Child and Adult Core Set Stakeholder Workgroup:
2021 Annual Review Meeting Day 2 Transcript
April 29, 2020

Hello, everyone, and thank you for attending today's event, the 2021 Child and Adult Core Set Annual Review Meeting, Day Two. Before we begin, we wanted to cover a few housekeeping items. Next slide, please.

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Thank you, Brice. Next slide.

Hi, everybody. I hope you had a nice evening and are recharged and ready for day two of the stakeholder review of the 2021 Child and Adult Core Set. We have a full day ahead of us today with measures in three domains to review: Dental and Oral Health Services, Maternal and Perinatal Health, and Experience of Care. We'll follow the same format as yesterday with an introduction of the measures by the Mathematica team, followed by Workgroup discussion, then public comments, next voting on the measures and finally, a discussion of gaps within each of the domains. I have a few housekeeping things that I wanted to start off with. Operator, could you make sure that Workgroup members are able to mute and unmute themselves at this point? And Workgroup

members just a reminder to keep your lines muted on your phone or headset when you are not speaking. And also, Workgroup members, please log into the voting app and navigate to the Core Set Review page, so that you'll be ready to go when voting occurs in a little bit. And just a reminder that only Workgroup members are eligible to vote on the measures.

So now, I wanted to give a quick recap of yesterday's meeting. First, we provided context and level setting to frame the Core Set Review for Workgroup members, federal liaisons, measure stewards and members of the public. Next, we reviewed the criteria for assessing measures for addition to and removal from the Core Sets. Then, we introduced the procedures for voting including a couple of practice votes, and just a reminder, please mute if you're not speaking. The first domain reviewed this year was Long-Term Services and Supports with two measures suggested for addition. Neither of the measures were recommended by Workgroup members for addition to the 2021 Core Set. The second domain discussed yesterday was Primary Care Access and Preventive Care.

There were two measures suggested for removal and three suggested for addition. One of the measures was recommended for addition to the 2021 Core Sets namely the Prenatal Immunization Status measure. All of the discussions were robust with substantial participation by Workgroup members. We also appreciated the contributions of public commenters and measure stewards to inform the Workgroup perspectives. Finally, the inclusion of the gaps discussion within each domain will be helpful in charting a course for the future to identify existing measures that could be considered for the future of Core Sets or the suggestion to develop new measures in the future. For those who missed the meeting or who would like to listen again, the recording is available on demand on the Core Set Review website where you registered for the meeting. I would now like to ask Gretchen Hammer and David Kelley, our two co-chairs, if they have anything to add. Gretchen and David?

Thank you, Margo. No, I appreciate the recap of yesterday. It felt like we did a lot of very important work. I would just remind us of some of the ground rules that we tried to set, which is, discourse is really a good component of this discussion. And we appreciate everyone being engaged and having a conversation. And also, continuing to act as a steward of the overarching mission and vision of the Medicaid and CHIP program, in addition to bringing your unique perspective based on the work that you do in your professional life. So, we appreciate that. I think the ways in which we acknowledged the changing landscape with the pandemic was really helpful yesterday, toggling between what we know we need to continue to measure and try and improve but also recognizing the changing environment. So, I appreciate that, and I look forward to our conversation today.

Thanks, Gretchen. And I want to thank everyone for the great discussion that we had yesterday. And then, hopefully, that will continue today and tomorrow and really appreciate the fact that the very well-thought-out discussion and folks have been very respectful of each other. So, really appreciating all of the hard work that the Workgroup has brought to the table and move on to our task at hand.

Okay. Thank you, Gretchen and David. And before we begin our review of measures this morning, I wanted to do a quick roll call of Workgroup members. When I say your name,

please unmute and let us know you are here. So, Gretchen and David, we know you are here. We've heard from you and thank you very much. Richard Antonelli.

I'm here.

Lowell Arye.

Hello. I am here. Thank you.

Tricia Brooks. Great, thank you. Tricia Brooks?

I'm here. Sorry. I'm trying to get off mute.

Sure. Laura Chaise.

Hi, good morning.

Lindsay Cogan.

I'm present.

Jim Crall.

Yes, I'm here, Margo. Thank you.

Anne Edwards.

Good morning.

Kim Elliott.

Present.

Tricia Elliott.

I'm here.

And Steve Groff had let us know that he's unable to attend this year because of the COVID pandemic. So, he will not be joining us. Shevaun Harris.

Here.

Diana Jolles.

Good morning.

David Kroll.

Here.

Carolyn Langer. Carolyn, are you there? Okay. We'll skip over Carolyn.

Okay. Lauren Lemieux?

Yes, I'm here.

Okay. If someone is speaking, please put your phone on mute. Jill Morrow-Gorton.

Good morning, everyone. I'm here.

Amy Mullins.

Here.

Fred Oraene.

Hello, I'm here.

Lisa Patton.

Yes, I'm here.

Sara Salek.

I'm here.

Marissa Schlaifer.

Here.

Linette Scott.

Present.

Jennifer Tracey.

I'm here.

And Ann Zerr also let us know that she's unable to attend today and also yesterday because of the COVID pandemic and hopes to attend tomorrow. Bonnie Zima.

I'm here.

Okay. Carolyn Langer, are you here? Okay. Well, we'll be on the lookout for Carolyn arriving later this morning. And I just also want to announce our federal liaisons who are non-voting Workgroup members, members of Agency for Healthcare Research and Quality, Center for Clinical Standards and Quality, Centers for Disease Control and Prevention, Health Resources and Services Administration, Office of Disease Prevention and Health Promotion, Office of the Assistant Secretary for Planning and Evaluation, Substance Abuse and Mental Health Services Administration, and the US Department of

Veteran Affairs. So, thank you Workgroup members. We know how busy you are and very much appreciate your time with us. Next slide.

Now, I'd like to turn it over to Alli Steiner to start the discussion of measures and the Dental and Oral Health Services domain. Alli, you have the floor.

Thanks, Margo. Next slide, please.

In the 2020 Core Set, there are two measures in the Dental and Oral Health domain, both of which are in the Child Core Set. The Dental Sealant measure is the percentage of children ages six to nine at elevated risk for dental caries that received a dental sealant on a permanent first molar tooth during the measurement year. This measure has been retired by the measure steward and will be retired from the 2021 Core Set. The Preventive Dental Services or PDENT measure assesses the percentage of children ages one to 20 who received at least one Preventive Dental Service during the reporting period. This measure is reported as part of the Form CMS-416 EPSDT report, which state Medicaid programs are required to submit annually in April. The PDENT measure has been proposed for removal from Core Set. Next slide, please.

We will start by discussing the measure suggested for removal, which is the Percentage of Eligibles Who Received Preventive Dental Services or PDENT measure. As I mentioned, this measure is derived from the Form CMS-416 EPSDT report, which states report directly to CMS. This measure is not NQF endorsed and is calculated using administrative data. The Annual Dental Visit measure has been suggested for replacement, which we will discuss next. All 51 states reported this measure for FFY 2018 as part of EPSDT reporting. A Workgroup member suggested this measure for removal for two primary reasons. First, because of the concern with the methodology: the measure requires only 90 days of enrollment in the denominator but counts services provided throughout the measurement year. Additionally, the Workgroup member noted that the Annual Dental Visit measure, which is part of HEDIS, is already being reported by plans. The Workgroup member noted that removal of the PDENT measure would reduce duplication of efforts for managed care plans.

