2023 Child and Adult Core Set Annual Review:
Meeting to Review Measures for the 2023 Core Sets Day 3 Transcript
April 7, 2022, 11:00 AM – 4:00 PM EST

Hello, everyone. Thank you for attending Day 3 of the Child and Adult Core Set Stakeholder Workgroup Meeting to Review Measures for the 2023 Core Sets. Before we begin, we want to start by covering a few housekeeping items. Next slide.

All attendees of today's webinar have entered the meeting muted. There will be opportunities during the webinar for 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. Those who are using the browser app can find the raise hand icon by clicking the ellipses. You'll find the option to raise and lower your hand in the list. You'll be unmuted in the order in which your hand was raised. Please wait for your cue to speak and remember to lower your hand when you finish speaking by following the same process you used to raise your hand. Note that the chat is disabled for this webinar. Please use the Q&A feature if you need support. Next slide.

If you have any technical issues with today's webinar, please send the event producer a message with the Q&A function located on the bottom right of your screen. If you're on the browser app, look for the question mark icon. If you're having issues speaking during the Workgroup discussion or public comments, please make sure you're not also muted on your headset or phone. And we've found connecting to audio using computer audio or the call me feature are the most reliable options. Instructions for adjusting your audio are included on this slide. And with that I'd like to introduce Tricia Rowan from Mathematica. Tricia, you now have the floor.

Great, thanks Dayna. Next slide please. Well, thank you and good morning, everyone. As Dayna said my name is Tricia Rowan, I'm a Senior Researcher at Mathematica. My name is not on the agenda. But I want to acknowledge that Margo Rosenbach was called away yesterday for a family emergency. So, I will be facilitating today's discussion. We want to welcome everyone back to the meeting to review measures for the 2023 Core Sets, the third day. We hope everyone had a nice evening.

We had a very productive day yesterday. It began with a rich discussion of the challenges and opportunities for using digital quality measures in the Core Sets. And then the Workgroup discussed measures for addition and removal in two different domains of the Core Set, including Primary Care Access and Preventive Care and Long-Term Services and Supports. The Workgroup discussed and voted on 10 measures. In the Primary Care Access and Preventive Care domain, the Workgroup voted on seven measures. Three measures met the threshold for recommendation for addition to the 2023 Core Set. These are Adult Immunization Status, Depression Screening and Follow-Up for Adolescents and Adults, and Lead Screening in Children. Three measures were recommended by the Workgroup for removal from the 2023 Core Sets. These are the Flu Vaccination for Adults Ages 18 to 64 measure, and the Screening for Depression and Follow-Up Plan for Ages 12 to 17 and Age 18 and Older measures. So the same measure, one in the Adult Core Set and one in the Child Core Set. The Workgroup also discussed and voted on three measures in the Long-Term Services and Supports domain. But none of them met the threshold for recommendation for addition to the Core Sets.

We look forward to another day of insightful discussion about updates to the Child and Adult Core Sets today. And before we dive in, I'd like to turn to our co-chairs, Kim Elliott and David Kelley, for brief welcome remarks. Kim, would you like to go first?

Sure, thank you. I really do appreciate everybody coming back, it's going to be another fun-filled day and very, very busy day for reviewing the core measure sets. On day three of the Workgroup meeting, we really do have a full schedule including discussion on how we can start incorporating, well we've already talked about how we start incorporating the social determinants of health, health disparities, and health equity into performance measures. And I think we'll continue that discussion throughout today's different measure reviews and certainly at the end when we're talking about the future direction of performance measures in the Core Sets. We also had a real good discussion on digital measures and how we can start to take advantage of different technologies and additional data sources in a standardized method, while reducing the burden on states, health plans, and providers on reporting performance measures. So, this is a really great opportunity to really advance the amount of information available and reduce burden. So, two wins in my mind.

For each of these topic areas, there's a big lift initially and I think everybody recognizes that because we certainly did talk about it over the last two days. The benefits really do have a huge potential to increase the completeness of the data, provide a better understanding of the quality of and access to care and services for the Medicaid program and the Medicaid members served. And we also discussed the huge potential to have access to potentially additional data points through electronic and digital reporting that may lend itself to better addressing or understanding the social determinants of health, health equity, and disparities that are sometimes identified.

And I would just say as you view today's measures that are primarily focused on care of acute and chronic conditions, we still want to consider how the measures advance health care quality at the local, state, national level, and whether measuring that topic area is actionable, and by implementing actions, will improve access to and the quality of health care and address disparities.

We will also have discussion focused on measure gaps today, similar to yesterday and the first day of the Workgroup meeting. And of course we will spend a little bit of time at the end of today's session focusing on the future direction of performance measurement for the core measure set. And as we work through today, we'll still work and consider the factors that we consider for all measures: the feasibility, the desirability, and the viability. But I would also add to that list that the measures are able to be linked to evidence-based interventions that are actionable by state managed care plans, providers, and in some case the Medicaid beneficiaries that they serve. So with that I think I will turn it over to David to do a welcome.

Well thanks Kim, and I just want to thank our committee members, our government partners, federal partners, and the Mathematica team for the ongoing support and the logistics to keep the, keep us on time and to really move through our agenda in an efficient way. Over the last two days I think we've had a real, a lot of great discussion from committee members, federal partners, as well as public input. I think that we've stayed focused on modernizing in some ways what we're recommending to the Core Sets. As evidenced by some of our votes yesterday on the immunization for adults. I think we're also trying to harmonize as best as we can. As evidenced by the recommendation at least to move to the NCQA measure for depression and follow-up. We certainly don't want many states, Medicaid programs do managed care. And as NCQA rolls out certain measures, our MCOs are doing those measures and it's extra work if they have to do additional measures as well. So I think it's always important to try to harmonize, modernize, and then the other key thing to keep in mind as we

keep moving forward, is to really try to stay in alignment with other government programs, mainly Medicare, but other government programs as well as the commercial marketplace. So with that I'm going to turn it back over to the Mathematica team.

Great, thanks David and Kim. Next slide. Alright, so now we'll conduct a roll call of the Workgroup members. Next slide. We ask that Workgroup members use the raise your hand function when your name is called, and we will unmute you to say hello. After you're done, please mute yourself in the platform and lower your hand. This will allow you to unmute yourself during the measure discussions today when you would like to speak. If you've also muted yourself on your phone or headset, please remember to unmute your own line to avoid the double mute. If you leave and reenter the platform at any time today or find that you've been muted by the host due to background noise, please raise your hand and we'll unmute you. And finally, if you have any technical issues, please use the Q&A function for assistance. And if you do need to submit something to the Q&A function, please select all panelists so that we can ensure someone from our team will see your question. Next slide.

On the next two slides we have listed the Workgroup members in alphabetical order by their last name. And when I call your name please raise your hand, we'll unmute you and you can indicate whether you're here and then remember to mute yourself in WebEx when you're all done. We've already heard from David and Kim. So let's start with Richard Antonelli.

Good morning. I'm here.

Good morning. Tricia Brooks. Oh, she did tell us yesterday that she needed to miss today's meeting.

Karly Campbell. Karly are you on the line? We don't see Karly yet.

Lindsay Cogan.

Hello, this is Lindsay Cogan.

Hey Lindsay. James Crall.

Good morning, I'm here, thank you.

Hey Jim. Curtis Cunningham.

Hi, Curtis Cunningham. I'm here.

Hi Curtis. Amanda Dumas.

Good morning, I'm here.

Good morning. Anne Edwards.

Good morning, everyone.

Hi Anne. Katelyn Fitzsimmons.

Good morning, present.

Hi Katelyn. Lisa Glenn.

Good morning.

Good morning Lisa.

Tracy Johnson. Do we have Tracy on the line? Okay, we'll come back to Tracy.

Diana Jolles.

Good morning everyone.

Next slide. Russell Kohl.

Good morning.

Good morning. David Kroll.

Hi everyone, good morning.

Hi there. Rachel LaCroix.

Good morning, this is Rachel.

Hi Rachel. Jill Morrow-Gorton.

Good morning, everyone.

Hi Jill. Kolynda Parker. Kolynda Parker are you on the line?

Good morning.

Mihir Patel.

Morning, it's Mihir.

Good morning. Lisa Patton.

Good morning everyone.

Hi Lisa. Sara Salek.

Good morning.

Hi Sara. Lisa Satterfield.

Good morning. And just so you know I was on yesterday, I just missed roll call.

Okay, great, thanks. Linette Scott.

Morning, I'm present.

Hi Linette. Jennifer Tracey.

Good morning.

Hi Jennifer. Ann Zerr.

Morning, this is Ann.

Hi Ann. And Bonnie Zima.

Good morning.

Good morning Bonnie.

Let me circle back, is Karly Campbell or Tracy Johnson on the line yet? Nope, okay, we'll keep our eye out for them to join. Go ahead and move to the next slide please.

We are also joined today by federal liaisons who are non-voting members of the Workgroup. Federal liaisons if you have questions, or contributions to the Workgroup discussion, please just raise your hand and we'll unmute you. I would also like to take this opportunity to thank our colleagues at CMS in the Division of Quality and Health Outcomes and the Center for Medicaid and CHIP Services. And also thank you to the measure stewards who are attending and available to answer questions about their measures during today's discussion. Next slide.

So now I'd like to turn it over to my colleague Alli Steiner to lead the discussion of measures in the Care of Acute and Chronic Conditions domain.

Alright, thank you Tricia. Next slide please. So first we'll start by reviewing the measures in the Care of Acute and Chronic Conditions domain in the 2022 Core Sets. There are two measures in this domain in the Child Core Set currently. The Asthma Medication Ratio: Ages 5 to 18 and Ambulatory Care Emergency Department Visits. And then in the Adult Core Set there are 10 measures in this domain. They include Controlling High Blood Pressure, Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis, which is new to the 2022 Adult Core Set and suggested for addition to the 2023 Child Core Set. So we'll talk about that one more later. There's also the Comprehensive Diabetes Care: Hemoglobin A1c Poor Control measure. There's the PQI 01: Diabetes Short-Term Complications Admission Rate. Next slide please.

PQI 05: Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate. PQI 08: Heart Failure Admission Rate. PQI 15: Asthma in Younger Adults Admission Rate. Plan All-Cause Readmissions. Asthma Medication Ratio: Ages 19 to 64, which is also in the Child Core Set for the younger age group. And then HIV Viral Load Suppression, which was suggested for removal, and we'll be discussing in more detail next. Next slide please.

So the first measure that we'll discuss today is the HIV Viral Load Suppression measure, which was suggested for removal from the Adult Core Set. This measure is defined as the percentage of beneficiaries age 18 and older with a diagnosis of HIV who had an HIV viral load

less than 200 copies per milliliter at the last HIV viral load test during the measurement year. The measure steward is HRSA, and it is NQF endorsed. The data collection methods include administrative and EHR data. This measure was reported by nine states for FFY 2020 Core Set reporting, with one state reporting substantial deviations from the specifications. A Workgroup member suggested this measure for removal because it has been in the Core Set since 2014 and only nine states were able to report the measure for FFY 2020 reporting. States have cited challenges obtaining the data needed to calculate this measure, including that states do not use LOINC codes and that privacy laws prevent states from obtaining the necessary data. Of note, HRSA, the measure steward, recently launched a four-year initiative to increase state capacity to report this measure in the Adult Core Set and to promote collection and reporting of high-quality data for this measure. Next slide please.

Now we'll discuss the measures suggested for addition. The first of these is Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis, which as I mentioned previously was added to the 2022 Core Set for the adult age group and is now suggested for addition to the 2023 Core Set for the child age group. This measure assesses the percentage of episodes for members ages three months and older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event. The measure steward is NCQA, and it is NQF endorsed. The data collection method is administrative. The Workgroup member who suggested this measure for addition noted that this measure has been used by state Medicaid programs and public health departments. They also noted that nearly 60% of pediatric bronchitis and bronchiolitis visits to emergency departments and physician offices lead to antibiotic prescription, and that this measure can help promote appropriate antibiotic prescribing in children. Next slide please.

Next, we're going to discuss a suite of measures that assess appropriate care for patients with diabetes. Two of the measures that we'll discuss were previously included in the HEDIS Comprehensive Diabetes Care measure but is now a standalone measure in HEDIS. And so the first of these measures we'll discuss is Eye Exam for Patients With Diabetes. This measure assesses the percentage of members ages 18 to 75 with diabetes who have a retinal eye exam. The measure steward is NCQA and the measure is NQF-endorsed. The data collection methods include administrative, hybrid, and EHR data. A Workgroup member suggested this measure for addition because, taken together with other diabetes care measures, it would give a better picture of the overall management of a common chronic condition among adult Medicaid beneficiaries. The Workgroup member also noted that this measure is already reported by Medicaid plans as part of the HEDIS Comprehensive Diabetes Care measure. Furthermore, there is substantial room for improvement, with Medicaid plans reporting, on average, that just over 50% of members with diabetes had an eye exam in 2020. Next slide please.

So now, we'll discuss the next measure in this suite of diabetes measures called Blood Pressure Control for Patients With Diabetes. This measure was also previously part of the HEDIS Comprehensive Diabetes Care measure. It assesses the percentage of members ages 18 to 75 with diabetes whose blood pressure was adequately controlled during the measurement year, which is defined as less than 140 over 90. The measure steward is NCQA and the measure is NQF-endorsed. The data collection methods include administrative, hybrid, and EHR data. This measure was suggested for addition for similar reasons as the eye exam measure, namely that it would provide a better understanding of the overall management of diabetes among adult Medicaid beneficiaries. There's substantial room for improvement for

this measure, with Medicaid plans reporting, on average, about 58% of adult members with diabetes had their blood pressure under control in 2020. Next slide please.

The next measure that we'll discuss is Kidney Health Evaluation for Patients With Diabetes. This measure was developed by NCQA in partnership with the National Kidney Foundation. It replaces the Medical Attention for Nephropathy indicator, which was previously part of the HEDIS Comprehensive Diabetes Care measure. The new Kidney Health Evaluation measure was added to HEDIS for measurement year 2020 and it assesses the percentage of members ages 18 to 85 with diabetes who received a kidney health evaluation, which is defined as receiving both an estimated glomerular filtration rate and a urine albumin-creatinine ratio during the measurement year. This measure is not NQF endorsed and is specified for the administrative data collection method. A Workgroup member suggested this measure for addition because diabetes is a common chronic condition among adult Medicaid beneficiaries. And this measure would give a clearer picture of the management of the condition. This measure is used by Medicaid managed care plans including those in Pennsylvania. Alright, next slide please.

The last measure that we'll discuss in this domain is the Statin Therapy for the Prevention and Treatment of Cardiovascular Disease. This measure is defined as the percentage of patients at high risk of cardiovascular events who were prescribed or were on statin therapy during the measurement year. The measure looks at three populations including patients who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease, ASCVD, including a ASCVD procedure; patients ages 20 years or older who have ever had a low-density lipoprotein cholesterol or LDL-C cholesterol level at 190, sorry, at or above 190 milligrams per deciliter, or those who were previously diagnosed with or currently have an active diagnosis of familial hypocholesterolemia, sorry that's a mouthful there; and patients ages 40 to 75 years with a diagnosis of diabetes. This measure has one performance rate that aggregates the three populations. CMS is the measure steward, and this measure is not NQF-endorsed. The measure is specified for EHR or clinical registry reporting. The Workgroup member who suggested this measure noted that statin use is a major factor in cardiovascular disease prevention. The Workgroup member also noted that statins are relatively inexpensive and readily available, making that an effective and accessible strategy for cardiovascular disease risk reduction. The measure is specified at the provider level, and it's included in several quality reporting initiatives, including the national Million Hearts Initiative and MIPS. It is currently in use by Texas Section 1115 demonstration for provider level reporting. And now I'll pass it back to Tricia to facilitate the Workgroup discussion.

