and the Primary Care and Access Preventive Care, which means they would not be in the mandatory reporting part of the Core Set. So I hope that might be where they land.

But given some of the conversations we’ve had around putting the focus and sometimes, at least as the conversation we’ve had in past years, adding something to the Core Set does sometimes then get resources to help get us over the bridge around some of the components. As Lindsay said, we can run claims data for these measures. They would not be as good as if we could integrate with our immunization registries; and with the COVID pandemic, we’ve actually done a lot of work to do that integration with our immunization registries that we didn’t have as far as long prior.

So would encourage us to bring these to the Core Sets – hopefully not in the mandatory section because I think there is a lot of work to do; and as states, we need to work up to that. But definitely agree with having these move forward so that we can do more work in this space. Thanks.

Margo Rosenbach:

Thanks, Linette. Ben?

Benjamin Anderson:

Hi, thank you. First, just to be brief, I want to echo everything that Joy shared out on the importance of these measures.

Second, as consumers we want good data, quality data that's accurate and informative. So putting states in the position to just mandatorily report out a bunch of bad data doesn't help anyone – not the states, not consumers. But I do want to say I think in a lot of these feasibility discussions it would be helpful to hear from the states on sort of what is needed to move something into feasible – what resources, what TA, what kind of support is needed. I actually had the exact same thought as Linette when she mentioned that by putting these things – recommending these things to CMS and getting them on the list of measures for mandatory reporting will open up those conversations about how do we move our data systems forward and get out and away from these broken siloed systems that Curtis was mentioning that are really unhelpful. They're helpful for folks at the state. I know you're probably expending a lot of resources to make it all work together, and they're not helpful for consumers either. So look forward to hearing more information on how we can move past these things. Thank you.

Margo Rosenbach:

Thanks, Ben. Rich, you will have the last word; but I also just want to mention that we are not taking public comments at this point, but there will be a public comment opportunity at the end of the day today for those who might have a public comment.

Richard Antonelli:

Thank you, I appreciate the conversation. I'm a little disquieted about this because what we're doing is we're voting specifically about this e-measure, and that's great. I'm mindful of how deep and important the conversation was two days ago with the Perinatal Oral measure and on the depression screening discussions that we had yesterday, and I'm laser focused on what this vote is. But for my money, I'm thinking in the arena of equity life course, something that we could do something about. Postpartum Depression is such a universal problem that to send a signal to the nation that we're going to do this -- and, Dave Kelley, you've offered some rays of hope about how we can get there.

So I'm in favor of advancing it, recognizing that there is work to be done. But I would have felt better in this conversation if we had a contingency – if not this one, then which one. So I feel that we need to focus in a rigorous, robust, stratifiable way on Postpartum Depression Screening and Follow-Up. Thank you.

Margo Rosenbach:

Thanks, Rich. With that, thank you, Workgroup members, for all of your comments. I will now turn it over to Alli and Talia for a vote.

Alli Steiner:

All right, thank you, Margo. So moving into our first vote of the day, the question is should the Postpartum Depression Screening and Follow-Up measure be added to the Core Set? The

options are: yes, I recommend adding this measure or no, I do not recommend adding this measure.

Voting is open and just a reminder to refresh your browser if you're not seeing the question appear. We're just waiting on a couple of more votes. Thank you for your patience. It looks like we might be missing Amanda. Amanda, can you try submitting your vote again? As well as Lisa Patton, I don't think we're seeing your vote either. If you could just try to submit it in the platform. Okay, now we're just missing one vote. Lisa, I see you have your hand raised. Are you able to submit your vote into the Q&A by selecting all panelists?

Lisa Patton:

Hey, there, nothing seems to be working right now. So I emailed my vote to you all. Can you grab it from the email?

Alli Steiner:

Yes, we can grab it from the email. Thank you, Lisa.

Lisa Patton:

Okay, and I'll do that for the rest of the votes so as not so slow the progress; and then I'll log back in.

Alli Steiner:

Okay, thank you.

Lisa Patton:

Yeah.

Alli Steiner:

All right, we received the expected number of votes, and now for the results.

Okay, so 69 percent of the Workgroup members voted, yes. That does meet the threshold for recommendation. The Postpartum Depression Screening and Follow-up measure is recommended by the Workgroup for addition to the 2025 Core Set.

Moving on to the next vote, the question is should the Prenatal Immunization Status measure be added to the Core Set? The options are yes, I recommend adding this measure or no, I do not recommend adding this measure. Voting is now open.

We're still waiting for a couple of votes to come in; but we did receive your vote through the email, Lisa, so you're all set. Thanks for your patience. We're just checking on which votes we're still waiting for. I think we may be waiting on Mitzi's vote if you're able to try to submit that again.

All right, we've reached the expected number of votes. For the results, 83 percent of Workgroup members voted, yes. That does meet the threshold for recommendation. The Prenatal Immunization Status measure is recommended by the Workgroup for addition to the 2025 Core Set.

Moving on to the third vote, should the Adult Immunization Status measure be added to the Core Set? The options are yes, I recommend adding this measure or no, I do not recommend adding this measure.

Voting is now open. It looks like we may be missing Mitzi's vote -- if you're able to try submitting again. I think we're also missing Joy's vote – if you can try making sure that you submitted your vote, please, Joy. Okay, we got your vote, Joy, thank you. We're still missing Mitzi's vote. Mitzi, if you're able to contact the panelists through the Q&A and try submitting there. Okay, we have the expected number of votes. We can close the poll.

Okay, 86 percent of the Workgroup members voted, yes. That does meet the threshold for recommendation. The Adult Immunization Status measure is recommended by the Workgroup for addition to the 2025 Core Set. That concludes the voting on the deferred ECDS measures. I'll now pass it back to Margo.

Margo Rosenbach:

Well thank you, everyone, for reconsidering these measures, having a very good discussion and then a pretty definitive vote here for CMS. So thank you, everyone. Next slide, please.

So on our agenda, we wanted to pivot to the use of Core Set measures to drive quality improvement. We are thinking about the future of the Core Sets, thinking about gaps, the prioritization of gaps. We thought it would be helpful for Workgroup members from several states to discuss how they use Core Set measures to drive quality improvement. As we've discussed in the past, there are lots of quality measures and lots of good measures; but to be included in the Core Sets, a measure should address a strategic priority for improving health care outcomes in Medicaid and CHIP, and it should be actionable in leading to measure improvement. Next slide, please.

So we asked a few people to share their perspectives on using Core Set measures to drive improvement. Karly couldn't be here today, but we have Clara and Laura. I'm hoping that they can speak briefly. Then we'll segue directly into the prioritization of measure gaps. We've fallen a little bit behind in our schedule. So rather than having Workgroup member remarks or Workgroup discussion, we'll just go right into the gaps conversation. Hopefully, these remarks will help to frame the Workgroup's thinking about how to identify what the gaps are, how to prioritize them, what measures for future development.

With that, Clara, can you go first?

Clara Filice:

Hi, everybody. Clara Filice from MassHealth. Yes, happy to speak a little bit about our experience in Massachusetts. So we use many of the Core Set measures, as most do, around across all of our MassHealth programs, so about 12 different places where we measure quality using either more or less of the Core Set measures depending on the setting and from the various Core Sets as well.

We use them not only to promote aggregate performance in our value-based purchasing programs, including for our ACOs and MCOs, which cover the vast majority of our membership and also in our OneCare and other plans. But we're also using stratified performance on the Core Set measures for the first time in this 1115 waiver cycle. So we're in the first year of our

new cycle to drive equity improvement and closure of disparities. For these programs in the next couple of years, our ACOs and hospitals will be moving from stratified reporting, which is being introduced this year, to incentivized disparities closure for populations by social risk factors.

So with regard to quality improvement, certainly Core Set measures have been essential to sort of helping us frame priorities, monitor our progress, and promote statewide progress as well. I will mention that while we do appreciate the breadth of measures that generally speaking with a lot of important attention to areas that are critical to our members' health, we do also continue to perceive some gaps in measures related in particular to child health outcomes, perinatal health, member experience of equitable access and care, access for members with disability, and language access, among other areas. These are probably in most cases largely reflective of a dearth of measures available nationally in those areas, but they continue to be notable to our team in that we aren't able to use Core Set measures to measure quality in areas that are critically important for our programming.

I'll pause there and turn it over to Laura.

Laura Pennington:

Thanks, Clara.

So Laura Pennington, Washington State. I would have to say that we feel very fortunate in Washington State to have access to a lot of different data sources, including the CMS core measure sets results, to monitor overall performance and identify gaps. We continue to balance a need to align measures across our various quality initiatives with reporting requirements and with the need to achieve quality outcomes for our members.

We do recognize that alignment for the sake of alignment is not always feasible or effective. However, when we do select measures for our various initiatives, including our state Common Measure Set, we do look for opportunities to align with federal quality initiatives including the CMS core measure set. So for us, the CMS core measure set provides an opportunity to not only compare performance with other states but also to compare with our other data sources, which is not only very helpful as a benchmarking mechanism but it's always helpful for us to understand any differences.

For example, we have an internal program that we use to select measures for our VBP agreements and contracts; and part of that process is analyzing performance data annually from our EQRO to identify any gaps or opportunities. But in addition to that, we recently established a new process to take a deeper dive into all of our data sources, including the CMS core measure set results. This will help us begin to identify and understand gaps and opportunities across all of our programs, not just our VBP programs. We're starting this process by looking at disparities. So I think any opportunity to get data stratified by race and ethnicity is very welcome and supportive of our processes.

I would say in addition we need to consider for us how we can use all of our data resources, including the CMS core measure set, to drive innovation, which includes the adoption of more outcome-based measures that truly demonstrate improved health outcomes for our members. The utility of the CMS core measure set in driving quality improvement, like other quality measure sets, can sometimes be limited by timeliness in data collection methods, which is why we feel that digital quality measures offer an improvement on turnaround of reporting and better

clinical data and would encourage that we continue to think about how we can view the core measure set through the lens of a shift to these digital quality measures.

In addition, appreciate the move to stratification of measures but want to make sure that we all use a similar approach to support accurate comparisons, which I believe was mentioned during that discussion thinking about OMB requirements -- or the OMB specifications or use categories, sorry.

