2025 Child and Adult Core Set Annual Review:
Meeting to Review Measures for the 2025 Core Sets, Day 1 Transcript
April 25, 2023, 11:00 AM – 4:00 PM EST

Talia Parker:

Good morning, everyone. My name is Talia Parker, and I'm pleased to welcome you to the 2025 Child and Adult Core Sets Annual Review Meeting to Review Measures for the 2025 Core Sets, Day 1. Before we get started today, we wanted to cover a few technical instructions. If you have any technical issues during today's meeting, please send a message to all panelists through the Q&A function located on the bottom right corner of your screen. If you are having issues speaking during our Workgroup or public comments, please make sure you are also not muted on your headset or phone. Connecting to audio using computer audio or the call me feature in WebEx are the most reliable options. Please note that call-in-only users cannot make comments. If you wish to make comments, please make sure that your audio is associated with your name in the platform. All attendees have entered the meeting muted. There will be opportunities during the meeting for Workgroup members and the public to make comments. To make a comment, please use the raise hand feature in the lower right corner of the participant panel. A hand icon will appear next to your name in the attendee list. You will be unmuted in the order in which your hand was raised. Please wait for your cue to speak, and remember to lower your hand when you have finished speaking by following the same process you used to raise your hand. Note that the chat is disabled for this meeting. Please use the Q&A feature if you need support. And finally, closed captioning is available in the WebEx platform. To enable closed captioning, click on the CC icon in the lower left corner of your screen. You can also click Ctrl-Shift-A on your keyboard to enable closed captioning. And with that, I will hand it over to Margo to get us started.

Margo Rosenbach:

Thank you, Talia. Next slide, please. Hi, everyone. My name is Margo Rosenbach, and I'm a Vice President at Mathematica. I direct Mathematica's Quality Measurement and Improvement Technical Assistance Contract with the Center for Medicaid and CHIP Services. It's my pleasure to welcome you to the 2025 review of the Child and Adult Core Sets. Thank you to our Workgroup members, our federal colleagues, and members of the public for joining us for this virtual meeting. Next slide.

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

We have a full agenda and important objectives to accomplish over the next three days. Here are our four meeting objectives listed on this slide. First, the Workgroup will discuss the five measures that were suggested for removal and the four measures suggested for addition to the Child and Adult Core Sets. And second, the Workgroup will vote on the measures suggested for removal or addition and make recommendations for updates to the 2025 Core Sets. Third, the Workgroup will discuss gap areas in the Core Sets and areas for future measure development. This discussion will take place on the third day of the meeting. We will ask the Workgroup to reflect on gaps raised over the past four years, as well as gaps that remain this year, and to comment on priorities for the future. And finally, we'll provide multiple opportunities for public comment over the next three days to inform the Workgroup discussion.

I'd like to pause for a moment and note that we are committed to a robust, rigorous, and transparent meeting process despite the virtual format. That said, we acknowledge that attendees may experience challenges with a virtual meeting format. I hope everyone will be patient as we all do our best to adhere to the agenda and fulfill the objectives of this meeting. Some of you may be wondering why we are not using video for this meeting. As we have mentioned the past few years, we found that some individuals in some locations do not have sufficient internet or Wi-Fi bandwidth to support video. To ensure full participation by all Workgroup members and the public, we want to mitigate the technical difficulties that sometimes arise with using video. I also want to remind the Workgroup members of a few ground rules for participation today. First, we acknowledge that everyone brings a point of view based on your individual or organizational perspectives. As a Workgroup, however, you're charged with recommending Core Set updates as stewards of the Medicaid and CHIP program as a whole and not from your own individual or organizational perspectives. Please keep this in mind during the discussion and voting. Second, we know that spending five hours a day in a virtual meeting can be challenging for all of us. We ask that you be punctual in returning from breaks so that we can have everyone present for the discussion and voting on the portfolio of measures. And related to that, we want to make sure that all Workgroup members who wish to speak may do so. This platform will enable you to unmute yourself when you want to make a comment or ask a question. If you find that you're unable to jump into the conversation, please raise your hand or contact us through the Q&A feature, and we will make sure you have a chance to speak before we move on. Finally, we want to remind public attendees that we will have designated opportunities for public comment, and we ask that you save your comments until we reach the public comment period. Now, I'd like to turn to our co-chairs, Kim Elliott and Rachel LaCroix, to offer their welcome remarks.

Kim?

Derek, can you please unmute Kim?

Kim, you should be unmuted.

Kim Elliott:

Can you hear me?

Margo Rosenbach:

Yes.

Kim Elliott:

Wonderful. As Margo said, I'm Kim Elliott, and I'm very, very excited to be with all of you today and want to thank all of you in advance for dedicating time, effort, and energy to this very important work we're going to do this week. It is always such a pleasure to participate in these discussions with subject matter experts and individuals that are absolutely passionate about improving and measuring the progress and quality of care and outcomes for members served by Medicaid. It continues to be my why and why I participate in these particular meetings. We've achieved so many milestones the last few years, such as ensuring measures have been tested and used in Medicaid programs, establishing minimum measure qualification criteria for

a measure even to be considered for the core measure sets, expansion of resources available to Workgroup members to make our jobs a little bit more fruitful and enjoyable and easier to do, and of course, all of the different technical assistance processes that are made available that have all led up to the big 2024 mandatory reporting. But however, today feels different than previous meetings. We have rounded that corner with all of our work towards measures and measure sets for the 2024 mandatory reporting, and I'm proud of that work that this Workgroup has done and achieved towards that end. This Workgroup has been diligent in its efforts to ensure that both the adult and child core measure sets reflect the population served by Medicaid and represent the whole person in areas that will continue to measure quality, access, and timeliness of care and services. This week's work will continue to build upon that work, and during our work this week, we'll be taking quality measurement to the next level, such as active and open discussions on stratifications by race and/or ethnicity to advance health equity. We will continue to assess the need for members' voice in the measure sets. We will continue to discuss measures to determine if they continue to add value towards measuring the quality of care and services delivered through the Medicaid program, and we will also discuss potential new measures to recommend for addition to determine if they may fill a gap in the Core Sets. We do have our work cut out for us. I believe we're up to this challenge, and again, I want to thank you for your attention and active participation in these meetings the next three days. I'm looking forward to hearing the passion from each of you as we continue to conduct this work this week. I'll now turn it over to Rachel LaCroix for some opening remarks.

Rachel LaCroix:

Good morning. This is Rachel. Can you hear me?

Margo Rosenbach:

Yes, we can.

Rachel LaCroix:

Okay, great. Thank you. Good morning, everyone, and I echo Margo's and Kim's welcome to our three days of the Core Set Annual Review Workgroup meetings. As they mentioned, we really appreciate everyone's time and the preparation that everyone has put into being ready for these discussions we're going to have about potential changes to the core measure sets. As Kim mentioned, there has been a lot of work over the years, but it definitely does feel a little different this year since we are anticipating the final rule related to mandatory reporting coming out soon, and knowing that these recommendations that we make related to the Core Sets will be coming within the context of mandatory reporting moving forward. I'd just like to also thank everyone in the Workgroup for their very thoughtful consideration of which measures to potentially remove from the Core Sets and which ones to add or make changes to and replace. And so I'm really looking forward to the conversation with all of you about these measures, how you may have used them, potential difficulties with some of the measures, but really just having a good conversation to see where we can move forward to include measures and to use those measures that can help us improve healthcare for our Medicaid and CHIP members. And with that, I will turn it back over to you, Margo.

Margo Rosenbach:

Well, thank you so much, Kim and Rachel, for your remarks. Next slide, please.

So now we'll introduce the Workgroup members and any disclosure of interests. Next slide.

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

When we go through the roll call, we ask that Workgroup members raise their hand when their name is called. We'll unmute you, and you can say hello, share any disclosures you may have, or indicate that you have nothing to disclose. We also have an icebreaker to start off the meeting. We'd like to briefly mention one thing you're looking forward to during this week's Core Set Annual Review meeting. When you're done, please mute yourself in the platform and lower your hand. This will allow you to unmute yourself when you would like to speak during the measure discussions. If you leave and reenter the platform or find you've been muted by the host due to background noise, just raise your hand, and we'll unmute you again. Next slide.

On the next three slides, we've listed the Workgroup members in alphabetical order by their last name. When I call your name, please raise your hand so we can unmute you. If you've also muted yourself on your headset or phone, please remember to unmute your own line to avoid the dreaded double mute. If you have any technical issues, please use the Q&A function for assistance. So, Kim, starting with you, please indicate whether you have a disclosure and mention one thing you're looking forward to during this year's meeting.

Kim Elliott:

All right. I have nothing to disclose. And what I'm really looking forward to is our discussions on the stratification of measures and how we're going to start advancing that.

Margo Rosenbach:

Thanks, Kim. And a reminder, you can repeat something that's already been said.

Rachel.

Rachel La Croix:

Yes. I have nothing to disclose, and I, too, am looking forward to the conversation about stratification of measures and particularly some of the different areas in which we can stratify measures to look at a number of different populations. I'm also looking forward to our discussion and circling back a little later to the ECDS measures that have been discussed in prior years as potentials for including in the Core Sets, as well as discussing the measure gaps.

Margo Rosenbach:

Thanks, Rachel. Ben Anderson, you are unmuted.

Ben Anderson:

Hi. Good morning. Ben Anderson. Nothing to disclose. And I'm looking forward to, you know, thinking about, talking about how we can use the Core Sets to advance equity within Medicaid, as well as the measures in particular that address maternal and child health.

Margo Rosenbach:

Thanks, Ben. Rich Antonelli, you're unmuted.

Rich Antonelli:

Yes. Good morning, everybody. I have no disclosures. I'm looking forward to two things. The first is the arrival of hummingbirds here in the Massachusetts coast after they're wintering over. And the second one is actually looking at the actionability of the implications for stratification of those measures so that we can close those gaps in equity going forward. Thank you.

Margo Rosenbach:

Thanks, Rich. Stacey Bartell.

Stacey Bartell:

Hi. I'm a practicing physician. I'm new to the group this year. I just joined the Academy of Family Medicine last year. So I'm excited to be here to help promote our priorities, which are access, equity, and health outcomes, with particular interest in maternal and infant health. No disclosures.

Margo Rosenbach:

Thanks, Stacey. Tricia Brooks.

Tricia Brooks:

Good morning, everyone. It's a pleasure to be here again. I would certainly ditto disaggregation and stratification. But I'm also looking forward to talking about the gaps in measures and particularly social determinants of health.

Margo Rosenbach:

Thanks, Tricia. Emily Brown. Derek, can you unmute Emily?

Derek Mitchell:

Hey, Margo. Not seeing Emily in our attendance list.

Margo Rosenbach:

All right. She has her hand raised.

Derek Mitchell:

Oh, my apologies.

Margo Rosenbach:

No problem.

Derek Mitchell:

Emily, your line is unmuted.

Emily Brown:

Hello, I'm Emily Brown. This is my first time on the Workgroup, so I'm excited to be here. I have no disclosures and no conflicts of interest. And I am looking forward to the discussion on the stratification of data as well as discussing the gaps. So thank you.

Margo Rosenbach:

Thanks, Emily. Joy Burkhard.

Joy Burkhard:

Good morning, everyone. I'm also new to the group this year and really looking forward to getting to know all of you and your perspectives and also truly believe that measures are a critical lever in which we can scale change in this complex U.S. health care system. And in terms of disclosures, I do want to share that in addition to being employed by the Policy Center for Maternal Mental Health, we are an organization that's been supportive of measure development around maternal mental health and did submit a comment letter in support of the maternal depression measures last year. Glad to be here.

Margo Rosenbach:

Thanks, Joy. Karly Campbell.

Karly Campbell:

Hi, everyone. I'm Karly Campbell. I am the Chief Quality Officer at TennCare, which is Tennessee's Medicaid agency. And this is my second year being part of this Workgroup. Our agency, like many Medicaid agencies across the country, use the core measures for a lot of our policymaking and strategizing. So I appreciate the opportunity to be part of this. As far as disclosures, I serve on the Public Sector Advisory Council for NCQA. I don't know if that really

counts as a disclosure, but that's the only thing I can think of. And I'm looking forward to really diving in more to stratification and how that might impact states. Thank you.

Margo Rosenbach:

Thanks, Karly. Stacey Carpenter.

Stacey Carpenter:

Good morning, everyone. I am the Fidelity Manager for the Healthy Steps program of Zero to Three. And I am also new to this process, so I'm really interested to see how this looks and how I can make an impact, especially with maternal and infant mental health. Thank you.

Margo Rosenbach:

And, Stacey, any disclosures? Stacey, can you unmute yourself? Do you have any disclosures?

Stacey Carpenter:

No disclosures, sorry.

Margo Rosenbach:

Great. Thank you so much. All right. Lindsay Cogan.

Lindsay Cogan:

Good morning. This is Lindsay Cogan. I'm with the New York State Department of Health. I have no disclosures or conflicts of interest. I am interested this year to delve in a little bit on, since we are moving to choosing measures for 2025, I'm interested to hear about sort of how we can balance the need to ensure that we're accelerating our measurement in this space, even in areas where there could be challenges, right? So, particularly around the social determinants of health, I don't know that that is something that we have all been able to get a great handle on how to measure, but, yeah, incredibly important. So that's kind of an interesting wrinkle to the meeting that I would like to hear more about CMS's perspective on.

Margo Rosenbach:

Thanks, Lindsay. Jim Crall?

Jim Crall:

Yes. Good morning, everyone. I disclose that I do some consulting for Georgetown University, a Consortium for Oral Health Systems Integration and Improvement, which is funded by HRSA. I do some consulting for Centene Corporation, an Envolve dental benefits program. I've received some non-monetary travel support from the Dental Quality Alliance to attend meetings, and my wife owns some stock inherited from her mother in Elevance. My wishes or goals for the meeting is that we continue to support the evolution of the Child and Adult Core

Sets and remain focused on how these measures can complement other Medicaid and CHIP program measures and serve as the basis for ongoing improvements that help Medicaid beneficiaries.

Margo Rosenbach:

Thanks, Jim. Next slide, please.

Curtis Cunningham? Curtis, are you able -- there you go. Okay. You are unmuted.

Curtis Cunningham:

I have no disclosures. I guess the thing I'm kind of interested in is this gap I'm seeing between measurement people and the operationalization -- if that's a word -- of actually collecting the data and doing the measurements by the states. It will be interesting when the rule comes out to do that, especially when we're talking about the diverse populations of Medicaid, whether long-term care for moms, babies, behavioral health, and the intersectionality of conditions that individuals may experience. I think measurement and managed care is easy. Measurement in HCBS and fee-for-service programs are going to be a big difficulty. So how do we bridge the gap between what we want to measure and race, language, ethnicity, social determinants of health to what the state's capacity is to do those measurements? I think that's going to be a good conversation. And just overall, very interested in measurement of long-term care since it is a significant portion of cost for the Medicaid program, even though it's a relatively small population. Thank you.

Margo Rosenbach:

Thanks, Curtis. Erica David-Park?

Erica David-Park:

Good morning. I'm new to the group. No disclosures, but just to note that I'm no longer with CareBridge, but I'm currently with AmeriHealth Caritas. In terms of what I'm looking forward to, definitely looking forward to some good discussion with colleagues from different states around the country, and also looking at methods to identify and rectify gaps in care. Thank you.

Margo Rosenbach:

Thank you. Amanda Dumas?

Amanda Dumas:

Good morning. I'm Amanda Dumas. I'm a pediatrician by training and still practice. I'm also the Associate Medical Director for Louisiana Medicaid, and I have no disclosures. This is my third year with this group, and I'm interested in just hearing how the conversation is evolving around digital measures, and in particular, you know, sort of the feasibility of collecting certain clinical data as we're moving forward and the barriers around that. And as always, just really love hearing all the various perspectives brought by this group and all the different expertise that are in the conversation. Thank you.

Margo Rosenbach:

Thanks, Amanda. Anne Edwards?

Anne Edwards:

Good morning, everyone. I'm Anne Edwards. I have no disclosures. You know, I'm really looking forward to the discussion on how we can use these measures to drive quality improvement, especially as it relates to issues of equity, and I think that that also ties to the discussion that we'll have around gaps. Good to be here again. Thanks.

Margo Rosenbach:

Thank you. Clara Filice ?

Clara Filice:

This is my first year with the group, so nice to see you all, or meet you all, I suppose. I'm the Deputy Chief Medical Officer at MassHealth Massachusetts Medicaid and a pediatrician. I have no disclosures. I'm very interested in the discussion, in particular around measure stratification as we are in the midst of implementing new health equity incentive programming in Massachusetts for our accountable care organizations and hospitals, which will include, among other things, stratification of our quality measures. So, interested in that discussion over the next couple days. Thank you.

Margo Rosenbach:

Thank you, Clara. Sara Hackbart? Sara, are you able to speak?

Sara Hackbart:

Yes. Hi. This is Sara Hackbart. I'm with Elevance Health. I do not have any disclosures. I think what I'm looking forward to the most is just speaking around gaps and gap areas when it comes to long-term services and supports, but also looking at health equity and stratification within that population, and specifically at disabilities. Thank you.

Margo Rosenbach:

Thank you. Sarah Johnson?

Sarah Johnson:

Good morning, everyone. My name is Sarah Johnson, and this is my first year with the group. I'm the Associate Vice President and Medical Director in Managed Care at IPRO. No disclosures. I'm most looking forward to discussing gaps in the measure sets and priorities for measure development and testing moving forward.

Margo Rosenbach:

Thanks, Sarah. David Kelley?

David Kelley:

Hi. Good morning. I'm Dave Kelley. I'm the Chief Medical Officer for the Office of Medical Assistance Programs and the Office of Long-Term Living at Pennsylvania Medicaid. I'm a general internist and have been part of looking at the adult and pediatric Core Sets since the inception of both of those sets. It's great to be a part of the committee, and I'm looking forward to hopefully closing some gaps and having good discussions around harmonization so we're not duplicating, making our MCOs duplicate nuances within measures. As far as disclosures, in the past I've been part of the CSAC at NQF. I currently am on NCQA's Committee for Performance Measurement and have worked with Yale University to look at some of the LTSS measures and then have also presented at CMS conferences around LTSS measures. So, thanks so much. I really look forward to the ongoing discussions over the next couple of days. Thanks.

Margo Rosenbach:

Thanks, Dave. David Kroll?