Thanks Alli. You're a trooper pronouncing all of those long words. We will now invite Workgroup members to discuss the six measures in this domain. We're going to take them, we'll take the first two separately. We'll discuss the suite of diabetes measures together and then wrap-up with a discussion of the statin therapy measure. So to start let's discuss the HIV Viral Load Suppression measure, which is recommended for removal. Workgroup members remember to raise your hand and we'll unmute your line if you wish to speak. And please remember to say your name before making your comment. Rich, Katelyn, and Lisa, I see your hands are up, I don't know if that's from the roll call or if you'd like to say anything. Let's start with Lindsay Cogan.

So I think this has been a couple years now that we've had this question around viral load suppression, I mean, this is really the measure that all of our measures kind of aim to be. This

is the ultimate outcome measure and that's sort of where we need to be striving. I understand that it is difficult, we in New York State have been reporting this measure for several years. It did take a level of effort to work in consultation with our Bureau of HIV to get through data permissions, I would say that it is a feat in and of itself. But one that has been well worth it. So, we've demonstrated that we can measure this. Eight other states have also demonstrated that they can measure this. It's not going to be a required measure. So I think there's still time for us to continue to build that capacity and work towards this goal. To take it off of the Core Set would leave a real gap in a condition for which many Medicaid members are vulnerable. So I'm just speaking out in favor of not removing this measure. Yet again, this is our ultimate outcome measure, it's for an important condition. I understand that it takes an effort to gather, but I think every year another state gets added. And I'm okay with the pace of this, I think we can continue to work on this and figure it out to get a comprehensive view of HIV across the program. Thank you.

Thanks Lindsay. Katelyn Fitzsimmons did you want to comment on this measure?

No, okay. Let's go to Jill Morrow-Gorton.

Lindsay, I totally agree with you about this being sort of the consummate measure. I have some concerns about the size of the population, which looks to me to be like 40% of 1.2 million across the country, which means that a number of states may have really small Ns. I think this is an opportunity to share with public health as well. Sometimes this gets followed through public health as much as by Medicaid. And I clearly am sort of on the fence about this one. But given that it is not reportable in 2024, I think that gives us a little bit different picture of it than if it was [subject to mandatory reporting].

Thanks, Jill. Linette.

Thank you. I would echo what Lindsay said. And again, because it's not going to be required in 2024, I think it gives us a little more room. The only thing in addition to what Lindsay said that I would offer is that in California, we've also been running the measure for many years in partnership with our department of public health. And in terms of the confidentiality piece, we're able to share the people in our program, in the Medi-Cal program (Medicaid program) who we think have HIV. And we send it to public health. They do the linkage, and they send us back summarized results. So even though we have state law that prevents them sharing the results on an individual person level, we're able to collaborate and do the reporting for the state based on data sharing agreements and appropriate privacy and confidentiality of the data that's being used. So just to reinforce that it is definitely a measure that helps encourage and almost requires collaboration with our public health programs. That is also a good thing as we move forward in terms of coordination of care. Thank you.

Thanks, Linette. Karly Campbell.

Hi, I'll just echo what some of the others have been saying. I think this is an important measure. You know, Medicaid programs cover 45% of all people living with HIV nationally. And so it's just important that we continue to measure as best we can. And we have time to take advantage of the different resources that are out there to provide technical assistance. Tennessee is part of the learning collaborative right now. And we've got our Department of Health and the Medicaid Office working together to try to figure out the best way to report this. So it is a challenging one, but I think a really worthwhile rate to strive towards.

Thanks, Karly. David Kelley.

Yeah, I'm in support of keeping this measure on the Core Set. In past years, I think I nominated it for removal, because this is still a challenge in Pennsylvania. A decade in, we're still unable to report it. But happily, about two years ago, by law, our Department of Health now is requiring this to be a reportable lab result. So we are going to work through a process similar to what Linette described in California. We're going to try that here in Pennsylvania with the goal of being able to report by 2024. So it's been over a decade-long journey here in Pennsylvania. I'm hoping we're getting close to the top of the mountain. But I think this is really a valuable measure. In the past, I've advocated for looking at the medication possession ratio measure in lieu of this, which is administrative. But I think this is the gold standard. And I feel that this is something that should not be removed from the Core Set. Thanks.

Thanks, David. Sara Salek, I think you were next.

Great. Thanks so much. And I'll be short and sweet but basically echo my colleagues in regards to maintaining this measure on the Core Set. I think we would be moving in the opposite direction of what we've intended to do, including addressing health care disparities, looking at outcomes as the gold standard, as previously mentioned. And so I think we need to maintain this. I did want to just add, I'm representing Arizona Medicaid, and we are not a state that currently reports on this measure but have recently been selected as a state to participate in that HRSA-funded effort to address overcoming some of those challenges as my other state colleagues have mentioned. So we're totally in support of addressing some of those data-sharing challenges, et cetera, in order to report this measure in the future.

Thanks, Sara. Rachel LaCroix.

Good morning. I just wanted to echo some of the other thoughts around this measure. It's one that I've been torn on for many years because it is an ultimate outcome measure, and it's very important to measure care for the population with HIV. It is one where we have had challenges getting the lab value data. We've required our managed care plans to report on those for years. But they've had difficulty getting those lab value data because of privacy concerns. We were able finally, over the last year, to be able to, as the Medicaid agency, get some of this data from our Department of Health so that we can internally run the measures. But it is something where I think we're still working to see, can we share those data with the plans so that the plans can actually run the measure as part of their regular performance measure calculation and reporting processes and get it audited? And then also have that plan-level data to make it more actionable. And as the previous member noted, I'm hopeful that HRSA's initiative around that will make it a measure that can have more easily obtainable data and be reported a little more easily. Or that there might be a possibility that at a federal level, maybe the data could be collected from the public health programs. And this might be a metric that CMS or the contractor might be able to run on behalf of the states because it is a really important measure.

Thanks, Rachel. David Kroll.

Thanks, Tricia. I think that some of the comments here have really highlighted also that there's a long game here. That there isn't a ton of pressure to get this right away because it's not going to be part of mandated reporting. But there has been this slow but steady momentum

towards improvement. At the same time, I think we've all really come to appreciate in the last couple of years that trying to synchronize state efforts to handle infectious diseases that are very socially complicated is incredibly difficult to do but, at the same time, incredibly important to do and is likely to be important in ways that we may or may not be able to foresee in the future. So the slow but steady progress that we were making on this measure, I think, is going to be helpful, not even just at this sort of surface value of the fact that we're getting this incredibly valuable outcome measure, but that this is also really laying the groundwork for future years where this process may continue to evolve and improve over decades.

Thanks, David. Rich Antonelli, go ahead.

Thank you. I'll just sort of indicate my agreement with keeping this. But I am going to add a different lens. I'm hearing hoof beats here. And hoof beats are around the way our Workgroup thinks about the data sharing, right? So, I'm mindful, David, and particularly you said it's been a decade. And you're almost at the top of that mountain, and that's really great. But I just want to call everybody's attention. A couple of years ago, we unanimously as a group agreed that the sickle cell antibiotic prophylaxis measure should be recommended for inclusion. And it wasn't because of data sharing problems. And then the second one, a couple of years ago, we voted the audiologic diagnosis and follow up off of the Core Set basically for the same reason. And I'm having a lot of agita about that, especially with sickle cell. Not only is this a group that is particular for children. But in fact, it is rife with disparities. And so I'm not comfortable keeping this one in when two other measures specifically were not recommended for inclusion because of data-sharing requirements. The optics of that, I think, are bad. It shows the country that HIV is way more important than children being on antibiotic prophylaxis if they happen to have sickle cell. So I just really want everybody to pause and think about this. Again, I'm in favor of this measure. But the fact that we're making slow progress up that mountain, it's time to start saying, and where are other gaps and disparities that we need to start focusing on right now? We should not, as a country, need to wait 10 more years to get the sickle cell antibiotic prophylaxis done. It should not be another decade for those audiologic screening. Audiologic screening is done for every child born in this country. So I just urge us to think about who are we not taking care of when we put all of this effort into data-sharing agreements between our public health colleagues and the delivery system side. Thank you.

Thanks, Rich. Kolynda.

I just wanted to speak up and say that I am in support of keeping this measure. As my previous colleagues stated, this HIV is a very important issue. And this measure is very important to the state of Louisiana. We've been monitoring and reporting on these measures for several years. But the measurement year 2021, in this current measurement year, we have incentivized this measure to ensure that the MCOs focus on this issue, focus on this measure, and continue to make progress on this measure. So I just wanted to voice my support in keeping this measure in the Core Set.

Thanks, Kolynda. Gigi Raney from CMS, I see you have your hand up. Did you want to add something?

Thank you. This is Gigi from CMS. I just wanted to correct the record related to what Rich's comment about why previous measures were accepted or removed from the Core Sets because the information that he provided is not a hundred percent accurate. So we just want to make sure that those listening to this call are given the accurate information for that. The sickle

cell measure, which was recommended for addition of Core Set several years ago, while we recognize the importance of this condition and the impact that it has on the Medicaid population, due to the population and distribution of this disease across the United States, there were not enough states with large enough sickle cell disorder populations to report it publicly. That is very different from HIV, though there are some low incidence HIV states. So because we were not able to make, we would not be able to publicly report the sickle cell measure nationwide state-by-state if it was tied into the Core Set. That was why that decision was made. And one of the things that CMS has worked on in an effort to provide information about sickle cell and to bring awareness is we actually have a sickle cell disease brief. You can see it on Medicaid.gov, where we have used our T-MSIS data to be able to provide some of the information that would have otherwise been able to be provided through the Core Set. So we've found other ways to try and make sure that the information that was related to this disease was actually able to be released to the public in a way that we were able to provide nationwide data, which we would not have been able to do if it had been added in the Core Set. So we're trying to look for alternatives besides just the Core Set because we're not the only solution for some of these measurement and disease challenges. And then HVL is a little bit more like AUD in that the public health does have the AUD data. And that was a challenge. And so I agree with Rich on that, but the Workgroup did recommend for that measure to be removed. And so we went and followed that recommendation. So I just wanted to make those corrections. Thank you.

Thanks, Gigi. All right. Are there any other Workgroup comments about the HIV Viral Load measure before we move on? I see Erin Abramsohn.

CDC wanted to voice our support for retaining the HIV Viral Load Suppression measure. And the U.S. is currently implementing the Ending the HIV Epidemic or EHE Plan for America plan. This ten-year geographically targeted initiative began in FY 2020 with the important goal of reducing new HIV infections in the U.S. to less than 3,000 per year by 2030. If taken as directed, HIV medication can reduce the amount of HIV in the blood, also called viral load, to a very low level defined as less than 200 copies of HIV per milliliter of blood, which is called viral suppression. So viral suppression helps to keep persons with HIV healthy and is a key prevention tool because persons who are virally suppressed cannot transmit the virus to others. Increasing the percentage of persons with diagnosed HIV infection who are virally suppressed is a critical measure of the EHE initiative. The impact of COVID-19 has resulted in steep decreases, which are not yet well defined in the literature, in HIV testing and an interruption in access to clinical services, including HIV care. Understanding the impact of reduced HIV testing and care services on the ultimate indicator of viral suppression is a key reason in our purview to retain this measure. Thank you. I appreciate the time.

Thanks, Erin. Sara Salek, I see your hand is up.

Yeah, thanks so much. This is Sara Salek from Arizona Medicaid. And first just wanted to thank Gigi for the clarification of prior history. And the other thing just as far as follow-up in regards to Rich's comments, I think if there are measures that the Workgroup had challenges as far as like the audiological measure in the past, around methodologies, this is a rapidly changing field, and we're continually striving for ways to improve data collection. So even if in the past we had selected measures for removing from the Core Set, if there are now advances, we should propose adding them back. So that would be my two cents as far as addressing and continuing to look at ways to measure health care disparities or issues. And so when there is a sample size and population size where we can report on a considerable size of

the population and it's reportable across states, let's think about how we come together and address the data concerns and propose them for addition back, or look at other alternative measures. Thanks so much.

Thanks, Sara. Rich, I see your hand up again.

Thank you. And Gigi, thank you for that clarification. I guess one, it's really good to hear that that's being done. And I appreciate the fact that the Core Set isn't necessarily the only tool in the tool kit. So thank you for that. With all due respect, though, that was only related to the sickle cell. The fact that this body recommended removal of the audiological one, a lot of that conversation was actually predicated on this very issue, the data sharing. So I raised those as examples, not two examples of the same thing. But I didn't hear a justifiable reason for the audiologic diagnosis other than the data sharing. But Sara, I appreciate your bringing that forward as well. You know, the group should be thinking about opportunities around data sharing because, especially for children, this is going to be important because of newborn screening, and equity is at the base of that. So I appreciate the insight so far. And I really hope that we can use data sharing as a way to get to some meaningful outcomes.

Right. I still see some Workgroup hands up. Katelyn, did you have a comment?

Sorry, that was from a previous comment.

Sure. Or David Kroll, did you have another comment?

Oh, sorry. No, I just forgot to lower my hand.

Okay. Just making sure. Same for Kolynda Parker, was there something else you'd like to add?

I don't have anything else to add. Thank you.

Okay. Thanks so much. And just as a reminder, we will do public comments for all of the measures after the Workgroup discussion. David, it looks like there was something else you wanted to add. David Kelley.

Yes, just kind of a parting thought for those states that have continued to have challenges in reporting this, that there, again, are some intermediary things that you can do to measure within your claims data. Like how many of your individuals living with HIV actually got any type of medical visit? And there's a simple way of looking at what percent of individuals that actually got the blood test. And just looking at that within Pennsylvania, I can tell you there's a lot of opportunity for improvement. So our holy grail is to actually report the percent suppressed in those that had one visit. But there are some intermediary steps that states can certainly take to evaluate what is actually happening within their HIV population. And a third measure is actually looking at medication possession ratio. So let's keep up the fight. Let's get to the mountaintop. But there are some kind of in-between things that state programs can do that are purely claims-based. Thanks.

Thanks, David. All right. Why don't we transition now to discuss the next measure, Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis, which was suggested for addition to

the Child Core Set. Reminder to Workgroup members to use the raise your hand function if you'd like to make a comment about this measure. Amanda Dumas, go ahead.

Hi, this is Amanda from Louisiana. And I wanted to say that this sounds like a great addition. I think this is obviously a very important clinical measure to follow. My only question about it, I don't know if anyone can speak to this, would be how we then rule out antibiotics that are prescribed for co-occurring illnesses that we often see in bronchiolitis. For example, one that maybe has also progressed to pneumonia requiring antibiotics or an ear infection. Again, these sometimes can co-occur and so just looking at bronchiolitis as the denominator might not capture that other factor. Thank you.