Lastly, I would just say that we understand that we'll be discussing gaps in the CMS core measure set but also would like us to be mindful of the size of the measure set, although I know there's not a threshold, and ensure that we don't add measures just to fill a gap on paper. Instead, I would encourage us to prioritize a real need to improve an area not already addressed with the core measure set. I think overall this will help states manage administrative burden and address gaps, and addressing gaps may be easier with a shift to DQMs and greater interoperability in the future understanding that there's barriers now. But I think we should keep moving forward and strive for innovation. Thank you.

Margo Rosenbach:

Thank you, that was really helpful and a great transition to a discussion of gaps in the Child and Adult Core Sets. Can you go to slide 28?

Now we'd like the Workgroup to suggest priority measures or measure concepts for future Core Sets and also priorities for measure development, testing, or refinement. I wanted to remind everyone of CMCS's remarks on the first day...that measures related to social determinants of health or social drivers of health are currently being tested and refined for use at the state level. So with that, I'd like to turn it over to Maria to introduce the gaps discussion. Maria?

Maria Dobinick:

Thank you, Margo.

Each year, the Workgroup discusses measure gaps in the Core Sets; and we have assembled quite a long list of gaps over the four years that Mathematica has been convening the Workgroup. This year, we will review frequently mentioned gap areas discussed by previous workgroups and note the gaps that have been filled since 2020. Then, I'd like to invite the Workgroup to suggest priorities for future Core Sets, including both gap areas previously identified by the Workgroup and additional gaps that were not previously identified. Finally, we would like the Workgroup to suggest which gaps should be prioritized for future measure development, testing, and refinement.

This slide should look familiar to those who attended the Orientation Meeting in December. This slide shows frequently mentioned gaps discussed either all four years or three of the four years. One common theme is the desire to use the Core Set measures to identify and address health disparities among Medicaid and CHIP beneficiaries. The stratification discussion on the first day addressed this gap. That discussion revealed strong consensus about the importance of stratification, the challenges encountered to date, and some suggestions for addressing those challenges.

Other measure gaps that have been mentioned all four years include: care integration across sectors and settings of care, especially for LTSS users and beneficiaries with complex needs;

quality and experience with care for long-term supports and services; oral health care access and quality for children and adults; screening for adverse childhood experiences; screening for social/emotional needs.

Gaps mentioned in three of the four years include: colorectal cancer screening; health care delivery and outcomes for male beneficiaries; integration of behavioral health and physical health, particularly through primary care; prenatal and postpartum care content and quality; screening, follow-up, and treatment for depression, especially maternal depression; suicide screening, prevention, and treatment. Next slide.

During the December Orientation meeting, we also mentioned several gaps that have been filled by the Workgroup over the past four years. For example, CMCS added the Colorectal Cancer Screening measure to the Adult Core Sets in 2022. CMCS also added a suite of three measures related to dental care for children and two measures related to long-term supports and services. Finally, the Workgroup previously recommended three ECDS measures that the Workgroup reconsidered this morning. Next slide.

We'd now like to hear from the Workgroup on their priorities for future Core Sets. We have prepared a list of discussion topics, which are shown on this slide. I will read through the questions and then turn it over to Margo to facilitate the discussion. Here are some questions for the Workgroup to consider during today's discussion: First, thinking about all gaps previously identified by the Workgroup, what are the priorities for future Core Sets; and are there existing measures to fill the gaps? Second, as Deirdra mentioned, NCQA has proposed to retire the Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD) measure, for HEDIS year 2024, which corresponds to the 2025 Core Set. Are there existing measures to fill this gap? Third, are there other high-priority gaps not previously identified, including both domain-specific gaps and cross-cutting gaps? Finally, what gaps should be prioritized for future measure development, testing, and refinement?

Now I'll turn it over to Margo.

Margo Rosenbach:

Thanks, Maria. It's exciting to reach this point because I think even in the last few days, the Workgroup has really sought to close some gaps. As I think David Kelley mentioned earlier, the two adult dental measures are really important progress. Also, I think -- thinking about the content and quality of prenatal care, that certainly Oral Evaluation During Pregnancy is also an indicator of the content of care and also the integration across sectors and coordination for all the cross-sectors. So lots of great progress, and of course the conversation this morning about the ECDS measures – those could fill gaps if included in the Core Sets in the future.

At this point, we wanted to open it up to the Workgroup to hear what you all have to say. I do want to hear a little bit more, particularly about tobacco measures that could come up in the past when the Workgroup has considered the MSC measure. We can devote a little bit of time to that and see whether anyone has some suggestions or whether that is a gap that should be prioritized for future measure development, testing, and refinement. With that, Workgroup members, please queue up; and we'll proceed. Joy Burkhard?

Joy Burkhard:

Hi, everyone. I wanted to comment just to acknowledge that around maternal mental health disorders there are two NCQA measures, as you may know – the one we voted on just now that focuses on the postpartum period, but also a prenatal depression screening measure. I just wanted to flag how critically important it is for us to consider that measure in future discussions. I've alluded to the reasons why earlier.

Though the research has largely focused on postpartum depression, that has started to shift pretty dramatically in the last couple of years. Both the U.S. Preventive Services Task Force and organizations like the American College of Obstetrics and Gynecology, American Psychiatric Association, American Psychological Association, all recommend screening in pregnancy. As I mentioned, it's a leading case of preterm birth and low-birth-rate deliveries. It's also critical to catch these disorders early in pregnancy. A new onset happens almost as frequently in pregnancy as in the postpartum period, and of course we know that many young women and birthing people are entering pregnancy with prior undiagnosed depression and anxiety; and time is of the essence if we wish to prevent dysthymia and untreatable depression and mental health disorders in the long term.

So I urge the committee or the Workgroup to consider the pregnancy maternal depression measure in the *very* near future.

Margo Rosenbach:

Thanks, Joy. Ann Zerr.

Ann Zerr:

Hello, I just had some kind of unrelated comments.

The first is whenever this group can help our policies align with things about Medicare that support our programs – and a perfect example is telehealth. For LTSS, telehealth could be a very important quality and convenience for members living in long-term care or in their homes with less access.

I feel very strongly about smoking. It's a huge health disparity; and lower-income people, those with less education, certainly smoke more; and the health consequences and the costs are incredible.

The last is primary care and behavioral health integration. Philosophically, I 100 percent agree. Indiana, like I assume most places, is suffering tremendously with workforce as well as evidence-based care.

And just being respectful for all sorts of delivery systems where only about 20 percent of Medicaid members get their care in places that integration is easily achieved. For instance, community mental health centers and FQHCs, the majority actually don't get their care in areas like that -- so I think creative programs to increase that. But again, I'm thinking about telehealth; I'm thinking about using libraries, those sorts of things that are not developed yet.

So those are my random comments.

Margo Rosenbach:

Thanks, Ann. Rich?

Richard Antonelli:

Thank you, so just a few comments, but I'll keep them brief, with respect to gaps. I want to make sure that the Workgroup isn't just focusing on gap filling by adding new measures, although we certainly can do that. A point that I raised at our December orientation meeting is existing measures in the Core Sets – are they stratifiable yet and how are we doing there?

As recently as just a few weeks ago, I was sitting in a meeting at a different forum where people said, "You know, these measures are starting to top out; and so we're thinking they should be retired." Fortunately, somebody pointed out that, "Wait a minute, they're not stratified yet." So I'd love to be able to look currently at existing measures to find out where are the disparities and opportunities in those existing sets, number one.

Number two, in terms of the stratification going forward, I'm looking forward to consideration beyond race, ethnicity, and language and really moving in, in particular to disability status, the intersectionality for persons with disabilities across the age spectrum. And let me explicitly say I'm not speaking simply as a pediatrician now but just as an advocate of health and social equity and justice – of identifying disability data standards that can be stratified – once again, existing Core Set measures as well as some of the gap areas.

I would like to point out – now I'm going to wear my pediatrician hat and think about special populations. I'm excited about the Health Home Workgroup that MPR will be hosting, and that's great. But children with medical complexity – including youth transitioning from pediatric to adult care – are particularly vulnerable populations whose care often uses lots and lots of resources but not necessarily to advance equity or meaningful outcomes for those patients and families, again getting back to the intersectionality for disability.

So I want us to think about children with medical complexity as a population, which for the most part right now is tracked primarily by its cost and utilization; and we've got to add another element to what we're looking at that. So that is a gap area.

Then finally, I always – I'm wired for inclusion and engagement. So some of the conversations that are happening even in the last couple of days around behavioral health, for example, I want to call out that HRSA and Maternal Child Health Bureau has a nationwide program of pediatric mental health access. For the folks on our Workgroup that aren't familiar with that, please take a look at that. I often find that gaps often occur when different agencies aren't necessarily working collaboratively. The reason this is *really* important is in some cases folks are thinking about the same population but approaching it differently; and it puts patients and families and persons and caregivers in this really almost unnavigable situation where what agency do I look for, for my integration?

I'll close my comments by saying I want to make sure that we think about not just gaps going forward for new measures, gaps in existing measures, and then also gaps in places where resources already exist – think multiple agencies that aren't necessarily collaborating. That last bucket for that – profound implications for advancing equity because the resources are already there, and we collectively just need to get them aligned and measure doing so.

Thank you for letting me make these observations.

Margo Rosenbach:

Thank you so much, Rich. I just want to remind everyone that this is for Workgroup discussion at this point. We will open it up to public comment in about half an hour. With that, turning it over to Lindsay.

Lindsay Cogan:

Thank you, Margo. It's been good to regroup with folks. I know the last couple of years have been tough to sort of maintain a focus, and so it's been good to pivot back to the importance of the Core Sets.

I do appreciate all of the comments. I think it's important for us as a group to be able to critically examine why we are including measures, what measures still make sense, where there's opportunity for improvement, where there may be gaps. I do echo a concern that we are mostly additive at this point, and I understand the perspective that every measure is important to someone; and there are many areas in which there may not be adequate measurement, or there may be important specific areas or health issues that we have not yet addressed. But we do need to think about the size of the Core Sets and the ability to use this information to drive improvement as a part of the overall process. So I think it is important for us to critically examine and ask these important questions. I was a little bit concerned with some of the tone with some of the Workgroup members, and I want to make sure that those that are new understand that an important part of this is to ask the question...why are we collecting this, how is it helping our population? I think that's an important question to ask.