David Kroll:

Hi, everyone. I'm David Kroll. I'm a psychiatrist based in Boston where I'm the Director of Ambulatory Strategy for Mass General Brigham Health Care, and also I'm involved with the American Psychiatric Association. I don't have any updated disclosures to include. I'm married to a consultant who has worked with a lot of private companies, but none of them have any connection to the Core Set that I'm aware of. I think what I'm most looking forward to, which is really every year, is just hearing from all the rest of the committee and the stakeholders. I feel like I learn a lot, and I actually really look forward to changing my mind about things. So, I look forward to the discussion. Thanks.

Margo Rosenbach:

Thanks, David. Jakenna Lebsock? David? Derek, can you unmute Jakenna? There.

Jakenna Lebsock:

I'm an Assistant Director at AHCCCS, our Arizona State Medicaid Program. I don't have any disclosures to share. What I'm most looking forward to is, one, hearing from all the varying perspectives of the different stakeholders that have been brought to the table to talk about these measures and how they're feasible and what it looks like from their perspectives, but then really also looking forward to diving into some of the challenges that are faced by the states when it comes to some of the nuances of these measures and the impacts that it can have in trying to obtain a reflective data set to be responsive to the needs and to the measures, but also the challenges that go along with that.

Margo Rosenbach:

Thanks, Jakenna. Next slide, please.

All right. Lisa Patton? Okay, Lisa, you should be unmuted.

Lisa Patton:

Hi. Hi, everyone. I'm happy to be here today. I'm Lisa Patton. I'm a clinical psychologist and no disclosures to report. I am really very much looking forward to the richness of discussion of this group. I think, as David said, I look forward to learning with you all every year. And I'm particularly interested in all things health disparities and how we do some more work around that and then also how we begin to move toward better examination of SDOH with all that we're doing. Thank you.

Margo Rosenbach:

Thanks, Lisa. Laura Pennington?

Laura Pennington:

Good morning, everyone. I'm a first-time member and I'm from the Washington State Health Care Authority, which is the Medicaid agency in Washington. I have nothing to disclose, however, I'm also a past member of the NQF CSAC. I am very excited to be part of the process to select measures that support our quality efforts, are meaningful, and have the potential to positively impact the lives of individuals in Washington State. In addition to that, I would say I'm also looking forward to discussing how we can use stratification to identify disparities and gaps in our population. And I'm also looking forward to hearing the perspectives of others on the Workgroup. Thank you.

Margo Rosenbach:

Thanks, Laura.

Grant Rich? Is Grant Rich here? I'm not seeing Grant. We can always come back later if we see him on the attendee list. Okay, Lisa Satterfield?

Lisa Satterfield:

Hi, everyone. I'm Lisa Satterfield from the American College of Obstetricians and Gynecologists. And I am looking forward to discussions on measure gaps, not only and obviously related to maternal health, but also with contraception access.

Margo Rosenbach:

Thanks, Lisa. Linette Scott?

Linette Scott:

Can you hear me now?

Margo Rosenbach:

We can.

Linette Scott:

Okay. Thank you. Good morning. Linette Scott with the California Department of Health Care Services, which is our Medicaid program. I've been with the core group for a number of years. We always really enjoy the conversation and discussion that we have as we think through the different measures and how we approach them. No significant conflicts of interest. I think I put down that this is part of my day job to understand the Core Set measures, working on those with my team here in California, and we present sometimes at different conferences. In terms of the conversation this year, I'm really excited to continue to talk about where there's gaps, where there's opportunities, how we think about different kinds of stratifications, and how that aligns with the other work going on across the Medicaid agency and the various transitions as we think about health-related social needs and how those impact the services we deliver. Thank you.

Margo Rosenbach:

Thanks, Lynette. Kai Tao?

Kai Tao:

Hi. Good morning. I'm Kai. I am a practicing certified nurse midwife with a large FQHC and an academic hospital here in Chicago, and also am a co-founder of Illinois Contraceptive Access Now. I'm excited to be here, very first meeting. A former midwife had to roll off because she had a conflict. I do not have any conflicts of interest. I'm here to really think about how we can advance, of course, reproductive equity, but also, I think it's really interesting to think about all these other important arenas of health that everyone has their specialty in. I often like to think about how do we, you know, steal shamelessly if something works in another field. And then, like many, I want to be sure to think about how is this actually happening at the health center, at the point of care, and truly changing the outcomes. Thank you.

Margo Rosenbach:

Thank you. Mitzi Wasik?

Mitzi Wasik:

Hi. I'm Mitzi Wasik. I'm the Vice President of Quality Stars and Member Experience at OptumRx under United Health Group. And this is my first year on the group, so excited to be here. I have no conflicts or disclosures, and I'll just say a little bit of all of the above that everyone else has mentioned, but really one of my, you know, key metrics that I look at is really metrics that matter and metrics that are realistic and are meaningful, so really looking at this not only from the quality perspective, but the data that lies under it.

Thank you.

Margo Rosenbach:

Ann Zerr?

Ann Zerr:

I'm Ann Zerr. I'm the Chief Medical Officer for Indiana Medicaid. I am also looking very much forward to learning from this group. Welcome to the first-year people. I was very lost my first year, so please ask lots of questions because the group is very experienced. I have no disclosures.

Margo Rosenbach:

Thanks, Ann. Bonnie Zima?

Bonnie Zima:

Hi, I'm Bonnie Zima, and I'm a child psychiatrist and health services researcher at UCLA. I actually direct the mental health informatics and data science hub for the department. I have no disclosures, and I think what I'm really going to look forward to most, and this has happened in our other meetings, is really a really important balance between things to measure with kind of counterbalancing that with feasibility, data quality, and particularly methodologic approaches that we should be using to safeguard against bias.

Margo Rosenbach:

Thanks, Bonnie. Sam Zwetchkenbaum?

Sam Zwetchkenbaum:

Hello, everybody. This is Sam Zwetchkenbaum . I am the Dental Director at the Rhode Island Department of Health and Rhode Island's Medicaid program. This is my first year on the Workgroup. I have no conflicts to disclose, and I am looking forward, like everybody else, to discussions around health equity, looking at access disparities and outcomes disparities, and particularly related to oral health.

Margo Rosenbach:

Wow, thank you, Workgroup members. I'd like to echo what Ann said. Welcome to all of our first-time members, all of our returning members, and thank you for sharing what you're looking forward to. We're really excited to get started with this journey. Next slide, please.

So I also want to mention that we're joined by federal liaisons. They are non-voting members. I'll read the name of the agencies but not do an individual roll call. Agency for Healthcare Research and Quality, Center for Clinical Standards and Quality, Centers for Disease Control and Prevention, Health Resources and Services Administration, Indian Health Service, Office of the Assistant Secretary for Planning and Evaluation, Office of Disease Prevention and Health Promotion, Office of Minority Health, Substance Abuse and Mental Health Services

Administration, and U.S. Department of Veteran Affairs. Federal liaisons, if you have questions or comments during the Workgroup discussion, please raise your hand. We'll unmute you.

And I'd also like to take the opportunity to thank our colleagues in the Division of Quality and Health Outcomes in the Center for Medicaid and CHIP Services, and also all the measure stewards who are attending and available to answer questions about their measures. Next slide, please.

So with that, I would like to introduce Deirdra Stockmann, the Acting Director of the Division of Quality and Health Outcomes and CMCS, to make some welcome remarks on behalf of CMCS, and then she'll be followed by Jessica Lee, the Medical Officer in DQHO, who will provide some additional remarks. Deirdra and Jessica, the floor is yours.

Deirdra Stockmann:

Thank you so much, Margo. Hello to everyone. What an incredible Workgroup we just got introduced to. I am so pleased to add my welcome to all of you, Workgroup members, to the chairs, to federal partners, and members of the public. Thank you for joining us. We look forward to this meeting with great anticipation year after year. We look forward not only to the results of the discussion, of course, the recommendations for updates to the Medicaid and CHIP Core Set, but we also look forward to the discussion itself and to the opportunity to hear from all of you, to learn from your expertise and experience. We listen intently to your thoughts and to your debates and to the concrete and real experience of Medicaid and CHIP programs, plans, providers, and beneficiaries as it relates to collecting, reporting, and communicating about quality of care in our programs.

The entire annual Core Set review process, the content of this meeting, and the resulting recommendations are part of the critical infrastructure of the Medicaid and CHIP Quality Program. As a result of the many years of thoughtful Workgroup input, the Core Sets have really come into their own as well-vetted, concise sets of measures that capture important and representative aspects of quality of care in Medicaid and CHIP. The Core Sets form the basis for our quality measurement technical assistance, as well as our quality improvement initiatives across the Center for Medicaid and CHIP Services. Because of the deep consideration the previous iterations of this Workgroup have given to each of the measure criteria, to the importance to Medicaid and CHIP populations, feasibility for state reporting, etcetera, the Core Sets are very strong as we head into 2024 and the first year of mandatory reporting for the Child Core Set and for the behavioral health measures on the Adult Core Set. But of course, the Core Sets are perpetual works in progress. They are never perfect, and they're never finished. So as the measurement field evolves and new and better measures emerge, as healthcare needs and priorities shift over time, we must continue to review and refine the Core Set list. And that's, of course, why we're gathered here today, this year, and every year to make sure that the Core Sets remain the vital resources that they are to the Medicaid and CHIP programs.

So that's all to say this is valuable work. Thank you for showing up. Thank you for doing your homework. Thank you in advance for the rich, robust, and thoughtful discussion that will come. And that is motivated by our shared commitment to measuring, monitoring, and improving the quality of care delivered to people in Medicaid and CHIP, and ultimately to improving health outcomes and equity in our country. Finally, I want to add my heartfelt thanks to the Division of

Quality and Health Outcomes Core Set Team, led by Gigi Rainey, and to the Mathematica Core Set Review Team, led by Margo Rosenbach, for all the hard work and thought that goes into making this such a successful and meaningful meeting. Now, before I hand it over to Jessica Lee, I have a few items of business to get right to. So, in the vein of continuous review and updates to the Core Sets to make sure the Core Sets remain strong, we wanted to make sure the Workgroup and others are aware of a handful of current Core Set measures that are either being retired or are under consideration for retirement by their measure stewards. When a measure steward retires or stops maintaining a measure, we generally have to remove it from the Core Sets because we can no longer provide updated specifications or technical assistance around the measure. So, we wanted to point these out.

Two Adult Core Set measures are currently under review by NCQA for possible retirement in measurement year 2024, which would correspond to the 2025 Core Set, and those are Medical Assistance with Smoking Cessation and Antidepressant Medication Management. So, CMS would retire these measures from the 2025 Core Set if they're removed from the HEDIS measurement set by NCQA, if they will no longer be maintained. NCQA, we understand, is scheduled to make their announcements later this summer. Additionally, NCQA has already announced retirement of the Flu Vaccine for Adults measure. Since this measure is no longer being supported by NCQA, CMS is considering updating the 2024 Core Set, which we've already released, to remove the measure. I do want to note that the Workgroup has previously recommended adding the Adult Immunization Status measure that would fill a gap left by removal of the flu measure. And as we'll discuss further on Thursday -- I think a few people have already alluded to this -- the Adult Immunization Status measure is an electronic clinical data systems, or ECDS, measure. CMS is in the process of establishing an agreement with NCQA to be able to use that measure.

Finally, we've been notified that the Use of Pharmacotherapy for Opioid Use Disorder, or OUD measure, is being considered for retirement by the measure steward, and we may have updates on that in the coming months. So, CMS will request that this Workgroup start to think about those, but specifically that the 2026 Workgroup, the next Workgroup, would discuss and address any measurement gaps that are left by these potential removals. So, with that, and with great anticipation for a robust Workgroup meeting, I am pleased to hand it over to Jessica Lee, who will give a few more updates on some measure alignment activities and measures addressing social determinants of health for us to think about as we get into the discussion. Jessica.

Jessica Lee:

Thank you so much, Deirdra. So, I wanted to give two updates, the first on the topic of the Universal Foundation. We wanted to note that earlier this year, CMS released a list of measures called the Universal Foundation. This measure set is intended to align measures across CMS's 20 quality programs to drive quality improvement and care transformation. In terms of implementation, going forward, a working group of representatives across CMS will be working on this implementation, defining processes to develop and coordinate measure selection, and align wherever applicable. We wanted to highlight that this initiative aligns with the existing processes and quality measures for Medicaid and CHIP. Specifically, first, that the announcement of the measure set specifically states that for Medicaid and CHIP, any changes to program measure sets will be made in partnership with states and other interested parties, reflecting our existing measure processes, such as this Workgroup.

And also, second, that the actual measures on the measure list align with the current Medicaid and CHIP Child and Adult Core Sets wherever applicable. There have been a number of questions about that, so we wanted to ensure that we gave an update. And finally, many Workgroup members have identified the area of social determinants of health as something they're looking forward to during this meeting. Social determinants of health represent a key element of both advancing health equity and improving health outcomes, and as such, this area is consistently identified as a measure gap by the Workgroup over multiple years. Development of measures to both assess social determinants of health screening and determine if support services have been provided has been a priority during this time. While there are now multiple quality measures related to this area, they have not yet been developed to meet the feasibility requirements to be considered for the Core Sets. As you know, feasibility and state testing are particularly important for potential Core Set measures in preparation for mandatory reporting of the Child Core Set and the behavioral health measures on the Adult Core Set.

Reporting quality measures at a state level requires a different level of data collection and coordination than collecting this data at the provider facility level. In balancing these needs, CMS has engaged with measure developers to advance the process that would make a measure feasible for state-level reporting, and today we wanted to convey that we agree that this is a critical gap and are making progress towards having social determinants of health measures that are both feasible for Medicaid and state reporting and ready for review by the annual Core Set Workgroup in the future. We're really looking forward to the discussion, and I'm echoing Deirdra's thanks for all of your work during this meeting and outside of this meeting. With that, I will hand it over to Margo.

Margo Rosenbach:

Thank you, Deirdra, and thank you, Jessica, for all of these updates. With that, we are ready to move on to the long-awaited conversation about stratification. Before we review the measures today, we'll dedicate some time to discuss this topic, stratification of Core Set measures to advance health equity. As Deirdra and Jessica mentioned, it's a priority area for CMCS in its efforts to advance health equity and Medicaid and CHIP, and we'd very much like to hear from Workgroup members on how we can continue to advance work in this area. I'd now like to turn it over to Alli Steiner to lead the conversation.

Alli Steiner:

All right. Thank you, Margo. Next slide, please.

As Margo noted, increasing stratification of Core Set measures is a priority area for CMCS. There's broad agreement that Core Set data reported at the aggregate state level can mask differences by subpopulations. However, stratified data can help identify disparities and focus quality improvement initiatives. Before we open up for discussion, we wanted to provide some context on the current options for state reporting of stratified Core Set data. For the FFY 2023 Core Set reporting cycle, which will occur this fall, states have the option to report Core Set measures by several stratification categories. These include race, ethnicity, sex, and geography. I'll go into these categories in more detail on the next slide.

For the FFY 2025 Core Set reporting cycle, which is the Core Set we will be discussing over the next three days, CMCS plans to provide additional guidance on expectations for stratification, including stratification categories and definitions. Note that future categories may include language and disability status, among others. However, the goal of today's conversation is to identify opportunities and considerations for using stratified data to advance health equity. Next slide, please.

To do a bit of level setting, I'll review the stratification categories that are included for FFY 2023 Core Set reporting. So, on this slide, we have the categories for race, which will include American Indian or Alaskan Native, Asian, Black or African American, Native Hawaiian or other Pacific Islander, White, two or more races, or other race. There's also an option to add additional race category that's not predefined in the system and a category for missing or not reported. Within the Asian and Native Hawaiian or other Pacific Islander categories, states have the option to report stratified data by more detailed categories, which are included on this slide. Next slide, please.

States also have the option to stratify data by ethnicity, which includes not Hispanic, Latino, Latina, or Spanish origin, Hispanic, Latino, Latina, or Spanish origin. Again, states have the option to add another category, and there's a category for missing or not reported. There's also an option to report more granular categories within the Hispanic, Latino, Latina, or Spanish origin category. Next slide, please.

And here we have the categories for stratification by sex, which include male, female, add another category, or missing, not reported. Next slide, please.

And here we have the categories for stratifying by geography, which include urban, rural, add another category, or missing, not reported. Next slide, please.

So, we'd like to spend some time hearing from Workgroup members. We've included some discussion topics on the slide, which include how can stratified Core Set data be used to advance health equity in Medicaid and CHIP? How are states currently using or planning to use stratified Core Set data? How are others currently using or planning to use stratified Core Set data? What are the key challenges to collecting, reporting, and using stratified Core Set data? What additional resources are needed to advance this work? And what are other considerations for advancing this work? Next slide, please.

At this point, we'd like to hear from Workgroup members to share their perspective. We'll start with Ben Anderson, followed by Emily Brown, Amanda Dumas, and Jakenna Lebsock. Remember to unmute yourself to speak and raise your hand if you need to be unmuted. So, we'll start off with Ben. Ben, are you able to speak?

Ben Anderson:

Hi, yes. Good morning again. So, I want to thank everyone for making this a part of the agenda this morning. We see this work and stratification of data as important to ensuring that people's full experience is documented in the Medicaid program. And that's also important for states to better understand, of course, how policies are impacting specific groups of people that are currently and historically overlooked. And this is something that consumers and consumer advocates have been waiting for, for a long time. We also know that this comes with

challenges, many of which are technical. We had the opportunity this past winter to host a workshop with a wide range of stakeholders on data stratification, and we learned many things from this. But one of the things that, you know, I want to share out to the group is, you know, we don't think that we can let the challenges stop this work from going forward.

And, you know, what we're looking for and thinking about is what resources, of course, do states, plans, providers need to move this forward in order to more fully ensure that people are represented in the data? And then we also know that there are particular challenges in how this data is collected, sort of, at the ground level. And some of what we learned at our workshop this past winter was that a lot of people are actually scared and uncertain about how their information will be used or what they should or shouldn't share. And we think that one of the answers to this and one of the possible solutions is ensuring that the providers, plans, state agencies are working with and hiring people from the community that can help navigate these conversations when it comes to the collection of data. That was one of the sort of major findings of our work. And so, I just wanted to share that out and, again, thank everyone for their work in this space.

Alli Steiner:

Thanks so much, Ben. And now we'll hear from Emily Brown. Derek, are you able to unmute Emily?