We wanted to provide a little bit more background on state reporting of the PDENT measure. First, states do not report this measure through the online reporting system used for other Core Set measures. States calculate the data elements in the Form CMS-416 based on their MMIS system and submit the Form as part of an Excel file directly to CMS. Second, CMS is currently testing replication of the Form CMS-416, including the PDENT measure, using T-MSIS data. The goal is to reduce reporting burden and standardize calculation across states. CMS intends to give states the option of having CMS produce the measure on their behalf starting with the April 2021 submission. A pilot of the replication process is currently underway with the first state. Next slide.

And now, we'll discuss the four measures suggested for addition to the 2021 Core Sets. The first measure we'll discuss is the Annual Dental Visit measure. This measure assesses the percentage of patients ages 2 to 20 who had at least one dental visit during the measurement year. The measure steward for this measure is NCQA and it is no longer NQF endorsed. This is a process measure and it has - it is being suggested by a Workgroup member to replace the PDENT measure. The measure can be calculated using administrative data. The Workgroup member who suggested this measure noted

that since this is a HEDIS measure, it is already being calculated by plans and could reduce reporting burden. They also noted that there is substantial room for improvements. According to NCQA, the measure steward, the HEDIS 2018 mean was 50.4% among 118 Medicaid plans that reported this measure. One thing to note is that this measure has been proposed for retirement from HEDIS because it focuses on access to dental care rather than quality. Proposed retirement would take effect in HEDIS Measurement Year 2022 to allow time for NCQA to introduce a new pediatric dental measure into HEDIS. Next slide.

The next measure we'll discuss is the Dental Sealant Receipt on Permanent 1st Molars measure. This measure addresses - sorry. This measure assesses the percentage of children who have ever received sealants on first molar teeth by their 10th birthday. The measure includes two rates. One rate for receiving at least one sealant and a second rate for having all four molars sealed. The measure is stewarded by the Dental Quality Alliance or DQA, and it is not NQF endorsed. This is a process measure and is suggested to replace the existing dental sealant measure in the Child Core Set, which was retired by the measure steward. The measure can be calculated using administrative data and the measure requires looking back into historical data 48 months for at least one sealant and for sealants on all four molars. Measure testing was conducted using data from four state Medicaid programs, one academic health center, and one commercial dental plan.

The Workgroup member that suggested this measure noted that the measure improves upon the existing sealant measure by promoting sealants on all molars by age 10, whereas the retired measure looked for sealant placement during the measurement year only. Additionally, the Workgroup member noted that placing sealants has been an effective intervention for reducing dental caries on permanent molars, and that lower-income populations are less likely to receive sealants. To facilitate state reporting of the measure, the measure steward noted that existing programming code could be adapted as a state technical assistance resource. As some states might recall, programming code was available for the previous dental sealant measure, which has facilitated calculation of the measure. Before we move on to the adult dental measures, I'd like to turn it back to Margo to facilitate the Workgroup discussion around the child dental measures.

Thanks, Alli. We'll now invite comments and questions from the Workgroup members. You may unmute your line if you wish to speak and please remember to say your name before making your comment. Let's begin the discussion with the Preventive Dental Services or PDENT measure and the Annual Dental Visit measure. As Alli mentioned, the PDENT measure has been suggested for removal and the Annual Dental Visit measure has been suggested as a replacement. Workgroup members, you may now discuss these two measures. Thank you.

Margo?

Yes, Jim. Hi.

Yes. Hi, Margo. Yes. Thanks very much. Maybe I'd like to start out with just a little bit of context and actually address an issue that Rich Antonelli brought up yesterday with respect to the order of voting on these various measures when we get around to that.

You know, there are actually six measures for consideration here this year, which is a big number for the dental landscape. I'll admit to being responsible for four of the recommendations: three additions and one removal. And I think it's better to think about these things as a package, rather than just picking them off one-by-one. The current measures we have in the Core Set and have had for a while really have a strong emphasis on prevention. And we have the PDENT measure and we have the dental sealant measure that's being retired by the DQA, meaning that the DQA will no longer invest the resources in maintaining that measure on an ongoing basis. Although, it'll still remain as part of a set of measures if entities would like to use that measure.

The sealant measure that we're bringing forward for consideration to replace the current sealant measure really stems from feedback that we have received initially from the NQF committee, where our current sealant measure was submitted for reendorsement or continuing endorsement. And the committee that dealt with it was the Population Health and Prevention Committee that really emphasized that they would like to see a - excuse me, more of a population health measure. Something that didn't just capture whether sealants were placed within a 12-month period but whether or not children were receiving sealants over a longer period of time. And so, that's what the new measure does. And so, I think thinking about the sealants measure removal and replacement, and also thinking about the PDENT measure.

Because if we don't approach the voting in a manner similar to what Rich Antonelli recommended yesterday for the immunization measures, we could end up in the situation where we have taken a radical departure from what's currently in the Core Set with an emphasis on prevention and actually have no measure that has an emphasis on preventive dental services in children. And I think - so it's better to segment the thinking and the discussion on this because two of the measures as you'll note are adult measures for which we have no dental measures in the Adult Core Set. So, I just wanted to give that sort of that contextual background before discussing the individual measures.

I'm actually, for the present, in favor of retaining the PDENT measure for at least one more year. A number of stakeholders have begun a conversation that was convened by CMS to discuss some of the limitations of some of the current measures. And the PDENT measure - I think the main concern about the PDENT measure is that it really depends upon the CDT codes which are the parallel for the CPT code for medical services. And the 1,000 series of the CDT codes which address preventive services, largely focus on what you would consider to be preventive services for children, and clearly the ones that we have good strong evidence base and in some cases US Preventive Services Task Force recommendation that would be for fluoride. But it also includes dental sealants, another very important modality for preventing tooth decay in children. However, the 1,000 series of the CDT codes also contain a few services that you wouldn't normally think of probably as typical preventive dental services. There are things like a space maintainer for when a child loses the tooth. And so, that's been some of the concerns about the - I think the PDENT measure.

But the PDENT measure really does focus more on preventive services. And the Annual Dental Visit measure can be any service. And so, there's a, in my mind, a big trade-off between PDENT and Annual Dental Visits. Partly because Annual Dental Visit covers any dental service a child could show up and get one X-ray, could show up and get -

what's that, an emergency situation, and get some service and that would be it. And maybe we serve no dental services in that year. The other major difference between the CMS-416 and the Annual Dental Visit measure that was pointed out in the introduction here this morning is a period of time that you have to be enrolled in order to be counted in the denominator. For the CMS-416 measures, it's 90 days. For the Annual Dental Visit measure, it's essentially the entire year with a gap of no more than 45 days in enrollment. I have some colleagues at the University of Iowa did some analysis based on Iowa Medicaid and CHIP data sometime in the past and showed that that difference significantly shrinks the percentage of the population that you're actually reporting on by using the Annual Dental Visit measure.