In the realm of where I think we should be continuing to focus is using that health equity lens and continuing to adopt the framework that CMS has put out. I think there's some real key tangible steps that we could take to look at how we approach the Core Sets. Rich, I think in the past you have brought up some good points about when people put forward new measures, it should be a requirement that they provide information that there is stratified results available somewhere so we can evaluate any disparities right up front as we're examining any new measures that we're thinking about putting into the Core Sets.

Then lastly in thinking about gap areas, I think it's important with a health equity lens to think about not only who makes it into the measure but who doesn't, right? So I think a lot of our health care quality measures are predicated on the ability to access care. So they may come as a result of someone having gotten into care already. So it's important to take a step back, as a state and as a nation, and look at the composition of the entire population. This became incredibly evident during COVID as we looked at the composition of the population of our states and then the morbidity and mortality and what the composition of that population looked like. It became glaringly obvious that the morbidity and mortality was focused on certain populations.

So I would just echo that I think it's important to think about ensuring while we get super laser-focused on drilling into our specific quality measures, we need to just take a step back and ensure that those populations that need care are also being able to access care and therefore making it into the measure so that we're focusing on quality improvement from sort of that macro level.

Margo Rosenbach:

Thanks, Lindsay. Curtis?

Curtis Cunningham:

Hi. Lindsay, I appreciate that comment because you can only get a quality measure if the person actually goes in. So that's where I would like to continue to move towards focusing on outcomes of negative health events. Screenings are good, but they can only be measured if the individual has access.

Areas that I think we would want to continue to talk about – obviously, LTSS, long-term services and supports, I think there's been conversations that a lot of the measures, such as NCI, do not have 25 states participating; but yet on the flip side of that, we are adding other non-long-term-care measures that are medical in nature that do not currently have 25 states reporting. So continue to want to talk about LTSS.

I also think dual-eligibles is an interesting area to really talk about because I think they can fall in the gaps, and it is a very expensive population for the LTSS side. Just one thought I had looking at those outcome measures, I think the OIG did an audit of critical incidents or potential hospitalizations that resulted in – that were due to what would be perceived as a critical incident. So maybe looking at hospitalizations for LTSS individuals that are a result of lack of care may be an area that would be interesting to continue to look at because I think for LTSS and that population, really the medical and the home and community-based services need to be looked at together. You can't have good HCBS if you don't have good medical, and you won't have good medical if you have – you'll have unnecessary medical utilization if you have bad HCBS. So how do we really assess the coordination of that and make sure we're not looking at it as two very different, distinct events and populations? Thank you.

Margo Rosenbach:

Curtis, can I ask a clarifying question for you? Because as you probably know, there is a fairly extensive HCBS Quality Measure Set that was released in 2022. I'm wondering if you think some of those measures are the kind that you have in mind. Also, in terms of the population to which it applies, or to whom it applies, are you thinking that primarily waiver-based programs; or are you thinking of them as general population-based programs? If there's anything more you could say about that, it might be helpful – of how you're thinking about the LTSS population, particularly as it applies to the Adult Core Set and the HCBS Quality Measure Set.

Curtis Cunningham:

I think there needs to be a merger of the two. Again, I do like a lot of the HCBS because it focuses on experience of care; but I think that it misses the gap of combining with medical services. For example, in our NCI data, we had data that suggested that individuals are very happy with their services; but then we asked an additional question of how many times you've been to the emergency room, and it was over five times.

So while you can be satisfied with your HCBS services, going to the emergency room over five times a year suggests to me that there might not be necessary access *or* that the medical side is not sufficient for individuals. Since in different states those waiver services are organized in a different way, some have them carved out of their medical programs and other things, it's something that I think we really want to get the whole person understanding of the experience and meeting their needs. We need to be able to measure. Did that answer your question?

Margo Rosenbach:

It did, thank you so much. Sara Hackbart?

Sara Hackbart:

Yes, thank you so much. I did want to mention – I'll continue on the HCBS and LTSS path – I am an LTSS Quality Program Director for Elevance Health. My background is in family therapy, but I've spent the last seven years administering the health home program for the state of Iowa and overseeing LTSS Quality for the local health plan under Elevance Health. I did want to just echo some of the comments.

I believe Rich had mentioned the stratification by disability. I do think members with disabilities – they do have compounded impacts of disability with age and race and ethnicity. I think it would be important to have a stratification specific to disability. A recent study did recommend that the American Community Survey disability questions and the Washington Group community disability questions should be used to collect patients' disability status. I think we should look at that further, just to determine if we can implement that stratification in order to look at health equity by disability.

The other piece that I wanted to emphasize was specifically looking at the child population within LTSS and HCBS. I just want to use Iowa here for an example. Within the health plan in Iowa specifically for the 1915(c) waiver population, looking at just that non-dual population almost half are ages 17 and under. When we're looking at specifically the LTSS measures that were added recently to the Core Sets, those all addressed individuals who are 18 and older.

Also and just referring to the HCBS Quality Measure Set, the State Medicaid Director letter announcing that measure set also recognized that most of the measures in that measure set have only been tested with adults. So the indication there was they have not been tested with children and adolescents; and as a result, the measure set may not be appropriate for use in HCBS programs that serve children and adolescents. So definitely an area there – a gap or a need – to really look at that population and look at those measures specifically for that child population.

Another concern there is caregivers of that population and looking at quality of care when it comes to those needs of the caregiver. That's all I have, thank you.

Margo Rosenbach:

Thank you, Sara, that was really helpful. Linette?

Linette Scott:

Good morning. I wanted to kind of piggyback on some of what Lindsay and Rich were talking about earlier and focus on the gaps of the existing measures, some of which we've talked about over the last few days. So to kind of clarify what I mean by that. For example, one of the gaps we talked about was the surveys and survey tools have very low response rates. One of the issues that everybody who conducts surveys is dealing with is how do we address the low response rates, what does that mean in terms of representation, and how do we make sure we get the important feedback that we're looking for that the survey is attempting to do but recognize that our historical survey tools are not working the way they used to? So, yes, we have a measure; but it's not necessarily filling the gap because the measure has its own challenges. So I just want to highlight that. And I know there's a lot of work. Margo, you and I

have talked about this a lot in terms of the HCAHPS survey and how to address cultural differences in terms of how people respond and those kinds of things as well. So there's that aspect.

Another gap in the current measures is when we don't have all states capable of reporting the measure, or when we report the measure, and we know there's data quality issues in terms of how it comes through. So one of the things we've talked about is that there's some of the measures that require specific codes to show up in the administrative data; and if not, you don't get credit. So we know that it's an underreporting because of the processes that are in place in health care and the administration of health care...that we're just not capturing the codes. So we know there's more happening, but it's not coming through. So we know that this is an underperformance of the measure. I would think of that as a gap as well.

Then the other thing kind of in this context as well that we talked about a little bit is just because we report doesn't mean it improves. So often when we talk about data measurement, we know there is the phenomenon that when you start reporting on things, there's often an improvement just because somebody is looking, right? It's the Hawthorne Effect in management. But simply reporting does not necessarily mean improvement. So I think it would be really helpful in future years as we have this conversation if we could incorporate some of the trends analysis.

Rich kind of hinted at this some in terms of which measures are perhaps reaching the highest they expect. That's one way of thinking about it. Another of looking at the stratifications, is the measure performing high but only for some segments of the population? So that's another way of looking at it. And then what is the change over time? Are we just reporting, or are the measures actually being used in a way to change it?

One of the challenges with a lot of these measures is that it is *really* hard to show change and hard to make a change in terms of performance. It takes really significant outreach, sometimes policy change, different kinds of interventions, to drive the quality improvement cycles that actually result in change on these measures. So I just want to think of those things as gaps as well, not just topical gaps in the measure set. To echo the earlier comment I think Lindsay made around making sure we don't just keep adding, but that we're really getting the full benefit out of the measures that we do have and that they are actually being used to drive improvements – which we should see as improvements in the measures and the values if they're actually being used.

Thank you very much for the opportunity to comment and thank you to this Workgroup for being so engaged.

Margo Rosenbach:

Thanks, Linette. Tricia?

Tricia Brooks:

Thank you. I actually want to speak to both the issue of gaps and driving quality improvement thinking about some of the comments that have been made. Those who have been on the Workgroup for a while know that I was always a proponent for continuous coverage for children in the measure set because it was the *only* specified measure that Congress built into the 2009 CHIP reauthorization, which actually launched the Core Sets. But happy to say that Congress has taken care of that problem by mandating continuous coverage for kids, so that gap has

been filled. But I think it's going to be very interesting to watch the experiences of Oregon and Washington State, who have both been approved for doing multiyear continuous coverage for young children, in particular to see how quality can be improved when we have multiyear continuous. There are other states that moving in that direction as well, so I'm very excited about that.

In terms of a true gap, ACEs (Adverse Childhood Experiences) continues to be very concerning because we know how that impacts a child's trajectory in life. So I think that's a gap we do need to fill even if it's additive.

Then I wanted to talk a little bit about driving quality because we did quite a bit of work with the child policy, the health policy community on helping to educate them, not only about the Core Set and the measures but also connecting all the dots between the state quality strategy, the health plans' quality improvement programs, the EQR technical reports, and procurement. We talk about this as being a cycle and that the stakeholder community can engage at any stage of that cycle. But it's important for states to think about how they work with the advocacy community and try to engage them because I think they can be helpful when change or policy changes or funding is needed in order to drive quality.

I'll just close with the soapbox I often talk about, and that is that we know that kids generally are very inexpensive to cover; and a lot of the focus on quality improvement, on cost-cutting measures, on value strategies, really focus on higher-cost populations. But we keep filling up the pipeline of adults who have multiple chronic conditions that are rooted in childhood. When we look at the quality goals of states, the EQR reports, sometimes we can't actually even find anything if you were to search for child or maternal or pediatric. We often find – I shouldn't say often – but we sometimes find that those are not appearing in the quality work that states are doing. I just want to remind our state friends that we've got to go upstream for these kids if we want to solve the long-term cost problem in Medicaid.

I think that probably does it for my comments. Thank you.