Emily Brown:

Hello. Thank you for the opportunity to join the discussion today. And, you know, I echo what was just shared before me around the challenges of collecting this information and the stratification of data down at the ground level, at the clinic level. I'm really kind of wearing the patient hat here, former participant hat here. And I've been involved in a recent project here in my community through our health equity learning collaborative here in Kansas City with multiple hospitals, clinics and providers all working to collect race, ethnicity, and language data in order to advance health equity in our community. And one of the things that we've found has been absolutely critical is engaging those voices of all stakeholders, particularly that of the patient. And so, I had an opportunity to participate with our children's hospital on their project of, you know, how do we collect this data. And so, the health equity team pulled together prompts and scripts that they worked on to help prompt their frontline staff to collect this information during check in or at different points of either an inpatient stay or doing outpatient clinic experience. And one of the things that was really interesting was that some of the language that was used to ask about, you know, why this was necessary. Again, that question of why do you need to collect this data was actually not received very well by many participants and patient advocates that were involved in this workgroup. So I guess I implore you to really engage all stakeholders and make sure that you're arming one, not only your frontline staff with the right appropriate language to use to collect that data, that you're providing all of the support materials, collateral materials to collect that data and that that has been vetted and shaped and messaged by that participant voice and that you're understanding kind of the concerns that might come from individuals with sharing that data and how it's going to be used. So being up front with the purpose of collecting it so that participants understand the value in providing that information. Thank you.

Alli Steiner:

Thank you so much. Thank you, Emily, for sharing that perspective. It's so important. Next, we'll hear from Amanda Dumas.

Amanda Dumas:

Hi. Thank you for the opportunity to speak on this. I'll be representing the Medicaid agency's perspective, more or less. In Louisiana, we've been stratifying measures by race, ethnicity, geography since about 2021. And really a lot of our data is retrieved from the MCOs directly. 90 percent of our enrollees do receive their care through an MCO. So that's something that we've leaned on quite a bit in terms of approaching the barriers to collecting and reporting and stratifying these. And we do that with different quality measures for sure, especially in our performance improvement projects where we're looking to stratify both by these demographic characteristics and both the processes that they're developing for these tips, as well as their outcome measures. And this is one of the ways that we determined that we really did have a problem with missing data. And as an example, one of the measures that we were working on was Follow-Up After Hospitalization for Mental Illness.

A lot of you track that as well. And just one of our five at the time MCOs was able to show that in terms of the race category of characterization, we only were missing about 10 percent or had 10 percent reported as unknown. But one hundred percent of the ethnicity data was unknown. So you can see we're sort of inching towards getting the data. But it's very messy right now. It's got a long way to go before it's something that we feel like we can really do a lot of interpretation with. So, one thing we're trying to do to really enrich our understanding is also implement the health needs assessment with all of our MCOs. Again, that's the majority of our enrollees, the vast majority in our state. And so for every enrollee now, they have to also attempt to collect data for the health needs assessment. That's where we're going even more granular. We're asking about gender. We're asking about communication barriers they may have. We're looking at involvement with the justice system and a lot of other characteristics that we feel help enrich the gaps we may ultimately be seeing in some of the services that are being received or the health outcomes that we're seeing amongst our enrollees.

Another consideration I wanted to add, this is really echoing the previous speakers, but when we're talking about measure development, you know, talking to our providers and our members, I think, was really spoken to really well. And I think it's very important. But I'd like to say on the other side, when we go back to interpreting the data and we interpret what we have collected, also going local and helping to understand from that more local level what it can mean and what then we need to do with that. And as a very broad example of that, I would just point to the fact that we had a lot of displacement from one of the hurricanes here in the Gulf and that really disrupted the care and health system for a lot of people. And so, again, when we go back and look at our outcome measures, like what sort of things can we take from the ground and from our citizenry in terms of what this means and where we can then make changes. I think the last thing I would just emphasize, Ben already spoke to it a little bit, but just that the TA that's needed and the administrative support that's needed is going to be really different in different states. And some of us are really lacking in that. And so, I think that that standing up some of these measures is just going to be much harder, depending on how much of that administrative support you have. Thank you.

Alli Steiner:

Thank you so much, Amanda. And now we'll hear from Jakenna.

Jakenna Lebsock:

Thank you. So there's a few things I want to highlight that happen in Arizona at our level as we look at the data and some challenges. Some may be unique, but also probably not uncommon from other states either. And so we use this type of data and we've used this type of data for years in many ways as we look at different performance measures and understanding our populations. And we also employ our health plans to similarly go through a same type of analysis to make sure that they're really honing in on unique needs of population served and how they go about evaluating their plans of care and the best approach to really drive those positive health outcomes. Where we face challenges is really more technical in nature. So, our data system currently, although we take in both race and ethnicity data in our outward-facing platforms, they're combined into a single data point in our system. So, we can't separate it out easily at this point.

And we also maintain our own data structure and our own data systems that are homegrown in Arizona at this time. And so, the effort required to make some of those changes with the other competing priorities -- so for instance, unwinding -- definitely make it hard to resource to drive the change that we need to really get to some of those nuanced levels of analysis. And so, we've already heard we have ideas in the works of how we want to enhance our data, but we've already heard it will be 14 to 18 months before it can be prioritized because now we're in the midst of unwinding and we can't pull away from that focus from a technical perspective. And finding resources, even on a contract basis, to support data system revisions are really challenging. So just keeping in mind that the levers in place are really hard to come by in order to make changes quickly. Although we definitely agree that it's important to do so and something that we're striving to do.

Another thing that we've heard pretty clearly is fear around disclosure, especially when it comes to race and ethnicity. So, in Arizona, upwards of 60 percent of our data is unknown or unreported because people opt not to provide that as they're becoming enrolled with our program and going through and seeking out services, which is a huge impact when you're trying to really analyze how you can drive change or target your messaging or how you engage on certain metrics. And so, overcoming that fear is a big thing that we're focused on. And we do think that some of our community partners, so like the providers, our health information exchange, things like that, they may have better data. But then linking that back, making sure that it's usable in a way that we can use it is another thing that we have to navigate. Our health plans have slightly better data, but it's still nowhere near a level of comfort or clarity that we would really want to see drive key decisions when it comes to race/ethnicity. And so even as we think about how to upgrade our system, we very much have to be very member-focused in terms of sharing the perspective of why that information is important, what we do with it, how it will be used, and that no way will how they answer impact their ability to access care. If anything, it will enhance how they access care. And so, there's a lot of fear, though -- and maybe it's because we're a border state, it could be a number of things -- in really disclosing that because they're afraid that something's not going to be given to them, that they feel is very much needed in terms of that care.

And so, we're always looking for ways to address that and be mindful of the reality that exists as we're trying to serve the populations across our state. The third thing I would point out, and this definitely won't be in every state, but to some extent, some of these basic demographics become very political in conversation. And so, we are incredibly mindful about how we present information, trying to be supportive to our legislature who drives our programming, approves funding, and who very much has one set of beliefs while also being supportive to our current governor, who is of a different political party and what their needs are from a health equity perspective and being responsive to the population. And then, of course, being responsive to CMS and others as we try and report. And at the end of the day, it very much is something that we are acutely in tune with because there are major implications, even reporting race/ethnicity and sex, which we are very limited in terms of the options. We don't add a lot of extra options for consideration.

But it's definitely one that even having language in place to start the collection process can pivot the state of the agency one way or another. And so that is a huge consideration as we consider what to report out, how to ask questions, what it should look like, how we can be responsive to the people that we serve, but also be mindful of the goals and objectives of those who ultimately can approve funding and things like that in our state. So, it's a very interesting place that we find ourselves in. So, you know, those are the big things from my perspective. And again, it won't be every state that faces those challenges, but they we're definitely not the only state either. And so thinking beyond the measure themselves and the impact that comes from being able to drive care to a Medicaid population, I think is really important as we think about some of the measure considerations. Thank you.

Alli Steiner:

Thanks, Jakenna. So thank you so much to Ben, Emily, Amanda and to Jakenna for these remarks. Thank you for sharing your perspective to start off this conversation on this really important topic. I'll now pass it back to Margo to facilitate the broader Workgroup discussion.

Margo Rosenbach:

Thanks, Alli. And I'll also add to Ben, Emily, Amanda and Jakenna, thank you for all of your insightful remarks as we all try to figure out how to advance this work. And with that, I would like to open it up to other Workgroup members to share their insights and experiences about stratification of Core Set measures. We put the discussion topics back on the screen and would invite you to raise your hand and I'll call on you. So, who would like to go first? I'm not seeing any hands raised. Linette. Can you unmute yourself? Or Derek, unmute Linette. There you go.

Linette Scott:

Yeah. I just wanted to really appreciate the comments that everybody has led with. Understanding our populations and our different populations by their characteristics in the Medicaid program is really important and it gives us a way to understand where we need to focus resources, provide additional support, various kinds of activities in order to help improve outcomes across all different populations. But it is also something that can be challenging, as was highlighted. People sometimes are hesitant about sharing their race, ethnicity or sharing different characteristics about themselves. So, when we think about how we compare data and

understand it, understanding how data is collected and how the collection may vary and based on collection, we may have very different results depending on whether data fields are optional or required. So, we use what we have and we do the best we can with what we have. But there is a lot of complexity underneath it.

So, I think just being aware of that as we think about how we do the stratifications, how we explain those stratifications and understanding that the data collection process is incredibly important if you want to have integrity or consistency of data, then on the analysis side. Also, one of the things just as we think about race and ethnicity, we've talked about the fact that we're going to be looking at how we report those separately as two different variables. And we realized that that's the guidance that we need to do for the Core Set. And we hadn't necessarily been doing it as we look more closely at some of our underlying race and ethnicity data. We are also realizing, though, that that there are folks that will identify, for example, as Hispanic, but then they don't identify a race. So, when we separate these two things, the race and ethnicity as two independent fields, there are going to be some interesting components just in terms of how people respond and whether they whether the people who are responding and describing themselves, whether they actually think of race and ethnicity as two separate things or they really think of it as part of the same whole. So those are just some general thoughts kind of as we're diving into this topic. Thanks.

Margo Rosenbach:

Thanks, Linette. Tricia Brooks.

Tricia Brooks:

Hi, and thanks for the opportunity. I think we all absolutely agree on the importance of stratification. And I think most everybody recognizes the challenges that we face in collecting the data. There's no doubt that a lot of work has to go into the efforts to get states ready for stratification to collect more reliable data. But I also think that, you know, we've talked about this for years and years and we have to move ahead and getting to a point where we can really look at how race and ethnicity impact outcomes. And that's going to help us pinpoint those areas where quality improvement is needed. We know that the Medicaid and CHIP population serve a disproportionate share of both children and people of color. And I just think that it's important to work on these challenges, but it's also important not to let the challenges be what shapes the future of stratification. We just have to figure out a way to get it done. Thank you.

Margo Rosenbach:

Thanks, Tricia. Amanda, do you have another comment? I see your hand is still raised. Great. And Linette and Tricia, if you could lower your hands, that would be great. And turning now to Lindsay Cogan.

Lindsay Cogan:

Thank you. Having been a state who has stratified and reported stratified results for our health plan measures for, I would say, at least the last 13 years, it is definitely a great place to start, is to report back out to the larger sort of stakeholder community and be transparent and share that information. I think it's a great first step. I appreciate what Medicare has done in putting

out similar types of information, benchmarking, so that plans, states can sort of view their own data in light of what it looks like in comparison to national. I would encourage CMS to think about something in that respect of putting out maybe something at a more aggregated, all together, this is what it looks like across the entire Medicaid program, and that would give us, the states, the opportunity to kind of compare how we're doing compared to more of a national. Understanding that that gives us a good place to start, but the population may look different across states depending on their Medicaid coverage, their expansion levels, and other such things. So, I think reporting out and being transparent is a really great first step.

The challenges in using stratified data is that the story sometimes emerges quite clearly and is consistent. So, you may see that persons with, you know, non-English speaking may have challenges across a variety of measures. You also might see that a particular stratification looks fine across a set of measures and not great according to others. So, I understand we've been challenged in sort of putting that information into actionable pieces because the story doesn't always come across as completely clear. It can get a little muddled and it can look like a lot of ups and downs and ups and downs. So, I think we need to be purposeful about where we focus and how we think about how to make this information actual, because we have been putting out a lot of information and with this idea of being transparent, but I don't know that that has necessarily been organically picked up and then worked on. So, I think there are other things that we can put into place, other parameters, other ways of sort of incorporating this stratification into other components of the work that we do at a Medicaid program that might make it a little bit more deliberate, right, as opposed to just an exercise in transparency, which, again, it's important, but it's not going to help us close gaps.

Margo Rosenbach:

Thanks, Lindsay. Joy Burkhard?

Joy Burkhard:

Thank you. That was helpful, Lindsay. My question is -- a question and a comment. The question is related to -- and forgive me if I missed this in the presentations, but are we collecting this data upon Medicaid enrollment on applications? Is that data that we're looking at, at an individual measure collection level, as I understand? Is that accurate? And then my comment is related to Ben's comments earlier and sort of fear of disclosing this information at the individual level. I wonder -- and, you know, what we've seen, very different at the nonprofit level, what we've seen, though, is if we explain how we're using the data. For example, we're collecting race and ethnicity to ensure that we're prioritizing populations with the greatest needs so that we can provide additional resources and supports, that that could go a long way. And also clarifying that we're not using the data at an individual level, but at a high level, you know, population level, to prioritize populations with the greatest needs could be helpful. So, a comment, question, thank you.

Margo Rosenbach:

Thanks, Joy. In terms of your question, I think my understanding is that it varies quite a bit by state, and perhaps other states will comment about how they are collecting data, what their challenges are. But in terms of – I don’t think there’s a one-size-fits-all about how it’s being collected.

I think I saw Curtis. Curtis, did you want to make a comment?

Curtis Cunningham:

Sure. Yeah, I just wanted to respond. I think one of the challenges in our state is, like, where do you collect the information, and then when you have conflicts, what is your, quote-unquote, source of truth? So, you know, for example, you can collect it at the eligibility application process. Managed care data is collected, and there's race, ethnicity, and language data there. And then the provider has it, too. And so, then who is responsible for collecting it, and how do you resolve conflicts in your data as that comes in is one of the things that we've struggled with. And especially for social determinants of health and health assessments, we did look at doing that at the provider level. The problem is we had, you know, six to eight HMOs all going to the providers with different tools to collect SDOH data and health assessment data, and that created significant provider abrasions. So, we had to pull that back, and we're currently having those discussions of what is the right level in the system to collect health assessment data, SDOH data, race, ethnicity, language. And the other thing I guess I would also like to think about is once we get the data, what are the logic models to take action on? Obviously, those are still evolving, but I think there's a lot of great stuff that states are doing, especially in birth outcomes, and how do we put those logic models together based on the quality measures to really get to outcomes? I think it would be a great conversation and somehow highlight those things. Thanks.

Margo Rosenbach:

Thank you so much. Kai?

Kai Tao:

There we go. Thank you. I'm not really answering the last question, but I wanted to just pivot a little bit about the sex category. I think earlier on this slide we looked at how sex was – I guess, is that the slide that you showed about the sex breakdown, is that currently how it is? Or that's what we propose? I only want to bring this up.

Margo Rosenbach:

I can tell you that is what is going to be asked for the FFY 2023 Core Set reporting. Would you like to go back to that slide? Would that be helpful?

Kai Tao:

I mean, we could for just the sake of this discussion. I think it was male, female, add another sex, missing or not reported. I just know, you know, when we think about some other key considerations, when we think about all our FQHCs who serve primarily our Medicaid population, you know, the UDS data set, I know we spent years looking at sexual orientation and gender identity, right? SOGI is often the acronym, and spending time on, you know, right-sizing our database. How do we work it into the workflow? How do we ask about it in the EMR so it's not repetitive? We also know having a non-binary or the gender fluidity is more commonplace in a younger generation, I guess, would be more accurate. So just something to

think about because there was so much time and energy spent on that. It was just something we should consider, I guess, as we are trying to work smarter.

Margo Rosenbach:

Yeah, thank you for suggesting that. I know there is a lot of work being done, as Alli mentioned, looking at various categories and also some work underway with OMB in terms of standards. So, lots of conversations about definitions and categories. So, thanks for raising that one specifically. So, Kate, if you want to go back to the question slide?

Mitzi, you're next. Mitzi, are you able to unmute?

Why don't we go to Laura next, and then we can come back to Mitzi.

Mitzi Wasik:

Oh, I think it just worked.

Margo Rosenbach:

Oh, there you go.

Mitzi Wasik:

Sorry, I think I clicked the wrong button. I'll just keep mine brief. But I'm just going back to kind of my introduction when it comes to metrics that matter. You know, I always look at data and say the so what. So, you know, there's a lot of layers that we're starting to put an overlay into the data. But what is the end goal to drive to as we're doing it? Because I think, you know, there's a lot of different organizations, different, you know, state, national, federal, whatever it might be doing different, you know, social determinants of health, risk adjustment, things like that, that it's going to get messy. And so, I just caution us to say what's the so what in it? What are we trying to drive to by utilizing this data? And is it, you know, just surrogate outcomes? Is it a true outcome? Things like that, that, you know, we have a lot of experience in the STARS measures for Medicare to say, you know, we have a lot of surrogate outcomes. Just because someone's adherent to their meds doesn't mean they haven't stockpiled their meds at home, and their A1C is controlled for diabetes. Right. So just I always think of things like that that kind of underlie into nice to have data and messy data that, you know, if we start from the top and put some pretty strict guardrails and keep us out of those scenarios is my recommendation and kind of feedback.

Margo Rosenbach:

Thanks, Mitzi. Laura?

Laura Pennington:

Thanks, Margo. I would say for Washington State, I echo a lot of the comments that have been made already, including acknowledging the complexity of collecting this information, especially as these fields are still voluntary. I would say stratification of gender is occurring to a certain

extent for us in one of our other programs. But however, we would like to acknowledge that the collection of the SOGI data or SOGI data is difficult, especially as that occurs in the BRFSS surveys. And so, meeting with our partners in Washington State at the Department of Health who manage those surveys, pulling out that Medicaid population from those responses is very difficult. However, we agree it's really important and we're always open to considering how we can improve our efforts to continue to collect this type of information and use it. We have started stratifying our measures. Our EQRO does that for us, but we've also done it internally for various topics. So, we're looking at ways to use the stratified data to identify gaps and start to address those gaps. But understand, you know, we can't prioritize everyone at once. But also thinking about how to use that data to connect with partners in the community to help reach certain populations that may, you know, have higher needs and gaps than others. So, I didn't really answer the question. It's more about, you know, acknowledging the difficulties, but also the importance of doing this work at the same time.

Margo Rosenbach:

Thanks, Laura. Mitzi, do you have another comment or are you -- do you want to lower your hand? All right. Who else has comments? Joy?