And it actually boosts - it apparently boosts the performance by using the longer period of time. But in fact, it doesn't change the underlying dynamics and percentage of kids that are getting services. It just uses a much smaller portion of the covered population. And therefore, you lose actual reporting on significant numbers of kids. So, I will stop there because I know I kicked off a number of points. But I did want to provide that context that in terms of what some of the trade-offs are and what I think ought to be some of the considerations in terms of the order in which we approach the voting on this.

This is Margo. I'll jump in quickly and do a little bit more level setting that I probably should have done to start. So, first of all, Jim, we're ahead of you on the voting. We've already switched it around so that we'll be voting on the Annual Dental Visit before PDENT similar to Rich Antonelli's suggestion yesterday on the flu immunization measure. We are doing that again today. So, we'll vote on the addition before we vote on the removal. The other bit of level setting that I wanted to mention when Jim mentioned that there was another measure for removal, we did not mention that the dental sealants, the current dental sealant measure was one that Jim had suggested but that because that measure is already being retired, we did not bring that before the Workgroup because that measure has actually already been retired. So, in fact, what I think the decision here today is knowing that there would not be a dental sealant measure retained in the Core Set for 2021.

Is this a good measure to replace that other measure which will be retired? So, I think that's the decision process today voting on the three pediatric dental measures and discussing those through the Workgroup and later on through public comments about the three pediatric dental measures that will get discussed. And thank you, Jim, for all of your expertise and knowledge about the different nuances of these measures and the history and evolution of the measures as well. So, perhaps with that, we'll open it up to other Workgroup members. And Jim, you're a great resource. So, if there are things that you want to actually respond to if people have questions please feel free to jump in.

This is Dave Kelley, Pennsylvania Medicaid. Thanks, Jim. I appreciate your comments and appreciate a lot of the hard work that you've done in bringing forth these measures. I liked how you teed off the discussion. From the state Medicaid program standpoint, I would say that - and we actually measure both the PDENT. We do the 416. But our managed care plans do the ADV. And actually, our pay for performance program that our MCOs currently looks at the ADV measure. With that being said though, we have had huge focus over the last five or six years on really pushing up preventive numbers. And we are internally, as NCQA is moving away perhaps from the ADV measure, we as a Medicaid program are increasingly really pushing the PDENT measure. We actually

share with our MCOs on a rolling annual basis quarterly, how they are performing against each other using the preventive dental measure. And we've put a whole host of interventions in place based on the PDENT measure.

I will say that the 90-day enrollment - I actually like that because we look at numerators and denominators. There's a huge drop-off in looking at both of them. So, there's a - because of the 90-day enrollment, more kids stay in that 90 days. And I know my managed care colleagues will say, "Well, how can we be held accountable for a child is only been enrolled for 90 days?" In my mind, you should be accountable from a public health standpoint and from a Medicaid standpoint for that child the day that they are enrolled. So, I would - personally I like the PDENT measure. I think NCQA is certainly headed towards removing the ADV measure. My one question, I have to you Jim on the sealants, is there - and I'm a big advocate for - I love the old measure. I know there were a lot of nuances and problems with the old measure. The new measure that's being proposed - is there a way to go back retrospectively in claims, or are there current dental codes that would indicate that sealants had been placed in previous years on any of the four molars?

Yes. Yes, David. That's exactly the way the measure’s intended to be used. And we know there would be for some programs a transition, if you will, from the data stream and what had been reported using the old measure which had a 12-month focus as opposed to the new proposed sealant measure which has a longer look-back period. But yes, that's exactly, it's meant to be able to go back. And states would have this data available. And we're also, yeah, encouraged by the possibility of T-MSIS being able to be a resource to actually provide that information and data as well. And I should mention when we'll get around to discussing the details of it. It also allows for assessment of whether a child has had all four of their permanent first molars sealed or at least one of the first permanent molars sealed. The new measure has that.

Thanks, Jim.

Hi. This is Linette Scott.

Okay. So, Linette next and then Jill. Go ahead, Linette.

Oh, okay. So, David, I guess, you and I are sort of on opposite sides of the conversation around the PDENT. I will admit I'm the one that's suggested this for removal. And that the whole issue around accountability is really a challenging one. And it's not so much about whether we should be held accountable or not. But it's, is the data actually there to be held accountable? So, if somebody is only eligible in the Medicaid program for three months, in the months before they became eligible, they had that service done. But then, they come in. We have no record of the service. They did actually receive the service that they needed to receive. But we don't have a record of it. So, we show as not performing on that measure. And so, that actually could potentially drive us to doing additional services that may not be necessary if the service had already been delivered and we just don't have a record of it. And so, that's my primary concern with having a mismatch between the reporting time period and the eligibility time period.

And we have in fact shown that like with our childhood lead testing that when we add in additional data that reflects when they may not have been enrolled, then the

performance is higher. And the performance - when people look at the performance - they don't say, "Well, we expect it to be 10% lower than a 100% as the max because we know that many services happen outside of the Medicaid program that should have been part of the numerator." They just look at the number and where it is compared to 100%. So, that I feel pretty strongly about having eligibility and when you look for services match up so that it's a consistent and a fair representation of the care being delivered. And I think that's a measure issue as opposed to an accountability issue. The accountability issue is part of it, but it is also different issue, and so, how we can be held accountable. And part of that accountability maybe around expectations, in terms of making sure you get their medical history, and are they needing something that they didn't have, or those kinds of things. But I just wanted to provide that comment. Thanks.

Thanks for that. And Jill?

And this is Jill Morrow. I would like to sort of echo what was just said in terms of - especially not just thinking about reporting and people being in the program but thinking about the frequency of the service, but then again, if you have a service that is preventive, and it's really meant to be once or twice a year. And you have 90 days - it may have happened before and you may have missed it. Or it may have happened and not redo again for after the 90 days. And again, you don't want more care that's not necessarily better. The other piece of it is is that access to dental services is always an issue. There are never enough providers. There are all sorts of ways that people tried to get access for kids. And it's not always - 90 days is not a lot of time to find an open appointment in some areas. So, again, I think that's another disadvantage of the PDENT measure. And I actually have a question for David. When you look at 416, it is a single number. Is the data available by age group just because as you're planning and thinking about services for kids, you're thinking about how do you do it for different age groups, and how you might do it for preschool group - Head Start, that sort of thing - is very different for how you would think about school age kids?

This is Margo. I can check in and say that, yes, when the data is submitted to CMS through the Excel file, it is broken out, I believe.