Margo Rosenbach:

Thanks, Tricia. Anne Edwards?

Anne Edwards:

Thank you, I will pick back up on what Tricia just said in a minute; but as I listen to the comments, I will try not to be repetitive but I note that – I think there's a call for us to say adding measures will not fill gaps, but to really understand deeply how these measures might be addressing the needs of our populations and to ask the questions why. I think that there's a real opportunity as we move to mandatory reporting to understand the quality improvement initiatives, to understand how different programs and different resources might intersect to inform. Is a measure meeting a need? Is it not? Is there a different measure? I think that's extremely important when we consider issues of disparities. We've talked about stratification. Maybe we have some of the early work about what should be included in stratification. So I would suggest that over time, we really need to consider are those the right elements; or are there others? Disability has been suggested; there may be others to do that.

I think the issue with going upstream – thank you, Tricia, for everything you just said. I won't repeat it; but as I was even thinking about some of the conversations we had about mental

health and we talked about, well, depression screening was better than some of the ED or hospitalization measures because it seemed more upstream. I would suggest that we're really not there until we get to thinking about helping mental/emotional development. Certainly that starts in the prenatal period for us if you're thinking about a pediatric population. But what would it really mean to have something and measures that supported us thinking about going upstream? Maybe part of that comes out in some of the quality improvement work that we might do, but a firm believer that we can do much to shift a life course if we do better in this upstream work.

Then ACEs was mentioned. I think that certainly we know the impact of that work. I would say that this is a space that we need to carefully engage our members/patients to understand what their experience is and how we work and partner with communities on this. We know that screening for ACEs may be triggering in and of itself for some communities. So how do we, if we're going to be committed to disparities and equity, think about how we involve individuals in that work to make it most meaningful and impactful?

So maybe I'll stop there. Thank you very much, this has been a great conversation.

Margo Rosenbach:

Thank you. Ben Anderson?

Benjamin Anderson:

Hi, thank you. It's been so great to hear all these, I think, fantastic ideas from all of the really, really smart, hardworking folks on this Workgroup.

I think where I'll start is in looking at the whole Child and Adult Core Sets, I do think we need more focus generally on outcome measures versus process measures. I think looking at the growth of the Core Sets, all of the various areas that it covers, if there were a look at scaling back, I think you'd want to look at process versus outcomes.

Second, in diving deeper into the maternal health space, I think everything that was raised by Joy is important to hone in on. Then I think more broadly, we also need to see a more comprehensive maternal health outcome-based measure. I think the measure on Low-Risk Cesarean Delivery makes sense, but we're in the midst of a maternal health crisis. We know that not all of the factors that are driving that are related to C-sections.

Second – or I think I'm on point three – third, we really are lacking in the area of consumer experience. That's something I don't think has been raised yet either. So I think we need to support our partners in this space who are currently trying to develop and further patient-centered or person-centered measures. One that I will raise specifically in the reproductive health space is the Person-Centered Contraceptive Counseling measure. I think we've heard a lot from folks about how difficult it can be for consumers to respond to surveys. What's fantastic about this measure is it's just a short list of four rankings about how respected a person was when seeking contraception – so a relatively easy survey to deploy and something that's, I think, further along in its testing. So I think more support with that particular measure or something like it would be useful. Then I think there's more work that needs to be done around advancing a person-centered maternal health measure.

On integration, I think I like what one of the other panelists said about integration of behavioral health. I think we also need to look at and think about integration of care across generations. So how can we measure whether families are getting a two-generational approach to their care? I think it would be helpful -- I know we got a little bit of an update on the screening for social drivers of health. I think it would be helpful, if not in this meeting perhaps in the future, to get more information from CMS to this body and other interested stakeholders around where things are going and where they're at with screenings for social drivers of health.

Then finally, where I'd like to sort of add – and I think it's reflected in sort of where I started – I really like what Curtis said about the utility of some of these screening measures. I do think that particularly in the maternal health side, it's sort of the best we've got. But over time if we can shift to more outcome-based measures, I think that would help consumers/states/plans, everyone in health care alike. Thank you.

Margo Rosenbach:

Thanks, Ben. Emily?

Emily Brown:

I echo much of what has been said, particularly from Ben. I am new to this body and just surprised by the lack of focus on outcomes versus process and really centering measures not only on outcomes but patient and member experience. That consumer voice I think is really, really important. I think really when we have the voice of all stakeholders, I think we can achieve the outcomes that we all seek.

I'm also very interested in kind of that integration of care, and I also appreciate kind of the update on the health-related social needs measures and that work that's going on. I will say I've kind of looked at all of the proposed measures or the measures that are taking shape in that space; and, again, none of them are centered on outcomes or patient experience. So just again, I think it's important for us to include those domains when we're building new measures and even when we're looking at the existing measures that we have.

I'm excited about the conversation around stratification and what that's going to do – hopefully really bring a magnifying glass to the disparities so that we can then take action to really improve outcomes. Again, I'm new to the committee. I'm so grateful to learn from all of you; and I agree there's been so many great ideas, and I'm excited about the future. Thank you.

Margo Rosenbach:

Thanks, Emily.

Following up on what you said and what Ben said, certainly hearing about the need for more outcome measures and better/stronger experience of care measures -- I think that's also a theme that Linette had mentioned and others – it sounds like those are areas, and I don't want to put words in your mouth, but what I'm hearing is that those are gaps that should be prioritized for future measure development, testing, and refinement.

I guess specifically, I'll tell you about outcome measures. Over the years, there's certainly been a push or a gold standard toward outcome measures. I think there's also maybe limited outcome measures that have been tested in Medicaid and CHIP and that are feasible for state

Medicaid and CHIP agencies. I'll mention specifically the one that Ben mentioned, the contraceptive care measure. I think that one has not been tested at the state level in Medicaid and CHIP. It's provider-based, and the sampling on that has some limitations for thinking about it as a robust measure at the state level.

So I think what I'm hearing from this group is that some of these gaps are going to be priorities for future measure development, testing, and refinement; and I certainly encourage folks to be orienting their comments in that way as well. We've gotten a lot of great ideas on gaps, and some of them I think – and I'll add the tobacco measure because that is one that we are interested in hearing about. We know there's going to be a gap, or likely to be a gap, and looking at ways that that gap can be filled because previous investigation has suggested that existing measures are not in use or specified for state-level reporting.

So with that, I will turn to Jim Crall.

James Crall:

Thank you, Margo.

I just wanted to echo and add my support to Sara's call for prioritizing greater focus on the special needs or physical and intellectual disabilities population. I think I've done a bit of work with folks at Georgetown University in Maternal and Child Oral Health Resource Center on developing a framework and a set of core measures for the child population as well as the maternal population, women of childbearing age, and really struck by the fact that we can't readily do comparisons of how well we're providing care for special needs populations. I think that we all know the complexity and the extent of services necessary there is definitely greater; it's a vulnerable population. So just wanted to add my voice to that call for a greater focus on that stratification.

Margo Rosenbach:

Thanks, Jim. We are running very short of time. If you have spoken before, I'm going to need to say that we're going to go to folks that have not spoken yet – Kim Elliott, Laura Pennington, David Kelley – and then turn to public comment. Oh, Lisa Patton just raised her hand. Okay, Lisa, you get the last word.

So Kim first, then Laura, then David, and finally Lisa. We will have time after the break to come back and talk about some future reflections, so hold your thoughts for that.

Kim Elliott:

Thanks, Margo.

I'm going to keep it really short; but I think over the years, we've really worked hard to make it a pretty robust, well-rounded core measure set that reflects the populations being served by Medicaid. Sometimes I think when we're talking through different measures to add, move, et cetera, more really is not always better; but what's really important is that quality of those measures that we're including, and I think that comes through every time we vote on these measures and the discussions of course that lead up to the voting.

I think that we still do have some gaps, particularly with all of the different changes in who's actually served by Medicaid, particularly younger men between the ages of maybe 25 and 64. We're always also pushing people more and more into the community versus living in nursing homes. So measures that really address the services that are being provided through home and community-based service programs and then of course continuing to pursue outcomes measures are always going to be a high priority for us. But some of our challenges with that are having to do with the measures themselves.

So if we think a little bit more broadly maybe about what we are thinking about in the way of gaps -- such as a gap in the number of states that are reporting some of the measures and what those reasons are, the lack of data that may be available, such as more complete race/ethnicity data to allow more accurate stratifications reporting, which would of course lead then to more of the quality improvement initiatives that we all want to implement to really improve the outcomes that we're measuring.

Of course the gap between Medicare/commercial measures – a lot of those we've often wanted to refer for consideration for our core measure set, but they haven't been tested in Medicaid. They haven't been tested at the state level. So those are the types of things that if we could think through ways to resolve some of those issues or barriers, I think we would all be well-served from a core measure set perspective.

Margo Rosenbach:

Thanks, Kim. Laura Pennington?

Laura Pennington:

Thanks, Margo.

I agree with most everything that's been said already, especially with Linette – that reporting does *not* always result in improvement, and therefore using trend analysis is critical. We've been talking about that in our state a lot. In addition, as others have mentioned, moving towards more meaningful outcomes-based measures that demonstrate whether an intervention actually led to improved health outcomes is critical.

I also agree with Ben; considering more patient-centered and patient-reported outcome measures would be great. I know this is an area that CMS is currently working on with their CMS Meaningful Measures 2.0 initiative. So it would be great to learn from that.

Finally, I would say I think it's helpful to consider how measures can leverage new technologies. For example, thinking about the discussion about low response rates for HCAHPS, I wonder if there's an opportunity to better understand the patient experience in real time. I know health plans are doing this already, and there's been some success in the mental health and SUD recovery efforts.

An example is after a recent medical appointment that my husband attended, we received an email that same day asking for feedback on his experience, which is great; but I wonder if there's a way to mine that information through the use of these quality measures. Not saying we totally scrap HCAHPS, but I think there's some new technologies out there that we could think about leveraging in the future.

I'll stop with that. Thank you, this has been great as a first-time attendee to hear everybody's perspectives.

Margo Rosenbach:

Thanks, Laura. David Kelley?