Joy Burkhard:

Hi, again. I just wanted to share a reflection that I've done some quality management work in my time at health plans and beyond, and it just seems to me that it would be most efficient to collect this type of information and have the source of truth, as we heard earlier, be the application, the Medicaid application, and have a process in place for amending information that a patient feels is important or an enrollee feels important to amend. And, you know, what kind of process that might be. You know, it could be as simple as having posters in clinics or, you know, an annual reminder that's pushed out through email or text that if you want to amend your gender or race, ethnicity or address or whatever, right, that you can do so by doing X, Y, Z. It just feels like a lot of rework, a lot of additional administrative burden if we're collecting this in various ways. And it feels to me that that's under the jurisdiction. It could be something that CMS could easily influence. I might be naive here, but done through a memo to the state. So, I just wanted to share my reflection.

Margo Rosenbach:

Thanks, Joy. David Kelley.

David Kelley:

Yes, I just wanted to comment on I think that there really do needs to be multiple ways to amend categorizations. And I think the more multiple ways to amend, there does still need to be a source of truth. I think in Pennsylvania our county assistance offices hold that source of truth. But I think we have capabilities where our managed care plans can work with participants and providers to amend. So, I think that it is important to have that capability. I also think that it's -- I mentioned in my opening comments about harmonization. Hopefully everybody gets on the same page with race and ethnicity and some of the, I'll say, subdivisions that currently exist that everybody will be harmonized between CMS, CMCS, NCQA. Many states, again, we have data collection systems that are maybe not as nimble as they could or

should be that need time to reflect any changes. So that's something that I think folks need to reflect on. And then lastly, I think, you know, and we've been collecting race and ethnicity data probably since 2007 or 2008. And I think one of the key things is to look at your data, especially match it up in areas where the current medical literature may actually reinforce some of your findings, especially if you're questioning those findings. And then I think it's really important to develop initiatives, but do those initiatives really at the local level, working with, I think, focus groups and working with participants to understand what issues may be, what barriers may be within that particular community, and then designing initiatives that hopefully will drive improvement. So, I really applaud CMCS for moving in this direction. I think some of us have been asking for this for a long time. And I think that always be careful what you ask for. But I think when used judiciously that this can really, this information can really be used nicely to drive quality improvement and close in gaps in care and close areas of disparity. Thanks.

Margo Rosenbach:

Thanks, David. Other comments? Karly.

Karly Campbell:

Hi, I just wanted to mention that, you know, across the whole federal landscape, it would be really great if the stratifications were aligned. So, you know, having really specific direction as to which ethnicity categories, which race categories, which gender categories, and that being consistent across all the various branches of government. I just want to point out how helpful that would be for interoperability across agencies.

Margo Rosenbach:

Thanks, Karly. Other Workgroup members with comments? We will have a public comment period when this is done. Linette.

Linette Scott:

Thank you. I just want to echo the consistency at the federal level in terms of how data is collected and how it's rolled up for reporting in terms of different categories, both for race and ethnicity as well as others. And then also just to piggyback on the work that's happening in the context of the CMS interoperability rule and the focus on the U.S. core data for interoperability. So, again, reconciling the different standards in terms of both collection and reporting. And then the other piece that we've been hearing about is the idea of equity reporting from CMS. And so just, again, how that's going to align with how data is collected and what data is available. One of the things that there's been lots of conversations around is around adding stratifications related to sexual orientation, gender identity. One of the challenges we have as a state around that is that our Medi-Cal, Medicaid application has not yet been approved by CMS to collect that data. So, we need to make sure we reconcile between what data has been approved to be collected in terms of our standard collection mechanisms and thus is available for various reporting and stratification and make sure we keep all that in mind as we move forward with the timing of some of the different activities that we're working on. Thanks.

Margo Rosenbach:

Thanks, Linette. Other comments? I'm hearing so many great comments. Other Workgroup members with comments? Curtis?

Curtis Cunningham:

Thanks. I do just want to reiterate the need to look at stakeholder input and what it is like at the member level and the person-centered level. Many of our members are engaged in multiple care delivery models, whether it's long-term care, acute and primary, behavioral health, and how when we're collecting this data, adding in, like, how many times you got to ask the member and the burden and just the impacts on members having to, you know, constantly address giving this information. I think that's something that really there needs to be a member-based stakeholder group to understand. The other thing I would like to have a discussion on is in regards to tribal populations and, you know, collecting information on tribal enrollment, I think it's a little bit different from race conversations, but I think something that's very important specifically for the Medicaid program due to the, you know, all the interactions that Medicaid has within tribal populations. Thanks.

Margo Rosenbach:

Thanks, Curtis, for adding that. Laura?

Laura Pennington:

I just want to echo Curtis's comments as well as a previous speaker that it's great to think about all this data that we can collect, but we need to be mindful of how we're going to use it instead of collecting it first and then determining how we're going to use it. Also, with the tribal data, you know, we've started having conversations about that in Washington State, and we recognize that, you know, it's imperfect data. It doesn't give us the full story. So just want to say, again, while it's important, we need to be thoughtful about how we start to use that data. Thanks.

Margo Rosenbach:

Thanks, Laura. Before we move on to public comment, I just wanted to make sure that we've heard all Workgroup members on all the discussion topics about how can stratified Core Set data be used to advance health equity and Medicaid and CHIP, similar to what Laura just asked. What are the key challenges? What additional resources are needed? And what are the other key considerations? Rich Antonelli?

Rich Antonelli:

Yeah, thank you. I wanted to sort of reflect with how I open with my icebreaker is I'm interested in the actionability, and it builds on several of the themes that we've heard. I was thrilled to hear the issue of trust being brought up. Ben, I haven't met you before, but I really appreciated your opening comments. And so in the context of the Core Set, and we're talking about stratifying these measures, I think we all have to be very humbled by the fact that in some populations, there are decades, if not centuries, of oppression that have led to outcomes. And so, I want to make sure that we aren't just focused, and this would be the collective we, not just

the Core Set review group, but the collective we. What is it that we're going to do about those disparities? Many of them we already know. Think perinatal mortality, for example, for women of color. So, I'm absolutely in favor of coming to agreement on what those common data elements would be. But I would urge us, and I'm reflecting on additional resources, I would urge us collectively to think about what's the action plan going to be? When we basically quantify what we already know to be true, example, perinatal mortality, what can we do about that right away? I think we owe it to the populations that have been traditionally under-resourced and minoritized. So, I'd really like to keep the focus on building the trust, the actionability, and thinking about additional resources beyond simply just collecting the data. And, again, I'd love the idea of community partners that could be promoting why this data is being collected. We have a lot of catching up to do when it comes to the communities that we want to serve. Thank you, Margo.

Margo Rosenbach:

Thanks, Rich. Ben Anderson?

Ben Anderson:

There we go. Thank you, Rich. And I actually raised my hand before you started speaking, but I think what you said ties in really nicely with what Curtis just mentioned, and I just want to call that out as another way to build trust. I do think if states and plans and providers can set up listening sessions with folks who are on Medicaid about how best to go about the collection of this data to make sure that it's representative, it's inclusive, and it's not -- you know, I recall other comments about how some of the questions or how the framing of some of the questions was actually driving people away from wanting to answer the questions. I think that's certainly something that should be avoided and support the concept of greater community involvement in the collection of this data. Thank you.

Margo Rosenbach:

Thanks, Ben. Lisa Satterfield, I saw your hand raised. Do you have a comment, or did you pull your hand down? Lisa?

Lisa Satterfield:

Sorry, I couldn't unmute. No, just the last two speakers, Rich and Ben, and actually Curtis, too, kind of said everything I was going to say. I think bringing in a work group of beneficiaries is important, and just for all of us to be cognizant of re-reporting data that we already know are out there, right? So they articulated it much better than I am. Thank you.

Margo Rosenbach:

Thanks, Lisa. We have time for one more comment before we open it up for public comment, and Emily Brown, you get the last word in this part of the meeting.

Emily Brown:

I just want to kind of remind everybody in the group, just from a participant perspective, that as you're navigating Medicaid and all of the other different sectors of the social safety net, that really that data becomes almost like your currency as you navigate through that system. So, I really love the comments on that, engaging all stakeholders, making sure that there's input from the beginning, and then making it actionable, because if we've given you all of this data, now what are we going to do about it? How do we close those gaps? And then remembering that, you know, one specific demographic, you know, these disparities don't exist just because someone is, say, Black or Latino. They exist because of that long-held underrepresentation, you know, marginalization, all of those things. And so just engaging those stakeholders so that they can be part of the solution, I think, is really important to remember.

Margo Rosenbach:

Thanks, Emily. Next slide. And now it is time for public comment. First, I'd like to thank all of the Workgroup members for this robust discussion. I think we all learned a lot, and it's given us a lot to think about. And so with that, we'll open it up for public comment. If you wish to make a comment, please raise your hand. We'll unmute you in the order in which your hand was raised. And we are not taking public comments through the Q&A function, so please do raise your hand if you have a comment to make. I'm not seeing any public comments yet. Are there any attendees who would like to make a public comment? Yes, Heike. And pardon me if I have missed your name. Please introduce yourself, where you're from.

Heike Thiel-Bocanegra:

This is Heike Thiel-Bocanegra from the University of California, Irvine. A very interesting discussion. I just wanted to mention that in the Census 2030, they are planning to have an additional category of Middle Eastern, North African populations, which currently are considered white and completely lost in the categorizations. And the Census data also is thinking of putting Hispanic back into race so that it's not race versus ethnicity, because as was pointed out earlier, if they say, yes, I'm Hispanic, they would not answer the race category. So, it would be great if all these discussions are also keeping Census 2030 discussions in mind so that often the denominator in studies is being taken from census data. Thank you.

Margo Rosenbach:

Thank you. Very helpful. Other public comments? Do we have anyone else who wants to make a public comment before we break for a little while? Give it one more minute. One last call. If you have a public comment, please raise your hand.

All right. With that, I think we will turn to a break. I just want to mention to Workgroup members, we will be doing some live test votes after the break. So please take a few minutes during the break to log into the polling platform. Make sure you can see the question we've posted. And if you have any issues, please reach out to us through the Q&A or the mailbox during the break, and we'll help you resolve your issue. We have a little bit of extra time for the break. We'll have 25 minutes altogether and return at 1:15. So please, Workgroup members, to make the practice voting go more smoothly, take some time if you can to experiment with the voting platform. Thank you, everyone, for a wonderful conversation, and we will be back at 1:15.

BREAK

Hi, everyone, and welcome back from the break. We're going to start the measure discussion shortly. But first, we'll describe the approach to the measure review and do some practice voting. Next slide, please.

So first, I'll provide a quick recap because most of us were together just three weeks ago during the Workgroup meeting to prepare for voting. But for folks who might be seeing this for the first time, the slides and other background materials are available on our website. As discussed before the break, the Core Sets are a critical tool for understanding and advancing health care access, quality and equity and Medicaid and CHIP. The Core Sets help CMCS and states identify disparities in care and to develop focused quality improvement efforts to advance health equity. The Workgroup's charge over the next three days is to assess and recommend measures for removal and addition in order to strengthen and improve the Core Sets. Next slide.

Most of you have seen this Venn diagram many times before. It shows the three elements used in the assessment, technical feasibility of collecting and reporting the measures, particularly in light of mandatory reporting beginning in 2024, the desirability of measures, which relates to the actionability and strategic priority of the measures, and financial and operational viability, which ties back to considerations like alignment across programs and state capacity for reporting. The goal for the Workgroup is to recommend measures that optimize these three elements. Next slide.

Another element to consider is multilevel alignment. This graphic shows how alignment can help drive quality improvement in Medicaid and CHIP. At the bottom, we have measures at the clinician or practice level, which feed into measures at the program, health plan, health system, or community level. And as an example, the health home Core Set measures are at the program level because they are for distinct subpopulations within a state's Medicaid program. The Child and Adult Core Set measures are considered state-level measures because they are intended to include all Medicaid and CHIP beneficiaries within the state. State-level measures can then be aggregated to the national level for monitoring the Medicaid and CHIP program as a whole. CMCS values alignment of quality measures across programs and levels because it can help drive quality improvement by addressing each level of care so that improvement at one level may lead to improvement at other levels. Additionally, alignment is intended to streamline data collection and reporting burden. We ask the Workgroup to consider how the measures under discussion may help facilitate quality improvement both within and across levels. Next slide.

Now we'll share a bit more information about the Core Sets overall to provide high-level context for the measure discussions. The 2023 Child Core Set includes 27 measures, and the Adult Core Set includes 34 measures. CMCS does not have a target number of Core Set measures, either minimum or maximum. We encourage the Workgroup members to consider each measure on its own merits according to the criteria. In terms of reporting on the Core Sets, FFY 2020 is the most recent cycle for which data are available. States reported a median of 19 out of 24 measures in the Child Core Set and 22 out of 33 measures in the Adult Core Set. As you would expect, the most frequently reported measures are those that states can calculate accurately using claims and encounter data. Less frequently reported measures include those with medical record abstraction, electronic health records, or survey data

collection. And not surprisingly, it often takes a year or two for states to ramp up for reporting new measures. Next slide.

This slide lists the seven Core Set domains. We want you to keep in mind that CMCS will assign the domains when updating the Core Sets for 2025, and we won't be focusing on domain assignments during the meeting. We also want to note that some measures cut across the Child and Adult Core Sets, and CMCS decides which Core Set to assign the measures to. Next slide.

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

I'll wrap up this section with some additional context for this year's review. As you know, mandatory reporting of all Child Core Set measures and behavioral health measures in the Adult Core Set go into effect in 2024. CMCS has not yet issued the final rule for mandatory reporting. The Workgroup should review measures taking into account the three sets of elements in the Venn diagram shown earlier. Second, CMCS is continuing to explore the use of alternate data sources to support calculation and public reporting of Core Set measures. The goals are to reduce state burden and improve the completeness, consistency, and transparency of measures. Core Set measures are currently being calculated on behalf of states using data from CDC WONDER and the NCI-IDD survey. Other data sources under consideration are T-MSIS and the CAHPS database. And last, there is an increasing emphasis on building state capacity to use digital measures and supplemental data sources for Core Set reporting. Next. Now I'll hand it over to Caitlyn to talk about the criteria for reviewing measures and to share the voting logistics.

Caitlyn Newhard:

Thank you, Margo. Next slide, please.

In each meeting, we always come back to our criteria for assessing measures. We know many of you have seen these slides several times before. However, we have some new Workgroup members and public attendees, and the criteria are foundational to the discussions over the next three days. The first category is our minimum technical feasibility requirements. All suggested measures must meet these requirements, so the measures we'll discuss this week have passed through Mathematica's initial screen based on these criteria. This means that the measures should be fully developed and have detailed technical specifications for producing the measure at the state level, have been tested in or are in use by at least one Medicaid or CHIP program, have an available data source or validated survey that includes an identifier for Medicaid and CHIP beneficiaries, and their specifications and data source allow for consistent calculations across states. CMCS also requires that the measure must include technical specifications, including code sets, that are provided free of charge for state use. However, Workgroup members do not need to consider this criterion. Next slide.

The second category is actionability and strategic priority. Measures that are recommended for addition to the Core Sets should contribute to estimating the overall national quality of healthcare in Medicaid and CHIP and performing comparative analysis of disparities, should address a strategic priority in improving healthcare delivery and outcomes, and can be used to assess state progress in improving healthcare delivery and outcomes in Medicaid and CHIP. Next slide.

Finally, a few other criteria to consider. Is the prevalence of the condition or outcome sufficient to produce reliable and meaningful results across states? Is the measure aligned with those used in other programs? And will states be able to produce the measure within two years of the measure being added to the Core Set? Next slide.

When Workgroup members are considering measures for removal, we ask them to consider whether the measure no longer meets the criteria for addition. So, for example, we ask the Workgroup to consider, is the measure no longer making a significant contribution to estimating the overall national quality of care in Medicaid and CHIP? Are states unable to access the data needed to calculate the measure, or is the data source leading to inconsistencies across states? Is the measure unable to be used to assess improvements in state Medicaid and CHIP programs? And is there another measure that is better aligned with other programs? Of course, this is not a comprehensive list of reasons for removal, but a few key considerations. Next slide.

And now, with those criteria in mind, I'll provide an overview of the voting process. Voting will take place by domain after both Workgroup discussion and public comment and will be for Workgroup members only. Federal liaisons and other attendees of today's meeting are not eligible to vote on measures. Workgroup members should let us know through the Q&A function in WebEx if they will be absent for a portion of the voting. Each measure will be voted on as it's currently specified. If a measure is being considered for addition, a yes vote means, “I recommend adding this measure to the Core Set.” If a measure is being considered for removal, a yes vote means, “I recommend removing this measure from the Core Set.” Measures will be recommended for removal or addition if two-thirds of eligible Workgroup members vote yes. Now, I'll turn it back to Margo. Margo?

Margo Rosenbach:

I am here. Thank you. So now we wanted to check whether -- thanks, Caitlyn -- whether there are any questions from Workgroup members about the criteria or voting logistics before the practice votes. Why don't we proceed? I'll hand it over to Talia to walk us through a practice vote.

Talia Parker:

Thank you, Margo. Okay, as a reminder for all attendees, voting will be for Workgroup members only. Workgroup members, please make sure you are logged into your voting account and have navigated to the Core Set review voting page. You can remain on this page for the duration of the meeting and new voting questions should appear as we make them available. If you don't see the new question, just refresh your page and it should pop up. If you need any help, please refer to the voting guide or send us a chat through the Q&A feature in WebEx. The second page of the voting guide has an FAQ section that answers most common

problems. During voting on measures, if for any reason you are unable to submit your vote, please send us your vote through Q&A or to our email address if you are not able to access WebEx. Your votes will only be visible to the Mathematica team. I will now hand it off to Alli to go through the practice vote and I will share my screen now.

Alli Steiner:

Thank you so much, Talia. So, if you're in the Poll Everywhere platform, you should see the first vote, which reads, “Do you prefer dogs over cats?” The options that should appear on your voting page are “Yes, I prefer dogs” or “No, I prefer cats.” So please select your response. If you’re not seeing the question, please try refreshing your browser. Talia, it looks like we’re seeing the response history. Yeah, that looks good. Thanks for bearing with us, folks. This always takes a little longer to get these first couple of practice votes in. So, we're just going to take some time to make sure everyone is able to cast their vote so that we can move through the process a little bit more efficiently once we get to the actual measure voting later on.

Margo Rosenbach:

I see we have some questions from Workgroup members. Tricia? Derek, can you unmute Tricia? Tricia Brooks.