Yeah. Thanks for that question, Amanda. I see Sepheen from NCQA is on. Derek, can we make sure Sepheen is un-muted to answer Amanda's question? Go ahead, Sepheen.

This is Sepheen Byron from the National Committee for Quality Assurance. And so this measure, what's not listed here, it has a series of exclusions to remove conditions for which antibiotics might be appropriate. So it has both exclusions for the sorts of co-occurring conditions. And it also has comorbid conditions that should be removed. So what you're left with are the conditions for which we are very sure should not be treated with antibiotics.

Thank you, Sepheen. Amanda, does that help answer your question?

Yes. Thank you.

Okay, great. Rich Antonelli, I think you were next.

Yeah, thank you. In fact, if the NCQA person could stay because I have a follow-up question. So for the folks on the group that aren't clinicians, this might seem very logical to just simply add it. But for people in clinical practice, it's very easy to game this measure. And it's what we've been tracking in the so-called AXR measure, the Antibiotic Utilization for Acute Respiratory Conditions that NCQA is putting into the HEDIS 2022 measurement year. And I'm mindful that everything in the Child Core Set will be mandatory. But I'm wondering if the measure steward could differentiate this measure from the AXR measure. Our first take from the team here in Boston is that AXR may be less vulnerable to gaming. It basically means that you'll know how to code well, which is not the same thing as doing the right clinical work.

So for those who don't know, the measure that Rich is referring to is Antibiotic Utilization for Acute Respiratory Conditions. And we actually see the measures as being complementary. So while looking at the bronchitis measure tells you whether or not the prescriptions that you received are likely inappropriate, the utilization measure that focuses on all respiratory conditions includes both inappropriate and appropriate conditions. So you might have a condition for which an antibiotic is okay to prescribe. And you might have one for which it is not. And so the idea is that looking at that measure, in addition to looking at the bronchitis measure, would give a health plan a wider lens to be able to say, okay, if my bronchitis measure is looking good, so we're not seeing a lot of prescribing yet, the utilization measure is very high, there could be some issue with maybe miscoding. Or it could also just be that it's difficult sometimes for a clinician to be able to make that judgment during the short time that's available for an appointment. But that said, I do think that the bronchitis measure, which does allow you to at least focus on a condition for which we know that antibiotics should not be prescribed, is still an important measure. And so we kind of see them as being used

accordingly with the other HEDIS measures. So I think for organizations who wish to use all the measures, it is a useful thing to be able to look at them all together, to make sure that the measures for which you know antibiotic prescribing should not occur are accordingly going down. And you also see the utilization measure not shooting up in some way that could indicate miscoding or some other practice.

Okay, thanks, Sepheen. And just to clarify, that was Sepheen Byron from NCQA, the measure steward for this measure. Kolynda Parker, you were next. Do you still have a question, Kolynda, or a comment?

No, I don't have a question. I apologize.

Okay. No problem. Jill Morrow-Gorton, go ahead.

I think there are a lot of good things about this measure in terms of promoting good care for a common frequent condition. There are a lot of collaborative efforts occurring around antibiotic stewardship and appropriate use. And I think this reinforces those. And I think the other positive is that there are a number of other programs that use this measure.

Thanks, Jill. Anne Edwards.

Thank you. And thank you for the prior questions. Rich, you highlighted one that always comes to the table. I think, as people have said, this is important to consider for overuse. I think one of the things that the COVID pandemic highlighted, and I'll say, a shift in access to care. And as we look at this rate, this includes outpatient, telephone, e-visit, or virtual check-ins. So beyond the in-person. And I think that this is an interesting measure to look at from those lens to understand how antibiotics might be prescribed and if there is a difference and where the actionability might be. So I think, despite all the complexities there, this may be a timely, necessary measure to continue to track and follow to assure access to appropriate care.

Thanks, Ann. Linette Scott.

Hello. I think one of the things about this measure that I guess it's a general question. So appreciate everything everybody said and won't repeat that. But one of the things during the COVID pandemic was that we saw a significant decrease in a variety of kinds of utilization, including outpatient visits and antibiotics in kids. Because they weren't going to school, they weren't being exposed to other things that typically trigger the use of antibiotics. And so I'm struggling a little bit with kind of two questions. One, recognizing that if this is added, it becomes part of the required set. And so this may actually be part of a later conversation. As CMS works on their rulemaking, are they going to have a pathway in terms of like having a two-to-three-year practice time so that folks get to start to use the measure before they, then it's part of required reporting? Which is sort of a broader question when we have required reporting. But then the other thing is, I don't know if anybody has been able to do any studies related to antibiotic use during the pandemic. And as we've been coming out of the pandemic, sort of how that's impacted utilization of antibiotics in children based on the experience that we all had. Thanks.

Thanks, Linette. Russell Kohl, you were next. And then, if anybody wants to respond to Linette's comment, feel free to raise your hand, or a question.

Thanks. So the two items that I wanted to bring up around it first, and it may just be a bias of coming from an academic teaching institution. But the diagnostic certainty around the diagnosis of bronchitis, as opposed to a more flippant, flippant is probably not the right word, diagnosis of bronchitis, I think can be a challenge around this. Particularly, as we look over the last two years and the number of upper respiratory infections that primary care physicians have dealt with, I would worry a little bit about the degree of diagnostic certainty that the patient truly had bronchitis. But I actually think that that's okay in this circumstance because of one small clause in the numerator that I think is really important to catch. And that is the three days after the episode date. So one of the things that I was concerned about when I first looked at the measure was what are the odds that somebody is diagnosed with bronchitis? And then a few days later, we go, nope, this is no longer bronchitis, this is pneumonia. Or the diagnosis was incorrect to start off with, and now we're dealing with something separate. I think by having that three-day limit on there, that does make this a useful way of looking at clinician intent. That the person did a diagnosis as bronchitis, and if they filled the antibiotics within three days, they clearly intended to treat it with antibiotics, which I think is kind of the sort of measure that we're looking for. So I actually think that this is, although I am loathe to add additional measures without a really good reason, I think this actually does give us a good view of the quality of care that's being delivered to patients.

Thanks, Russell. Are there any other Workgroup comments on this measure, the Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis before we move on? Erin, go ahead.

We wanted to voice, from CDC's perspective, our support for this measure. Acute bronchitis and bronchiolitis is almost always caused by a virus and gets better on its own. And therefore, individuals without other health problems should not be prescribed an antibiotic. Yet nearly 60% of pediatric bronchitis and bronchiolitis visits to EDs and physician offices lead to an antibiotic prescription. And cough illness and bronchitis is one of the most common manifestations of COVID-19 in children, occurring among 37% of children zero to nine, and 41% of children 10 to 19 years of age. And other than fever, this is the most common manifestation. So while the most common virus associated with bronchiolitis is RSV, SARS-COVID-2, the virus that causes COVID-19, has also been shown to cause bronchiolitis. Inequities in the quality of antibiotic prescribing for children have been described in children with less access to pediatricians. Those more likely to be seen by family physicians or advanced practice practitioners like NPs and PAs are more likely to receive unnecessary or inappropriate antibiotic treatment. A quality measure related to improving antibiotic prescribing in the Medicaid population is important for reducing inequities in the quality of care. Inappropriate antibiotic prescribing is common for telehealth visits. Others already brought this up and I appreciate that. The widespread use of telehealth for common syndromes, like bronchitis, bronchiolitis has the potential to reverse important gains that have been made to improve prescribing for respiratory infections in recent years. Addition of this measure to the Child Core Set would also improve alignment across the Core Sets. Thank you. I appreciate your time.

Thank you, Erin. Are there any other comments from the Workgroup on this measure before we move on to the suite of diabetes measures? Okay. Let's move on.

So as I said, we're going to discuss the three diabetes measures together, including the eye exam measure, the blood pressure control measure, and the kidney health evaluation measure. So Workgroup members with comments on any of those diabetes measures, please go ahead and raise your hand, and we'll call on you. Lindsay Cogan, go ahead.

Great, thank you. This is Lindsay Cogan. So, I mean, diabetes is an incredibly important condition. It's one that affects a large portion of our population. We currently have again a really good, focused outcome measure, looking at diabetes hemoglobin A1c control. And then we also have additional preventable hospitalizations around the care of persons with diabetes. So I think that it's a worthwhile discussion to think about, you know, what do these additional measures bring that were not currently on the Core Set? Again, this is, we're looking at a balanced Core Set that we want to ensure that we have representation across many conditions. So I worry about loading on too many measures in one particular area. We want to ensure that we have the space to grow and include additional conditions. The blood pressure control component, I feel, is represented already. We have the control on high blood pressure measure. While it does not specifically relate to those with diabetes, those persons living with diabetes are included in that measure. So we have that opportunity with the state to drill down a little bit further when you look across that entire measure to identify those persons living with diabetes because we know that there are important cardiovascular overlays in those two conditions. So I would not be in favor of adding the blood pressure measure. The only one that I would even entertain, I think, is the eye exam. And I want to hear other people's perspectives on that. This is one of those measures that goes across many sets, including Medicare. I believe Medicare still includes that in many of their programs as well. And it's, again, it's one of those disparity-sensitive measures. And I say that meaning that it takes another step in the process to be evaluated, referred, and go and see another provider. And again, it's about getting access to all components of your care. So that one intrigues me a little bit more than the others do, in that it, again, it takes that extra step and really that care coordination of ensuring that someone living with diabetes is being recommended to have their eyes evaluated and that continued component of their health. So that would be the only one I would entertain, but I'm open to hearing others' thoughts on that.

Thanks, Lindsay. Ann Zerr, I saw you had a hand up. Did you want to anything?

I would just say this is such a common condition. And our success at treating it appropriately is terrible. And I think these three components actually do reflect good care. But I certainly am respectful of the burden of this condition. But as weight increases, we're seeing this more commonly in children. And I think there's a lot of, even though these measures are for 18 and over, there's a lot of room to measure the care in a much more systematic way.

Thanks, Ann. Jill Morrow-Gorton, go ahead.

I just had a quick question for the measure steward, if they're here, about the decision to separate them out into individual measures as opposed to looking at them as a suite of measures related to diabetes.

Sepheen, from NCQA, are you able to answer this, or Emily Hubbard?

Yeah, Emily Hubbard can address that.

Great. Derek, can we make sure Emily is unmuted?

Great. Thank you. I'm Emily Hubbard. I'm a Senior Healthcare Analyst at the National Committee for Quality Assurance. And thank you for that question. The intent behind separating the measures out from the measure set into their individual standalone measures

was really to think about improving our ability to maintain each of these measures appropriately over time. Having them as standalone measures will allow us to reevaluate each one, again, over time and think about measure-specific changes that might be appropriate to one, but not across all. This is also in alignment with how the measures are used outside of NCQA often. So for example, with the National Quality Forum (NQF), they are endorsed individually and across other programs as well. So we wanted to stay in alignment with how the measures are used and think about how we can best maintain them in the long run.

Thanks, Emily. Jill, does that help answer your question?

It does. Thank you very much.

Are there any other Workgroup comments on the suite of diabetes measures? Erin Abramsohn, I see your hand is up. Is that from before, or did you want to comment on these? Okay. All right. Well, why don't we shift the discussion to the final measure in this domain, which is the Statin Therapy for the Prevention and Treatment of Cardiovascular Disease measure. Any folks, Workgroup members, or federal liaisons with comments on this measure, please raise your hand.

Lindsay, go ahead.

I have mixed feelings about adding in another medication measure. I don't know that in thinking about the composition of the Core Set, that cardiovascular disease is not something that we have overtly covered. And certainly putting in a medication management measure is an easier lift, and certainly it's administrative. Actually, this is not administrative. This is the CMS version. There's also another statin therapy measure that could be run administratively. I just don't know if this is getting to the types of outcomes that we are looking to drive towards. But I would like to rely a little bit more heavily on my clinical colleagues in thinking about statin therapy. I know it's an important medical intervention, but there's also a level of, I think, not always agreement on statins. So before we put in another medication measure, is this going to really optimally get us towards the outcomes that we are seeking to kind of level across the Medicaid population?

Thanks, Lindsay. David, go ahead. David Kelley.

Lindsay, in reply to your comments and questions, again, this is not the NCQA measure. I think this is the CMS measure. I think the NCQA measure is a little narrower, does not hinge on an LDL level, I don't think, but really looks at people that already have cardiovascular disease. And there are, I think, a couple of age bands, and then there's just looking at whether or not they received a statin. And then I think there's a statin adherence ratio. I think it's 80%. So I think, at some point, we do need to rethink having a cardiovascular measure. I do believe we have the PQI for congestive heart failure. I'd have to go back and look to see if we have anything around acute MI. I don't think we do. But this measure is a little bit broader, and it looks at different populations, so it actually looks at three different populations, whereas the NCQA measure is administrative and just looks at people in, I think, population one. So I'm a little ambivalent about adding this. I think, at some point, we do need to. I think there also was a change in guidelines several years ago where we've moved away, again, from looking at LDL levels and treating individuals with statins. I like the population three because that is probably an area ripe for improvement. And I guess one question I would have for CMS is, is

this something that's used in your quality program, in your MIPS program, or is this used in any of your quality incentive programs in terms of thinking about alignment?

Thanks, David. Just to clarify, it is a MIPS measure. I see David Clayman on the line from the team that stewards this measure. David Clayman. Derek, can we make sure he's unmuted? Go ahead, David. David, you might be muted locally.

Thank you. Yes, this is a MIPS measure. There is three modalities. It's an eCQM. It's a registry, which is a CQM, and we also have a web interface version of this measure that's used.

Thanks, David. Jill Morrow-Gorton, I see you have your hand up.

Yeah. I wanted to come back to David Kelley's comments about the new guidelines related to treatment of cholesterol. And in my reading of those, and it's been maybe a little while since I last looked at them, they are quite complex, with a number of different algorithms with different scenarios. And I don't know if we know when this measure was developed, but I think my question would be, was it developed after the new guidelines were created, and does it reflect the sort of permanent guidelines around treatment? I totally agree about the diabetes. I think this is a really important issue. I think it's a really important preventive issue, but I wonder if this captures the complexity of the field.

Thanks, Jill. Russell Kohl?

Thanks. So, as I look at any of them, the measure steward does not, NQF, NCQA doesn't have an NQF number. One of the challenges that I face is, as we look at primary care physician practices ultimately, yes, this is measuring Medicaid, but they have to get the data somewhere, and if it's not a claims-based data, if it says electronic health records or clinical registry, that means that's going to flow down ultimately to the clinicians who are doing the work to somehow report it up to the state. And the concern that I have is, across the country, the average number of payers in a primary care physician's office is six, and it is incredibly rare for Medicaid to represent greater than 25% of their practice. And so the concern that I have about adding additional measures that are electronic health records or clinical registry based that are not already standardized across other payers is, you're adding a new administrative burden to collect a dataset that is not necessarily going to be consistent with the five other datasets I have to collect and report. And so I think it's really important to keep in mind that alignment of measures across payers, which hasn't necessarily been done with MIPS and has created a challenge for some folks, but certainly something that we should keep in mind, I think, from the Core Set perspective.

Thanks, Russell. I see David Clayman on the line. I think you were going to respond to Jill's question. Is that right, David?