David Kelley:

Thanks, great discussion. I'm thinking very broadly here and the challenge – hopefully, our CMCS colleagues are on the line -- that within Medicare there's the MIPS program, and there's the whole electronic reporting system that has been turned on for providers for Medicare patients. Why not do the same thing for Medicaid? Included in the quality reporting is hemoglobin A1c, the CAHPS survey, Controlling High Blood Pressure. There actually is a tobacco measure there looking for screening and/or treatment. There's adult immunizations sitting in there. The statin therapy that we discussed and the depression screening and follow-up measures all sit within that MIPS quality reporting system for Medicare. I'd like our federal colleagues to think in terms of why not develop that for our Medicaid providers as well. I think CAHPS is sitting in there as well, so that information could be captured electronically more real time and hopefully even more meaningful. From a screening standpoint for depression and follow-up, again, I always believe in harmonization. I think in terms of the CDF adult measure. Why not take that measure and parse out the prenatal depression and postpartum depression as subgroups of measurement? And oh, by the way, what if that was part of a MIPS electronic reporting system? You could actually do that within the Medicaid provider set. I've said several times I'd like to see more harmonization. I'd like to really see a subgroup of individuals sit down looking at the Core Set and looking at the HEDIS measures. A huge burden for MCOs and states is when there are nuances between the Core Set and NCQA's HEDIS measures, and this drains a lot of unnecessary resources and would really push to harmonize as much as possible those particular measures.

Along LTSS, again, I'm a big fan of the home and community-based CAHPS. We use one measure that actually asks participants about whether or not their care plan is meeting all of their needs – very participant-centered, gets to the gist of our home- and community-based program.

I also would think in terms of whether our federal partners looking at any claims-based Core Set measures. If you're going to require us to report on our dual-eligibles, you have the Medicare claims and you have the T-MSIS claims. Theoretically, you may be able to actually report on those measures within that subpopulation, so food for thought. Again, I think CMS has done a great job in making Medicare claims more available to states; but centralizing that might actually help things.

Hepatitis C is a huge gap that continues to exist; and would encourage looking at the cascade of treatment from screening all the way to getting a cure for a disease that now has great medications for cure, and the pricing has come down significantly.

I advocate again, as others have, for an ACEs measure.

Then lastly, to Jim Crall's point, we have actually been doing a dental measure for children under 20 for intellectual and developmental disabilities. We've reported on that using our EQRO-derived measure for probably almost 17 or 18 years, but that is an example of how a gap

could be filled looking at specifically those populations and those disabled individual participants. Thanks.

Margo Rosenbach:

Thanks, David. You reminded me of another shameless plug I will do for the CMS Quality Conference, which is next week. In fact, there will be an HCBS session; and someone from Pennsylvania will be talking about each HCBS measurement in Pennsylvania and lots of other great sessions. So hope that many of you will attend the Quality Conference next week.

With that, Lisa Patton, you get the last word from Workgroup members. I think every other Workgroup member can lower their hands. If you are a member of the public and want to make a public comment, please raise your hand. After Lisa Patton, we will turn to public comment. All right, Lisa?

Lisa Patton:

Thank you, Margo.

I promise that I was going to make these comments earlier; and several of you -- including you, Margo -- have already stated this a few times, so I'll be brief. I just wanted to note that it's very interesting to see historically we have largely had process measures to select from, right? So we have, to some degree, been very hampered in what we could pull from for the Core Sets. So what I was actually going to say earlier is I'm feeling very optimistic now because I feel like we *are* in a place where we're really focusing now through the stratification on those particularly vulnerable populations. How are those measures that are in the Core Sets now performing for those particular folks that we really need to be focusing on? We can learn much more about that, so it's a real pleasure to be able to begin to do more of that critical work.

Then of course outcomes are so important, and we want to really get to – we want to get to those outcomes as soon as we can. But I also think, as several of the speakers have mentioned, we're doing the best we can on many of the conditions including behavioral health. And to be able to have an ACEs measure or some measure of trauma included would be very helpful. As one of the speakers mentioned, the ACEs themselves can be triggering for some participants. So we would need to think very carefully – measure developers would need to think very carefully about what that would look like in this larger space, but I think moving in that direction so that it would also get at health and equity.

It would also enable us to know much more about the people sitting with us in our offices. So I think that kind of information could be critical.

I also wanted to put in a plug for using technology around driving those surveillance rates for the patient-reported experience. I think we're all committed to getting there; and now we can ask people, "Well, how do you want to be surveyed?" The speaker mentioned getting the survey the day of. Well, if we talk to people and we learn that really mobile technology is what they're in need of -- no, they don't want the day of. Then really now we have that potential with the variety of technology offerings out there to be able to be much more patient-centered even in how we ask those questions and learn about the care they've received.

So just food for thought as we move forward, but I think we're in a really great position with this group to begin to learn more about who the person is in front of us -- who those individuals are and then where the health care delivery system is failing them or supporting them. Thank you.

Margo Rosenbach:

Thanks, Lisa. Next slide, please. So now we are moving into our public comment period related to gaps in the Child and Adult Core Sets as well as priorities for measure development, testing, and refinement. If you would like to make a public comment, please raise your hand. Next slide, please.

I see we have a few people queued up here – first, Ned Mossman.

Ned Mossman:

Hi, thank you so much, and thanks for the opportunity to comment; and thanks for the wonderful discussion. My name is Ned Mossman. I am the Director of Social and Community Health at OCHIN, a nationwide network of community health centers and critical access hospitals. I have experience on the HL7 Gravity Project as a Strategic and Technical Advisory Committee member and developed and submitted measures around health-related social needs.

I want to speak sort of on behalf of alignments of measures, particularly adopting measures that fill gaps like those for social determinants of health and health-related social needs. But not just between programs, but I would also say within programs. I've heard a lot on the call about focusing on outcomes rather than just process, and I completely agree; but I think it's also not an either/or. I think trying to develop sort of cascaded measures that use the measures around screening in processes to then drive outcomes and then identify how the outcomes are progressing as well in those types of measurement cascades can help inform where the processes or where the initiatives are falling down. To that end, we've proposed measures in the MIPS measure set and are submitting for the hospital measure set this year under CMS that build on social needs screening and positive identified needs rates to then also measure connection to community services and ultimately resolution of health-related social needs. Those are very much patient-centered measures that focus on the patients' definitions of resolve and of their needs.

So just a plug for thinking about and aligning social needs measures and prioritizing that as a gap, but also aligning both across measure sets and within measure sets in ways that address the outcomes but also don't sort of give up on measuring some of the important process measures that help us understand the why's and how's of where the process is going. Thank you for your time.

Margo Rosenbach:

Thank you. Julia Skapik?

Julia Skapik:

Sorry, can you hear me?

Margo Rosenbach:

Yes, now we can.

Julia Skapik:

Okay, great. Hi, great, Julia Skapik, CMIO from the National Association of Community Health Centers. Agree with Ned's excellent comments.

I'm here also to comment firstly on social drivers of health. I believe we had a conversation about this about a year ago, and I'm disappointed to see that we don't have something on the docket here to consider. I would say that SDOH screening is very mature, and that CMS can be part of the movement to standardize social interventions that align to social determinants of health screening. I will say that I don't think that screening is adequate. We know from our work with health centers that there is a moral injury both to patients and to care team members who screen and ask questions like, "Do you have a stable place to live?" and the patient says, "No," and there's no action taken from that. So I would encourage CMS to develop an SDOH measure where they can start with the implementation of screening and move rapidly to the implementation of follow-up with a closed-loop referral that results in an action that reaches the patient.

I would plus-one the comments about ACEs and behavioral health. We don't have enough measures in those areas.

I did want to speak to the factors also of maternal health, which was mentioned earlier by the Workgroup. We definitely need a comprehensive approach to maternal health. One of the biggest challenges in assessing maternal health quality is actually the availability of standardized data. NACHC has, for several years in a row, I think four years now, commented that we should require EHRs to support the necessary data elements to take action on both prenatal and postpartum care, and that includes the transmission of structured data to support care around the episode of birth. We encourage CMS to work with ONC on that and, again, to develop over time a measure which becomes a composite measure that has individual measures of quality embedded within it, particularly around identifying high-risk patients and appropriate high-risk follow-up.

I also wanted to speak to the comments about outcome measures. I think actually it's very – CMS at one point had said we're going to move away from process measures to outcome measures. I would argue that all measures should have both process and outcome components, and the nice thing about that is we can also do staged implementation of those measures. It's good to know whether or not the patient's A1C came under control. But if that was due to no action whatsoever because the patient joined a gym and they lost a bunch of weight by the provider versus the patient who has an A1C of 10 and will never come under control without a bunch of interventions, we need to combine all of these measures so we can understand the differences in these outcomes.

To that point, I wanted to make one more plea that CMS also convene some multistakeholder work about encounter definitions and panel empanelment management because without good encounter definitions – in fact, the ONC USCDI mentions encounters as a class without actually defining what they mean by that. Those encounter definitions – we won't be able to gather large-scale data and what's effective intervention wise. And I would extend my comments about encounter definitions to have clear telehealth and virtual service encounters, as well as nonbillable encounters that involve other members of the care teams taking actions. Again, if we

don't know which patients have had how many telephone visits and what kind of interventions from the medical assistance, it'll be really difficult for us to know what's moving the needle.

In regard to panel management, I would encourage CMS to say any EHR vendor that is going to provide services to people who see Medicaid and Medicare patients must have a panel management component and an easy opportunity for patients to view both the members of the panel and the quality measures that CMS enforces. Thank you very much.

Margo Rosenbach:

Thank you. I'm seeing that our next two public commentors are also from the National Association of Community Health Centers. I'm going to ask you to please hold your public comments until the final public comment period so we can take a break. We're running a little bit behind right now. We are scheduled to reconvene at 1:35 p.m. Why don't we say we will reconvene at 1:40 p.m. That gives everybody a little bit more than 15 minutes. So we will reconvene at 1:40 p.m. Thank you, everyone.

BREAK

All right, everyone, welcome back from the break. We've come to the reflections part of the meeting. Next slide, please.

This slide presents an agenda for this part of the meeting. To begin, I wanted to recap the Workgroup's recommendations for updating the Core Sets. The Workgroup considered a total of nine measures, including five measures suggested for removal and four 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.