Tricia Brooks:

So, all I'm seeing is the history of my votes from last year. And I don't see the Q&A function in order to submit something to you guys, just so you know.

Margo Rosenbach:

So, you might see the Q&A function. Do you see the three dots down at the bottom right corner of your screen? If you click on that, that might reveal the Q&A?

Tricia Brooks:

It doesn't. It tells me to switch audio, to copy the webinar page, or move the meeting.

Margo Rosenbach:

Okay.

Alli Steiner:

Tricia, is there all the way to the bottom corner right where it says participants and chat, do you see another three dots?

Tricia Brooks:

Okay, got it. All right. I got the Q&A now, but I don't have it. Thank you. Somebody gave me instructions on that.

Alli Steiner:

All right. We are at 26 votes, so we are going to continue to troubleshoot folks who have entered questions in the chat box.

Margo Rosenbach:

I think Kai has a question. Kai, can you unmute yourself? Yeah, there you go.

Kai Tao:

This happened. Yeah, just as we're trying to troubleshoot this, am I allowed to ask a question about kind of the general, since this is my first time? Hopefully it's a simple one and forgive me if it's been reviewed so often. I know we're looking at adding and removing. That's what we're doing, this over the next few days.

Margo Rosenbach:

How about if we focus on the voting and troubleshoot the voting?

Kai Tao:

Okay, I thought there were troubleshoots on the back end.

Margo Rosenbach:

Okay. Yeah, that would be great. Thank you. All right.

Alli Steiner:

Folks, if you're seeing only the voting history, make sure you're navigated to the Core Set Review page. Also, as a reminder, the voting is only for the Workgroup members, so unless you're on the Workgroup, you would not be able to access the voting platform.

Margo Rosenbach:

And it's specifically for the Child and Adult Core Set. I know we have some folks listening in who might be on the Health Home Core Set Review Workgroup, so this is just for members of the Child and Adult Core Set Review Workgroup.

We're still at 26, and we're expecting 31. Should we move on to the next practice vote?

Alli Steiner:

Sure. Why don't we close the vote? We'll move on to the next one, and we can continue troubleshooting.

All right. The next vote is, “Do you think spring is the best season?” The options should appear as “Yes, spring is the best season”, or “No, spring is not the best season.” So just a reminder to try to refresh your browser if you're not seeing the vote.

Margo Rosenbach:

Karly, do you have a question?

Karly Campbell:

Yes, I'm sorry, I had to step away for a moment, but I'm trying now. And it's telling me -- I'm trying to log into the Poll Everywhere. And it's telling me an incorrect password, even though I'm using the instructions for the voting guide 2025.

Can you hear me?

Margo Rosenbach:

Yes, we can. Dayna, did you want to try and troubleshoot that? I know that we've had some Workgroup members with issues with the password, and I think it has to do with syncing up with emails as well.

Okay. And Talia did you have answers to Tricia's question?

Talia Parker:

Yeah. So make sure that you are typing in “coresetreview” into the join presentation box. That should help you navigate to our presentation.

Karly Campbell:

And it's all one-word lowercase, is that correct?

Talia Parker:

Yes, I believe so.

Karly Campbell:

Is that after you've already logged in to Poll Everywhere?

Talia Parker:

Yes. So first log in to Poll Everywhere and then you should be met with a screen that says join presentation. And that's where you type in “coresetreview.”

Karly Campbell:

Okay, I can't log in. So, I’m stuck before that stage.

Dayna Gallagher:

Karly, you may have been one of the people who had an existing account on Poll Everywhere, so we may not have been able to reset your password. So, if you need to log in, you may just have to send yourself a password recovery email.

Karly Campbell:

Oh, okay. I definitely already have it. I just didn't realize.

Dayna Gallagher:

Yep. You can use your existing one if you remember that or do password recovery and we'll get you in the next round of voting.

Karly Campbell:

Okay, thanks.

Margo Rosenbach:

How are we doing? Where are we now?

Alli Steiner:

All right. Thank you for bearing with us, folks. We're still working on troubleshooting for a couple of Workgroup members. We are at 25 votes right now. We're expecting 31.

Margo Rosenbach:

As Alli said, thank you for bearing with us. We seem to be having a number of issues with logins this year, more than usual. I'm going to suggest that we move on to talking about the next set of measures in Maternal and Perinatal Health. We have one measure to discuss and to vote on. And then after that, hopefully we'll be able to do a little more troubleshooting. And we will suggest that panelists who are Workgroup members who cannot vote can send privately to the Q&A feature and we will enter your vote. But let's keep working on it. But I think we should move on in the interest of time.

So, we have 27 results and spring is not recommended. Look at that, Alli.

Alli Steiner:

I'm surprised to see that. All right. So we do have 21. Sorry, we have 27 out of the 31 expected votes. So we'll continue to work on those four remaining votes as we move on. So, I'll pass it back to Talia from here.

Talia Parker:

Thanks, Alli. I think I'm actually passing it over to Caitlyn for our first domain.

Caitlyn Newhard:

Thanks, Talia. Next slide. Perfect. Now let's move on to our first domain, Maternal and Perinatal Health, for our first measure discussion. Next slide.

I will start with the current Core Set measures in the domain. There are five Child Core Set measures and three Adult Core Set measures. This slide lists the 2023 Child Core Set measures in the domain. These include 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. Next slide.

This slide includes the current Adult Core Set measures in the domain. They include Prenatal and Postpartum Care: Postpartum Care, Contraceptive Care - Postpartum Women Ages 21 to 44, and Contraceptive Care - All Women Ages 21 to 24. You will note that the two contraceptive care measures are included in both the Child and Adult Core Sets for different age groups. Next slide.

We are moving now to the measure suggested for addition, Oral Evaluation During Pregnancy. This measures the percentage of enrolled persons aged 15 through 44 with live birth deliveries in their reporting year who received a comprehensive or periodic oral evaluation from a dental provider during pregnancy. The measure steward is the American Dental Association, or ADA, on behalf of the Dental Quality Alliance, or DQA, and the measure is not NQF endorsed. The data collection method is administrative.

On this slide, you can see the denominator and numerator definition for the measure. The Workgroup member who suggested this measure for addition noted that this measure addresses a gap identified by the Workgroup related to access to and use of dental services for pregnant individuals. The Workgroup member cited evidence about the important connections between oral health and overall systemic health. Among pregnant women, pregnancy is associated with increased risk of gingival inflammation and caries, periodontal disease is associated with an increased risk of adverse pregnancy outcomes, including preterm birth, low birth weight, and preeclampsia, and maternal oral health is directly associated with child oral health. The Workgroup member explained that because of the importance of dental care to overall maternal and child health, the American College of Obstetricians and Gynecologists and the American Public Health Association have emphasized the importance of access to oral health during pregnancy.

The Workgroup member commented that the Workgroup has had concerns with adding dental quality measures to the Adult Core Set due to inconsistencies in adult dental benefits across state Medicaid programs. However, the recent change that all states provide dental benefits to pregnant individuals effective October 1, 2022, should address this concern. The Workgroup member mentioned that this is the only standardized, tested, and validated claims-based measure of dental care access during pregnancy and will enable Medicaid and CHIP programs to establish baseline performance, set improvement goals, and monitor progress over time. Additionally, this measure promotes dental medical integration and focuses on improving both maternal and infant outcomes. Next slide.

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

Margo Rosenbach:

Thanks, Caitlyn. We'll now invite discussion about the Oral Evaluation During Pregnancy measure from Workgroup members. You may unmute your line if you wish to speak, and please remember to say your name before making your comment. I see we have Jakenna. Jakenna, are you able to make your comment?

Jakenna Lebsock:

Once you have the information updated nationally. Arizona actually has not been approved to offer dental care to pregnant women. It has failed in our legislature for the past four sessions. And so, we do not offer that benefit except in select circumstances. So, from our state perspective, there's still a challenge in being able to offer it, or to report on it, especially if it was mandatory, as we do not have this coverage. Even though we are aware that nationally it does appear as though that is the case, but it is not accurate.

Margo Rosenbach:

Thanks, Jakenna. Sam and then Jim.

Sam Zwetchkenbaum:

Hi. So, I'd just like to speak to this. Dentistry does have a history of access disparities where those with wealth and privilege are most likely to have a dental home. And by a dental home, that's a provider who's there when you need them and gets you in for that routine preventive care. We also have significant disparities in oral health outcomes in the U.S. based on race, ethnicity, and socioeconomic status. And we know that this ultimately impacts overall health. And COVID-19 has really highlighted, especially here in Rhode Island and also in many other ways. So why is it important to address oral health during pregnancy? When I first practiced at a community health center here in Providence, pregnant women would come in with dental problems stating they were unable to find a dentist who would treat them because of their pregnancy. I knew that dental care during pregnancy was safer than not sleeping, not eating, and perhaps taking excessive opioids or other pain management. So, of course, I'd address their dental needs. But what I didn't do back in 1989 is tell them to come back for a preventive visit. Maybe I'd say come back after you have a child, but we all know that can be difficult because of all the work she has as a new mom. I didn't tell her to come back because I must have had some sort of bias and thought maybe it wasn't fully safe.

Having good oral health during pregnancy prevents pain and infection. There's also data showing better pregnancy outcomes in those with good periodontal health. Finally, we know that this is the best time to educate a parent about the future oral health of their child. We have them in the chair, and they want to learn. A parent with good oral health is more likely to value this for their child. States and dental schools have been doing the hard work of educating dentists and dental hygienists that not only is dental care during pregnancy safe, it's recommended. We need to improve access. We also need to push our non-dental providers, OB-GYNs, doulas, midwives, et cetera., to make a referral for dental care. We've been working

on a medical-dental integration project with a health center in Cranston, Rhode Island, where the medical side has been including oral health interventions for pregnant patients. They perform a risk assessment, screening, education, and referral. We've wanted them to also provide education in fluoride varnish, but they've struggled with this.

They have a co-located dental clinic, and referrals are going up. They have dental hygienists who are very public health-minded, who are able to get the patients in to do the work. Initiatives to promote oral health during pregnancy are equity measures because they're intended to correct disparities that are a result of privilege. We know from PRAMS data that those of higher-income, education and white communities are more likely to have had a dental visit. Adding this measure will prompt states to look at the data and support quality improvement initiatives. Getting processes like the one in Cranston will make a difference and will be motivated by having this measure. Finally, our data analysts at Rhode Island Medicaid have been able to use the DQA guidance to produce the measure. We're going to do some additional work, including stratifications by race, ethnicity, age, and zip code. It will help us focus on further quality improvement with the goal of better processes to reduce disparities. Thank you.

Margo Rosenbach:

Thanks, Sam. Jim Crall you're next. Jim, did you have a comment? Why don't we move on to Amanda?

Jim Crall:

Sorry, Margo. Yeah, I just got unmuted. Thank you. Yeah, certainly. First of all, as the Workgroup member who suggested the addition of this measure, I want to speak strongly in support of its addition. Those of us who have been on the Workgroup for a number of years know that we've been challenged to find an Adult Core Set dental measure that fills a recognized gap in the Adult Core Set. So, upon learning from CMS that as of October 2022, all 50 states, and we've heard now that Arizona may be an exception, that all 50 states and D.C. have an oral health benefit during pregnancy and the postpartum period, the DQA moved quickly and conducted testing using T-MSIS data and subsequently approved the Oral Evaluation During Pregnancy measure. I'd also like to point out and reemphasize and recognize by directional relationship between overall health during pregnancy and oral health. Note that this measure aligns with recommendations from the American Dental Association, ACOG, CDC, American Public Health Association regarding the importance of dental visits during pregnancy. It complements other measures in the CMS Core Set Maternal and Perinatal Health measures, and I was very happy to see it, that it was proposed for addition to the Maternal and Perinatal Health measures. And it also helps support a focus on better integration between medical care and dental care. We know from a systematic review that fewer than 50 percent of all women see, obtain dental visits during pregnancy, and that the rates are even lower among Medicaid, roughly a third.

We also know Medicaid covers about 40 percent of births, so, you know, a very important program within pregnancy benefits. The testing data that was done on data from five states showed a range from 14 percent to 23 percent of persons with live births -- live birth deliveries having an oral pregnancy evaluation, so lots of room for improvement and demonstrated gap. They fully appreciate and recognize the important role played by non-dental providers in

supporting oral health during pregnancy, but the focus of this measure is on access to dental care system and evaluations. The testing data, you may have questions about the age range that was selected, but the testing data showed very few births from below age 15 or over age 44, and my understanding is that the age range that was chosen aligns with other measures in the CMS Maternal and Perinatal Core Set. When it comes to many of the stratifications that were discussed during our early sessions today, these measures clearly can be -- this measure clearly can be stratified on variables related to age, sex, geographic location, race, ethnicity, et cetera, you know, based on the data completeness and the quality of the data obtained through the administrative claims data. So, again, I encourage my colleagues to support the addition of this measure. Thank you.

Margo Rosenbach:

Thanks, Jim. Next up, Amanda.

Amanda Dumas:

Thank you. I just wanted to voice my support for this measure as well. I, you know, echo everything that's been said about the importance of oral health in pregnancy, and I just wanted to bring up the idea as well that as states are extending postpartum care coverage to the full 12 months after birth, I'm wondering if in the future this might be something that we're at it also, if this does -- you know, if this were enacted and turned out to be a successful measure, if we could down the road look at continued oral health care received in that 12 months postpartum if coverage, you know, has been extended to those states. And I did have a technical question, though, in terms of -- I didn't see it in how the numerator was described, but when we're looking at defining the pregnancy itself based on the date of the live birth, is that going back 270 days or for a certain amount of time? And one reason I think of that as well is because of the correlations that were already brought up. If we're looking at a live birth at 26 weeks versus 40 weeks, I think that would be important when we continue to consider the outcomes of poor oral health on pregnancy outcomes. Thank you.

Margo Rosenbach:

Thanks, Amanda. Maybe if we have someone from DQA, the measure steward, you could respond about the numerator. If you raise your hand, Jill or Erica, we'll call on you in a little bit. Thank you. Rich Antonelli, you're next.

Rich Antonelli:

Yeah, I'll keep my remarks brief. I'm enthusiastically in favor of this. It's a wonderful opportunity to leverage what we know is pretty significant science of the so-called life course. Imagine doing something for a mom that then impacts the child after birth. So, I think that there's a tremendous opportunity not only to advance equity, but to leverage life course. And then that mom, decades later, we know that there's a correlation between oral health and cardiovascular morbidity and mortality as well. So, I think life course, relatively low investment for long-term outcomes. And, again, enthusiastic in my support.

Margo Rosenbach:

Thank you, Rich. Lisa Satterfield.

Lisa Satterfield:

Thank you. I have a question and then a comment. My question is, what happens to our colleagues in states like Texas, Arizona, Florida, that have emergency only services coverage for pregnant persons with Medicaid? So, if we could address that at some point, because I know there will be some concerns. But however, the American College of Obstetricians and Gynecologists supports this measure. We have policies that support, obviously, oral health throughout pregnancy. And we encourage our obstetricians and gynecologists to counsel on oral health throughout the pregnancy as well.

Margo Rosenbach:

Thanks, Lisa. Curtis.

Curtis Cunningham:

I guess I'm thinking more -- first off, I guess I want to applaud everybody's efforts, because I just always want to make sure when I'm making comments on the quality measures, it's not to not celebrate many of the efforts that have been done. But I do have concerns about this measure due to the fact of eligibility. And so maybe this is a technical question, but, you know, many of the individuals that become eligible for Medicaid become eligible based on their pregnancy. I think the average time they come into the Medicaid program is probably in the sixth or seventh month of pregnancy. So that means that the measure would not pick up anything prior to that service. The other thing is that since it is around eligibility, I assume that Wisconsin is another state that has only a one-month postpartum extension and so has not expanded to the 12 months postpartum. So that also complicates the measurement. And then I am concerned about how many states are actually able to calculate this measure. So, just some concerns that I wanted to raise about the accuracy of being able to calculate this measure in a consistent and comparable way across state to state. So, thank you.

Margo Rosenbach:

Yeah, thanks, Curtis. And I think the comments that have been made about postpartum, that's actually not what this measure is reflecting. It's looking at Oral Evaluation During Pregnancy. So, I think good questions have been raised about continuous enrollment requirements and look-back periods and so on. And so, I see we have Jill Herndon in the queue. And, Jill, can you speak to some of these numerator and denominator considerations?

Jill Herndon:

Are you able to hear me?

Margo Rosenbach:

Yes, now we can.

Jill Herndon:

Okay, great. Thank you. Good afternoon, everyone. Yes, so thank you for the question about the denominator definition. So, we are looking, as Amanda noted earlier, at those live birth pregnancies. And then in terms of capturing that pregnancy episode, which can be challenging with claims data, but we know it's possible, as you can see in the other Core Set measures, which take a similar approach, we have prior to that live birth delivery, there is an enrollment requirement of at least 180 days or six months. And that was designed to balance capturing enough time for someone to be able to schedule and obtain a dental visit as well as having the majority of the pregnancy period covered, so not having it be too long where you would exclude a very large number of individuals or too short where there's insufficient time to secure that dental visit, that oral evaluation. Now, we look back further than that six months prior to the live birth date for the dental visit. So, to be in the denominator, you need to be enrolled at least six months continuously prior to and including the delivery date. But when we look for the dental service, we look back the entire nine months for that visit, because that enrollment requirement is a minimum requirement of six months. I don't know if that helps to clarify the understanding of how we're defining that.

Margo Rosenbach:

Thanks, Jill. Why don't we move on to Kim Elliott and then Joy Burkhard.

Kim Elliott:

Hi. Historically, I've not been a real fan of this measure simply because of the differences in coverage across the states. But over the last year, two years, almost all states now are covering oral health for pregnant women. So, I think it’s time. I think that because of the health benefits to the mom, the health benefits to the infant, the long-term health of the mother, I think this would be, from a quality perspective and outcomes perspective, a measure that is really worth considering this year.

Margo Rosenbach:

Thanks, Kim. Joy Burkhard.

Joy Burkhard:

Thank you. This measure makes sense to me, but I do have a couple questions. One is, can someone provide us a general overview of NQF endorsement? And this would be applicable to all measures, not just this one. I don’t know if this is the right time, but it feels appropriate to ask right now. I heard in the presentation that this was not endorsed by NQF. Was that because it wasn’t reviewed by NQF? Or if it was, could someone shed some light on the concerns that might have been raised? And then, goodness, there was one other thing that I can’t remember now, so I’ll turn it back to you, Margo.