Yeah. And pretty fine slices, less than one-year-old, one to two years old, three to five, six to 14. So, there's some definite slices and some targeting that can be done through analysis and the 416 data. I'll just comment a couple of things, if I could may, Margo. On the 90-day issue, we first have to say that impacts when DQA did its testing, we looked at essentially all three possibilities: 90 days, the 11 months, or the Annual Dental Visits window, which I think is overly generous and risks missing on the other end of the spectrum that Dr. Scott was talking about. And we landed on 180 days, they can move back against time. But that's not the measure before us. And I will also say that the current CMS array of measures I think are much more robust than they once were 25 years ago. There was a single dental measure that included an exam or a few preventive services. We got to a point to where there were three: whether a kid got any dental services, any preventive services, or any treatment services.

And now, we have a much broader array that not only includes dental services, but preventive services that could be provided by a primary care provider. And they use the 90-day window and CMS, if you look at the 416 data, either the national figures or the state figures, which I have done over the years, there has been substantial

improvement. And so, it's not that that measure can't drive improvement or accountability on that matter. If I could just say where I think we ought to be moving and this is part of another Workgroup that's talking about the long-term measures for the Core Set. We ought to really be focusing on two particular services: sealant and topical fluoride application. Those are the two services that have the most evidence that they're going to have an impact on childhood caries. And the other part of the backdrop of movement that can place is to rather than just looking at all children as being the same that we actually assess their risk for developing tooth decay and adjust the recommended frequency of services such as fluoride for higher risk.

And we, in California, currently have this as part of something called the Dental Transformation Initiative, which is part of our current 1115 waiver. A domain that is recommended for expansion beyond the Dental Transformation Initiative to be risk-based, which includes recommendations that children who are deemed to be high risk to receive periodic evaluations and a bundle of preventive services including fluoride on an every-three months basis. So, that would really put the emphasis on your higher risk kids, identifying them and getting them in within that 90-day period or as soon as possible. So, that I think there's history that shows that that measure can be used to drive improvement. And there's also a movement to recognize that it's not just two times a year for every child regardless if they're in Medicaid or not in Medicaid. But within Medicaid or outside of Medicaid, if they're at higher risk for caries, we need to be more intensive in our preventive efforts.

Thanks, Jim. Workgroup members?

This is Rich Antonelli. Hi, Jim. Thank you for that. I'm going to sort of segue back a little bit to the point that I made yesterday, where we had the gap especially within primary care because I think it's relevant here and the assessment of risk, I think is critically important. I like to start with a - I think it would be wonderful to be able to have a focus in the Core Set of the preventive type performance measures as well as something that is interventional. That the point around accountability has been raised several times, so, I'd like to unpack that a little bit of when I'm in discussions that are capital A Accountability. So, speaking about the ACOs and taking on financial risk for finding what are often almost non-existent Medicaid dental providers. For measures that are linked to having access to a dental provider, I use dental codes as opposed to, say, what a primary care provider could do.

I'm always really nervous about that because it's not like those ACOs are purposely excluding Medicaid-eligible dental providers. So, to the extent that a state Medicaid program wants to have a broad incentivization to bring Medicaid providers in, I'm comfortable having measures that look at dental service access that are broad. But I just want the group to be mindful of thinking one of the principles I think about with quality measures in general is, are they fit for purpose? So, I just want to make sure that in the minutes from the discussion today and the report that goes on to CMS…

Rich, we're losing you. Rich, we're losing you. Can you go back to fit for purpose and then make your statement again? Rich, are you there? I just want to comment for the Workgroup and public out there, there seems to be some internet and bandwidth issues today. And so, we apologize with the work from home environment that some people

may be having some connection problems. And that seems to be particularly in the Boston area where Rich is, I am, and Alli is. So, I apologize in advance.

Again, can you hear me now?

A little better.

Hello? Yeah.

Yes. I can hear you a little better now.

I'm glad that this is not a video chat because I'm literally standing in the closet where my modem is. Margo, can you tell me where you guys dropped, or should I start at the beginning of my comments?

Go on from the point of fit for purpose and what you think the fit for purpose is. So, go on from there.

Thank you so much.

Thank you.

So, when I think about quality measures, I'm thinking about fitness for purpose. So, I want the group to recognize that if we put out a measure around dental service access for both adults and kids, if that level of financial accountability goes to the delivery system as opposed to the broader state Medicaid program. So, I just want to really call that point out. Nothing would make me happier than to collect data on adults, the access in particular, because I think there's a greater gap there for Medicaid than there is for pediatrics. But nothing would make me happier to put out quality measures that informed the expansion of adults-based capacity. But I do want to make sure that we raise the issue that putting financial accountability on the delivery systems for somehow getting Medicaid eligible providers. And that could potentially exacerbate problems have people leave the system has delivered. So, I wanted to raise that point. And then, in some in case there was a discontinuity in my comments. Jim, thank you for the way you segmented the discussion. I feel strongly putting something around access and around prevention in the Core Set is absolutely essential. Thank you.

Thanks, Rich. So, Alli is going to go try and stand in her living room when she gets to speak. So hopefully, we'll be working through the sound and going into your closet did help. Thank you. Other comments from Workgroup members before we move on?

Margo, this is Lindsay from New York. I just had a question actually that kind of dovetails nicely into what Rich just said. The CMS-416 Form, can someone clarify for me if that actually includes the preventive as well as a treatment component. Right now, currently in the Core Set is only the preventive portion. But there is another - I believe there's another component that looks at treatment. And if anyone can clarify what kind of treatment is covered in that, I'm just thinking of the path forward that involves not including the new measure and adding burden to states. But perhaps leveraging if we're - we as the states are already required to submit to CMS-416. I just want to better understand what that other measure includes.

And Margo? I can comment on that. Yep. And the -

Sure.

I think you're referring to the Line 12c, Lindsay, which is labeled treatment. And the Line 12a would include any dental service. And very much like the Annual Dental Visit measure except that again, the duration of eligibility 90 days versus 12 months. And 12b is the preventive services, and those are the typical like I said, sealants and preventive. The treatment on 12c is anything other than a diagnostic preventive service. So, it's a filling. It's an extraction. It's a root canal, could be periodontal disease or replacement of teeth. It's everything that is beyond diagnosis and prevention.

Dental health is not my expertise. Where do sealants and fluorides fall? Do they fall under the preventive?

Yeah.

Right now? Currently? Okay.

Yes. They do. But the sealant measure has the specificity about whether that preventive service is actually a sealant. And we even break it down into two separate measures one for the first permanent molars and one for the second permanent molars. But we've only brought forth one of those measures for consideration. And again, as part of a journey and a pathway to get to what we think would be a really solid Core Set that is evidence-based and so sealants and fluoride is where I would hope we will ultimately land. But it's a question of, how many departures do we take from the current path to get there.

And I will follow on in terms of the journey over the years. The measure that Jim referenced the dental treatment services line was called TDENT and it was removed from the child Core Set after 2014. So, it was in the Core Set previously and then removed, which is a little bit of historical context. Other comments from the Workgroup before we move on to the next few measures?

Great. Can you hear me?

Yes.

This is Erin Abramsohn. I'm with the Centers for Disease Control and Prevention. And I am filling in for Jennifer Fuld. She's double booked just for this morning session. Is this an okay time to provide, we have a very brief comment?