Of the five measures suggested for removal, the Workgroup did not vote to recommend any of the measures for removal. Of the four measures suggested for addition, the Workgroup recommended two measures for addition, the Oral Evaluation During Pregnancy measure and the Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults measure.

In addition, this morning the Workgroup reconsidered the three ECDS measures, had a great conversation about those measures; and all of them were recommended again to be added to the Core Sets. As Deirdra mentioned, the soonest they would be added would be for 2025.

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

I think our gaps conversation this morning really addressed a lot of the concerns and considerations of Workgroup members. Then also, all the feedback that we got over the last couple of days during voting really showed a little bit of the tension and also the balance across desirability, technical feasibility, financial and operational viability.

So now we'd like to hear Workgroup members' suggestions for technical assistance to help states with reporting of the Child and Adult Core Set measures, and specifically suggestions on how to build state capacity for calculating and reporting Core Set measures. I think the discussion yesterday was really strong about the need for technical assistance related to the screening for depression and follow-up plan measures, the CDF measures, and a lot of really good suggestions on how maybe coding could be improved and how workflow could be improved, incentives that could be provided or learning opportunities. There are others. I would like to open it up to Workgroup members at this point to talk about opportunities for technical assistance that would be valuable. I'll also add about stratification – great conversations on the first day with lots of great suggestions on not just the importance and the challenges, but also constructive suggestions on how the data could be improved. With that, I will open it up for Workgroup members. Please queue up.

Joy?

Joy Burkhard:

Hey again, everyone. I hope that these remarks are coming at the right time. Margo, correct me or stop me if not.

I just wanted to share reflections as a new member, and really appreciated the dialog and starting to understand the process more about how measures are developed, the role of CMS, et cetera. A couple of reflections from me was that it really struck me that it was interesting and perhaps a bit of the tail wagging the dog in that measure developers might be sunsetting measures that perhaps this group and others would feel are important. I'm wondering if there's a way that CMS can comment on that – perhaps not today but at some point – around should the process look different, should this group and others be suggesting measures that should be developed and then put out a call for proposals for measure developers? That seems to make sense to me, wanted to share that reflection.

Also, it does feel like it could be helpful just recognizing that Medicaid agencies and health plans have limited capacity whether we like that or not. We can't measure everything. So what does that mean in terms of process for this group and others? I kind of like the idea of assessing, like, capacity of an average Medicaid plan and then lining up what does that mean in terms of the number of measures or the complexity. Is there a complexity factor in measures? And some of that work being done up-front before we have conversations about what should be in the Core Set could be helpful.

Then also, really appreciated someone flagging earlier that it's helpful for us to know from a Workgroup perspective is this going to be punitive in some way for state Medicaid agencies and/or plans? Are there rewards tied to getting this right? All of that would be quite helpful, I think, for Workgroup members to understand as we head into these conversations.

Then just to reiterate -- I know, Margo, you've said this quite a few times – what does TA look like? So if a measure is *really* hard to collect data on but states like Massachusetts, I think we heard yesterday have overcome challenges, how do we identify those best practices and make sure that the Medicaid agencies and plans can take advantage of what other states have learned? Thank you.

Margo Rosenbach:

Thanks, Joy, that's a really good point – speaking about the learning opportunities to share. There are definitely some approaches that are available. We'd love to hear from other Workgroup members about what's working, what can be improved, and what the needs are. With that, I'll turn to Rich Antonelli.

Richard Antonelli:

Thank you.

I'm mindful that this is the first time now in a couple of years that we actually haven't looked at an LTSS measure. I actually think that we've said a couple of things in the last couple of days that I want to really highlight and then bring this to a point that I think we could use some technical assistance and guidance, and that is thinking about the LTSS and the home/community-based services populations. This also comes back to that children and youth with medical complexity issue before.

As we try to move not just looking at medical outcomes but health outcomes and thinking about what does comprehensive health look like, equitable access to education, equitable access to community-based agencies, I want to highlight an issue that I'm finding in many conversations with colleagues around the country; and this is the sort of data sharing. If we're looking at the approach to getting a person, say, with housing insecurity into secure housing, how does that information get recorded and tracked? How does that actually roll up into a plan of care, et cetera? So being that the perspective that I always take around equity and health and social justice is through that lens of integration, it would be really helpful if we could think collectively. And, CMS, if in your thinking about these more integrative outcomes around health, not just medical, how do different agencies relate to each other? How do they share data? And how do those data flows actually track into providing evidence that referrals are happening, resources are secured, and the outcomes that are desired? I would love to get some technical assistance around breaking down siloes through those different data sources.

Margo Rosenbach:

Thanks, Rich. Other Workgroup members? Laura Pennington?

Laura Pennington:

I agree with a lot that's been said already, but I just want to acknowledge one thing that really works for us to help our annual reporting is – first of all, thank you for going to a simpler reporting mechanism with the MCDT. All of the webinars were super helpful, and all of the resources on the current website have been really helpful to our data analysts who report that information.

With that said, I think the current conversations that occur in different platforms – whether it's the monthly MAC Quality Forum or the QTAG calls – they're really helpful. For us though, it's on us to get the right people there to listen in and participate in the conversation. Unfortunately, data folks many times are a little on the quieter side and don't want to speak up in that large of a forum. So I wonder – and I'd love to hear from other states – if it would be helpful to have just kind of a data users group who can help share what's working for them and what isn't. But again, appreciate all the resources that are currently provided and look forward to trying to figure out how to report some of those follow-up measures. Thanks.

Margo Rosenbach:

Thanks, Laura. Other Workgroup members? Rachel?

Rachel La Croix:

Yes, I just wanted to say I agree with a lot of what's already been said but did want to go back to comments that a couple folks made discussing the gaps, especially related to bringing in data on dual-eligibles to be able to report on them during the mandatory reporting one that comes up. I think that could be an area where a lot of technical assistance could potentially be helpful.

I also very much support the idea that David Kelley put out about CMS investigating calculating some of those administrative measures for states using both the Medicare and T-MSIS data. But I think any technical assistance that can be offered for states and any contractors they might be working with to do the Core Sets to really work on correctly linking Medicare and Medicaid data to be able to report on that population and some of the other areas that are being considered for stratification and all of that – just for stratifying different groups, how to look at continuous eligibility across different groups – for example, CHIP and Medicaid – and some of those different areas that were proposed in the Proposed Rule that came out regarding mandatory reporting.

Also, to go to a point that a couple of other folks have mentioned here, just trying to be able to learn more from states that have had success with calculating some of these measures based on some of those other ECDS data sources that not all of us are as experienced with yet. That would definitely be helpful.

Margo Rosenbach:

Thanks, Rachel. Other Workgroup members? Tricia?

Tricia Brooks:

Thanks, Margo.

I just want to commend Mathematica for how organized and supportive you guys are of this process. It amazes me how you can produce these agendas and stick to the time and yet not feel like we left people wanting to say a lot more, so just kudos. I've watched this process evolve. I've watched the criteria through which we determined whether a particular measure is ready for discussion by the Workgroup. In any event, I just really have a tremendous amount of respect for the team there and the competent work that you all do, so thank you.

Margo Rosenbach:

Thanks, Tricia, that means a lot. Well, maybe that's a good segue to feedback on the 2025 Core Sets Annual Review Process. We certainly have a spirit of continuous quality improvement, and so we would love to hear from Workgroup members if there are ways that we can improve the review process for next year. We started off with some really nice compliments, Tricia. We really appreciate that and wonder if anyone has any other comments – not just compliments but feedback.

Erica?

Erica David Park:

I apologize, there was a little lag with me unmuting. Can you hear me now?

Margo Rosenbach:

Yes.

Erica David Park:

Good, perfect. Unfortunately, I'm going to start with compliments too. I just want to say thank you to Mathematica and the full group. I thought as a brand-new person on the Workgroup, it was a very good experience. I know there have been some technical issues, but overall I think it went pretty smoothly. I think the voting platform for me – I had my laptop pulled up and the voting platform on my phone, and it just worked very well. So I think that was great. Definitely having the room and time for appropriate discussion of each area I thought was a wonderful thing too, so great on that.

One thing and I'm just going to briefly add something else just because I didn't get a chance in one of the other discussions. But I thought overall and also to compliment the rest of the Workgroup members, I thought there was really great discussion overall. Really most people had very thoughtful rationales behind what they were saying and good discussions in terms of their reasoning behind what their thoughts were. I'm not going to go a lot further.

But one thing I did want to call out is I was glad to see some other Workgroup members had that support of equity, particularly for individuals with disabilities. I think that's an area that isn't always looked at generally in terms of health care, so I was very happy to see that part.

One other thing I'll say too is in terms of like the stratification discussion, also excellent; and I was glad to hear that others had support of potentially doing some stratification with including individuals with disabilities, whether they're physical or intellectual also.

One additional part I would like to add in there too is just when we look at the stratification on racial/ethnic grounds that we may want to -- if there's a way that discussion with other members of different communities could be brought in to make sure that descriptions of categories are fully inclusive. I think one person in the public forum called out – I think that there was like the classification of individuals in like North Africa -- didn't really fit them, so things like that. But there are other areas where they may be some gaps too. One, I would say, is when we look at the Black/African American population, looking into that categorization, that just has that that but doesn't break it down. Others may identify more based on nationality. As an example, you may have individuals who are – they're Black, but they're from Nigeria or from Jamaica or something along those lines. So whether we want to think about further breakouts – just things to discuss, I think, with the community.

The last thing I'll say is definitely happy to hear the thoughts about integrating more within LTSS in particular. So we have individuals who are receiving LTSS, but definitely not a lot of support for really integrating/connecting people who are receiving LTSS and looking at their physical health benefits too and what's happening there. Because generally, it is all connected. So the way someone is having their LTSS benefits presented out and the services and care they're receiving there has direct impact in terms of their physical health. So I think methods that we

can look at to try to connect those things together and really integrate them as we're working forward in this process would be great.

I will stop talking now, but thank you so much for the opportunity to be part of the group. I'm really looking forward to additional experiences next year, so thank you.

Margo Rosenbach:

Thank you, Erica. We're just as thrilled with all the Workgroup members. I know we had a lot of you Workgroup members, a couple of old-timers – actually a fair number of old-timers – but it's just been a great blend of conversation and really appreciate everybody's feedback. Other Workgroup members, either technical assistance needs or feedback? David Kelley?