Margo Rosenbach:

Thanks, Joy. So first and foremost, NQF endorsement is not required for Core Set measures. So, the fact that it is not endorsed is not a criterion for voting not to recommend it. That's a lot of double negatives. But NQF endorsement is not required. I will ask Jill if you know whether

NQF endorsement was pursued or not. There are lots of reasons when measures are not pursued for NQF endorsement, and that is not necessarily an indicator of whether it is a good measure and should not be construed about whether it is a good quality measure or not. But, Jill, can you speak to NQF endorsement related to this measure?

Jill Herndon:

Yes, I can speak to it. The measure was actually just completed testing in November and was approved by the DQA at its November meeting. So there was not actually a time prior to this to pursue NQF endorsement. And as you may know, NQF has been -- the endorsement process has undergone transition. So that determination as we see how all of the endorsement processes unfold will help determine moving forward with pursuing any endorsement efforts. But I can also say we use for every DQA measure, it undergoes the same testing that it would undergo as if it were pursued for NQF endorsement. So, our reliability testing and everything was the same, and that's what the DQA evaluates when they determine whether or not to approve a measure to go forward.

Margo Rosenbach:

Thanks, Jill. Kai?

Kai Tao:

Hi, yeah. I just want to say, yes, strongly recommend this measure. I think most people have said it, but, you know, I work at a large FQHC, probably the fifth largest in the United States for the number of deliveries. And as we know, we are doing so much to address kind of that holistic health, not just about her pregnancy. With preterm labor, very low birth weight, low birth weight being continuing to be the vexing problem of only associations and not, you know, any direct ways to prevent it. This one seems like if we know there's very strong association that we can prevent this preterm labor by oral health, I think I feel very strongly that we should be endorsing this. Thank you.

Margo Rosenbach:

Thanks, Kai. The Workgroup members with hands raised are ones that have already spoken. Do you have additional comments to make? Or do you want to lower your hand? Jakenna? Amanda? Joy? And Workgroup members, please remember that you need to make your comments out loud. Q&A is not for comments, either from Workgroup members or from the public. Curtis?

Curtis Cunningham:

Yeah, that was me. I'm busted. Sorry. I was just wondering, could you restate how many states are currently reporting this measure?

Margo Rosenbach:

Well, what I can say is that the measure is not in the Core Set yet. So, there are no states that are actually reporting the Core Set measure. But the measure has been tested. And, Jill, do

you want to say anything further about the measure testing and its feasibility for state Medicaid and CHIP agencies?

Curtis Cunningham:

Thank you. I appreciate it.

Margo Rosenbach:

Thanks, Curtis. Jill, are you able to unmute?

Jill Herndon:

Yep. Here we go. There was a little bit of a lag. So, we did testing with five state Medicaid and CHIP programs using data, the T-MSIS data, the Transformed Medicaid Statistical Information System data. And we do know that there are states who have been reporting independently similar metrics of dental service utilization and so forth among pregnant women. So, for example, the state of Michigan has a dashboard. So, we do know that it's certainly very feasible. Again, it was just approved. So, this specific measure following these specific specifications are not in widespread use yet because there simply hasn't been time. But we do know that it's certainly feasible based on our own testing and based on states that have been reporting dental utilization among pregnant beneficiaries using their own variable approaches.

Margo Rosenbach:

Thanks, Jill. David Kelley?

David Kelley:

Thanks so much for that information, Jill. Could you tell us what the five states are? And this is kind of interesting to know from a feasibility standpoint. Michigan is very similar to Pennsylvania, so that gives me some comfort. But what the five states were. And then what was the range of your findings? Was there a lot of variation? And what's the opportunity for improvement? And I will say I'm very generally supportive in my earlier comment about filling gaps that have been identified for a long time. This is one of them.

Jill Herndon:

Yes, thank you. The five states were Alaska, Idaho, Michigan, North Carolina, and Washington State. And our range in performance on these was 14 percent to 23 percent, so clearly significant opportunity for improvement.

David Kelley:

Yeah, absolutely. So, lots of room for improvement. And, again, you know, there may be some data challenges, but it sounds like, you know, from CMCS's movement in October to get states to move towards dental coverage, I think is a step in the right direction. I guess one clarifying question, and maybe this is for CMCS, is was that made mandatory for state Medicaid

programs for pregnant women? It's not an issue here in Pennsylvania, but I'm just wondering, was that actually -- did it become for pregnant women a mandated benefit?

Margo Rosenbach:

Is Andy on the phone or somebody else from CMCS that wants to speak to that? Andy? Derek, can you unmute Andrew Snyder? All right, Andy.

Andrew Snyder:

Dr. Kelley, no, there's not a new requirement related to pregnancy-related dental coverage. Just the October announcement was in recognition that we had passed every state offering at least some level, even if that is emergency coverage, to adults that were inclusive of their pregnant population. So, because there had been, you know, one or two previously that had offered nothing, and those moved into offering some pregnancy-related dental coverage. But, no, there's no new requirement.

David Kelley:

Okay. Thanks so much. Appreciate the clarification.

Margo Rosenbach:

And we have time for one more Workgroup member comment. Joy, did you have another comment?

Joy Burkhard:

Yes, thank you. Others might have the same question, and it's a process question. Can you remind us whether there's a limited number of new measures that can be accepted into the Core Set?

Margo Rosenbach:

No, there is not a limited number. They should each be considered on their own merits for addition or removal. Thank you. Yes, thank you. That's great.

Okay, so with that, let's move on to the next slide and the opportunity for public comment. So, we had a request for submission of a written public comment by a member of the public who has a voice disability. Dr. Mark Casey submitted written comments, and I am going to read them. And so please bear with me. They are long comments. They are actually in two parts. So, one of them I will read now, and it will also pertain to the Ambulatory Care-Sensitive ED Visit measure. And the other part I will read later when we get to topical fluoride. So here goes. First, I would like to applaud the Workgroup. Oh, and let me just say that Dr. Mark Casey is the Dental Officer for North Carolina Medicaid.

First, I would like to applaud the Workgroup for being proactive in considering adoption of two measures developed by the Dental Quality Alliance, the Oral Evaluation During Pregnancy measure as an addition to the Maternal and Child Health Core Set of measures, and the

Ambulatory Care-Sensitive Emergency Department or ED Visits for Non-Traumatic Dental Conditions, NTDC, in adults measure as an addition to the Dental and Oral Health Core Set measures. In my opinion, the Workgroup's deliberations on the addition of these two measures is timely given a growing wealth of evidence that has emerged regarding the relationship between poor oral health and increased susceptibility to adverse birth outcomes for pregnant women and the increased bidirectional risk of exacerbation of chronic diseases like diabetes and heart disease in adult chronic patients. The two measures under consideration for inclusion in the Core Set will enable state Medicaid agencies to compare program performance to benchmarks established after collection and analysis of data for these two measures over multiple years.

This data and information will be critical to determination of success or failure in the prevention of avoidable poor systemic health outcomes and significant increases in healthcare spending caused by gaps in the delivery of dental oral health services to pregnant Medicaid beneficiaries for the Oral Evaluation During Pregnancy measure and all enrolled adults for the Ambulatory Care-Sensitive ED Visits for NTDC and adults measures. From my perspective, I cannot think of two better dental oral health quality measures to use to gauge state Medicaid agencies' performance when it comes to the optional Title 19 adult dental benefit. Adult dental benefits vary considerably from state to state. However, it is hard to argue that all states should not be making improvements in the delivery of oral healthcare to prevent adverse birth outcomes when all 50 states now cover dental benefits for pregnant beneficiaries, including postpartum care, up to one year following delivery. Since nearly all state Medicaid agencies cover emergency dental care for adults, it is imperative that the Adult Core Set of measures feature a quality measure which can be used to ascertain if ED visits for non-traumatic dental reasons are impacting not only state Medicaid agency healthcare expenditures, but also the quality of life for disadvantaged adult Medicaid beneficiaries. I think I will stop there because most of the rest of that relates now to the NTDC measure, and I'll come back to that later. I'll just conclude, in my 16 years at NC Medicaid, I have seen time and again the power of quality measures to drive policy. If one wants action on the policy front, one of the best ways to guarantee improvements is to adopt measures that quantify the need for action. So, again, those were remarks by Dr. Mark Casey from North Carolina Medicaid.

And I see we have another public commen, An. Derek, can you unmute? And, Joy, could you please lower your hand? Thank you. And please introduce yourself as well and where you are from.

An Nguyen:

Can you all hear me?

Margo Rosenbach:

Yes, we can.

An Nguyen:

Okay. I want to say, first off, good afternoon, members of the Workgroup. Thank you for providing a forum for us to share some comments and really deeply appreciate your work to incorporate feedback from a wider public and practice community in the decisions that you all

make. My name is Dr. An Nguyen, and I'm a public health dentist by training. I'm here today to provide comments on behalf of the National Network for Oral Health Access, or NNOHA, as the organization is known. For those of you who might not be familiar with NNOHA, we are an organization that's been providing technical assistance and support to safety-net oral health programs from across all regions of the United States for the past for over 30 years. These resources reach beyond our 5,200 members. And in 2019, over 19,000 oral health professionals and more than 1,100 health centers provided services to more than 6.7 million patients in underserved communities across the country. NNOHA's membership, we're leaders in implementing quality science, delivering care and integrated systems. And we're also early adopters of dental best practices and are frequent participants in and advocates for state-based innovation projects, including within accountable care entities and within value-based payment systems. All of this work we do to help drive the achievement of the triple and quadruple aim.

So as such, NNOHA membership have deep expertise and a vested interest in the discussions that you all are having here today. The oral health measure on Oral Evaluation During Pregnancy that's before you all today aligns with the best evidence available in dentistry and has been rigorously vetted and tested for use across the spectrum of dentistry and oral health delivery systems. It's designed to provide a snapshot of oral health during a key moment in the lifespan. And the Dental Quality Alliance has spoken about the framework and processes used for its development. And NNOHA has been really pleased to have supported its development and the adoption to DQA's measurement set. And we also recommend your adoption of it into the Maternal and Perinatal Core Set. I won't reiterate comments in favor of this measure that has already been shared. But what I will say is this measure is actionable and can support important health promoting behaviors.

With the National Maternal and Child Oral Health Resource Center, NNOHA has been hosting a learning collaborative on oral health care for pregnant people and children through a medical dental integration model. In this work, we have seen a 29 percent increase in pregnant patients that receive an Oral Evaluation During Pregnancy. And while it's too soon for us to share our specific data on that through our collaboratives, we also see evidence that when mothers receive dental care, their children receive earlier care and at higher rates that can support the opportunity for primary disease prevention. And to amplify many of the other speakers' previous comments, dental care during pregnancy is not only safe, but it is necessary to support individual and population oral and whole-body health. So, for these reasons, NNOHA encourages you to vote in favor of adding this measure to CMS's Maternal and Perinatal Core Set. So, thank you for your attention and for your time for comments today.

Margo Rosenbach:

Thank you so much. Next up, Chelsea. Derek, can you -- thank you.

Chelsea Fosse:

Conversation and the opportunity to comment. This is Chelsea Fosse at the American Academy of Pediatric Dentistry, or AAPD. I'm a general dentist and diplomat in dental public Health. Just like the last public comment, I will not spend too much time reiterating all the benefits that have been previously mentioned, but want to jump back to emphasizing the positive impact that this measure could have also on children. At AAPD, early childhood caries

is one of our most significant concerns. And when we think about going upstream from early childhood, we look at that perinatal and maternal phase. And as was just stated, when parents, particularly moms and moms-to-be, get the care that they need, we know that their children are more likely to get off on the right foot in the earliest stages of their lives with oral health and overall health. As has been mentioned and has been brought up as a potential concern, particularly states without robust or very long-term coverage for the pregnant population, there has been some really good news out of states that have done pilot programs for the pregnant population as well. There's obviously lots of room for improvement in all states, but it looks as though in a short amount of time, there can be real impact in the number of pregnant people who are aware of the benefits that they have and who also take advantage of those benefits. So, thank you for the opportunity. We at AAPD would urge the Workgroup to consider adopting this measure.

Margo Rosenbach:

Thank you so much. Well, thank you, everyone, Workgroup members and the public, for your comments. We are now ready for voting on the measure, and I'll turn it over to Alli and Talia for voting.

Alli Steiner:

All right. Thank you, Margo. So, for today's first vote, should the Oral Evaluation During Pregnancy measure be added to the Core Set? The options are yes, I recommend adding this measure to the Core Set, and no, I do not recommend adding this measure to the Core Set. Voting is now open.

As a reminder, if you don’t see the question, please refresh your screen. All right. Thanks, everyone. We’re at 28 votes. We are still waiting for a couple more to roll in. Thanks for your patience.

Thanks for your patience. We're just waiting on the votes. Okay. We've reached our expected number of votes, which is 30. So, we can close the vote. Okay. And now for the results. 87 percent of Workgroup members voted yes. Excuse me. That does meet the threshold for recommendation. The Oral Evaluation During Pregnancy measure is recommended by the Workgroup for addition to the 2025 Core Sets. And now I'll pass it back to Margo.

Margo Rosenbach:

Great. Thank you. And I think we got the hang of the voting. So, thank you all so much for that. And we are now ready to take a break. We will take a ten-minute break and return at 2:35. And please be prompt because we have the next domain to vote on.

BREAK

Hi, everyone. Welcome back from the break. Now I'd like to turn it over to Kate Nilles and Caitlyn Newhard to lead the discussion of measures in the Dental and Oral Health Services domain.

Kate Nilles:

Thanks, Margo. First, we'll review the measures in the Dental and Oral Health Services domain in the Child Core Set. One, Oral Evaluation, Dental Services. Second is Topical Fluoride for Children. And third, Sealant Receipt on Permanent First Molars. The Sealant Receipt Measure was added to the 2021 Core Set, and the other two measures were added to the 2022 Core Set. The first Dental and Oral Health Services measure we will discuss today is the Topical Fluoride for Children measure, which has been suggested for removal from the Child Core Set. This measure is defined as the percentage of enrolled children ages 1 through 20 who received at least two topical fluoride applications within the measurement year as one, dental or oral health services, two, dental services, and three, oral health services. The measure steward is ADA on behalf of DQA, and it is NQF endorsed. The data collection method is administrative. This measure was added to the 2022 Child Core Set, and reporting is still underway.

A Workgroup member suggested this measure for removal and suggested replacing it with a different measure focused on the youngest children who would most benefit from topical fluoride treatments. The Workgroup member also mentioned that a measure that focuses on the youngest children would be easier to implement with providers. Now we will discuss the measure suggested for addition to the 2025 Child Core Set to replace the current Topical Fluoride for Children, TFL-CH measure. This measure is also called Topical Fluoride for Children. It assesses the percentage of members one to four years of age who received at least two fluoride varnish applications during the measurement year. The measurement steward is NCQA, and it is not NQF endorsed. The data collection method is administrative. This is a first-year HEDIS measure for MY 2023. The measure was included in HEDIS with the permission of the Dental Quality Alliance and American Dental Association, and it is an adaptation of the DQA/ADA measure that is currently in the Child Core Set. The Workgroup member who suggested this measure to replace the current Core Set measure noted that the new measure limits the age range to children ages one to four to allow for enhanced targeting of younger children where states have the best ability to make an impact. Now I will pass it back to Margo to facilitate the Workgroup discussion about the Topical Fluoride for Children measures.

Margo Rosenbach:

Thanks, Kate. We'll now invite Workgroup members to discuss the Topical Fluoride for Children measures. Next slide, please.

And please indicate which measure you are referring to in your remarks, specifically the DQA measure in the current Child Core Set or the NCQA measure, which has been suggested as a replacement. Please unmute your line if you wish to speak. Jim Crall.

Jim Crall:

Yes, thank you, Margo. Well, I'll start off by saying I would like to speak strongly against removal of the current DQA measure. I believe it's a robust measure that reflects evidence-based prevention, the emphasis on two topical fluoride applications per year at a minimum. It recognizes that topical fluorides must be applied with a frequency on an ongoing basis over multiple years to be maximally effective. My perspective is informed by research I conducted many years ago on topical fluorides and mechanisms of action in a career working to

understand the nature and determinants of dental caries or tooth decay, as well as looking for effective methods for preventing or minimizing the effects of caries. And I'm trying to take that knowledge and work with clinicians. I'm a pediatric dentist by clinical training and with federal, national, state, local policymakers to mitigate the impacts of that chronic disease, the most common chronic disease of childhood still. The DQA measure covers the entire age range of the EPSDT population. It allows for stratifications consistent with the CMS-416 report. The proposed replacement measure covers only a small segment of the Medicaid child population, ages one to four. It's a derivative of the existing topical fluoride measures. At least that's how it's characterized. That's how it's understood, I believe, by the DQA. It's described in the proposal as an adaptation. And the NCQA measure, as far as I know, there has been no original testing conducted by the measure steward.

My remarks should not be interpreted as not appreciating the importance of topical fluoride in young children or the interest and contributions of health care providers who are not dentists to oral health. However, I think we must also recognize the limits of those activities, both from the standpoint of their potential limited impact on tooth decay and because of the age restriction of the measure and the relatively low volume of such services. I happened to be looking around last night at CMS-416 data, a bit of a data nerd that probably doesn't apply to at least in this particular area to a lot of folks on the group. And I noticed that if I look at the national data for 2019, as well as 2020, 2020 obviously being impacted by COVID. So I looked at the 2019 year, the pre-COVID year, and, you know, it heartened me to see that we've got a long way to go yet in these preschool age kids, but there has been some substantial progress over the decades. Part of that progress comes from other folks other than dentists, primary care providers, family practice, pediatrics, community program. But if you look at that data and you look at the various lines, kids getting any dental services, kids getting preventive dental services, kids getting oral health services, which in Medicaid is defined as not directly provided by or under the supervision of a dentist. And then there's also a measure in the 416 that looks at whether the kids got either services provided by a dental provider or an oral health care provider.