Yes, please. Thank you. Go ahead.

Sure. So, I'll start by acknowledging others have already pointed this out and we really appreciate that. However, CDC would just like to note on the record the importance of maintaining a preventive measure related to dental services. So, the sealant measure was updated back in January. I would like to just state that we would not like to see both the preventive dental visit measure and the dental sealant measure removed without adequate replacement. And that's all.

Okay. Thank you, Erin. Other Workgroup comments? Anything else on the Preventive Dental Service, PDENT, or Annual Dental Visit, or the sealant measure before we move on? Okay.

Margo -

Sure.

Okay. I was just going to ask whether or not we're going to move the voting on these before we do the adult measures or whether we're going to discuss the adult measures as well?

Yeah. Thanks, Jim. We're going to discuss the adult measures and then do the voting all at once on all of the measures that are up for voting.

Yeah. Thank you.

But we will make the change that we discussed in terms of the order.

Well, Margo, on that point, and I'm trying to recall yesterday. But I think Richard's proposal yesterday was that we vote on the existing measure before we voted on a new measure. And I'd like to suggest we do the same thing around the event and Annual Dental Visits. And I for one would like to know whether or not I had lost my baby and the bathwater.

Okay. Well, maybe I could ask the co-chairs if you have a preference of PDENT measure first, and then ADV.

Again, this is David Kelley. I don't have a preference and Jim if that is your recommendation, I am fine with that. Before we do close the discussion, I would like to see if NCQA was available I would like to ask them to comment on the ADV measure and their current position on I think potentially removing this from the NCQA measurement sets.

Sepheen are you on? I believe we have some folks from the NCQA. So, if you're there and you can unmute, and if you can't unmute raise your hands and we'll make sure that you're unmuted.

And Deidre Washington, your line is now open.

Hello, good morning. This is Deidre Washington from NCQA. Can you hear me?

Yes, we can. Thank you.

All right. Thank you. So, in response to the question, if NCQA still intends to move forward with recommending the ADV measure for retirement, I will note that when we take this to our committee on performance measurement in May which is the body that will ultimately vote. We are actually recommending that we defer retirement for another year. So now, looking at Measurement Year 2023, and this is so that we have adequate

time to adapt and a new measure into HEDIS. So, that has not been finalized yet. That's something that needs to be voted on. But I just wanted to put that forward for your consideration as well. So, we are moving forward with recommending retirement.

Thanks. And Sepheen if you're also in the queue, please press star one to be -

And Sepheen your line is now open.

So, great. Thanks. Yes. So, Deidre actually went over it correctly. I just wanted to make sure I was able to get off mute for a future question. But yes, NCQA is going to recommend as our next course. It will be later - it will be May that we present it to our committee for a vote.

Okay. Thanks, Sepheen. Any other comments from Workgroup members or measure stewards before we move on? All right, so, with that I'm going to turn it back to Alli to walk us through the remaining Dental and Oral Health measures. Alli?

Thanks, Margo. Next slide, please.

And hopefully, you can hear me a little bit better now. I apologize for that. So, the next measure we'll discuss is the Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults measure. This measure assesses the number of ED visits for ambulatory care sensitive non-traumatic dental conditions per 100,000 beneficiary months. This measure is also stewarded by DQA and focuses on the adult population. The measure is not NQF endorsed and it is an outcome measure. The measure can be calculated using administrative data. And it's important to note that the measure can be calculated with enrollment in medical claims data. It does not require dental visit data. Measure testing was conducted using Iowa's and Oregon's Medicaid program data. The Workgroup member who suggested this measure noted that the measure would address a gap in the Adult Core Set, as there are currently no measures related to adult oral health. The Workgroup member also noted that non-traumatic adult condition ED visits are largely avoidable for primary prevention and early identification of disease.

Furthermore, the Workgroup member noted that low-income individuals are at greater risk of having non-traumatic dental ED visits. To facilitate reporting of the measure, the measure steward noted that existing programming code could be adapted as a state technical assistance resource. Next slide, please.

The last measure suggested in this domain is the Follow-Up After Emergency Department Visits for Non-Traumatic Dental Conditions in Adults measure. The measure assesses the percentage of ambulatory care sensitive non-traumatic dental condition ED visits that resulted in a follow-up visit with a dentist within seven and 30 days of the ED visit. This measure is also stewarded by DQA. And again, it is focused on the adult population. The measure is not NQF endorsed and it is an outcome measure. The measure can be calculated using administrative data and requires access to both medical and dental claims. Measure testing was conducted using data from Iowa and Oregon's Medicaid programs.

The Workgroup member that suggested this measure noted that the measure would address a gap in the Adult Core Set, as there are currently no measures related to adult oral health. The Workgroup member also noted that follow-up dental visits are important to avoid ongoing pain, worsening of the dental condition and repeat ED visits. In particular, there is a growing body of research indicating important connections between oral health and overall systemic health. Measure testing data found that only one-third of dental related ED visits among adult Medicaid beneficiaries were followed up with a dental visit within seven days. The Workgroup member also noted that there are evidence-based interventions that can be used to link patients seeking care for dental problems in the ED to dental providers. Moreover, these interventions have been associated with lower health care costs. To facilitate state reporting of the measure, the measure steward noted that existing programming code can be adapted as a state technical assistance resource. And now, I'll pass it back to Margo to facilitate the Workgroup discussion.

Thanks, Alli. And we now invite comments on the two measures that Alli just presented. Please unmute your line if you wish to speak and remember to say your name before making your comment.

Hi, Margo. This is Tricia Brooks from Georgetown. I have a question about the last measure that was discussed on the follow-up after emergency department visits. Do we know how many states cover adult dental? Because with the Core Sets data only being released when at least 25 states report the data, I'm not even sure that we're at the threshold that we would ever see these data if it were added to the set.

Jim, would you like to respond to that question or perhaps someone from DQA?

Margo, I'm attempting to look at the actual number. Okay. So, this is as of February 2020, 35 states including the District of Columbia provide at least limited dental benefits for adults. And typically, there was a set of states that provide what we would consider fairly robust basic dental services. You can get fillings. You could get a root canal, etcetera. And then, there's another set of states that offer only limited or emergent care. But the follow-up, what is covered is typically at least a treatment for an emergency. So, the number that I have as of February 2020 is 35.

Okay.

And if I could add, I would just say that one of the reasons we're actually focusing on this measure is an attempt to try to get space to recognize that at least that basic set of services would help people address acute infection and pain.

This is Jennifer Tracey. That is so helpful to hear. Okay. That was actually going to be my question - for states that maybe aren't covering adults' dental visits or covering them in a limited capacity, how could they use this information? And how likely is it that they would then maybe shift their benefits or somehow cover additional services based on this information? And if you have any thoughts on that or have examples of maybe where that's happened, that would be really helpful.