That's correct. I just want to say that this has been updated to the 2019 ACA/AHA guidelines, and we update this measure every year. So there was an update from, I think it was the FDA about pregnancy, and we removed that exclusion for 2023. So this measure is constantly updated every year with current guidelines. Thank you.

Are there other comments from Workgroup members or federal liaisons on this measure? David Kelley?

With a question to David Clayman. So providers that are in the MIPS program seeing Medicare patients, they would have the opportunity to leverage the same electronic means to report this particular measure?

Yes. You know, the program's a little bit different. The Medicare program is different than the Medicaid program, but as you know, the providers, where it's possible at the clinical sites, directly submit to Medicare. So they're able to use data from their EHRs and submit the data there. So either they could use, like, the eCQM, which does use lab values, or they could use the registry, which does use HCPC codes. So it depends.

Okay. Thank you.

Thank you. Erin Abramsohn, I see you have your hand up. Go ahead.

CDC would like to voice our support for adding the statin therapy measure. Heart disease is the leading cause of death for men, women, and people of most racial and ethnic groups in the United States, and stroke is also a leading cause of death in the US and a major cause of serious disability for adults. It's also preventable and treatable. For people at high risk of having an ASCVD event, including heart attacks and strokes, taking a high- or moderate-intensity statin as appropriate can greatly reduce risk of having a primary or a secondary event. And because of their generic status, statins are relatively inexpensive and readily available, making this highly effective cardiovascular risk reduction strategy accessible to many and an intervention that states should be tracking. So measure specifications have been improved since the measure was last submitted for consideration, and it continues to be included in numerous quality reporting programs. In a recent analysis, we estimated that 25.2 million people aged 35 to 64 are recommended to be taking a statin, according to clinical guidelines, but are not, putting them at a greatly increased risk of having an ASCVD event. While the specific analysis was not included in the study, a significant portion of those people, I shouldn't say significant, probably. A portion of those people are likely Medicaid beneficiaries. So thank you. I appreciate it.

Thanks, Erin. David Kelley, was there anything else you wanted to add?

No. I'm sorry.

That's okay. Any final Workgroup comments on this measure? Amanda Dumas, I see you have your hand up. Is that from before?

Yeah.

All right. Well, I don't see any other Workgroup comments, so why don't we move into public comment. Can we go to slide 21? Thank you. So now we'd like to provide an opportunity for public comment on the six measures just discussed by the Workgroup in this domain. If you would like to make a comment on the Care of Acute and Chronic Conditions measures under review, please use the raise your hand feature in the bottom right of the participant panel to join the queue, and please remember to lower your hand when you're done. When we unmute you, please introduce yourself and give your affiliation. I see Edwin Corbin-Gutiérrez. Derek, can we unmute Edwin?

Thank you. This is Edwin Corbin-Gutiérrez with NASTAD, the National Alliance of State & Territorial AIDS Directors. Thank you for the opportunity to provide comments today. I would like to speak to the HIV Viral Load Suppression measure. NASTAD is a nonpartisan nonprofit association. We represent state public health officials who administer HIV and viral hepatitis programs. And on behalf of our members, we would like to convey how critical the measure is to Ending the HIV Epidemic goals, and we are working with HRSA in 10 states, developing technical assistance resources to increase the capacity of state Medicaid and HIV programs to report the viral suppression measure to CMS. State HIV surveillance programs across the country collect viral suppression data and are our key partners and sources of viral load test results to calculate the measure. We are working with 10 states currently, including HIV and Medicaid programs using a tailored approach based on the level of data sharing that is allowed by each state's HIV confidentiality statute. And through our dissemination and technical assistance over the coming years, the project will also be able to support additional states in reporting the measure. The measure is particularly important in reducing health inequities. Medicaid programs cover 45% of people living with HIV across the country. Women and black people living with HIV are more likely to be covered by Medicaid than other sources of coverage. And then also, in terms of coordination, the HIV viral suppression measure represents an opportunity to coordinate with Ryan White programs to address social determinants of health, providing comprehensive wraparound services. And then across the country, Medicaid beneficiaries who receive Ryan White support had a sustained viral suppression rate eight points higher than Medicaid beneficiaries without Ryan White enrollment. Medicaid churn has also been associated with lower retention and HIV viral suppression, so making coordination with these programs, again, is critical to ensuring continuity of care. So I cannot emphasize the importance of keeping the measure in the Adult Core Set and its role as a catalyst for coordination between Medicaid and public health programs. Thank you for your support in this critical matter, and please don't hesitate to reach out to NASTAD with some questions. Thank you.

Thank you for your comments, Edwin. We appreciate that. I see Marlene Matosky from HRSA. Can we make sure Marlene is unmuted?

So good morning and good afternoon, everyone. I am Marlene Matosky. I am from HRSA. I not only represent HRSA as a federal liaison, but I'm also the measure steward for the viral suppression measure. I want to thank the Workgroup members for the meaningful and rather deep conversation you had about viral suppression. And I wanted to kind of dovetail with what Edwin just talked about. Edwin is the recipient that we have for our cooperative agreement that's working with the states to help them overcome these challenges that you very eloquently talked about in reporting the viral suppression measure, and I just wanted to say a couple things about that. First is, it's a fairly sizeable investment for us in the HIV program. It's $4 million a year that we're investing in this over the course of four years, so we're really committed to trying to make demonstrable changes with our states to help them overcome these challenges to sustainably support where, as Edwin said, we already have 10 states that lined up that we're working with. We're looking to bring on additional states in the future. So obviously, if you're interested please come back to me or to Edwin to talk more about this. But we're also going to be sharing information that comes out of this project in nearly real time. So I know we heard a couple of colleagues from states saying that you're having significant issues around the data sharing piece. So as we learn stuff from these states we're working with, we're going to be sharing it out with you and your fellow colleagues in the Medicaid program. So much more to come on this. And then I just want to say that, somebody made this comment. We were here a couple of years ago, and I was here with hat in hand to talk about why this

measure is important and why we needed to keep it. And I've heard you loud and clear. And it took us a couple of years to make this funding available, but we are really committed to doing this. And I think that as we heard about, I think that this is sort of the tip of the iceberg, and I think that there's going to be lessons that can translate into other measures in terms of the data sharing pieces in infectious disease as well as other entities. We heard about sickle cell and others today where this may be information that comes out of this can translate to other measures. So I want to, one, thank you for your thoughtful conversation. I took copious notes, and we're going to be incorporating some of what you said into our cooperative agreement and that technical assistance. But then thank you for the thoughtful conversation and the real consideration of keeping something that's really hard to do because, sometimes, the hard stuff to do is really what we need to be doing. So just a thank you.

Thanks, Marlene. Next up, Allan Oglesby. Derek, can we unmute Allan?

Hi, everyone. I'm Allan Oglesby, and I'd like to also thank you for the opportunity to provide comment on the proposed suggestion to remove the HIV Viral Load Suppression measure from the Adult Core Set. I'm a health outcomes research scientist from ViiV Healthcare. ViiV is the only pharmaceutical company that's 100% dedicated to combating, preventing, and ultimately curing HIV and AIDS. And as I'm sure this group knows, advances in HIV treatment have transformed HIV from a terminal illness into a manageable chronic condition that's resulted in improved rates of viral suppression for people with HIV across the US, but we're still well short of our national goals of achieving 90% viral suppression for people living with HIV. And I have to say, I'm very encouraged by the debate earlier and the support expressed by the members of this panel to retain the viral load suppression measure, as this is the very tool that allows us to continue to measure success in combating this epidemic. As expressed in that discussion, HIV Viral Load Suppression is the ultimate goal of HIV treatment, and it's also the outcomes measure that allows us to compare progress across cities, states, programs, and other systems of care. And it was mentioned by one of the panelists that, since 2019, the Department of Health and Human Services has prioritized a massive effort to end HIV in the United States called the Ending the HIV Epidemic Initiative. And this plan consists of a coordinated effort across several federal government health agencies in 57 states and other jurisdictions with the highest rates of HIV in the country. The federal government has allocated hundreds of millions of dollars towards this effort in the past three years, which does include capacity building and reporting infrastructure, which will hopefully remove some of those barriers expressed by some of the panelists for reporting viral load suppression.

But removing this measure from the Core Set would run counter to these efforts, which I don't think that anybody would want to see. The Ending the Epidemic Initiative relies on scientifically proven models of effective HIV care, and the success of this effort is measured in the proportion of people achieving viral load suppression, and these results are reported and compared in online federal dashboards. It's for this reason that many advocates and experts have repeatedly urged CMS to promote expanded reporting on HIV Viral Load Suppression by all state Medicaid programs and to require Medicaid-managed care plans to report viral suppression rates publicly as well as to CMS. This would continue to drive continued improvements in state and federal alignment and also serve to promote health outcomes in HIV goals across Medicaid.

As mentioned by several members of the panel, several state Medicaid programs have already linked HIV quality measures to manage care performance and have incentivized successfully viral suppression for people with HIV, and this has been demonstrated, as mentioned, in New

York State, Louisiana's Bayou Health, and several others. In closing, I'd just like to say that optimal clinical outcomes for people with HIV can only occur if systems are measured and we're able to benchmark the performance against current standards of care. Therefore, we encourage CMS to retain the HIV Viral Load Suppression measure. Thanks for the opportunity to comment.

Thanks, Allan. Is there any additional public comment before we move to voting? All right. Well, I'm not seeing any. Thank you, everyone, for your comments. Let's move to the next slide, and I will pass it over to Alli and Dayna to walk us through the voting.

Okay. Thanks so much, Tricia.

So I'd like to encourage all the Workgroup members to make sure you're logged into the voting platform, and we will get started with our first vote. So for our first vote for today, the question is, should the HIV Viral Load Suppression measure be removed from the Core Set? The options are, yes, I recommend removing this measure; or no, I do not recommend removing this measure. Voting is open. Thanks so much, everyone. I see the votes are starting to stream in. Looks like we're just waiting on a couple of more votes. Ann, I think we might be missing your vote. If you could try to submit your vote. I think we also are missing Karly Campbell's vote. Okay. I think one Workgroup member must have had to step away, so I think we will move ahead. We can close the vote.

And so for the results, voting is now closed. Thirteen percent of Workgroup members voted yes. That does not meet the threshold for recommendation. The HIV Viral Load Suppression measure is not recommended by the Workgroup for removal from the 2023 Core Set. Next slide, please.

And now we'll vote on, should the Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis measure be added to the Child Core Set? The options are, yes, I recommend adding this measure; or no, I do not recommend adding this measure. Voting is open. We're still waiting on a few more votes to come in. Thanks, Ann. We see that you submitted your vote via Q and A. Looks like we're waiting on Lisa Satterfield. If you're able to put your vote in the Q and A, we can submit that for you. All right. Thanks, everybody, for submitting your vote.

So moving onto the results, 83% of Workgroup members voted yes, and so that does meet the threshold for recommendation. The Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis measure is recommended by the Workgroup for addition to the 2023 Child Core Set.

Next vote, please. So now the next vote is, should the Eye Exam for Patients With Diabetes measure be added to the Core Set? The options are, yes, I would recommend adding this measure; or no, I do not recommend adding this measure. And voting is open. Okay. Thanks, everybody. Sixty-three percent of Workgroup members voted yes, and that does not meet the threshold for recommendation. The Eye Exam for Patients With Diabetes measure is not recommended by the Workgroup for addition to the 2023 Core Set. Next vote, please.

The next vote is, should the Blood Pressure Control for Patients With Diabetes measure be added to the Core Set? The options are, yes, I recommend adding this measure; or no, I do not recommend adding this measure. And voting is open. It looks like we still might be waiting

on Katelyn's vote. Katelyn, if you could please submit your vote on the platform or, if not, send it to the Q and A please.

Okay. Looks like we reached the expected number of votes. Forty-eight percent of Workgroup members voted yes. That does not meet the threshold for recommendation. The Blood Pressure Control for Patients With Diabetes measure is not recommended by the Workgroup for addition to the 2023 Core Set. Next vote, please.

Next, should the Kidney Health Evaluation for Patients With Diabetes 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. Looks like we might be waiting for Lisa Satterfield, so if you could submit your vote or send it through the Q and A, please. Okay. Looks like we reached the expected number of votes. Okay. Twenty-eight percent of Workgroup members voted yes. That does not meet the threshold for recommendation. The Kidney Health Evaluation for Patients With Diabetes measure is not recommended by the Workgroup for addition to the 2023 Core Set.

Moving on to the final vote, should the Statin Therapy for the Prevention and Treatment of Cardiovascular Disease 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. Okay. Thanks, everybody. Twenty percent of the Workgroup members voted yes. That does not meet the threshold for recommendation. The Statin Therapy for the Prevention and Treatment of Cardiovascular Disease measure is not recommended by the Workgroup for addition to the 2023 Core Set. All right. Next slide, please, and I'm going to pass it back to Tricia.

Great. Thanks, Alli. We have to do abridged discussion today. We are a little bit behind on our agenda, so I think what we're going to do is take our break now as scheduled, and we'll have our discussion of gaps for the Care of Acute and Chronic Conditions domain as well as the other domains that were not discussed and cross-cutting gaps after the break. So why don't we break now? Please be ready to start again at 1:00 PM Eastern Time. So that's about 12 minutes from now, and we'll see you then. Thanks, everybody.

All right. Hi, everybody. We're going to get started again. I know that was a short break, but we have another one coming up soon, so I promise we'll give you another little respite in a few minutes. Let's see. Can we go back to slide 29? Okay. So because we're a little bit behind schedule, what we're going to do for the next 45 minutes or so is discuss the gaps in the Care of Acute and Chronic Conditions domain. Then we'll also discuss gaps in the domains that have not already been discussed during this week's meeting, and then we'll discuss cross-cutting gaps. So first, we'll begin with hearing from Workgroup members about possible gaps in the Care of Acute and Chronic Conditions domain. We're interested in your thoughts on what suggestions the Workgroup has for further strengthening the Core Sets, what types of measures or measure concepts are missing in this domain, and whether there are existing measures to fill the gaps, or whether a new measure would need to be developed. So we will look for Workgroup comments on gaps in this domain. Please remember to raise your hand, and we'll call on you. Jill, go ahead.

I'll start it out. As I look at, and we had some conversation about disease-specific measures, I wonder if there isn't a way to capture effectiveness of the health care system in terms of making sure that things happen. It's really more probably care coordination for chronic

conditions maybe more as a general state, as opposed to based on an individual condition. It's a little harder because cardiovascular disease prevention, there are statins and there are guidelines, but just wondering if there's, and I don't know of any measures, but if there's a way to look more collectively at how chronic care occurs in the system.

Thanks, Jill. Are there other Workgroup comments on gaps in this domain? Mihir Patel, go ahead. Derek, can we make sure Mihir is unmuted?

Thank you. Yeah, I would agree with what Jill just mentioned. If there was a better overall perhaps composite score on how a patient is doing, apart from the disease-specific measures that we have in place. When we think about pharmacy metrics in general, we know that, at least for the Medicaid population, the diseases that burden this population is different than the commercial or Medicare population. And when we hone in on specific adherence metrics that have been developed for Medicare or commercial populations, it may not be as relevant. So if there's a composite score around adherence, around overall chronic condition management, that can be developed, I think that could potentially get to what Jill is speaking to as well.