David Kelley:

Thanks, really appreciate all the hard work that the Mathematica Team has done. It's greatly, greatly appreciated.

One area that we may want to think about in the future is providing just a little bit more time from when you're holding the preliminary conferences towards the end of the year and then opening up that period of time in which we can submit changes, additions, or deletions – expanding that time and not making it around the holidays. I think that might be helpful. Everybody's busy, and the holidays are also a time where we're especially busy as well. So just food for thought in the future, maybe queuing up the discussion earlier in late fall and providing more time for us to review/submit additions and deletions in the future.

Margo Rosenbach:

Thanks, David. I will have something to say about that before we wrap up. Stacey?

Stacey Bartell:

Good afternoon, everyone. I just first want to thank Mathematica, just applaud you for all your organization and the smoothness. Even with minor technical issues, I think it was overall pretty smooth being a long three days; so I appreciate that.

Being a new member, I appreciate the other committee members – your enthusiasm but also your specifics with statistics and also giving the historical information. That was really helpful in the voting process, so I just wanted to thank everyone for that.

Margo Rosenbach:

Thanks, Stacey. Lindsay?

Lindsay Cogan:

Thanks, Margo.

Something I brought up in the *very* beginning as sort of a goal for this meeting was to also think about the fact that we are now talking about 2025 core measure sets. I know that that was done purposefully to help with sort of onboarding and ramping up for mandatory reporting. But I just want to make sure that we're not losing sight of new and emerging areas that may start to

unfold in the next year or so, and then there would not be the opportunity to add those to a Core Set until 2026. So I just wanted to kind of note that and just see if CMS had any thought to that on how to kind of remain an accelerator in the field. I don't know what the right balance is because we don't want to add burden or overly complicate Core Set reporting; but if there's an opportunity for states to optionally submit measures, I don't know if CMS would be open to that.

I think it's along the lines of what you were talking about, David, about sort of allowing folks to submit electronic measures as an option – open up another option to ensure that we don't fall behind, particularly around the social determinants of health. I think we're going to end up next year feeling like we fell behind, or in two years feeling like we still aren't going to see data in two years on the social determinants of health. I just want to throw that out there as just some food for thought. It was one of the things I came into the meeting wanting to identify.

Margo Rosenbach:

Thanks, Lindsay. It's a really good point as CMS tries to accelerate the process to allow states more time for knowing what's on the measure set, getting tech specs earlier, changing contacts and change with vendors and with plans. It's a very delicate balance here, so it's a really good point.

I assume that when you say being left behind or emerging issues, are you referring specifically to measures related to health-related social needs; or are there other things that you have in mind?

Lindsay Cogan:

That is top-of-mind; health-related social needs is probably top-of-mind, but there may be additional areas. ACEs has been mentioned as a gap. That may be something that potentially could open wide up here, and we could have a technical solution come through – imagine that – and we're still having to wait two-three years before we see measurement happen, so just something to think about.

Margo Rosenbach:

So I'll go out on a limb and ask what you're thinking, whether if a new emerging measure that would fill a gap that the Workgroup has identified with great consensus were to emerge, you're saying discuss it, say in 2026-2027, whenever it is, and then have it added to a Core Set that had already been released. Is that kind of what you're suggesting?

Lindsay Cogan:

I think that could be one path, right. So we could allow states to – I wouldn't make it a mandatory measure, but allow states to voluntary report certain measures that have been identified as key priority areas. But for feasibility or otherwise, challenges can't be – I mean, that could be one suggestion. I'm sure there's others that people are thinking about. The idea is to kind of continue – you guys do a great job at environmental scan and kind of pulling together information from various sources when you see them show up in public reporting. So that's another option. But again, just wanted to plant that seed – that I don't want us to become – I don't want us to lag behind.

Margo Rosenbach:

Thank you, that's very helpful. Joy Burkhard?

Joy Burkhard:

Thanks, Margo. As a new member, it just dawned on me that it could be helpful to do a new member orientation before the full group meetings to go over things like what is NQF. There were a couple other – Margo, you also shared some more background about NQF isn't necessarily important for these conversations. So some of that background, I think, could be helpful and help us run the meetings perhaps a teeny bit more efficiently to go over some of those things in the background before these meetings.

But I really appreciate your leadership as well and your team's leadership and the process, thank you.

Margo Rosenbach:

Thanks, that's a good suggestion. We have thought about it, and I would say one of the other things that has happened a lot this year is that we've added new members throughout the cycle and some as recent as maybe even last week. So it's definitely been an interesting experience onboarding a lot of new people. But it's a great suggestion and one that we've thought about, and we'll certainly consider that very seriously – especially when we have a large cohort. But we're always available to answer questions. So thank you for that. Rich Antonelli?

Richard Antonelli:

Thank you. I'll start by once again expressing my sincerest gratitude to the MPR team. You folks are all-star status, thank you. The prep's great. I also wanted to compliment you at MPR and CMS. I really love the diversity of the voices. As somebody who's been at this a while, for me personally and professionally to advance mission it just gets more meaningful all the time. So thank you to the CMS and MPR, thank you.

A couple of things that I'd like to suggest – one, I want to celebrate the fact that new measures have to demonstrate stratifiability. Margo, I'm sure that you could hear my fist bumps going when you made that announcement last year; that's great.

I also want to call out building on the gap discussion about what do we currently have. When I went through the measure information sheets, it said, "Measures are stratifiable." I'd love to in the future know and what are those data elements, right? So if they're stratifying by race, for example, is it just black/white? I think as a nation we have to appreciate the fact that there are nonstandard ways for what those data elements are for our REAL, disability, SOGI, and health-related social needs, et cetera. I know that this would put a bit of a burden on the MPR team, but I'd like to get as much specificity as possible both for existing measures in the Core Set – are they being stratified and, if so, what are the data elements – and then certainly going forward for measures of consideration. My intention is not to add work, but my intention is to minimize possibility of disparities because I think we do have to look to harmonize what those data elements are so we can actually declare that something is a problem that needs our attention or isn't.

Finally, one other thing that we should be considering as we look at populations and get increasingly into disability and chronic conditions, particularly with children, the opportunity to align with some of the priorities that HRSA and the Maternal and Child Health Bureau are

thinking about, those Title V programs at state and territorial levels, I think that there could be another voice here.

It wouldn't be on the Workgroup, but I don't know, Margo and/or CMS, whether HRSA MCHB has ever been invited to these conversations. I know the ones that I have with them in my role at the Coordinating Center, they're *very* interested in knowing what's happening both with Core Set and then eventually with Health Homes. So I'd make that request to see if we could bring in one more agency for engagement in this work.

Then finally, I put this in the Q&A on Day 1 because I didn't think it was worth using airtime for; but we are using the term "NQF endorsement" almost synonymously with "endorsement," and that is now an anachronism. CMS has reprocured the consensus development process to a different organization. NQF hasn’t gone away, but I was finding it a little bit confusing to think about, okay, so one of our criteria is NQF endorsement. What is that going to mean when this group reconvenes next year?

So just thinking about tweaking that language or maybe, Margo, what we need is, you know, if NQF endorsed this three years ago even though they're no longer in consensus development process territory, we're still going to consider that. So it's just a micro suggestion but hopefully will obviate confusion going forward.

Margo Rosenbach:

Wow, there's lots to unpack there. So first of all about NQF, NQF actually went away as the entity maintaining – I'm not exactly sure how to define what NQF's role was here, so forgive me, but on March 27th. So that was a month ago. We were so far into preparation into all of our materials. We deliberated, we discussed. So your point about what will it look like a year from now is a really good one, and we will let you know how we proceed with that; but that's a really good point.

Another point I'll make is about HRSA/MCHB. We do have HRSA as a federal liaison. It's a great point about MCHB specifically. We can certainly take that back and make sure there are connections. Similarly, CDC is a very diverse – has one federal liaison that coordinates within CDC. So these are large federal agencies with large subject matter experts and lots of different priorities and programs. So it's a really good point about MCHB; I think that's great.

Then finally on stratification, you were in our brains all the time as we were working on those measure information sheets, Rich. Like, what would Rich want? So we thought about that a lot. There are a couple of challenges that we face.

First of all, measure stewards don't always specify whether measures are incorporated for stratification. So we followed up with every measure steward when it wasn't explicit. Second of all, it's going to be very dependent on the data source. So if it's an administrative claims data source, there are going to be different availabilities of stratifiers. Some have race and ethnicity combined; we heard about that. Some have race and ethnicity separate than language disability, and so on. We've even had conversations about how to define geography. We think urban and rural; but in various convenings that we've been part of, there's a lot more complexity even to thinking about geography. So I think that we appreciate you continuing to push this conversation forward; but as much as we'd like to be farther along, I think it's still somewhat early days in thinking about the data, the categories, and standardizing and so on. I think we're working really hard to move in that direction. I think there are some bright spots, and we will

hopefully be seeing some of those in the near future with more states stratifying more data or more data sources permitting stratification. But I think the fact remains that there are some limitations. Then the last thing I'll say about that is that it's also going to be dependent on the denominators. Some states have smaller populations overall, so denominators that might not support the full array of stratification; or they have different distributions in the denominator and may not be able to support stratification. So we are looking at this a lot with CMS and really working toward the end goal that I think you are hoping for, and others are hoping for, but realizing that these are still earlier days than we might expect or hope for.

Richard Antonelli:

If I could just react to that because that is so well stated, and I would actually argue that just for the new members of our group but possibly even some of the older ones, just hearing that it isn't – just because something is stratifiable doesn't mean it's where we needed to be. So I guess that's what I would like to make sure that as we go forward, understanding that it's stratifiable but there are limitations – data sources, et cetera, et cetera.

It's so important to eventually get us to where we want to go – full transparency, comparability, actionability, et cetera. So I want to make sure you know I'm not anticipating that we're going to fix this, but I think just to be able to characterize what are the gaps – then maybe in that year's gap discussion we would say, "Let's prioritize coming up with a more robust set of stratifiers." So I absolutely want to thank you for that degree of candor, but I honestly can't let go of being on the journey to stratification and why it's so important and being respectful of how it will look different from site to site will be key.