So, this is Jill Morrow. I can give you some examples. I have to say I really like this pair of measures. But if we only had one choice that ambulatory care sensitive ED visit

measure is a great start. In terms of, even if you don't have dental covered, there are programs that people can access often through federally qualified health centers or the look-alike a community health center, which may do it on a sliding scale fee - sliding fee scale. So, there are some interesting programs looking at diverting dental, sort of non-traumatic dental conditions that people go to the ED because they don't have regular routine dental care and diverting that to more appropriate dental care. Having worked in an ED, we don't want - as a physician, you know very little about dental and basically end up giving people antibiotics and sending them off. But so, I think that yes, that could this identify ways that states could one identify how much utilization there is and how much they would potentially save from emergency care that could be put into routine dental care would be a really good start. And with 35 states with dental services of some kind or another, that's a fair number.

Hi, this is Carolyn Langer. Oh, sorry. This is Carolyn Langer -

Go ahead. Thank you.

Oh, sorry. This is Carolyn Langer from Fallon Health. So, I agree that the linkages between dental health and physical health are really important. And I think it's also important to try to drive change among the states that have poor coverage. I am maybe like Jill a little bit more in favor of the first dental measure. The second one is I think going to be more challenging giving the variability of dental coverage across the states. If when we're talking about some states that only offer emergency care, if they've already been seen in the ED presumably when they come for their 7 or 30-day follow-up, it may not be considered an emergency at that point. So, there may not be coverage. But I just think that one is going to be a little bit more challenging to operationalize across the states. And as one of the previous comments was made, it would be really interesting to see where some states have been motivated to expand their dental coverage among the adult population with that thought that Jill raised about maybe doing cost shifting away from the ED into providing more preventive services, dental services proactively. Thanks.

Thanks, Carolyn. Jill Herndon, did you want to make a comment? If so, press star one.

Hi, this is Jill. Can you hear me?

Yes, we can.

Oh, great. Actually, when I was trying to get in, Dr. Crall addressed it very well. I was just going to provide that information about the states that do provide for the coverage, 35, and virtually all have some type of emergency coverage. And I wanted to kind of address that. So, that was already handled very well. So, that was where I was going to chip in. And also, that these are really good gateway measures to looking at oral health access. And we did want to note that the main ED measure is a measure of access. And then, the follow-up measure really indicates those who were not getting those dental care needs resolved that they have. Thank you.

Thanks, Jill. Other Workgroup members?

This is Kim Elliott. One of the things I would say is, when I think about the Core Set and the limited amount of what we really have for inclusion of measures, the focus for me is on things that are consistent. So, consistent benefits, consistent requirements, so that when we're looking at the results of the core measures, we're able to do some comparability and where states are performing well or where states maybe have opportunities for improvement. So, with the emergency dental, adult dental being inconsistent across states, the comparability is a little bit lacking. I agree that it probably does give states an opportunity to consider their benefit structure with the covered, non-covered. But it doesn't necessarily lend itself with that comparability of the quality of care being delivered.

Hi, this is David Kroll. I wanted to - I actually feel a little bit differently about that. I think that one of the distinctions we should make when we're talking about the impact of state, individual state, non-coverage of services is that in some areas, non-coverage of services will cause a state to perform poorly on the measure. And in other areas non-coverage will make it harder, impossible for the state to report on the measure. And I think that allowing states to perform poorly when they're failing to provide care that we think is really important in a measure of quality is actually okay. And part of the purpose of using quality measurement. And I think it's the first measure, the one about ambulatory care sensitive emergency department visits, falls into the category of states that don't provide dental coverage should still be able to report this measure but may perform poorly on it if they're not providing the services. And I think fills a real gap in this area. Whereas the second one about ambulatory follow-up, I think, probably falls into more of the pitfall of states maybe not being able to report it consistently. I do wonder if others agree with that or not. Thanks.

Hello. This is Shevaun with Florida. I actually agree with that. I think the worst state of our Medicaid programs only covers dental for emergency purposes. However, our health plans are covering comprehensive care as an expanded benefit. So, we're not having to cover that with any state or federal dollars, and so in essence we end up with comprehensive care, but if we didn't have the concept let's say with our health plans, we would struggle on the second measure the follow-up visits. But we would be able to report on this first one. And it may highlight some issues in our health care delivery system. But it would be illuminating in terms of where we may need to refocus our efforts. So, I think I'm more in favor of the first one than the second from that perspective.

This is Lindsay from New York. I just want to be kind of careful about where the conversation is going. Obviously being from New York, we are an incredibly generous Medicaid benefit across our state and theoretically, obviously we want the states to be able to cover the minimum benefits that we said we feel is necessary. But in some situation, it's really its cost. It's an added cost. So, I think we need to be careful. I don't know that the goal of the Core Set is to be pushing states to expand coverage. Those decisions are made multifactorial. They're made based on many different pillars and cost being one. We're looking at a state fiscal budget this year.

We're completely broke as a state. So, I don't know how other states are faring but with the stall in the economy, I think you really do need to think about cost, factoring cost into some of these benefit and measure calculations. So, I just kind of wanted to note that for the record, that again, going back to the purpose of this Core Set, I think we're extending

a little bit, our reach a little bit further than what I think the original intent, goals, and purposes of the Core Sets are. I agree it's to be able to compare quality, to be able to look for opportunity for quality improvements. I don't know that everyone on this Workgroup would agree that that purpose of the Core Set is to drive coverage of benefits. So, I just kind of wanted to throw that out there as where I think we're kind of extending our reach a little bit here in the discussion.

I do agree with that.

This is Richard Antonelli. This is exactly my point about fitness for purpose. I'm not sure that any - I think we would all be naive if we assumed that putting measures in the Core Set will encourage closing gaps that need to be informed by other conversations. And so, that's exactly something that I am concerned about and even worse, if those measures turn into financial accountability measures for ACOs that could be really a significant death knell financially for those provider organizations that are really already struggling.

Margo?

Yes, go ahead, Jim.

Yeah. This is Jim again. I just wanted to add. I mean I think all of those points that were made are excellent points. And I didn't mean to imply that this was sort of driving everyone to comprehensive coverage and dental benefits for adults in Medicaid, I mean, as people have duly noted, those are political decisions that get made within each and every state by virtue of the way that Medicaid is designed. I just looked at another source here. And I actually believe that with 35 number for states that provide some dental coverage. I'm looking at a document that’s prepared by the Center for Health Care Strategies that actually categorizes the states. So, I'm happy to send that to you, Margo. If your staff may already have it, but it’s about 16 I believe the number of states that provide what are characterized here as extensive dental services. I think that would be what I was mentioning earlier that you can get fillings with root canals.

There's another 19 or so that provide limited, what's called limited. So, those are not going to be in the full array of procedures and coverage that you're going to have under a commercial plan probably, but in fact, are more than just emergency care. And then, there are actually 11 more states that are characterized as emergency only, leaving only three states that have no coverage for adult dental benefits. So, I think that's the - what we're trying to highlight here. And when we did this measure - I say we because at the time we developed the first set of measures like this - we actually have child measures the same as these two adult measures. The child measures actually were endorsed by NQF. They are endorsed. And the adult measures used the same methodology.