Great. Thank you, Mihir. Other comments on this domain? All right. Oh, I see Lindsay. Lindsay, go ahead. Lindsay Cogan.

I think there has not been a lot of discussion in this year's Workgroup around COVID and impacts of COVID on many of our covered lives, particularly those with undiagnosed or diagnosed and not-well-managed chronic conditions. So I don't know how we think about ensuring that as or if COVID continues, that those who suffer the greatest burden are receiving the care that they need, and then also thinking about our approach going forward, if there is another pandemic or a similar like that is just going to kind of burn through our most vulnerable communities. So how can we ensure that we are prepared and able to adapt and pivot and well manage this population so that they are not so hard-hit the next time something like this comes around? So that is a gap, and I don't have an easy solution or a fix to this, but it is a gap that we are continually thinking through. It's how to better align our goals as they relate to both measurement and quality improvement around ensuring that we don't have the same issues perpetuate that we saw during COVID.

Thanks, Lindsay. Linette Scott, go ahead.

So, Lindsay, I was kind of mulling that over in my head as well around, what about long COVID? And it's way too early to add it because we're still literally just getting the right diagnosis codes and procedure codes in place to be able to track it, but that seems like something to watch over time. The other thing I was looking at, what are, like, the common causes of major disease burden, and I think we have things fairly well scheduled that we covered, but we don't really have something that gets at accidents, injury, along those lines because this is care of acute and chronic conditions. And so most of what we have, I think, is actually chronic conditions. We don't really have something to represent acute. And so I wonder if there's, and I don't know offhand, I wonder if there's something in the arena of injury, and I was kind of thinking about in the context of suicide or, traffic accidents obviously went down when we had COVID, but people are driving crazier now that we're driving again. So I'm not sure what it would be, but I would just flag this as perhaps a gap that we might be able to take a look at in terms of addressing acute injuries, workplace injuries, et cetera. There probably should be something in that space. Thanks.

Thanks, Linette. Rich Antonelli, go ahead.

Yeah. Thank you. I guess I want to frame my comments rather broadly. So the discussion so far around acute and chronic conditions sounds pretty traditional to me, but I'd like to reflect back on the Day 1 discussion around equity and the social drivers, and I'd like us to consider thinking about chronic conditions like poverty and other types of conditions that are the social drivers. And yes, I know we had a discussion about this then, but I really want us to be thinking broadly about what we even consider to be a chronic condition. Along those lines, the LTSS discussion yesterday was an important one, but I don't want to use LTSS discussion as a proxy for rather large portion of the population, both adult and children, that have intellectual and developmental disabilities themselves. And so what are some of those measures there? And I don't just simply mean in terms of, are they getting their annual checkups, but in fact, around issues of inclusion and communities and things like that, so really getting at health outcomes for large populations with a condition that is not traditionally considered medical. And then the last one that I call out, and we raised this a little bit yesterday, but it kind of reflects on Jill's apt comment, which is this: I don't think we need to have different measures necessarily for specific diagnostic categories, especially those with low prevalence, but we should be able to be thinking about what some of the experiences are of those persons that have those conditions, both medical, behavioral, and some of the social ones that we talked about. So there are adult and child measures, for example, of the experience of integration across members of the care team that is not just delimited to the medical providers, but including social service, behavioral health, dental providers, et cetera. And those measures exist, and they're broad, and to be clear, they are not disease specific, so they could be generally available. And then the final comment that I would make is, other than the depression measure, ADHD, and asthma, woefully little represents children and youth with special health care needs in the Core Sets. And considering the fact that these small percent of children are accountable for an overrepresentation of the amount to spend, and yet their care fragmentation is pretty substantial, I'd like to be able to challenge measure developers and/or the current measure stewards to even think about stratifying. This is a population that often struggles. Families and caregivers struggle to find a way to cohesively provide a plan of care, to finish school, to get a job, or to keep a job. So I appreciate the ability to make those observations during this gap discussion.

Great. Thank you, Rich. All right. Let's move on. Can we go to slide 32? Okay. So what we'd like to do now is discuss measure gaps in the Core Set domains that have not been discussed this week, including Maternal and Perinatal Health, Dental and Oral Health Services, and Experience of Care. And then we'll discuss cross-cutting measure gaps. So, next slide. So starting with the Maternal and Perinatal Health domain, this slide looks at 2022 Child Core Set measures in the Maternal and Perinatal Health domain, including Live Births Weighing Less Than 2,500 Grams, Prenatal and Postpartum Care: Timeliness of Prenatal Care, Contraceptive Care–Postpartum Women Ages 15 to 20, Contraceptive Care –All Women Ages 15 to 20, and Low-Risk Cesarean Delivery. Two of these measures, the Low Birth Weight and Low-Risk Cesarean Delivery measures, are measures that CMS calculates on behalf of all states and some territories using vital records as submitted by states and territories, compiled by the National Center for Health Statistics and CDC WONDER. Next slide. And this slide has the measures from the 2022 Adult Core Set in this domain, including Prenatal and Postpartum Care: Postpartum Care, Contraceptive Care–Postpartum Women Ages 21 to 44, and Contraceptive Care–All Women Ages 21 to 44. These two contraceptive care measures are included in both the Child and Adult Core Sets for different age groups.

So now we'd like to spend about seven minutes or so on Workgroup member discussion about gaps in this domain. Please raise your hand if you have any comments on the Maternal and Perinatal Health domain. Lisa Satterfield, go ahead.

Hi. Thank you for bringing these measures up for discussion. I have probably what's a comment for CMS on the cesarean delivery measure. And we appreciate and we're glad that cesarean deliveries are being collected in that way. However, there are some exceptions that are not captured in the measure and not captured in vital statistics. So we feel, like, at times, the measure is reporting high because it's not capturing some of those indications for cesarean that are not as clear cut.

Thanks, Lisa. Are there other Workgroup comments in this domain? Jill, go ahead.

So I'm trying to remember back to the behavioral health measures and whether or not there is some screening around substance use and pregnant women. I don't think that there is a current measure that gets at that in the Core Set currently. So that's likely a gap.

Okay. Thanks, Jill. Rachel LaCroix?

Hi. My comment actually was right along the same lines as Jill's. I know that one area we've been trying to focus on with prenatal and postpartum care is around substance use with pregnant women and new mothers, but also broadening. I know we have the metric in there for the Child and Adult Core Sets about screening for depression, but really wanting to capture screening more generally for substance use and other mental health conditions in the prenatal period to try to make sure that appropriate services can get into place for women in the perinatal period and to help continue that care in the postpartum period.

Thanks, Rachel. Let's see. Anne Edwards, you were next, and then we'll go to David Kelley.

Great. Thank you. Thank you to others for raising substance use, and would put that both in the maternal care and obviously the neonates, especially, as there's work done on NAS and other impacts on the infant. But I guess the other thing that I'm going to raise that's a little bit higher level, when I think about our discussions around disparities and impact on different populations and think about maternal morbidity, mortality, which relates to neonatal outcomes, I raise the question if this is the set of measures that is getting to addressing some of that. Maybe I'll suggest some opportunity around measures that would look at systems, maybe OB care related to neonatal care. Again, I don't have a specific measure. I think some of this starts to hint at it, but as we're starting to think forward and think about the prevalence and really the numbers, that this might be an area that is worthy to explore and continue to develop measures and to address.

Thanks, Anne. David Kelley.

So I would propose that there's a good opportunity to leverage some of the current core measures and do some sub-analysis, so for instance, looking at pregnant women, both prenatally and postpartum, for depression screening and follow up. So, it's a current measure. Why not do some sub-analysis thereof? As a program, we actually do that through multiple ways. We actually do a chart review that our EQRO has developed. But that may be an opportunity to, again, I think to some earlier comments take some existing measures and do slightly different stratifications. The same thing with any of the measures around opioid use

and looking specifically at pregnant women who were offered the opportunity for medication-assisted treatment, or MOUD. So that may be, again, an opportunity, and I know duration of treatment, I don't think, is a Core Set, but that's another kind of sub-stratification of a current measure that is out there that looks at duration of treatment and could be sub-stratified for pregnant women.

Thanks, David. Lisa Patton.

Yeah. Thanks, Margo. Yeah. I was headed essentially where Anne went, and I appreciate the comments on SUD for this particular population as well as depression and follow-up care. And I also just wanted to mention the importance of looking at risk for or experience of interpersonal violence, especially with what we know about the morbidity and mortality rates among this population, and so sort of broadening our thinking about that. And I'll also just mention the impact of stigma on getting at the offering and acceptance of MOUD for pregnant and parenting women. And, so I know that there's also sort of the legal and community context in which these services are screened for and offered, and I just think we have to be mindful of that impact as well as we seek to draw out these measures in that kind of more inclusive direction.

Thank you, Lisa. Lisa Satterfield.

Thank you, and thank you, Lisa, for mentioning that because that was also going to be my comment. I think I like David, I believe it was David, his idea of stratifying current measures, and so that would be an aggregate way for states submitting that information perhaps without placing any mothers at risk for actions against them because, unfortunately, we still hear about those instances with substance use and drug abuse. So I wanted to comment on that. I also wanted to share that there is a measure, Measure 336 in the quality program called Maternity Care: Postpartum Follow-Up, and Care Coordination. And so not only is it measuring that the postpartum visit happened, but it's also requiring certain things be discussed with the patient for the measure to be fully met. So that might be a consideration for the counseling and things like that. And then also, I'm not aware of an intimate partner violence measure, but I think that's a great idea and would love to explore how to do that. Thank you.

Thanks, Lisa. Diana Jolles.

Hi, everybody. Diana Jolles, nurse-midwife. I'm a provider in public health and also a health services researcher. I just wanted to state, on behalf of the American College of Nurse-Midwives, how hopeful and positive we are about the mandatory reporting of the low-risk cesarean birth measure. This is a robust measure that really captures so many things. It has embedded within it some risk adjustment. It is getting at overuse, misuse, underuse, and appropriate use, which is very important for quality, value, and of course, safety and health. I think the elephant in the room, which other commentors have mentioned, is the egregious health disparities that we're experiencing right now. These measures must be stratified by race and ethnicity. So that's a glaring gap. Our current state of affairs, even with our metric portfolio, is a direct reflection of the processes that have led us to where we are, and I'm including the process that we go through to come up with ICD-10 and CPT. The day when we start measuring health in our billing system, so normal, healthy, low-risk people getting measurably different care, than a disease process billing system that's continuing to drive overutilization, misuse, and cause harm to a large population of people in the United States. So that's a glaring deficit here. We've heard this in other conversations, and we're sort of stuck in our own

hamster wheel on this process. Network adequacy is a big deal. As our other commentors have discussed, David and Lisa, the issues for this population, when you look at maternal mortality, which is a glaring omission from this measure set, maternal mortality, I don't know how it's not here. But when you look at maternal mortality and you look at the collection of data we have from the state Maternal Mortality Review Committees, it's largely coming from social determinants of health, and the workforce needs to look measurably different. It's not clinical care that's driving many of these outcomes. It's social determinant care. So network adequacy is a big deal. Patient preference measures are glaringly omitted from the portfolio in general, including this portfolio. And if we really want to be wild and crazy, we need to start marrying our silos. So maternal and perinatal metrics, many of the issues are very similar to our end-of-life care issues, which I realize that's Medicare, and we've siloed that. But if you just took a chunk and went with patient preferences and married the beginning of life and end of life, you would save so much money and improve value for a big population. And that's all. Thanks for the ability to comment.

Thanks, Diana. David Kelley, I see you have your hand up. Did you want to comment here, or is that from before?

Actually, I did want to circle back and comment on, again, maternal mortality. I think this is a huge topic when we look at the disparities that we see in mortality, but not just mortality, but morbidity as well. And there are claims-based ways of looking at various types of morbidity, and we've done some of that work with our university partners. I think that's something that we need to really think in terms of measuring the extent of those morbidities during different postpartum periods, or even perinatal and postpartum periods, and need to really think in terms of reporting not just the mortality but the morbidity. I think this is a huge topic. I think there's been, nationwide, I know certainly in Pennsylvania, this is a disparity. This is an inequity, and I really think this is something that we need to get our measure stewards focused on trying to come up with something. And I know we have also looked at postpartum blood pressure remote monitoring and have done some things with the University of Pennsylvania, and they've shown the need for blood pressure monitoring and intervention in a fairly high percent of women in the postpartum period. So I think there's a lot of opportunity to really go beyond where we're at with the maternal and perinatal health measures. Thanks.

Thanks, David. Rachel LaCroix. Rachel, did you want to make a comment on this domain, or is that from before?

I apologize. That was for before.

Okay. Tracy Johnson.

Thank you. I want to echo the comment around measures in the maternal mortality and morbidity domain and to also suggest that, maybe some qualitative measures around being listened to. That seems to be the consensus, at least in some of the literature I've read, is that there is a missed opportunity, and to really kind of get a handle on that opportunity would be useful. Separately and kind of to your question about cross-cutting gaps, there's so much of an increase in telemedicine in the Medicaid delivery right now that, how to capture that in various measures, and do we even need to think about measures differently. Like, members are getting remotely monitored. Have they been screened, you know? And just really thinking about this somewhere between, at least, just to throw out some numbers in Colorado, 10 to 15% of codes that are available on the physical health side for telemedicine are being used for

telemedicine, and it's more around 30% for behavioral health and has been as high as 50 or 60% during different peaks during the pandemic. So it's a substantial part of our delivery system and making sure that we understand, is telemedicine included in existing quality measures? Do we need something different just to kind of play this out a little bit? You know, there are a growing number of entities that provide services only by telemedicine, and so they're providing services that look like primary care, use primary care codes, but in our state, are not considered primary care providers, and so are not in a lot of these measures, you know. So do they need their own measures, or do they need to get pulled in? So I just think thinking through that whole space, I think, would be really valuable.

Thanks, Tracy. Lisa Satterfield, did you have another comment?

I do, thank you. And I didn't say before, but I'm from the American College of Obstetricians and Gynecologists. So I wanted to address a lot of the comments these have been brought up, and I appreciate all of the great ideas that are being brought forward. I really appreciate the idea of a blood pressure measure at postpartum. I think that's a really great idea, along with the remote patient monitoring, and I think it would be interesting for Medicaid programs to measure access in some way, not only access, how many providers do you have enrolled in the system, but are they taking more than one patient a year on their case from the Medicaid program, things like that. There are a couple measures - there's one measure the inpatient hospital group at CMS is using now that I would encourage consideration, and it's to measure if hospitals are participating in perinatal quality collaboratives. I think it's a really great way to up the quality of care, so that may be one to consider for Medicaid programs as a whole to report. I do want to say that any maternal mortality and morbidity measures need to be approached a little bit with caution because we don't want to get in a situation where one small rural hospital that doesn't birth very many patients a year or it has one incident that really just destroys their measure rate. And similarly when you're talking about the state of California, you would have much larger numbers than the state of Rhode Island. So we want to make sure that the maternal mortality measure in particular doesn't disclose information where it can be tracked to the deceased or one incident that was essentially an anomaly. So very important that the MMRCs are doing that work just as a measure. Again, want to approach it with caution. Thank you.

Thanks, Lisa. Gigi Raney from CMS wanted to make a comment. Derek, can we unmute Gigi?