Margo Rosenbach:

Thanks for that, Rich. I think we're all on this journey together; and I personally found the conversation on the first day to be really inciteful, really helpful, both in terms of stating well what's been tried, what the goals are, what the challenges are. I think hopefully progress will be made over the next year or the next couple years, and there will be an opportunity to report back on that. I think as everyone thinks ahead toward mandatory reporting, we all know that there will be certain elements of stratification that will be required – so lots to hopefully see in the future going forward.

And to I think David Kelley's point about harmonization, we have been working hard on this looking at CDC WONDER for a couple of the maternal health measures, looking at T-MSIS, just generally looking at what the data sources have; and they all differ. So it's really hard to come up with a strategy for the Core Sets, even when you're looking at one set of measures because you're looking across data sources.

Richard Antonelli:

Yes, thank you.

Margo Rosenbach:

Sure, well, thank you. Other Workgroup members before we turn to public comment or any other reflections? Last call...Okay, so the next slide, please.

Opportunity for public comment – and if you have a comment, please raise your hand; and I will call on you. Angela Parker, you have your hand raised. Derek, could you unmute Angela?

Can you introduce yourself? You should be unmuted. Angela, if you're speaking, we can't hear you. You may have just muted yourself again.

Angela Parker:

Can you hear me now?

Margo Rosenbach:

Now we can hear you.

Angela Parker:

Okay, thank you. This is Angie Parker with Kentucky. I was included in this I believe last week. I did accept all three days, but I was not able to participate but very little – not at all yesterday and on Tuesday for a couple of hours in the afternoon and then this afternoon a little bit. So that's been my challenge. I think what I have been able to listen to has been a lot of great information. I didn't realize I was a public comment person, so that's probably because I missed the very beginning of this.

But I agree with a lot of what I have heard and listened to with what everyone is saying on all the issues. I think it was Tuesday regarding the dental and the ED. I had some comments but didn't really know how to get on. But Linette, the person who spoke the most about it, is the person I agreed with most I believe on that. I know it passed and that's fine, but just a general comment that it's kind of challenging sometimes to do three straight days, although I understand why it was and the time period.

Margo Rosenbach:

Thanks for that. We know it is definitely a lot, and we are in the final half hour or so. So it's definitely been a lot of intense conversation and concentration. If you are interested in making a public comment when the Draft Report is released, please do that. We'd love to hear from you, and thank you for all that you do with Core Set reporting in your state. We really appreciate that.

All right, Raymonde? Derek, can you unmute him? There you go.

Raymonde Uy:

[Inaudible]…From the National Association of Community Health Centers; Physician Informaticist doing clinical terminology, data normalization, and I work with a couple of CDC folks on data extraction and all that stuff. I wanted to thank everyone, especially Mathematica, for the very professional way of conducting the past three days and all of the great minds that have contributed and commented on all of the measures in the past three days.

My only comment really is to hold our EHR vendors accountable for supporting different standard terminologies that make it difficult to do this kind of reporting. For example, for dentistry, we know that CDT is still one terminology that's billable and is being used; but there's really lack of support for SNODENT, for example, for really representing and capturing dental-specific and dentistry-specific information in a standard way that isn't captured by any CDT

code. And the same specific comments apply to clinical medicine, where there what I'm seeing personally is minimal support for SNOMED CT, where there's a lot of social drivers or social determinants of health concepts representing a standard code with SNOMED CT. In the same way, you don't see a lot of LOINC codes also in any of the measures. I know everybody wants billable codes and all that stuff; but if you really want to have meaningful semantic ways of presenting the concepts that we want to see here – like process and outcome measures – we would really want to support all of these standards and not just the ICD-10 HCPCS and CPT codes. That's it. It is tough. I completely understand; but one way of doing that is to support these standards. That's my extent. Thank you so much.

Margo Rosenbach:

Thank you, and thank you especially for those comments related to dental and oral health. I think I saw Karolina Craft with a hand raised. Do you still have a comment to make? Derek, can you unmute Carolina?

Karolina Craft:

Hi, this is Karolina Craft from IPRO. I did have really just quick question. It was sort of just saying thank you. I was just wondering, Margo, if you could repeat again which measures were (inaudible).

Margo Rosenbach:

Karolina, you're fading in and out. Can you try your microphone headset?

Karolina Craft:

Can you hear me now?

Margo Rosenbach:

Yes.

Karolina Craft:

Okay, so I just wanted to ask, Margo, if you could repeat the measures that were recommended for addition. I know you repeated that before, but I missed a few; so I was just wondering if you could do that again. Thank you.

Margo Rosenbach:

Sure, so the first measure is Oral Evaluation During Pregnancy. The second is Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults. Then this morning, we also discussed and voted on the deferred ECDS measures. So these had been recommended in prior years and deferred by CMS, so Postpartum Depression Screening and Follow-Up, Prenatal Immunization Status, and Adult Immunization Status.

Karolina, say again where you are from.

Karolina Craft:

I am with IPRO.

Margo Rosenbach:

You are, okay.

Karolina Craft:

Thank you so much.

Margo Rosenbach:

Sure, thank you. Other public comment? Are there any others who wanted to make a public comment? Last call for public comment before we wrap-up...All right, well, thanks to those who made comments. Next slide.

As we begin to wrap up, I wanted to thank our Workgroup members for your flexibility and patience in conducting this meeting virtually yet again, another year. I'd now like to call on our Co-Chairs, Kim and Rachel, for any final remarks they would like to make.

Kim Elliott:

Thank you, Margo. I do want to thank Mathematica for all of the hard work that that team – of course, led by Margo – puts into the core measure Workgroup meetings that really makes it a very efficient process. As always, the results reflect the hard work and dedication of this group of individuals. I also want to thank everyone for their participation and work over the last three days. I appreciate the amount of time this important work takes away from our already probably very busy days.

After much discussion on specific measures, the Workgroup provided informed recommendations to CMS regarding addition and removal of measures from the Core Sets. In addition, we had a great opportunity to dig a little bit deeper into the feasibility of the measures including the data sources, code sets, and access to data that the states may have. We also continued to discuss the future of measures such as these for the ECDS measures; and overall, there appear to be some general support for the use of the measures recognizing that there are still challenges that the states may have in implementing them.

Also, the discussion on use of additional stratification, such as those focused on disability stratifications and others, that really reflect the population served by Medicaid was a really valuable conversation.

I think our work is done. The discussion is ongoing regarding measure feasibility, resource burden, and how to improve the methods of data collection. Workgroup members continue to strongly support outcomes measures and the members' voice in the Core Set measures, which I found really gratifying. The discussion on our future work and the opportunities available for our focus was also amazing today.

Thank you again for all participants in the Workgroup and the contributions that focus and highlight the quality of care and services in the member experience with the Medicaid program.

Rachel?

Rachel La Croix:

Thank you, Kim. I too would like to thank Mathematica for all the work they did to prepare all of us for this meeting and provide us with detailed information about each of the measures and the context of the measures and all of the details around how many states have been able to report measures that were recommended or suggested for removal by also really providing a lot of context around the suggested measures for addition.

I'd like to thank the Workgroup members for all of the conversation and thoughtful considerations that were brought forward in our discussion of these measures and being able to get to some consensus regarding the Workgroup's recommendations. I also really appreciated everyone's candid observations and suggestions as part of addressing the measure gaps, and particularly appreciated Workgroup members talking about ways that we could move forward and some potential things to think about in the future of the Workgroup in terms of having some nimbleness in possibly being able to bring in measures as they are emerging and being newly developed so that we can try to start addressing some of those areas without as much lag while also not putting measures on states without as much advance notice. I think striking a balance between those important, and I'm glad we were able to talk about that.

In general, I just feel like this has been a really good Workgroup meeting once again. I would like to just make an overall observation that I know this is, I believe, the third year that the meeting has been held virtually. I know at the beginning when these meetings started happening virtually, I had had some concerns that they might not end up being as robust as some of the in-person Workgroup meetings had been in the past. But I really want to commend everyone on still having very robust conversations and everyone's ability to participate and share all their ideas and thoughts in a virtual platform. Even though we can't see each other face-to-face, I really feel like it's still been a very high-quality, robust conversation. So I'd like to thank everybody for that and thank Mathematica for their leadership and convening the group virtually and sparking that conversation. Thank you.

Margo Rosenbach:

Thank you so much, Kim and Rachel. We definitely appreciate your support throughout this journey as well. Next slide, please.

Well, by now this slide should look familiar. It lays out the key milestones for the 2025 Core Sets Annual Review process. Our journey began on December 14th and continued with the April 4th webinar to get organized for this week's meeting. As others have said, we're so grateful for all the time you have taken to prepare for this meeting and that you've spent the better part of three days with us.

Our next step is to review and synthesize the discussion that occurred over the last three days and prepare a Draft Report. Then, the Draft Report will be made available for public comment in July. 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. From there, CMS will review the Final Report and obtain additional input from interested parties including other federal agencies and also from State Medicaid and CHIP quality leaders.

CMS will release Core Set updates by December 31st.

I also want to choose this opportunity to share an update on the schedule for the 2026 Child and Adult Core Set Annual Review. As I mentioned a bit earlier, in the future CMS would like to release the Core Sets earlier to provide states with more time to prepare for mandatory reporting requirements and to make systems and contracting changes. Therefore, CMS is adjusting the timeline for future Child and Adult Core Set Annual Review Workgroup meetings.

As a result, we plan to start the orientation process for the 2026 Annual Review cycle later this summer. The Annual Core Set Review Workgroup meetings will be held in early 2024. The schedule has not been finalized; but when we have more details, we will notify Workgroup members and provide more information the public. Next slide.

If you have questions about the Child and Adult Core Sets Annual Review, please email the Mathematica Core Sets Team at the address shown on this slide. Next slide.

Finally, one last thank you to the Workgroup members, federal liaisons, measure stewards, and public attendees for your contributions. We also want to express our appreciation to staff in the Division of Quality and Health Outcomes at CMCS for your support. A special shout-out to the Mathematica Core Set Team. This meeting would *not* have been possible without everyone's help, especially with the voting.

We wish everyone well. This concludes the 2025 Child and Adult Core Sets Annual Review Workgroup meeting. This meeting is now adjourned.