But we recognized that this would be additional effort on the part of the state to be able to synchronize and analyze at a beneficiary level data that came from what we call the medical stream of data as well as the dental stream of data. So, we recognize that. But we do - again, as this has been pointed out, believe in the oral health, systemic health connection, the dental care if you will or oral health care connections to general health care. So, that was the reason for developing the pair of measures. And also, recognizing that it's been pointed out that you can get services for symptomatic relief, hopefully,

controlled section of pain in an ED, but you don't deal with the underlying issue. And so, states are going to pay for that one way or the other.

Well, thanks Jim. And thanks to all the Workgroup members for this conversation. It's definitely been very robust. Before we turn to public comment, I wanted to ask Gretchen and David whether you have anything to add or reflect on at this point.

Yeah, this is Dave Kelley. Just to add to the discussion - I really like the suggested measures, the adult measures. And as a state that has - used to have a full robust benefit who's now rolled that back, I do have concerns about adult access to care. We actually make our managed care plans measure adult access to care. And I will tell you, it's abysmal. So, I like both measures, quite honestly. I know that my measures even put my adults' measures for folks that are not even going to the emergency room are abysmal. So, I would imagine that second measure, the 7- and 30-day follow-up rates, are probably horrible. So, I don't know if I'm going to learn a whole lot new from that particular measure because the results are already terrible, as far as basic access to dental care for adults.

So, I like the first - I actually like both measures. But the first measure gets to the essence of poor access to care, whether you have an adult dental benefit or not. The folks who are showing up in the emergency department, they either don't have a benefit, they don't understand their benefit or they're showing up and they're getting I will say pseudo treatment or treatment that's not going to resolve their issue. So, I think it's an important measure. And I know there's a limited amount of real estate here on the core measure set. So, I like both. But if I had to go with one, I would really - I think there are a lot of benefits to that first measure. And again, you do not have to have the adult, a full or even partial adult dental benefit.

All right. Thank you, David. Gretchen, do you have anything to add before we move to public comments?

No, I just want to appreciate Lindsay jumping in and giving us the sort of reframe. I do think the conversation has been great. I do believe everyone has been operating sort of as stewards of the program and really been thinking. And I recognize that in the course of a conversation we're going to bob and weave through different components of the discussion. But I think that it was a good reminder that we're here to talk about quality measurement, comparability and other things. And I think the conversation has been very illuminating. And we know that CMS and others that members of the public are listening. So, I think that we're ready for public comment and to move to the voting.

Great. Thanks, Gretchen. Okay. And with that we'd like to provide an opportunity for public comment. If you would like to make a comment or ask a question, please press star one to enter the queue. And please remember to say your name and affiliation before you make your comments. Operator, do we have anybody in the queue?

We do not currently. As another reminder it is star one, if you'd like to make a public comment, star one. And at this time, we have no one in the queue.

Okay. Well, I think with that then, we can move to voting. And now, it's time to vote on the five measures. I think based on the conversation earlier about the order. I know that

might have been a little bit confusing. But we are going to vote on the current measure first, which is the PDENT measure. So, Dayna will open up the voting on PDENT. And then, we will vote on the Annual Dental Visit measure, and then the sealant measure, and the two Adult Dental Visits - two adult ED measures. So, thank you for the comments, and now, Dayna, turning it over to you for voting.

Great. Thanks, Margo. So, I hope everyone has navigated to - not everyone, just the Workgroup members, have navigated to the voting page. And do let us know in the Q&A if you're having any issues. So, next slide, please.

Great, so, the first question is, should the Percentage of Eligibles Who Received Preventive Dental Services measure be removed from the Core Set? And the options are, yes, I recommend removing this measure or no, I do not recommend removing this measure. And voting is now open. Just a reminder, if you don't see the poll, try refreshing the page. Okay. We have 21 votes in so far, we're expecting 25. So, I'm going to give it another 10, 15 seconds to see who else comes in.

And Dayna, I think some people may be having difficulty refreshing the page. I'm wondering if there are some internet issues today.

Yes, if you are having issues accessing the poll and you have not voted yet, feel free to send us your vote through the Q&A function and we will record it.

Hi, this is Linette. I am having a very difficult time with the system right now, both of them. So, I'll send you my vote, somehow, I think.

Ok, thanks, Linette. It seemed like everything worked so smoothly yesterday.

Well, the first one's always the hardest. We do have 23 in, and I know we have one more just came in through Q&A. As soon as we get Linette, I think we should be good to go.

I don't think I'm going to manage to get this in either way because both of them are frozen. So, sorry, with the internet.

Linette, if you want to email me, you can do that. This is Margo.

And that's what why I'm frozen too.

Okay.

And thank you for bearing with us folks. We'll have the answer in just a moment. Okay. So, the results are in. I will go ahead and lock the poll. And voting is now closed. So, for the results the two-thirds threshold for this measure is 17 yes votes to pass. We received five yes votes. That does not meet the threshold for recommendation. So, the Sealant Receipt on Permanent 1st Molars measure - oh, yeah. Sorry. Nope, sorry. I got confused with the switching of the order. The Percentage of Eligibles who Received Preventive Dental Services measure is not recommended by the Workgroup for removal from the Core Set. Okay. Moving on to the next measure, we have - next slide, please.

Thank you. The next question is should the Annual Dental Visit 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. Okay. It appears we do have all our votes in. So, I will go ahead and lock the poll. Okay. We are expecting 25 votes. We have 25 votes. The two-thirds threshold for this measure is 17 yes votes to pass. We received five yes votes. That does not meet the threshold for recommendation. So, the Annual Dental Visit measure is not recommended by the Workgroup for addition to the 2021 Core Set. Next slide.

Okay. The next question is should the Sealant Receipt on Permanent 1st Molars 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. Okay. We are expecting 25 votes and we have received 25 votes. So, voting is now closed. So, the results, the two-thirds threshold for this measure is 17 yes votes to pass. We received 19 yes votes. That does meet the threshold for recommendation. So, the Sealant Receipt on Permanent 1st Molars is recommended by the Workgroup for addition to the 2021 Core Set. Next slide.

Okay. The next question is should the Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults - that's a mouthful - 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. Okay. That went quickly this time. We are expecting 25 votes and we have received 25 votes. So, at this time I'm going to lock voting. Voting is now closed. For the results, the two-thirds threshold for this measure is 17 yes votes to pass. We received 13 yes votes. That does not meet the threshold for recommendation. The Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults measure is not recommended by the Workgroup for addition to the 2021 Core Set. Next slide.

So, the last question is the Follow-up After Emergency Department Visits for Non-Traumatic Dental Conditions in Adults, should that measure be added to the Core Set? The options are yes, I recommend adding this measure to the Core Set or no, I do not recommend adding this measure to the Core Set. And polling is now open. Okay. We have 25 results. With that I will lock voting. And for the results. The two-thirds threshold for this measure is 17 yes votes to pass. We received five yes votes. That does not meet the threshold for recommendation. So, the Follow-up After Emergency Department Visits for Non-Traumatic Dental Conditions in Adults measure is not recommended by the Workgroup for addition to the 2021 Core Set. So, thank you everyone for bearing with us. It looks like by the second one we got the hang of things. And now, I'll turn it back to Margo to facilitate the discussion of gaps in the Dental and Oral Health Services domain.