Thank you, Derek. This is Gigi Raney at CMS, and I just wanted to speak to Tracy Johnson's question about telehealth and telehealth codes and quality measures. CMS uses quality measures that are, for the most part, derived by external measure stewards. That is, measure stewards that are not CMS based, NCQA, PQA, all sort of different quality organizations that have developed those measures. And we really do rely on a measure steward to determine whether or not is it appropriate for telehealth to be provided as a service related to those quality measures. So each measure individually, by each measure steward, it's determined whether or not telehealth can be included. I'm going to say that most of our measures actually do include the option for telehealth to be provided. Obviously, there are some measures, especially those that are pharmacy-based or lab-based, where that's not going to be an appropriate option, but the majority of the rest of the measures, especially the process measures, do allow for telehealth as an option with the caveat that, of course, it is also up to each state whether the state determines that telehealth is an optional service that they would consider for either that particular visit or that type of setting. So most measures do include it at this point. We know there's been an increase in that, obviously, over the last couple of years,

and it is something that is reflected in the quality data that we get. I hope that answers your question.

Thanks, Gigi. Any other comments on gaps in this domain?

Okay. Go to the next slide. So on this slide, you'll find the 2022 Child Core Set Measures in the Dental and Oral Health Services domain. And these include Oral Evaluation and Dental Services and Topical Fluoride for Children, both of which were added to the 2022 Child Core Set in response to this Workgroup's recommendations last year. And Sealant Receipt on Permanent First Molars, which was added to the 2021 Child Core Set. So we'd like to just invite Workgroup member discussion about gaps in the Dental and Oral Health Services domain of the Core Set. Jim Crall? Go ahead.

Yes, thank you very much. Well, at the risk of stating the obvious, I think a major gap here is that this is my fourth year on the Workgroup, and our initial focus really has been on the children's measures. And I think we've done an excellent job as a Workgroup in terms of approving the addition and replacement of some of the older measures with some new measures that are evidence-based, highly evidence-based in the case of the fluoride and the sealants, and also another measure that looks at whether children are receiving some type of a thorough evaluation or assessment. So great progress in that regard. And those measures, I think really do help complement the CMS 416 measure. However, when it comes to adult dental measures, we've made no progress. And it's not for the lack of trying, or champions such as David Kelley who has repeatedly called out this gap. We have proposed some measures in the prior years, most recently the adult ED visits for non-traumatic dental conditions, which parallels a DQA, NQF-endorsed child ED measure that's more limited just to caries. That adult measure has been thoroughly tested by DQA, and the testing results are certainly available. But I think we've suffered the same fate as the attempts on this year's LTSS measures' experience, and that the voting is oftentimes close, but no cigar. And my sense is that the challenges we face in getting adult measures added to the Core Set boils down to three things.

First is the typical challenge we face in convincing policymakers and other health disciplines to prioritize oral health among other health care issues. But because of the highly prevalent and impactful nature of dental diseases, particularly in the Medicaid population, I think that there's growing support there. Secondly, the fact that the adult dental benefits are not required in Medicaid. That's been pointed out in a fairly recent 2021 MACPAC issue brief where they noted that states can choose to provide either no dental benefits, which you know, on the positive side, only three states as of March 2020 had no dental benefits for adults in Medicaid. States can choose to provide treatment for emergent conditions only. That's typically extractions. There are about six states in that category. And then the bulk of states, roughly 32 states, provide a range of some type of diagnostic, preventive, and treatment services, but that range's rate goes from relatively limited set of services to more expansive. There is a small number of states that also provide limited benefits that just cover dentures. The MACPAC brief also noted that 37 states cover dental benefits by virtue of their Medicaid MCOs providing some dental coverage. And I think that's likely due to the growing recognition that the impact of dental conditions is substantial, and that it extends beyond the mouth. It impacts other aspects of health, and certainly impacts Medicaid program costs, regardless of which sector the services are covered by. And I think the ED visits are highly indicative of that spillover cost. I'd also note that many states are moving to add or expand their adult dental benefits. I recently reviewed a paper for a peer-reviewed journal that looked at the expansion or additional use,

the impact of ACA expansion on dental use. And interestingly found that the states that expanded coverage, and particularly states that expanded coverage and had a more comprehensive set of services, saw an increase in tooth extractions. That's generally felt to be the result of just a backlog of needs and the need to get out some teeth that are seriously affected by dental diseases.

The third challenge, I think that we, and sometimes I'll say "we", and I'll mean the Workgroup, and sometimes, "we", I can't dissociate myself entirely from the Dental Quality Alliance and work I've done there for over 10 years along with many other colleagues, I think the issue that again applies to many measures is administrative burden on the states. So you know, we have tried to approach that by proposing measures that rely on claims data, which really are accessible, and the states have the ability to access, and compile, and manage that data. But beyond that, the DQA has allocated resources, its own organizational resources, to acquire and analyze the T-MSIS data, which we've used to begin constructing state profiles for a number of DQA measures, including our Child Core Set measures. And those are recently being rolled out. DQA is a small shop financed largely by member dues; however, staff informs me that we anticipate having state profiles for the adult ED measure by late summer of this year. Therefore, I anticipate that in the future that there will be a proposal to add the adult ED measure, again, with a stronger case base being made and data from the T-MSIS data to actually illustrate how that can be, can reflect on various state programs. And that will allow an ED measure that joins other Core Set ED measures. So we have embraced that ED measures for certain conditions. I'd also point out the DQA is willing to work with states to reduce administrative burden of reporting for Child Core Set measures.

So in summary, I think it's clear that dental diseases remain an important chronic condition. It impacts Medicaid beneficiaries disproportionately in general, and some racial/ethnic groups and people with disabilities more than others. Social drivers are clearly important considerations, and the measures typically that are in the Core Set or that have been proposed for the Core Set are amenable to stratification. States appear to be acknowledging the importance of providing dental benefits for adult Medicaid beneficiaries, but because of the diversity in state coverage for adult dental benefits, I, at least individually speaking for myself, still believe an ED ambulatory-sensitive condition-type measure seems the best fit given the criteria for Core Set measures. So in closing, I'll just say thanks for the opportunity to comment. Let's not make the perfect the enemy of the good. You know, I appreciate the previous calls for us to move more upstream. But let's get started with a meaningful, feasible measure given the increasingly sparse real estate in Core Set measures. Thanks for the opportunity to comment on the gap.

I'd also like to suggest that the Workgroup, Mathematica, and CMS consider some modification, or augmentation, addition to our Workgroup proceedings to gather feedback that will help measure developers. If we can somehow ascertain reasons why Workgroup members are not supporting addition of certain measures, maybe favoring the removal of measures, maybe some type of an anonymous survey, again to provide some more direct rationale or guidance for measure developers as to what types of measures, or what are some of the limitations of measures that are being proposed that are not making it across the threshold. So again, thanks for the opportunity to be on the Workgroup and to comment.

Thank you so much, Jim. Kim Elliott, I see you have your hand up. Go ahead.

Yes, I did. And over the many years I've been working in Medicaid, I've had the pleasure of working with several dental directors that are really fantastic. And they continually pointed out that oral health, and good oral health, is really an indicator of overall health and well-being. It really impacts everything else in our bodies. And I also recognize that there are some limitations as far as coverage across states for dental, and we do need to recognize that. And I think that has impacted some of our voting over the years on different dental measures that have been introduced or recommended for addition. But I think we have seen some other shifts that may make that look a little bit different, such as Medicaid expansion where we're really increasing the number and volume of adults on Medicaid. And with that, if there's maybe just a way we could think a little outside the box, and maybe do different types of notations in reporting so that if it isn't a benefit, a state wouldn't be negatively looked at, I guess, from a reporting perspective. But it would really allow states that do cover that adult dental to show the improvements that they're making. And I'll talk a little bit more when we talk about overarching and different things like that, and how I would connect it to a few other things. But thank you.

Thanks, Kim. Ann Zerr?

I was just going to add a couple things. I also am incredibly supportive of good dental care. I think in Indiana and in many parts of the country, dental incentives are particularly misaligned. And I think that that was perfectly illustrated by, we have some states that only cover emergency dental care. So that's when everything has fallen apart when somebody either presents to a dentist's office or to the emergency department. So you know, we're providing the worst care in the wrong place. And the last thing the emergency room doctors that I work with want to see is a toothache. So I don't know how we can begin as a group to encourage states to align the incentives to focus on prevention. And you know that we know that for children and for adults, investment in dental care has a very high return on investment. The other thing that's quite different, at least I'm going to say as an internist looking at the dental community and trying to work with them in my Medicaid agency is sort of the idea of quality measures and dentists as responsible for them. Because in Indiana, and I'm sure across the country, most dentists are in either solo practice or small group practice. So it's quite different than pediatricians feeling very tied to providing those five visits up until age 15 months, wants to get all of those immunizations done, to do all of the anticipatory guidance. We just don't see that kind of engagement with our dentists in Indiana. And we actually pay dentists much better than we pay internists and pediatricians in Indiana. And sadly, dental care is very expensive, so people who are new to our program have incredibly unmet needs. So anyway, we have access issues. We have very misaligned incentives to get people to care about their teeth starting from a young age and continuing that investment. So those are just my thoughts.

Thanks, Ann. All right. Any other comments? David Kelley, I see you have your hand up.

Yes. Thanks. First of all, I'd like to thank Jim for all his work that he's done in really moving the needle on the current dental measures. I think we're in a much better place than we were a few years ago. I made some comments, I think yesterday, about the access to care around dental, and adults especially. And quite honestly, if there are 37 states that have offered at least some type of adult dental benefit, I think it's certainly worth measuring if we can get almost all of those states to report. And again, in Pennsylvania, we worked with our EQRO to write our own specifications for adult access to care for dental care. It's a very simple measure. It's administrative. And you know, we have the blessing of having all of our dental claims going to a common data warehouse for both our LTSS, as well as our regular managed care. So this

is really a huge issue. You know, increasingly the literature is showing, not surprisingly, that a lot of chronic conditions, inflammatory conditions in the oral cavity translated into poor outcomes from other medical diseases like cardiovascular disease and diabetes, and others. And also some states have qualifications to participate in Medicaid as an adult. You know, to work kind of, if you've got a few bad teeth that are hurting, it's kind of hard to show up for work when indeed you've got a really horrible toothache. So I really think that we need to keep pushing the needle on looking at adults and access to dental care. And then I think the other subgroup that I think we should be looking at again are both kids and adults with specific disabilities. I think that most dentists are not trained to deal appropriately with individuals with intellectual and developmental disabilities, or with adults with severe physical disabilities. So that's another area that I think we need to be thinking in terms of, and again, this gets back to Rich's stratification of measures around certain subgroups that are important to us. Thanks.

Thanks, David. Rich Antonelli, did you have a comment on this domain?

Yes, please. Thank you. And David, thank you for synergy here. I want to point something out. It's less about the measure that I want to comment on, but how the measure would be used. And so I guess my comment would be for the group, but also I want to make sure that the appropriate elements at CMS hear this. So to the extent that these core measures get into contracts, and that they get attached, say, to financial accountability at the level of delivery systems that may not have sufficient capacity to meet those measures. So I want to call that out. And there's probably we're a little bit better with behavioral health, although the pandemic has certainly pushed that in the wrong direction in terms of building capacity. But as Jim eloquently pointed out, it's kind of a desert on the adult side. The pediatric side is getting better. But if you just look at the slide before us, the oral evaluation can't be met at the primary care level. And so I just want the group to recognize that we need to continue to promote equity measurement. But the implementation, especially in an area that has such a profound dearth of eligible providers is not a burden that we should be putting on the frontline medical providers singularly. So I'd want to encourage using these measures as a way to build more capacity, and doing so with appropriate incentives. And Ann Zerr used the word "incentives" several times, and that's what really inspired me to bring this out. We have to build the capacity on adult and on pediatric dental providers the way we've done to some measurable success with behavioral health. So thank you.

I see Erica has her hand raised as the measure steward. Derek, can we make sure Erica is unmuted?

Good afternoon. Thank you for the opportunity to comment. And we're grateful to the review group for its emphasis on quality measures and recommendations to date for the Child Core Set. And want to add our voice about the opportunity to consider a measure for adult usage of emergency rooms for non-traumatic dental conditions. It's really an opportunity to assess the resource used. It's a rising public health concern, a strain on existing resources. And introducing such a measure is really just that, the opportunity to assess resource use for oral health conditions that would be better treated in ambulatory care settings and diverted from the emergency room. And we're hopeful that the dashboard of oral health care quality that which demonstrates the current state of oral health care quality for Medicaid beneficiaries is a starting point to allow states to assess how their resources are being used. So right now our focus is on the pediatric measures, and we will by the end of the summer have the adult measures as well. Thank you.

Thanks, Erica. Okay. In the interest of time, I'm going to move onto the next slide. So our final domain to discuss is the Experience of Care domain. The CAHPS Health Plan Survey is included in the Child and Adult Core Sets for their respective age groups. And as noted in other discussions this week, the Adult CAHPS Survey is also the source of the Flu Vaccination for Adults and Medical Assistance with Smoking and Tobacco Use Cessation measures. So now we would like to invite Workgroup comment on gaps in this domain. Jill, go ahead.

Yeah. I think I've said this before, but I know this has been sort of the mainstay of how patient experience and satisfaction has been gathered over the years. But with the experience of declining responses to these surveys, the sort of over-surveying of participants, and the error of the non-response that we don't measure, I'm just wondering if we need to think about gathering experience of care in some other manner. And I don't have the answer to it. But this staple process is sort of, I wonder about how accurate it is in terms of reflecting the whole population, which is what it is supposed to do.

Thanks, Jill. Linette, go ahead.

I guess I would just piggyback on that a little bit. I know we've talked about the CAHPS measures over the years, and the fact that we don't really have something better. But there's cultural differences in terms of how people respond to surveys. I know in some of the conversations I've been in over the years, right, we really, really want to hear from consumers. And yet you tend to hear from either people who are really happy or really unhappy in terms of what they've received. So it's really easy to end up with a biased response based on who's responding as opposed to being a true cross section. And then the other challenge, I know there's lots of challenges in terms of what does it mean to capture consumer and to capture patient feedback? Again, really want to hear from patients and understand their experience, but it seems like we've gotten some of the best feedback when we have focus groups or other kind of interactions that are not surveys. Again, surveys having a challenge because there's perhaps context. It's high-level. It's based on recall. And again, just the survey response rates are providing challenges. And I know some of the experience too is sometimes we find ourselves as clinicians in a catch-22 providing appropriate clinical care is not necessarily what patients want in the current experience, which is one of the measures we talked about today in terms of antibiotics for bronchitis/bronchiolitis, right? You don't use antibiotics for viral, yet, often people come to the doctor because they think they should have an antibiotic. And so if they don't get it, they're going to be unhappy. So the consumer engagement, the patient engagement, it's really a challenging area. And sort of thinking about how do we do that at scale while getting truly meaningful feedback, I think is an ongoing challenge, but something that really deserves some attention in this area. Thank you.

Thanks, Linette. Any additional comments about gaps in this domain from the Workgroup? Okay. So we are a little behind schedule, which is fine. I think what we're going to do is take our break now. And we'll come back after the break and discuss cross-cutting gaps and have public comment on gaps, and then move into reflections and future directions. So why don't we take a break and we'll resume at 2:15. Everybody be back at 2:15. Thank you.