So, the real impact has come and at present is demonstrated really in the one- to two-year age group of where we still see 60 percent of the kids who are getting preventive services, getting those services from a dentist, which I can tell you is up considerably in terms of the absolute numbers from what it was, you know, 10 years ago. But if you look at the marginal impact of oral health care providers, not dentist or not services provided under the supervision of dentists, in the three- to five-year-old age group, that's a five percent addition. Good. We appreciate it. It's good for the kids to have a higher level of services and to get those additional. But 50 percent of the kids in the three- to five-year-old age group now that are getting preventive services are getting them from dentists, dental providers. So, I don't want my remarks either to be construed as not recognizing the positive steps that NCQA has taken in replacing its former Annual Dental Visit measure with two measures, oral evaluation by dental providers and this limited age range topical fluoride measure that we're considering today. So I think, you know, in terms of HEDIS measures and measures looking at plans, that's a step forward in some ways, certainly over the old Annual Dental Visit measure. But for the Core Set, I think that the current topical fluoride measure, along with the dental sealant measure that we have approved is a more precise measure of whether Medicaid kids are getting evidence-based preventing services. You know, I have a 30-year perspective of looking at those improvements. And 50 percent is still only a glass half full. But it is a lot better than the 18 percent we were seeing back in 1993. This measure is easily able to be calculated based

on straightforward analysis of Medicaid claims, administrative data, reporting on the topical fluoride measure, using T-MSIS data that is available on the DQA dashboard for all states, you know, for the years when the T-MSIS data are available. Therefore, I am going to strongly encourage my fellow Workgroup members to vote to retain the current measure and to vote no on removal of the current topical fluoride measure. Because in my opinion, I think the criteria for removal of the current topical fluoride measure have not been met. Thank you.

Margo Rosenbach:

Thanks, Jim. There are a couple of things I'll just follow up quickly on that were included in the measure information sheets to clarify a couple of points you made. First, you mentioned that you weren't sure if the measure had been tested before adaptation, the NCQA measure. And we did confirm with NCQA that no, it had not been tested in Medicaid and CHIP. I do also want to note that this is a first-year HEDIS measure that is currently being reported measurement year 2023. So, it's in process as a first-year measure. I will also say that it's a first-year Core Set measure for FFY 2022. And we are in the process of winding down that Core Set reporting cycle. So, we don't have data that we can share, because they have not been publicly reported. They're still being reviewed by states. But what I will say, maybe going a little bit out on a limb, is that enough states did report the measure so that it will be publicly reported for FFY 2022. So just a little more information, maybe from the standpoint of feasibility, to say that we do have evidence that states are able to report the current measure in the Child Core Set because it has been part of Core Set reporting in the most recent cycle. So, with that, I think those were the comments that I wanted to add on.

Sam, turning to you. Sam, you should be able to unmute. Derek, can you make sure that Sam is unmuted?

Sam Zwetchkenbaum :

Thank you. Yeah, I just wanted to also speak against removing the current measure. We've been using this in Rhode Island with our managed care program, the RIte Smiles Program, as a way for their quality improvement initiatives. They've been doing a good job outreaching to all child age groups, whether it's through community events or supporting school-based screening. And we have a school-based sealant program, but they also can do fluoride varnish. We promote it all the way up to age 20 just because the evidence promotes that it is an effective preventive measure. It's effective for both primary and permanent teeth. And even though I'm not a pediatric dentist, I do know that permanent teeth typically erupt starting at age six. Children have continued risk for dental caries, especially those in Medicaid populations. I will tell you our recent Rhode Island basic screening survey data, which looks at third graders, found a rate of decay experience of 45 percent and over 50 percent in those in schools with greater than 50 percent free or reduced school meal programs. So, again, we see disparities based on socioeconomic status. We also know that one in four had untreated caries. So, we want the MCO to continue using this as a measure, and we’re afraid that if we reduce a measure to, say, just one to four, it could send a concerning message to parents and dentists that it’s no longer recommended. Fluoride varnish is recommended for all of the age groups. So, again, encourage not removing this measure. Thank you.

Margo Rosenbach:

Thanks, Sam. Lindsay Cogan, you're next. Lindsay, are you able to unmute, or Derek, can you unmute Lindsay?

Lindsay Cogan:

Okay, I got it. Thanks. Thanks, Margo. I'm going to comment on sort of a different perspective and that of sort of the state effort that goes into these measures. This is one I've mentioned before. It would have been great if this measure could have been completed for the states, because I believe it is a part of the measures that are looked at for the 416, much like we do for the – much like CMS does for the other dental measure. They program that for states. This would have been another one that I would have really highly suggested, and I think I have said previously, that that also be on that list of things that could be done for states. Then my other comment is, you know, to swap out a measure that's so close in nature, that's a tough justification for state-level resources to be put into pivoting on a measure. If there was really strong evidence that the current measure was not achieving the goals that we were trying to achieve in the implementation of that measure, if there were issues with sort of changing clinical guidance or changing guidance around dental care or appropriateness of fluoride treatment, I would say absolutely. That totally warrants the state-level resources that would go into that. But as such, it is just a derivation of the current measure with a couple of changes. I would say at a state level, that does not warrant the resources that would go into having to reformat and reprogram this measure. And I just want to comment that people always tend to fall back on claims-based measures being something that, you know, is very agile and easy to sort of pivot on, and I would really encourage folks to become more educated about the costs that go into that at the state level of programming these measures. Often states make contracts with vendors. A change request takes time and is incredibly costly on some of these contracts. So, I would just encourage folks to really consider the fact that I don't really care if it's administrative. It still takes effort to program these measures. Thanks.

Margo Rosenbach:

Thanks, Lindsay. And one thing I'll say, if you recall earlier in the day, we mentioned exploring the use of alternate data sources to calculate measures, and this is one measure that we have been exploring, the use of TAF data. I can't say whether CMS will decide to move in that direction, but it is work that has been underway to speak to your question or concern about ways that we might be able to ease state burden. So that work is underway. So, thank you for your comments there. Jakenna?

Jakenna Lebsock:

Thanks. So totally different perspective and respect everything that's been shared to date. Arizona is a state that does report this measure as currently written, but I think we do have some concerns around the measure. And I think the reality that comes with any of the measures, even if they're found on the Core Set, is that there are still only a limited pool of resources that can go into driving change and having meaningful impacts. And it's decisions that we make every day as we deliver care and services to the populations that we serve. And I think that while that oral health continuum and support for all EPSDT members is really important, the place where we can really establish good habits and build upon a solid foundation is for that younger population. And so, I'm actually in favor of moving towards a more targeted population. I think that it will resonate better in the way that our state's

structured. I think it drives, again, that really targeted focus where we actually have an opportunity to have outcomes and positive benefit associated with it. I think it gathers the attention of the health plans that are in alignment with us to serve these populations.

Another thing that has been a very big consideration, and this may be Arizona specific, but we have a very large population, very outspoken against fluoride varnish. And so, to make that argument in general education really becomes challenging. And we actually see a lot of disassociation in terms of how this is received and how the population feels about the fact that state and federal dollars are being used to deliver this service. And so we have to be mindful of that, regardless of personal belief about benefit or anything like that. And it is something that we hear regularly as being a point of concern versus benefit. And so there's a lot of moving parts that come into any measure, as I said even earlier. But we definitely have concerns in terms of that full-scale implementation. Again, we can report on it. That's definitely not the issue. But in terms of where we can really leverage our resources mindfully and drive outcomes, we think a more targeted focus would really be in the best interest of the state.

Margo Rosenbach:

Thanks, Jakenna. Clara?

Clara Filice:

Hello. I believe I'm off mute now. I just wanted to comment that here in Massachusetts we do intend to continue using the DQA measure, which is being implemented in our Accountable Care Organization program this year. And there are a couple of reasons. I'll just highlight some of which have been already spoken to. But we do believe that the preventive care across the full spectrum of kids up to age 20 is important, especially given disparities in care that we do observe in older kids as well as in younger kids and the significant prevalence of caries and other dental issues among older kids as well as younger kids. We also, you know, the USPSTF recommends up to age five. Bright Futures, I believe, still recommends up to age six. USPSTF is also in the process of developing new recommendations for kids 5 to 17, which just weren't included in the initial recommendation, not because preventive interventions for that group should stop after age five, but just because it wasn't scoped into the review for the original recommendation. So, we would favor continuing to use the measure that's already in place, the DQA, rather than replacing with the NCQA measure.

Margo Rosenbach:

Thanks, Clara. Well, with that, I think we're going to move to the next measure. So thanks for all the comments on the topical fluoride measures. We'll vote on these measures after we discuss the last dental and oral health service measure and have an opportunity for public comment on all three measures in this domain. So now I'll turn it over to Caitlyn to introduce the last Dental and Oral Health Services measure.

Caitlyn Newhard:

Thank you, Margo. Next slide.

Now we will discuss the Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults. This measures the number of emergency department, or ED, visits for ambulatory care sensitive non-traumatic dental conditions per 100,000 member months for adults. The measure steward is the American Dental Association, or ADA, on behalf of the Dental Quality Alliance, or DQA, and the measure is not NQF endorsed. The data collection method is administrative. On this slide, you can see the denominator and numerator definitions for the measure. The Workgroup member who suggested this measure for addition explained that this measure fills a significant gap in measuring adult oral health care. The Workgroup member noted that non-traumatic dental condition ED visits, one, represent untreated disease, which remains untreated due to a lack of definitive care in the ED, two, are associated with high rates of opioid prescribing because care is not definitive and commonly focuses on alleviating pain, three, are disproportionately experienced by Medicaid beneficiaries compared to commercially insured individuals, four, reflect racial disparities, and five, reflect health inequities.

The Workgroup member also noted that there is a growing body of research indicating important connections between oral health and overall systemic health, with even larger implications for beneficiary well-being. The Workgroup member commented that the variation in definitions of non-traumatic dental condition ED visits has been a barrier to making comparisons between entities and for monitoring changes over time. The standardized code sets used in the suggested measure would allow for consistent calculations between entities and over time. This measure was discussed during the 2021 and 2022 Core Set annual review meetings and was not recommended by the Workgroup for addition. The Workgroup members expressed concerns that dental benefits for adults enrolled in Medicaid vary across states, and not all states had dental benefits at the time. However, in 2023, all states offer dental services for pregnancy-related Medicaid coverage and some level of general adult coverage. Therefore, the Workgroup members suggested the measure for addition to the 2025 Core Set. Next slide. Now I'll pass it to Margo to facilitate the Workgroup discussion.

Margo Rosenbach:

And thanks, Caitlyn. And I know we had some earlier conversation about the frequency of pregnancy-related Medicaid coverage being in all 50 states. But we do know that there is some level of general adult coverage now in all states, and so that’s the context in which we now talk about this measure.

So with that, I will open it up to Workgroup members to make some comments. Jim, you're still listed as -- or do you want to make -- there you go. Sam?

Sam Zwetchkenbaum:

Hi again, everyone. This is Sam from Rhode Island. Yeah, using the emergency room for non-traumatic dental conditions, you know, those that are preventable by routine dental care, it's very costly. They don't actually provide care, and it really reflects failures in the dental health care system because, again, people who use the emergency room for non-traumatic dental conditions, they don't have a dental home. So, it really is kind of an outcomes measure for how states are doing. Rhode Island has been using hospital discharge data for emergency room use. It's a very difficult analysis. It does not allow tying in other Medicaid data, but it does point out that there is work to be done to achieve equity. We do see that Black Rhode Islanders use

the emergency room at three times the rate of white Rhode Islanders for non-traumatic dental conditions. I know this has been presented previously, but this has really come to the forefront as states are looking to reduce any unnecessary emergency department use. COVID has increased the use of emergency departments. So, if we can address this better, it's really important.

Also, use of opioids has traditionally been -- that's kind of the only thing they can do. So, if we can look at this as a measure to reduce opioids for dental care. In Rhode Island, we are developing a program in collaboration with an emergency physician team to position a dental hygienist in an emergency room to help with triage and care coordination. The goal, again, is to reduce unnecessary visits and get someone to appropriate care. There are other states that have projects currently -- a community-based intervention in Michigan that provided oral health education and dental services to uninsured adults, decreased the number of patients going to the local ED for dental pain by 70 percent over a six-year period. There was a community dental access program in rural western Maryland that had a decrease in ED visits. And a Maine hospital opened a dental clinic for low-income adults that sees more than 500 patients per year. So, again, this is really now at the forefront more because of COVID, and it has resulted in more quality improvement projects. So, I would strongly encourage approval of moving this measure forward. Thank you.

Margo Rosenbach:

Thank you. Sarah? Derek, can you make sure -- Sarah Johnson, yes, I think you're unmuted now.

Sarah Johnson:

Can you hear me now?

Margo Rosenbach:

Yes, we can.

Sarah Johnson:

Oh, great. Yeah, I just wanted to mention that we're working with a couple of states currently who are using this measure to guide performance improvement efforts, and I just, you know, wanted to say that I think this measure in particular adds a ton of value. You know, a lot of our measures and as a result the corresponding improvement efforts really focus on getting everyone in for preventive visits. The entities and staff are really putting systems in place to get everyone in for that preventive visit. You know, that's what we want them to be doing, and the nice thing about this measure is that it really highlights the instances where those systems are falling short and those QI efforts aren't working, and it really forces the entities to think about the population that ends up in the ED and those missed opportunities for prevention. So, you know, I think that understanding why the systems don't work in those cases is just incredibly valuable for states' improvement efforts, and so for that reason I wanted to endorse this measure, and that's everything for me.

Margo Rosenbach:

Thanks, Sarah. Kim Elliott?

Kim Elliott:

I think I continue to struggle with this measure. I understand the value of it, and I think it's a really important topic, but if all states are not providing coverage for all adults for dental care, including the preventive types of care, I think we're going to have continued problems with data, data sources, ability of states to dedicate resources to implementing this measure, even though I think the topic itself is really an important topic. I think from a measurement perspective, I'm not sure that we're ready yet for it to be added to the Core Set.

Margo Rosenbach:

Thanks, Kim. Jim Crall?

Jim Crall:

Yes, thank you, Margo. Yeah, I think, you know, I've been on the Workgroup for many years now, and, you know, the question, why is this brought up again? And there's always expressions of reluctance around the issue of the extent of coverage. But, you know, I think if we get out of our siloed mindset, if we look at Medicaid beneficiaries and the well-being of Medicaid beneficiaries, they're impacted regardless of the extent of benefits, dental benefits that the state has. And there's nothing that precludes the state from using some other mechanism to improve the oral health and to reduce the ED expenditures that they're seeing directly from services being provided, which don't address the root cause of the problem. No pun intended. And also, you know, the related issues of things like dental visits and EDs being one of the prime, if not the top diagnosis when opioids are prescribed. So, to me, it doesn't matter in the end, you know, whether or which states right now have which coverage. And I'm glad to see that many states are actually moving to improve their adult dental benefits and Medicaid, hopefully to address this and other sort of related issues. But I think the time is now to do this. And the other reason I think it was brought back is that, you know, there were 20 organizations that provided feedback after last year's Workgroup meeting that said that they were disappointed that this measure didn't get voted in again. And I think we do need to listen to our broad stakeholder community. So,, thank you.

Margo Rosenbach:

Thanks, Jim. Linette, you're next.

Linette Scott:

Thank you. I mean, I'm listening to Kim and Jim and just thinking about the different components that come into play, recognizing that this measure, because it is emergency department visits, there is an aspect that for states that have hospital data collection and emergency department data collection, there's additional data that can be used other than just the Medi-Cal claims data. But I struggle in terms of what does it mean? So, what does it mean when we understand this? And when is the right time to add it? Kind of piggybacking on Kim's comment, I mean, in some ways it seems like if we see high levels of ED visits for dental and

that correlates with states that don't have adult dental benefits, that perhaps is a case to be made for adding adult dental benefits, which given this can be done with claims data, I mean, that would be a fascinating study to see and to maybe have those results feed into the policy conversation. But I'm wondering, kind of given some of that context, is this the right time to make it a Core Set measure? Is that the use of the Core Set measures to try to drive those kinds of policy changes and coverage? Or is it how we're measuring performance in the context of services that we do cover and do provide? So, it's a little bit of a philosophical question, but just kind of wanted to raise it from that perspective for us to think about. Thanks.

Margo Rosenbach:

Thanks, Linette. One of the things I was thinking about as you were talking is that we're talking about the 2025 Core Set. So that would be for utilization in 2024. So, a year from now, a little less than a year, and it would get reported at the end of December by states in 2025 and would get publicly reported in 2026. So, we're looking pretty far out now when we start accelerating the Core Set Review to now be looking at 2025. So, I just want to give everybody that frame of reference because it was something that was occurring to me as you were talking that we're talking a little bit farther out in the future by the time we would actually even have this data to understand what's happening. All right. David Kelley, you're next.

David Kelley:

Thanks so much. And I'm not a dentist, just a general internist, but from a population health standpoint, I think it's really vital that we add this to the Core Set. Whether you have an adult dental benefit or not, it's pertinent. In our state, we have an adult dental benefit with some limits, but we also know that less than 30 percent of our adults actually access any dental benefit. So, looking at this ED measure is important to me, and we look at something very similar to this, but it actually gives us an indication of where are the failures at. You know, what particular EDs is this really a problem? Are there certain counties or are there areas where there's poorer access?

So, if you're looking at this from a population health standpoint, to me it makes total sense. One of the other Core Set measures is looking at diabetes admits, I believe, short-term complications per 100,000. And there was a recent article that looked at the lack of periodontal treatment in diabetics and how those costs were actually, I think, 13 percent higher in those folks that did not have access to periodontal treatment. So, it would be interesting to actually look at, you know, how does ED visits and diabetes for short-term complications, how does that actually go hand-in-hand? So, this isn't really just a judgment call on who has an adult dental benefit and who doesn't. I think there are a lot of benefits within each state to look at what's actually happening. If you really truly believe in whole person care, the oral cavity, the last time I checked, is actually connected to the human body. And there's a growing piece, pieces of evidence, some have already been cited, around the inflammatory process that goes across multiple diseases, including cardiovascular disease, as well as diabetes, as well as some other perinatal conditions that have been previously discussed. So, I'm very supportive.

I think it's time we've had this discussion. States that don't have an adult dental benefit, fine, you still pay for emergency room visits. Don't you want to know how many of them are actually occurring? We do. In fact, within our managed care plans, we look at dental visits and we actually do efficiency adjustments and pull those costs out of their rates because we expect

them to get folks out of the ED and actually to dentists. So I'll finish up by saying I'm very highly supportive of this measure, and I think it's about time that we add it to the Core Set.

Margo Rosenbach:

Thanks, David. Next up, Ben Anderson. Ben, are you able to unmute?

Ben Anderson:

Okay, there we go. I just got the option. Thank you. Yeah, I wanted to weigh in, you know, just thinking through this from a consumer perspective. I mean, it's quite alarming to think that if you had a dental issue, that the first place that you might need to go would be the emergency department. And it seems to me that there ought to be a way to know how often that's happening within Medicaid. And so, I'm really persuaded by a lot of the comments I've heard in that regard. You know, but I'm also sensitive to, you know, the issues of feasibility and so forth. And I'm wondering if folks who have already commented against this or other folks waiting in the queue have any additional information around those sorts of technical and feasibility issues? Or is some element of this already being captured by the states in a way that would be widely available and reported by all states? If it's not, it seems to me that this is something that ought to move forward.