All right. Welcome back. Let's go ahead and get started. Can we go back to slide 32? All right. So now we will turn to discussion of cross-cutting measure gaps. And you can see some topics to guide the conversation here on the slide. These include: What measure gaps should be considered for future Core Sets? What are the implications for developing new quality measures for Medicaid and CHIP, including the domains for future focus? Data sources for

state-level reporting, such as claims, encounter data, electronic health records, and surveys, and use of other existing data sources including T-MSIS. So a few rules for this discussion. We ask that folks not repeat gaps that were already mentioned in the previous domain-specific discussions, but instead use your comments to build on the discussion and keep the discussion moving forward. And try to offer new insights to help improve the Core Sets, and how they can drive quality improvement in Medicaid and CHIP. So again, we'll open it up to Workgroup comments on cross-cutting domains. Please raise your hand and we'll call on you. Curtis Cunningham, go ahead.

Yeah. I think this is really an important conversation for Medicaid in general because of the nature of comorbidities across the various populations. I'd especially like to see some measures that really look at the quality of long-term services and supports relative to the medical results, and actually vice-versa. Looking at falls, burdensome transfers, unnecessary transfers. You know, even knee surgeries, an admission to long-term care and access to those types of services. So I think there's a lot of work to do here. I think you could also look at that across the behavioral health with medical. So just a gap, but I think it's really important if we're getting to patient-centered care, we are still too much looking at either one chronic condition, or looking at acute and primary, or behavioral health, or one category. And so how do we really look across and understand that an experience of care for an elderly individual that is going to the ER five times and transferred in and out of a nursing home a variety of times is not a good experience of care, and how do we capture those in the measures that we're working on? Thank you.

Thanks, Curtis. Kim Elliott? Go ahead.

Thank you. There are really two things that come to mind for me when I think about the gaps in our core measure set. And one of those, I know that we work on and we continually talk about, but there just haven't been really good measures for it, and that is really measuring outcomes. We have so many measures on our set that we talk about screening, and rate of screening, and all sorts of things, but we never really get to the outcomes. Our efforts that we're making, all of the intervention and activities that we're doing really drive quality improvement and resulting in good outcomes for the Medicaid members. A good example of that is the developmental screening measure. Okay, we're measuring the screening rate, but is that really having the positive outcome or is there other things, are there other things that we should be looking at in relation to that? So it's kind of follow-up on some of the things that we've been working on for years and do a reasonably good job at. Now taking it to the next step, but I know that there aren't a lot of really good outcome measures out there yet for such a scenario that we might want to think about and focus on a little bit more. And the other area that I continually think about when I think about Medicaid, and a lot of it has to do with the disabled populations, the long-term services and support members, home and community-based, but it's all of the safety issues. If we're not addressing the safety issues, of course it also will impact their health, their well-being. So those are just areas I think that are still kind of gaps for us that we might want to explore a little bit further in future meetings.

Thanks, Kim. Rich Antonelli? Go ahead.

Yeah. Thank you. I want to really resonate with something that Curtis said because it reflected something that I said yesterday and earlier today. And this is this notion of really asking the patients their experience, not just their satisfaction. For me, satisfaction presumes that the respondent knows everything that they could expect from whoever that delivery system or

entity is, the purveyor if you will. And you know, there are validated measures for both adults and pediatrics on care integration. They are not medically-specific, so it could include multiple providers. And perhaps looking at the integration sections of CAHPS to see whether they can be augmented would be helpful. And so I don't think that would be a very heavy lift, and would really move us in that space, and may even move us toward parsimony. So rather than asking me if I sent a document, ask the patient if the patient perceives the outcome of my sending that referral document. So there's an opportunity both for equity, really getting the patient voice and the caregiver voice in there as the experience, not just simply the satisfaction. And I think that would be an important next step. And then finally I want to raise the issue again in the LTSS space that I did yesterday. I feel pretty heavyhearted that we really couldn't get anything moved yesterday. And I think the votes were close enough, so I don't know, I don't know if it's procedurally possible, but it'd be great to find out what where the pain points for the folks that were one or maybe two votes shy of putting forward at least one of those LTSS measures? And can they be mitigated so we're not sitting on them, sitting on that gap in the Core Set for that population for another year. I think that we're close, and I'd love to challenge us to think about can we really move that thing forward, in addition to the urgency of course on the social determinants. But the LTSS piece, we're really close to being able to do something important, and I'd like to encourage us to seize that opportunity. Thank you.

Great. Thanks, Rich. Linette Scott? Go ahead.

Hello. So a couple of things just leaning back in what some of the folks have said, but also some of what we've talked over the last couple days. So one thing that I think would be really helpful for CMS to address as they think about their rule making is to be able to be clear about what will happen when we bring on new measures. So in the context of required reporting, I think one of the things that will help states feel comfortable from the feasibility and technical perspective is if it's clear that when a new measure comes on board, for example, that it will be, "voluntary" may not be the right word, but that there is a support aspect for the first two to three years as people get used to doing the measure and it gets sorted out, and all of that before it becomes part of the fully recorded and publicly-reported measure. So I just wanted to slide that in, and make sure that comes up because I think as we've been looking at measures over the next year, that's going to be the more important, and will probably flavor considerations around what measures to add at that point in time.

Another thing that, as we talk about outcomes and trying to get to results, so the ECDS measures certainly are going to be, I think, our opportunity to do that. And so having some thoughtfulness and maybe education or technical assistance related to ECDS measures, the pathway for NCQA in terms of plan accreditation. While not all states have managed care plans in their Medicaid programs, many do. So being able to have that context and tie those things together, and maybe look at timelines in that context to see if there's alignment. So kind of like flagging that as cross-cutting issue. And again, that then really leads to this idea of results. So you know, the comment that we do a lot of screening, but we don't look at the outcomes. So whether it's blood lead, or chlamydia or other kinds of things, it really would be great to get to the outcomes to know that if it is a positive, does the treatment occur? Because we really want to be able to do that. And then the other aspect, to piggyback on the LTSS comments, the long-term support services, I think that's an area that a lot of folks are thinking about and trying to do. And so maybe there's some opportunity related to technical assistance working with states around really what are some of the measures that have been proposed over the last few years? Could we have some focused work supported by CMS that takes a look at some of those measures, and working with states to really look at them. Because I

think if there were clear demonstration that those measures are being used, that would really help us to get over the edge, so to speak, in terms of being able to get those added to the Core Set. Thank you so much.

Yeah, thanks, Linette. Jill Morrow-Gorton? Go ahead.

Thinking about Rich's comments about LTSS measures, I was reminded that there has been some work by CMS and I believe included NCQA and Mathematica around potential measures for LTSS, so looking at it, kind of a set of measures. And I don't know whether that's something that will be coming in the future that might be helpful in terms of kind of some measures that have maybe some more experience. And maybe the part of the problem is the measures are, some of them are relatively new. But I don't know whether there's anybody that might be able to speak to that work that's been done.

Thanks, Jill. I'll try to find an answer to your question. In the meantime, I would like to also read a comment that we got from Tricia Brooks, who is a Workgroup member who was not able to be here today because of a conflict. So I'm going to read aloud Tricia's comment here for folks' consideration. She says: "I hope the Workgroup will consider signaling the urgency of advancing DOH, or Determinants of Health measures, to CMS. They've been talking about DOH as a gap for years, and yet like climate change, we don't seem to move forward with the urgency that is needed. Tuesday, two public commenters from CCSQ suggested asking CMS to put a placeholder for DOH measures. I'm not sure that's feasible, but hope we can push on advancing use of DOH measures in time for inclusion and mandatory reporting." So again, that was a comment from Tricia Brooks, a Workgroup member who's not able to be on the call today. Is there’s anyone from CMS on the line who would like to speak to Jill's question? If not, we can follow-up.

I can also share. I have a couple of documents that I've been looking at that sort of brought out the question. So I could share those if that would be helpful.

Sure. Thanks, Jill. Curtis Cunningham? Go ahead.

Yeah. I just wanted to follow-up and also say I think, this is my first time, but it sounds like LTSS measures have been on conversation for a long time. And I think there was, I forget who made the comment, that maybe that it would be a good to have some sort of group or conversation with the smaller groups to try to work through some of it, you know. Because it's just such an important area. And I feel like this is within the Medicaid space. And when we talk about social determinants of health, it's even more outside. If we can't figure out a way to get some robust measurement for LTSS, I think it's unfortunate due to just the significance and the magnitude of what Medicaid means for home and community-based services. And so I just thought I'd add that comment.

Thanks, Curtis. Gigi Raney is on the line from CMS.

Okay. I just wanted to give a little bit of an update on the home and community-based services measure set and the work that's being done in the LTSS space. Now I'm going to say this all with the caveat that this is work being done through our Disabled and Elderly Health Programs Group, DEHPG, so it is not work of the team led by the Division of Quality. So with all of these caveats, this is my understanding. And we do meet with them regularly to talk through this. That division has been working over the last several years on developing a slate of measures

for use in home and community-based services with the LTSS program. There have been lots of Workgroups, lots of stakeholder feedback and meetings, in fact, they had a couple of them in the past month, working with these groups to try and help make sure that not only are they including measures that are relevant and important to this population, but they're also making sure that, however they are implemented, that they will be feasible for the program to use and be able to use within the state programs as soon as possible. So there's been lots and lots of conversations about not only the feasibility of those measures, the importance of the measure, the experience of care being part of that, but also all of the other issues that are associated with individuals receiving these type of services. But also that there's alignment through these measures and through the Core Sets, which is one of the reasons why we had placed a pause on adding that LTSS measure that was recommended last year because we wanted to make sure that whatever we do in the Core Sets is something that also is being done with the HCBS measures space. So with that in mind, I know that they've been meeting with stakeholders and that they do have a list of measures and are working to put out guidance, official CMS guidance, in the coming months. And we're really looking forward to seeing that.

And so I think a lot of the work that both Jill and Russell were just referring to needs to be done has actually already been done, not necessarily through this particular Workgroup but through the Workgroups that they've convened for HCBS in particular. And we're looking forward in future years, once that measure list comes out, having our Workgroup members take a look at it, and see what's in there and make recommendations for how we can align with the work that they're doing better for measures that state programs are already using and testing within the states that they found to be not only effective and efficient, but reflecting the needs of the beneficiaries in that space. So we're really looking forward to it. I kind of see that we're going to have probably an explosion of LTSS measures in the next couple of years as that comes out and we're looking forward to seeing how that work comes to fruition.

Thanks, Gigi. We appreciate that update. Other comments on cross-cutting gaps from the Workgroup before we move to public comments? All right. Well, seeing no more hands raised, let's move to the next slide. So now we would like to provide an opportunity for public comment. If you would like to comment on gaps in the Child and Adult Core Sets, please use the raise hand feature in the bottom right of the participant panel to join the queue. And please remember to lower your hand when you're done. We'll let you know when you have been unmuted to speak. And again, this is public comments on gaps in any of the domains that were discussed today or cross-cutting gaps.

All right. I'm not seeing any new hands raised. Any public comments on gaps? All right. Let's move on to the next slide. Okay. Great. So now we have come to the reflections part of the meeting where we review the Workgroup recommendations and consider opportunities to support states in reporting the Core Set measures especially as they prepare for mandatory reporting in 2024, and provide feedback on this year's review process. So next slide. This slide provides a high-level agenda for this portion of the meeting. So to begin, I would like to recap the Workgroup's recommendations for updating the Core Sets. The Workgroup considered a total of 19 measures. Actually, I think that might be 20. Eight measures for removal and 12 measures for addition across several domains of the Core Sets. And to quickly summarize the votes, in the Behavioral Health Care domain, the Workgroup voted on four measures for removal. And none of these measures were recommended for removal from the 2023 Core Sets by the Workgroup.

In the Primary Care Access and Preventive Care domain, the Workgroup voted on seven measures. Three measures were ultimately recommended for addition: Adult Immunization Status, Depression Screening and Follow-Up for Adolescents and Adults, and Lead Screening in Children. And three measures recommended for removal: Flu Vaccinations in Adults Ages 18 to 64, and the Screening for Depression and Follow-up Plan for Ages 12 to 17, and Age 18 or Older. The Workgroup also voted on three measures in the Long-Term Services and Supports domain, and none met the thresholds for recommendation for addition. And finally, today the Workgroup discussed six measures in the Care of Acute and Chronic Conditions domain. One was suggested for removal and five were suggested for addition. Only the Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis measure was recommended by the Workgroup for addition to the 2023 Child Core Set.

All right. Let's see. So reflecting on the Workgroup discussion and recommendations over the past two-and-a-half days, there was considerable discussion around the three criteria discussed on the first day, which were 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 data and calculate the measures for Core Set reporting, and financial and operational viability for measures which relates to state reporting capacity and resources. So now we'd like to hear some constructive and creative suggestions for technical assistance that could help states prepare for mandatory reporting of the Child Core Set measures and the behavioral health measures in the Adult Core Set. We are curious and interested in folks' suggestions on how we can help build state capacity for calculating and reporting these measures as we move toward 2024. So at this point, I'd like to open it up for Workgroup discussion on opportunities to provide technical assistance to states as we move toward mandatory reporting. Again, please raise your hand if you'd like to make a comment. Kim Elliott, I think maybe your hand was up from before. Curtis Cunningham, go ahead.

I do think that the concept of mandatory reporting in 2024 is very concerning. I don't think when we look at many of the measures, we're not even close to having all states do that. And I do worry about the resources that states will have to employ to do system changes, and you know, collection, and you know, even changing managed care contracts, and other things. So I think there's a lot to be done that has not been mapped out to get to mandatory reporting. So that would be one thing. And I really want to make sure that what is the vision for the Core Set reporting, i.e., what will be done with the information or what will the states be required to do once this information is reported? Because this effort will take time and resources away from oversight of our programs, to run our programs, resources to upgrade systems. And there's a lot of other regulatory demands on states right now. So I just want to be mindful of that. So giving states the vision of where it's going to go and how these are going to be used to actually improve state Medicaid programs and the lives of people, I think will be very important. I think technical assistance, it would be good to really think through all those things you have to do, and assist states in what they will need to do to collect the measures. And so yeah, I just am very concerned about how that's going to look in such a short time period. That's not to say, you know, I want these measures to be reported. I think it's good to hold some accountability, but I also want to make sure it's fully thought out and there's time. I see other things like EVV, HCBS settings rule, ARPA, HCBS funding, all of these things have been rolled out, and it’s really a lot of pressure on the state. So if we want to do this well, we just need to be mindful of that. So thank you.

Thanks, Curtis. I do want to say that CMS is unable to comment on the proposed rule at this time, but they are on the line and listening. And encourage states to submit comments through the public comment process when the Notice of Proposed Rulemaking does come out.

Yeah, will do. Thanks.

Let's see. Are there other comments from Workgroup members on preparing for mandatory reporting? Russell Kohl, go ahead.

I would just comment that it's important to keep in mind the impact on patients of whatever actions may occur as a result of a state Medicaid program's failure to fulfill that reporting. You know, it's a difficult situation in that most any of the levers that CMS might have to attempt to improve compliance at a state level are by and large going to roll down to affect the patients themselves. And so it's a bit of a rabbit trail comment, but I think it is an important one to keep in mind that it does very much have to be a program that incentivizes states to do the right thing as opposed to focuses on a regulatory or a punitive sort of approach if they don't do the right thing because those punitive aspects are simply going to hurt patients as opposed to hurt state agencies. And so as you think about the technical assistance, I would almost encourage to step back from that and think of it as a driver diagram of what is it that the states need to in order to be able to be effective and compliant with this, and really approach it really from that perspective, almost a checklist of the items required for success, so that state Medicaid agencies have the ability to do an internal evaluation in advance that says, "Okay. Here are where our constraints are going to be." And then really to focus any technical assistance around those constraints as opposed to trying to create a one-size-fits-all approach to how you would move forward with a technical assistance or an implementation plan.

Thanks, Russell. Jill Morrow-Gorton? Go ahead.

Yeah, I was sort of thinking along the same line more in light of a gap analysis in terms of what are the strategies for each of the different measures for each of the states. There are some measures that come from T-MSIS data. I guess the question would be is it more efficient to have them all calculated at a central level, and then allowing states to work on the other measures? But I think, yeah, this is hard work. The IT piece of things is not straightforward always. And I think that it will be important to find ways to incentivize states without punishing the Medicaid recipients.

Thanks, Jill. Other comments? Tracy Johnson, go ahead.

Yes. Hi. Thank you. This was discussed a little bit when we talked about electronic measures, but I think specifically for that set of measures or the measures that allow that kind of data having an ability for states to invest in HIEs and complementary systems, I think will really make that successful. Somebody said yesterday, I wish I could remember whom, but you know, pulling together the strategies across multiple federal agencies to sort of map out where we're headed would be really helpful, and kind of doing that from a policy lens, but also an implementation lens, and those might be two different documents, would be really helpful.

Thanks. Rich Antonelli, go ahead.

Yes. Thank you. I've got two questions, and if they need to be deferred because it will be involved with rulemaking, I would understand. But the first is for those states that have 1115

waivers in hand that have different measures than what are in the Core Set, will those measures be additive to the mandatory reporting for the Core Set, or will CMS defer one to another? So I'm thinking about burden for example, especially at the level of organizations that have to do hybrid measures. So that's my first question. In fact, maybe let me just parse it. I'll stop there and see if I'm able to get a response to that.

I see Gigi has her hand raised. Go ahead, Gigi.

Yeah, Rich, this is Gigi Raney at CMS. The 1115 process and the quality measure reporting, and quality programs associated with that are separate from those of the Medicaid and CHIP Child and Adult, Health Home Core Set programs. So our mandatory reporting requirements are laid out in statutes, 1139A and B in the Social Security Act. And theirs are done through those 1115 administration programs and their associated stuff. So they are separate programs with separate reporting requirements. That being said, we do work really hard to work really closely with the 1115 program to make sure as much as possible that the measures that are included in the 1115 demonstrations align with the measures that are used for the Child and Adult and Health Home Core Sets. So when we're looking at the measures that are included in those, in the two different programs, there is significant overlap in those measures to help to reduce that burden for states for their reporting with the hopes that they won't have to do all of the programming, and all the data collection, and all of that in multiple different ways.

And that's very, very helpful and also very reassuring. And not surprisingly, different states are currently and likely will continue to progress differently around that whole person integrated approach. And so I think Gigi, to the extent that there is an active process, an intentionality to either harmonize those requirements or at least to be able to rationalize why they need to be co-reported will be very helpful. Because we don't want to squelch innovation at the level of the state. So I appreciate that. And then the follow-up question is related but not exactly the same. Mandatory reporting versus public reporting. Are they one and the same? I asked this question a year ago, and the answer I got was: "We're not quite sure yet." So are you at liberty, somebody to tell me whether they are the same? And if it is public reporting, is there going to be messaging that is specifically contextualized for the patients and patient advocacy groups in particular?

So I can take this one as well. The statute says that states are required, it's mandatory reporting for the Child Core Set and the behavioral health measures on the Adult Core Set by states to CMS starting with 2024 reporting. We are also required by statute to publicly report data on the Core Set measures annually by September 30th of each year. But however, we have established, not through necessarily statute, but through precedence in the years in the past, and we talked earlier about the 25-state threshold. So while mandatory reporting will apply to the measures that I just indicated for states starting with 2024 reporting, we do still plan to keep our threshold of 25 states for public reporting of data at this point in time. So I think that's about as far as I can go right now without saying anything that might be in the rule that I shouldn't be talking about. Yeah.

Okay. And I appreciate that candor, and very much appreciate the thoughtfulness going into it. Thank you, Gigi.

Thank you.

Thanks, Rich. Jim Crall.

Yes, thank you. I was just thinking that all of this is really about improvement. And I think we all generally agree that measurement is an essential component or an antecedent to improvement. So, and I just wanted to mention an activity that I was aware of during some time that I spent back in the precursor of AHRQ, where they took advantage, I think, of the attitude that states generally like learning from each other. And you know, to foster maybe a more collaborative approach, and shorten the learning curve or not make it so steep for some of the states that are struggling with many of the measures, given the current level of reporting. I just wonder whether CMS has some type of activity in place whereby states could voluntarily opt to focus, and to come together, and work with and learn from other states who have managed to actually do this. You know, recognizing full well that, you know, Medicaid programs vary across the states and the infrastructure varies across the states. But I mean even thinking about ways to identify resources or methods that states who are able to report are reporting. Again, just to try to make that a more collaborative improvement experience as it relates to measurement.

Thanks, Jim. Other comments or suggestions from the Workgroup? All right. Well, moving on to the next bullet point on the slide here, in spirit of continuous quality improvement. We'd also like to give Workgroup members the chance to suggest ways that we can improve this review process for next year. So any thoughts, questions, or suggestions about the process and everything from the call for measures, the materials that our team prepares, these meetings, et cetera? It's all fair game. Kim Elliott? Go ahead.

I actually want to give a compliment to Mathematica. The materials that were provided for this year's review were much more streamlined than prior years. And it made it a very efficient process to review each of the measures and make recommendations. So thank you for that. I think you did a great job.

Thanks, Kim. Jim Crall?

Yes, thank you. I certainly echo that. I think that the Mathematica group does a great job of compiling and actually working with members who are proposing additions or measures for removal from the Core Set. I want to go back to the suggestion I made when I was talking about the adult dental measures, and I think Rich Antonelli also sort of suggested a similar thing, which is finding a way for us to either gather feedback on reasons why members did not support a proposal to add or remove. If we do that after the voting, that takes advantage of all the discussion that everybody's heard. But I wonder if there isn't even a way prior to convening us for the meeting, if individual members have some issues or concerns about a particular measure, they could go ahead and express those in some kind of a collective fashion that maybe Mathematica could identify. And you know, even anonymously. But just to sort of get out there what some of the concerns are so that we can, particularly in the cases where these votes are quite close, and in areas where we've identified that we know we've got a gap and we need to get started with more measures. If we could somehow, in the process, build that in either after the fact or maybe even prior to the convening of the actual voting meeting.

Thanks, Jim. We appreciate the suggestion, and can consider ways of accomplishing that in a way that maintains the integrity of the public meeting process. We appreciate the suggestion. Others? I see Ann Zerr has her hand up? Ann, did you want to make a comment on this topic? Maybe that hand was from before.

It is. Sorry, I'm having trouble unmuting and putting my hand down. But no, I again would just echo what a great job Mathematica has done and the Workgroup members who clearly came prepared. And we had great discussion.

Great. Thank you. Jill? Go ahead.

So every year this comes as like, oh my gosh, I have to look at measures. I'm wondering if there is some way to think about, one, I think it's very helpful for the Workgroup to make recommendations, but by using just the Workgroup, are we missing measures that might be really good measures, but that we just either didn't think of, haven't come across, having experience with? So just wondering if there's a role for some other way to get suggestions for measures. And then there are always sort of these concepts of measures that come up but, and maybe this happens, and I just don't see it. It feels like the concept comes up, and then it's unclear that it goes anywhere. And I think there are some things that we bring up maybe year-after-year even, and just wondering if there's a way to kind of take those concepts and see if some of them might not be able to be sort of researched and evaluated, and to figure out if there's some way to do that? Because I think we identify gaps, but if that gap or that concept of a gap doesn't go anywhere, then it's, you know, we sort of still have that gap. So just wondering if there's some way to kind of broaden some of these processes. And I would like to say Mathematica, you do a wonderful job with all the materials. They're always very helpful.

Thank you. David Kelley, go ahead.

Thanks. I'll build on what Jill's concept, I think, she was proposing. And maybe once we've made our recommendations, I'll just say whenever there's an offseason, if there really is an offseason in this process, maybe there's a subgroup, to Jill's point, that looks at the gaps that have been identified, and works with Mathematica to talk to others, to measure stewards. And there are a whole host of measures stewards, but talking to folks at let's say NQF, and NCQA, I think they both have Medicaid advisory groups. It would be just really nice to say, okay, I mean NQF has a huge, huge portfolio. And do they have portfolios that would actually meet some of these gaps? And maybe going to NQF, NCQA, other actual measure developers and stewards who may have some things in the queue, but they haven't been able to work with a Medicaid state to actually operationalize a particular measure. I think that would be very helpful, and it would hopefully move things along so that we don't talk about the same gaps over and over again. That we really are aligning these identified gaps with our measure steward colleagues so that they're measuring the things that we think are really important to the Medicaid program. And also I think, and I think Mathematica does this quite a bit, is circle back with the Medical Directors Network, Medicaid Medical Directors Network that represents, I don't know, 46 states. I think having that feedback loop as well is vitally important. But you know, in the quote/unquote "offseason", look at some of these gaps. Look at some of the portfolios that are out there. And if they are not being piloted by a state, start to have that discussion with one or two state Medicaid programs to see if they might be willing to operationalize looking at some of these gaps. There are other organizations that Medicaid state agencies and their academic partners actually do a lot of claims-based quality analyses. And I think being able to connect that dot. If again there are gaps, maybe we should be talking to these measure developers to make sure that we work to get the right measures developed, and then to actually test them. So I think somebody mentioned either today or yesterday about kind of an incubator accelerator. So I'd like to really kind of throw that concept out there in the offseason. And you know, I have quotes around off-season because I'm not so sure

Mathematica feels that there ever really is an off-season. But those are just some of my thoughts.

Thanks, David. Are there process improvement comments from the Workgroup? All right. Well, on behalf of our team at Mathematica, I will just say thank you for your feedback and your suggestions for improvement. We really do take it seriously and try to find a way to honor the spirit of your suggestions as we prepare for each new year and the year's review. So let's go to the next slide, please. Now we'd like to provide one last opportunity for public comment. If there's anyone on the line who would like to make a public comment that hasn't had a chance to be shared before, please use this opportunity to use the raise your hand feature in the bottom right of the participant panel and join the queue. And we will call on you and let you know that you've been unmuted. Last call for public comment? All right. Well seeing none, we thank the members of the public who have attended this meeting over the last three days for sharing your thoughts and suggestions for the Workgroup and this discussion.

Next slide, please. Now as we begin to wrap up, I'd like to thank our Workgroup members, especially our co-chairs, for your flexibility and your patience, and conducting this meeting virtually especially as our team has had some other things going on behind-the-scenes. I would like to give Kim and David a chance to make any final remarks. So Kim went first this morning, so maybe David, do you want to go first today or this afternoon?

Oh, sure. Thank you. And I'll be very brief. I just want to thank Mathematica and CMCS, all of our federal partners in the Workgroup, and measure stewards, and the public that stepped up during this process to really work on honing in on the most important quality metrics for the Adult and Pediatric Core Sets. While things are not in the perfect state of condition, I think that our recommendations are good sound recommendations. I think we're trying to move forward in, into more of the electronic age. I think we're trying to really harmonize measures more so. And I think that most of the measures that were added, there weren't very many, but they were pretty much administrative measures, so hopefully they're not going to be an increased burden on states as they head into 2023 and then into 2024. So really appreciate all of the collaborative efforts, the respectful conversation even when perhaps there were differences of opinion. It's just nice to know that we can come together and professionally have a really great, robust discussion. So thanks so much, and I appreciate everyone's time. And thanks for the opportunity to co-chair this group. It's been a privilege. Thanks.

Thank you, David. Kim, go ahead.

Thank you. And also I thank you for the opportunity to co-chair this group as well. It's a great pleasure. I also want to thank everyone for the continued work that we're doing in this committee and Workgroup that really does benefit the Medicaid program, at least I believe it does, and more importantly the people that are served by the Medicaid program. I'm just continually impressed with the knowledge base, and not only the conditions themselves that we're talking about, but also in measurement and how to drive improvement. And the real passion that everyone brings from their own perspective to this process. It's just an incredible experience and incredible work that gets done. I really do appreciate too that everyone was so actively engaged and provided informed feedback during each of the sessions that we had. And the wide range of participants that we do include on this Workgroup really does bring perspective, but sometimes reinforced and sometimes change their minds on how we thought we were going to vote on different measures that are being discussed or considered. So I also think that this meeting, in particular, was somewhat unique in that it has that addition of the

social determinants of health, health disparities, health equity. But we've always talked about that and consider that, but we really had a lot of emphasis on that throughout each of the sessions during the meeting, which I think is really going to continue and hopefully change the trajectory of what we do with core measure sets going forward. But also the discussion on the digital measures and how that's really going to advance measure reporting, and completeness of data and information so that we're able to do an even better job on reporting core measures and really improving the quality and outcomes for the people that are served. So with that, I think I will end it. And again, thank you so much for the opportunity to work on the committee. It's just really good work.

Thank you both, David and Kim. We're so grateful for your support on this journey. Next slide. All right. So by now this slide should look familiar, although the red box keeps moving further down. It lists out the key milestones for the 2023 Core Set Review Process. Our journey began back on December 15th and continued with the March 24th webinar to get organized for this week's meeting. We're grateful for all of the time you've taken to prepare for this meeting, and that you have spent the better part of three days with us on WebEx. I know that's a lot to ask. Our next step here at Mathematica is to review and synthesize the discussion that occurred over the last three days and prepare a draft report. The draft report will be made available for public comment in July. And in addition, Workgroup members will have an opportunity to review and comment on the report. Our team will then review all of the public comments that we receive and finalize the report, which will be released in August. And from there, CMS will review the final report and obtain additional stakeholder input from other federal agencies and from State Medicaid and CHIP quality leaders. And CMS will release the updates for the 2023 Core Sets by December 31st.

Next slide. If you have any questions about the Child and Adult Core Set Annual Review Process, please e-mail the Mathematica Core Set Review Team at MACCoreSetReview@mathematica-mpr.com. The e-mail address is here on the slide.

Next slide. And finally one last thank you the Workgroup members, federal liaisons, measure stewards, and public attendees for all of your contributions this week. We want to express our appreciation to staff in the Division of Quality and Health Outcomes at CMCS for your support as well. And a special shout out to the Mathematica Core Set team. This meeting would not have been possible without everyone's help. We wish everyone well. Stay healthy and stay safe, and we really hope to see you all next year in person. And that concludes the 2023 Child and Adult Core Set Annual Review Workgroup meeting. This meeting is now adjourned. Thanks everyone.