Margo Rosenbach:

Thanks, Ben. Lisa Patton.

Lisa Patton:

Thank you. Yeah, I'm really torn on this one. And I will say I was nodding my head vigorously when Linette was talking and then also when David was talking. So, I'm really torn. But, you know, I like the work we've been able to do. So, we've done a lot of work around ER visits for people with serious mental illness. And I know that's had a very positive impact on care coordination. And so, I think the access to care issues that this gets at are really vital. And as the previous speaker was saying, you know, it's really tough, but it's the reality that many people do seek their dental care through an ER visit. And we really want to begin to build those better networks and connections and engage in preventive care. So, I think that messaging and that focus is right on point. Not for today, Margo, but it might be helpful because I do also look at this from the opioid and perhaps drug seeking perspective, you know, to look at this measure as part of the larger context of the opioid measures that we do have in the Core Set. So, it might also, you know, be worthwhile to kind of discuss where it might fit in with that, given that some of the dental care, you know, is focused around that opioid access. And I'll stop there.

Margo Rosenbach:

Lisa, those are great comments. And in fact, CMS recently released an oral health infographic that has some data related to this measure and also about opioid prescribing. So, you're very much on point, I think, with the way work is currently underway. And we will send out a link through the chat with that oral health infographic for those who are interested. It has some really good data. Laura Pennington.

Laura Pennington:

Thanks, Margo. Just really briefly, Washington State, we're supportive of this measure and we get asked for this information on a fairly regular basis. In addition, I think this information is helpful to understand ED utilization patterns, which we're very interested in, including those that are potentially avoidable and how we can do a better job of reversing that. That's really all I have to say. I agree with a lot of comments said already, but I think for Washington State, at least, we're supportive of this measure. Thank you.

Margo Rosenbach:

Thanks, Laura. Rachel.

Rachel La Croix:

Hi. I just wanted to – a number of folks have already made some of the comments that I would like to make, but I will just say that Florida supports this measure as well. This is a measure we've already been requiring our dental plans to report on for several years. Although adult dental services are not a covered benefit under our state plan, they are covered as an enhanced service being offered by our dental plans. They are offering preventive dental services for adults. To go back to a point that several folks have made, this is a good outcome measure in regards to dental care. I know that we've talked a lot in the other years of the Workgroup meetings as well about wanting to shift to outcome measures when they are available in different areas. Then one of the other things, too, is also that focusing on these adult dental-related ED deficits, particularly ones that are potentially preventable, is a really good opportunity for providing better care coordination for those members to try to get them to seek preventive dental services and care in other more appropriate places and really offering just better care coordination and planning with members. This is an area where we've put requirements in place for our dental plans as well in terms of needing to follow up with any members that have dental-related ED deficits and use that as an opportunity for education and care coordination, establishing a dental home, and all of those things. So, I do think that this is a good measure that really could spur quality improvement in a number of different ways.

Margo Rosenbach:

Thanks, Rachel. We have time for one more comment from Stacey Bartell.

Stacey Bartell:

Hi, thank you. I agree with the previous speakers. From a care perspective, this can impact many things, including times in the emergency room. As was brought up earlier, the relationship to chronic disease management, like with regard to diabetes, how it drives up the blood sugar. From an all-person perspective, we probably need to be looking at what matters to people and what's the overall cost. Even though we live in states that do provide this benefit, if we're not measuring it, how do we know how well the benefit is working, and how do we know if we have good access? So, I think there's improvement to be made in many states, not just in those states that aren't offering the benefit right now. But I think even in states that are offering it, we can use this as a jumping point to improve care, reduce cost. Certainly, antibiotic

prescribing is over-prescribed in the emergency room when these patients come in, along with pain management. So, I think there's a lot of potential for improvement here.

Margo Rosenbach:

Thanks, Stacey. I see Kai, you have your hand raised. We'll take a comment from Kai and then turn to public comment. Kai, are you able to unmute?

Kai Tao:

Now I am. It wasn't allowing me to, just so you know. I think I would love to hear a little bit of -- like, I'm hearing all the great reasons, like, downstream of, like, why this is such a, so to speak, like a proxy to primary care. But do we have any data about race, ethnicity breakdown about this? And, of course, I'm making generalizations, but we know certain countries, you know, just have a very little value about dental care. And I'm wondering who is going to the emergency room as a place because they have found no other source, right? Are they going there liberally because that's just where they go? Are they going there because it's gotten so bad? And then if there's some race, ethnicity, because I often find in Southeast Asian culture, dental is like, it doesn't matter how bad it is. It's just not that big of a priority.

Margo Rosenbach:

Thanks for that comment, Kai. We did put the link to the oral health infographic into the chat. And there is some information in there about variation in rates by states. And also, in fact, some information about the topical fluoride measure as well or some analytics related to topical fluoride. So I hope everyone will take a look at that. And with that, let's turn to public comment. Next slide, please.

And so, I think with public comment, we have three measures to talk about. And given how different they are and how much we've heard about these measures, I'd like to start with topical fluoride and then turn to the ED visit measure. We have about 15 minutes total, so give about five to seven minutes for each. So, I see we have Chelsea and Anne again. Why don't you start, Chelsea? And please, please be brief.

Chelsea Fosse:

Great. Thank you, Margo. This is Chelsea Fosse again at the American Academy of Pediatric Dentistry, AAPD. As mentioned, I'm commenting specifically on the topical fluoride measures being considered. AAPD maintains a publicly available resource, our Oral Health Policies and Recommendations. It's known in our segment in the profession as the Reference Manual Pediatric Dentistry. In each of our policies, best practices and clinical practice guidelines are reviewed and revised as necessary, turning to the latest research at least every five years. There are a couple items relevant to the topical fluoride measure discussion from our policies and recommendations. Our policy on fluoride use and our best practices on fluoride therapy. The policy and the best practice recommend the professional application of topical fluorides throughout childhood, not limited to early childhood. They note that professional fluoride products are intended for application by dental or medical providers. They recognize that topical fluoride is not a one and done preventive service. Further, while the varnish form of topical fluoride has emerged as a preferred product, gel and foam forms are still used by

providers and are indeed effective, and they're effective for primary teeth and permanent teeth, taking us from early childhood to later childhood and beyond. The Academy urges the Workgroup to maintain the existing DQA topical fluoride measure. The DQA measure has been tested and endorsed by NQF. It's developed in alignment with systematic reviews from Cochran and many others. The DQA measure doesn't limit to just one type of product in measuring the service provision, which is effectively what the alternative measure, the NCQA measure, would do. The DQA measure maintains that there are multiple topical fluoride product types with proven effectiveness. The existing DQA measure captures really important information about our oral health service delivery in our complex health care system, allowing us to better understand where, how, and from whom children are getting these preventive care services. And most importantly, from our standpoint, it will continue to measure this important preventive service delivery throughout childhood. Again, we urge the Workgroup to maintain the existing DQA measure, and thank you so much for your consideration.

Margo Rosenbach:

Thanks. An?

An Nguyen:

Hello, can you all hear me?

Margo Rosenbach:

Yes.

An Nguyen:

Okay, I will try to be brief, but I will reiterate that the DQA version for Topical Fluoride for Children has been rigorously vetted and tested and aligns with the best evidence available in dentistry. So, on behalf of NNOHA, again, I want to reiterate that in dentistry, topical fluoride supplementation is one of the best prevention-based interventions that we have with the strongest evidence of efficacy and outcome improvement associated with this intervention. And we have workflows and evidence of its therapeutic benefit throughout childhood, not just limited to those under five years old. It is an intervention where therapeutic benefit is associated with frequency and repeated application. So those elements are really important.

Likewise, the DQA version of the measure captures the broader coding workflows practiced in dentistry to include all forms of topical fluoride and really enables a truer reflection of the application of this evidence-based practice. There are examples of implemented workflows to support the achievement of the DQA's version of this topical fluoride measure in practice. For example, the implementation of a comprehensive management program that included topical fluoride in health centers in Colorado targeted at children through the age of 20, aligned with reductions in operating gram utilization for general anesthesia and reduced caries rates in the dental population served. So, we know that measures that are valid, reliable and feasible, which the DQA version is, that reflect real practice workflows and capture wider populations are really important to helping to advance population health. And so, for these reasons, NNOHA also speaks strongly in support of retaining the DQA version of the topical fluoride measure for children. Thank you for your time.

Margo Rosenbach:

Thank you, An. As I mentioned earlier, Dr. Mark Casey, the dental officer in North Carolina Medicaid, submitted written comment. And his comments are very, very similar to all of the great comments that have just been made by our two previous speakers in terms of the lack of testing for reliability, feasibility and/or validity by NCQA, whereas the DQA measures have been tested for reliability, feasibility and validity. Also, the narrower age limit for the NCQA measure and the broader age range for the DQA measure is preferred. It's stratified by age groups, which include a subset of the same under age five pediatric population on which the NCQA measure focuses, but the benefits of topical fluoride application for children go well beyond the age of five. And not including older children in the denominator and numerator of a dental or a health quality measure is a missed opportunity for meaningful data collection regarding the prevention of disease in older children. Anecdotal information from our enrolled North Carolina Medicaid dental providers has confirmed that the COVID-19 pandemic resulted in changes in diet and oral hygiene practices, which impacted school age children more so than preschool children. It would be a mistake to not collect important data on the efforts to prevent disease at a time when caries rates in school age Medicaid and CHIP enrolled children have increased significantly.

He goes on to mention the benefit of having the topical fluoride rates reported according to type of provider. The NCQA measure does not differentiate between provider types and appears to combine children receiving fluoride varnish from any provider type in one numerator, unlike the three separate numerators which make up the DQA topical fluoride measure, children treated by dentists, by non-dentists, and children treated by a dentist or a non-dentist. As a Medicaid dental manager from a state with a robust physician fluoride varnish program known as Into the Mouths of Babes, I can assure you that the three separate numerators are helpful to our strategic planning for improvements in service delivery, more so than a measure that would combine all provider types in one numerator. So many other comments, but I think that's just a bit to share now.

Any other comments on the topical fluoride measures before we turn to the ED visit measure?

Okay. So why don't we turn to the ED visit measure. I will also mention, I know I did mention earlier a couple comments that Dr. Casey had made around the NTDC measure, the ED visits for non-traumatic dental conditions in adults measure.

There are a few things that I wanted to add. I'll just read a few of them here. Adult dental benefits vary considerably from state to state. However, it is hard to argue that all states should not be making improvements in the delivery of oral health care when all 50 states now cover dental benefits. Sorry, that was related to the adverse, to the oral health during pregnancy. Since nearly all state Medicaid agencies cover emergency dental care for adults, it is imperative that the Adult Core Set of measures feature a quality measure, which can be used to ascertain if ED visits for non-traumatic dental reasons are impacting not only state Medicaid agency health care expenditures, but also the quality of life for disadvantaged adult Medicaid beneficiaries. The ED visit measure can demonstrate to policymakers that the price of inadequate dental coverage can be high in terms of increases in hospital admissions, elevated numbers of prescriptions of opioids, and all deleterious effects associated with that trend, lost productivity, and wages due to absences from work and other health care and societal costs. I

am confident that once measurement of ED visits for NTDC and adults becomes required by our federal partners, that more states will be motivated to expand adult dental benefits to improve their scores on the measure. So those are comments from Dr. Mark Casey. Other comments on the ED visit measure before we turn to a vote? An?

An Nguyen:

This is An Nguyen, again, representing NNOHA. I think I will just say, as NNOHA is the body that represents the dental safety net in this country, I think speaking to the ED visits for non-traumatic dental conditions is really critical for us. There are very few systems where medical-dental integration is practiced as deeply as it is in the federally qualified health centers. Measures like this one in particular bridge the gap between medicine and dentistry and can help drive work that FQHCs are doing to improve health care coordination and reduce costs for the millions of Americans served by FQHCs. Likewise, we know that approximately 2 million ED visits are attributable to non-traumatic dental conditions. This is disproportionately amongst the underserved. Those with Medicaid coverage, young adults, and Black race in particular. And we also know the emergency room or the emergency department is not the location for where definitive care is frequently rendered. So, this represents an important cost driver in the health system for insurers like CMS. Many, many FQHCs are active participants in state-based innovation projects like accountable care organizations and value-based payment programs, which are often looking to reduce costs associated with hospital-based care. And thus, they also need validated measures to support this kind of work.

The proposed measure has been thoroughly vetted and tested as a way to do so, and it helps to drive the system to invest in quality improvement for right care in the right place. I would also go to say the visibility this measure gives to issues that we know exist in underserved communities, especially highlight to serve important linkages that FQHCs have already established with very little or inconsistent support to do so, like embedding dental case management, care coordination, and even dental providers within hospital systems, with the goal of diverting non-traumatic dental conditions away from the costly emergency room and into the dental safety net where definitive and continuous care can be rendered. Within NNOHA, we very frequently say that we believe in the adage, what gets measured gets done. And a measure like this reflects a really key area that's critical to improving oral and whole-body health, especially for underserved communities. And so, we thank you for considering our comments today in your vote and, again, ask you to add the ambulatory care sensitive ED visits for non-traumatic dental conditions to the Adult Core Set. Thank you.

Margo Rosenbach:

Thank you. Thanks to everyone who's made comments, Workgroup members, as well as public comments. I think we are ready now to take a vote on the three measures. So next slide, please.

So before I turn it over to Alli and Talia for the voting, I wanted to mention that the Workgroup will first vote on whether to add the NCQA version of the topical fluoride measure, which has been suggested as a replacement to the current DQA measure, and then the Workgroup will vote on removing the DQA version of the topical fluoride measure. This has been a topic of conversation over the years of how to vote on paired measures, and the Workgroup has indicated a strong preference to vote first on a measure for addition before a measure for

removal. So, the Workgroup will first vote on whether to add the NCQA version before it votes on removing the DQA version of the measure. So, with that, let's turn to voting. Alli?

Alli Steiner:

All right. Thank you, Margo. So, for the first vote in this domain, the question is, should the Topical Fluoride for Children NCQA version 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 now open.

As a reminder, please refresh your browser if the question does not appear for you.

Thanks, everyone. We're just waiting on a couple more votes. Thanks for your patience. We're just waiting on one more vote.

Thank you for your patience. Looks like we're waiting on a vote from Karly. Karly, if you're back, could you either try to vote or to put your vote into the Q&A and select all panelists, please? All right. Thanks for your patience. Looks like we might be down one attendee right now, so give us one more moment.

Okay, we've reached the expected number of votes. Okay, so 26 percent voted yes, and that does not meet the threshold for recommendation. The Topical Fluoride for Children NCQA version measure is not recommended by the Workgroup for addition to the 2025 Core Set. Moving on to the next slide.

The next vote is should the Topical Fluoride for Children measure, the TFL-CH DQA version, be removed from the Core Set? The options are yes, I recommend removing the measure, or no, I do not recommend removing this measure. And voting is now open.

Thanks for your patience.

Okay, great. We can close the vote. Okay. And so, for the responses, seven percent of the votes recommended to remove the measure from the Core Set. That does not meet the threshold, so the Topical Fluoride for Children TFL DQA measure is not recommended for removal from the 2025 Child Core Set. Okay, moving on.

The last vote is should the Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults measure be added to the Core Set? And the response options are yes, I recommend adding this measure, or no, I do not recommend adding this measure to the Core Set.

We're waiting on a couple more votes. We're just waiting on two more votes. Thanks for your patience. Thanks, folks. We're just trying to figure out whose votes are missing. Okay, great. I think we might be missing Tricia Brooks. Tricia, could you either -- oh, okay, I think we just got up to -- I think we just got up to 30. Let us just double-check that, and then we'll close the vote. Okay, we're at 30 votes, so we can close the poll. Thank you for your patience.

Okay, for the results, 80 percent of Workgroup members voted yes, so that does meet the threshold for recommendation. The Ambulatory Care Sensitive Emergency Department Visits

for Non-Traumatic Dental Conditions in Adult measure is recommended by the Workgroup for addition to the 2025 Core Set. Thank you so much, everyone, for your voting, and now I'll turn it back to Margo.

Margo Rosenbach:

Wow, that was pretty intense. Thanks, Alli. Thanks, Talia. Thanks to everyone who was working behind the scenes to track the votes.

So that brings us to the end of our measure discussion today. Thank you, everyone, for a robust conversation. We appreciate everyone's contributions during both the stratification conversation this morning and the measure discussions this afternoon. So, in terms of the agenda for tomorrow, well, first let me recap what happened today for those who haven't been on for the full afternoon. So first, Oral Evaluation During Pregnancy was recommended by the Workgroup for addition. Topical Fluoride for Children, the NCQA measure, was not recommended for addition. So, the Topical Fluoride for Children measure, the DQA version, will remain and is recommended to remain in the Child Core Set. And the Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults was recommended for addition. So, thank you, Workgroup members, for all of your consideration. I know there was a lot of deliberation both in terms of the Workgroup and the public comment. In terms of the agenda for tomorrow, next slide.

So tomorrow we'll discuss measures for removal and addition in three domains. Care of Acute and Chronic Conditions with two measures suggested for removal and one measure suggested for addition. Behavioral Health Care with one measure suggested for removal. And Experience of Care with one measure suggested for removal, which has two rates, one for child or two components, one for child CAHPS and one for adult CAHPS. We'll begin promptly at 11 a.m. Eastern again tomorrow, and we ask Workgroup members to sign in about 10 minutes early. Kim and Rachel, do you have any final remarks to close out the meeting today?

Kim Elliott:

It's a fun meeting. That was great. Yeah, it was a very, very productive, informed, packed day today. Everybody was just fantastic, all the participation, all of the real thoughtful consideration that went into the feedback and discussion. I think it allowed all of us to really make some good decisions on our voting today, and I'm looking forward to an even more impactful day tomorrow with chronic disease, behavioral health, and member experience.

Rachel La Croix:

This is Rachel. I'd just like to echo Kim's comments and just thank everyone for sharing their perspectives and thoughts around all the measures that we discussed today. I know I always learn a lot from everyone during these calls and meetings, and it really is helpful to see the range of perspectives around these measures and what consensus we are able to come to on the measures. So, I look forward to that continuing tomorrow.

Margo Rosenbach:

Thank you, Kim and Rachel. We wish everyone a nice rest of the day, and this concludes day one of the 2025 Child and Adult Core Sets Annual Review Meeting. We are adjourned for the day. See you all tomorrow.