Okay. Thanks, Dayna. And thank you Workgroup members. So, as Dayna said, we're going to hear from Workgroup members now about possible gaps in the Dental and Oral Health Services area. What types of measures or measure concepts are missing in the Core Sets? Are there existing measures that could fill the gap, or would a new measure need to be developed? And please remember to say your name before making your comment.

So, this is Jill Morrow. I will jump in. I really liked what Jim said around preventive care, thinking about fluoride application and whatnot. I think that perhaps the gap is in who

can provide that. There are a lot of different ways that states have - and local areas have tried to make the preventive care more accessible to children. And so, I think from a child standpoint that that would be a really good measure because we know that that makes a difference. So, from the vantage point of the adult measure, I actually like the ambulatory care sensitive one. And it didn't mean that emergency care has to happen in the ED. So, maybe some other way of measuring where emergency care happens, since there's so many states that covered even just emergency care.

Margo?

Hi, Margo. This is Tricia Brooks at Georgetown. Just a point that was brought up earlier in this discussion and could apply to any number of the measures and is consistent with the measure I had recommended last year on continuity of coverage. This still continues to be a critical problem in Medicaid. And we follow dramatic declines in enrollment in Medicaid for kids. Some of which were absolutely appropriate. But many of them, as a result of system glitches and other problems in the states, the kids going in and out of coverage just isn't going to allow us to do the best job we can on measuring the quality of care and improving it over time. And I just think we need to keep searching for a measure that helps us to better assess continuity of coverage.

Jim, I think I heard you next.

Thank you, Margo. Yeah. I was just going to pick up on the first comment about both the focus on fluoride and also the looking to try to capture multiple ways that those fluoride applications can be just applied or received. And so, in the current 416, CMS-416, there is, among the oral health measures, recognition of services that are provided not under the supervision of the dentist, and it could be from other types of providers, including a primary care provider. So, I think moving along that pathway to, again, to increase the focus on the fluoride and the sealant, but also to capture information on fluoride application in particular. Because those are the services that tend to be provided by an array of different types of health care providers, including community health workers in some cases that move along that path. Of course, I personally am in favor of not just throwing all those data in the one measure, but at least segmenting it out. So, that you know where services are being provided by different types of providers or settings. So, I just want to add that comment.

Other comments on gaps?

This is Dave Kelley. Comments on pediatric dental, one of the things is that - and Jim, maybe you can comment on this, is developed, and we've done this in an incentive program for our dentists in Pennsylvania, where we actually have developed a bundle of care that within a year's period of time there are various preventive dental services done including when age-appropriate - the sealants, the fluoride varnish, the oral examination. And I always miss this, another one. So, to think in terms of a bundle of quality instead of just preventive visits I think really would take preventive dental visits to the next level. And that it really pushes getting that comprehensive bundle of preventive care that is really so vital.

And then, my other comment is unfortunately we continue to not have an adult dental measure. And I'm looking at our stats, at least the environmental stats that I think 11

million people have Medicare and Medicaid and there are 15 million expansion adults. So, I would say that's a fairly large chunk of the US population. And again, I know Medicare does provide a little a bit of a dental benefit sometimes. It's in some of the Medicare Advantage Plans and DSNPs. But quite honestly, as states, we're really - that provide an adult dental benefit, we are really the ones responsible for providing adult dental care for a very large number of individuals. So, I think that this is a huge gap. The fact that we have no adult dental measure continues to be a gaping hole in the Core Set.

Thanks, David. Another comment?

Yes, David, just to respond - Margo, I'm just going to respond to David first in the comment because it did trigger a thought that in fact, what you're really pointing toward in that bundle concept, which again some states including California now are looking to use the bundle notion of really trying to align intensity of services with levels of risk or disease management. I absolutely agree with you on that point that there is some value in doing that. Obviously, it will have to be looked at from a measurement perspective as well. But what it reminded me of was ultimately what everyone would like to know is to what extent that pays off. And I think one of the ways that we could get to a place where we might have a better idea of whether it's paying off and what is paying off is by actually finally getting to the place where ICD-10 or some sort of diagnostic things are actually submitted as well. So, we would know not only whether people are receiving dental services but actual impact on their health, actual on their health status.

Thanks, Jim. We're paying -

T-MSIS might help with that.

That's right. That's right. So, we're a few minutes over when we were going to break, but I don't want to cut anybody off that wanted to make a comment and hasn't already done so. If anybody else has a comment, please, go ahead and then we'll switch to the break. Okay. Well, with that we'll take a 20-minute break. So, please be back at 1:05. And as a reminder, don't disconnect your phone to avoid having to reconnect. So, back at 1:05, and then, we'll talk about Maternal and Perinatal Health measures. Thanks everybody. Enjoy your break.

BREAK

Hello everyone and welcome back from the break. We are now ready to begin with the next domain, Maternal and Perinatal Health. And I'd like to turn it over to Chrissy, I hope everyone had a nice break. Chrissy?

Thanks, Margo. Can everyone hear me?

Yes, you're coming across clear, I think.

Okay, great. So, I'm now going to go through the Maternal and Perinatal Health domain. I'm going to start with a brief overview of the current 2020 Core Set Measures. There are six Child Core Set measures and four Adult Core Set measures. Next slide.

The first measure in the Child Core Set is PC-02: Cesarean Birth, which assesses the percentage of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth. Audiological Diagnosis No Later than 3 Months of Age assesses the percentage of newborns who did not pass hearing screening and have an audiological diagnosis no later than 3 months of age. This measure has been suggested for removal. Live Births Weighing Less Than 2,500 Grams assesses the percentage of live births that weighed less than 2,500 grams in the state during the reporting period.

Prenatal and Postpartum Care: Timeliness of Prenatal Care, assesses the percentage of deliveries of live births that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in Medicaid or CHIP. Contraceptive Care - Postpartum Women Ages 15 to 20 assesses the percentage of women who had a live birth and that were provided a most effective or moderately effective method of contraception or a long-acting reversible method of contraception. The rates are reported at two points in time: within three days of delivery and within 60 days of delivery. Contraceptive Care - All Women Ages 15 to 20 assesses the percentage of women at risk of unintended pregnancies that were provided a most effective or moderately effective method of contraception or a long-acting reversible method of contraception. Next slide.

So, turning now to the Adult Core Set, the first measure is PC-01: Elective Delivery, which assesses the percentage of women with elective vaginal deliveries or elective cesarean sections at 37 weeks or more and less than 39 weeks of gestation completed. This measure has also been suggested for removal. Prenatal and Postpartum Care: Postpartum Care assesses the percentage of deliveries of live births that had a postpartum visit on or between 7 and 84 days after delivery. And then, the two contraceptive care measures are the same as those in the Child Core Set with an older age range of 21 to 44. So now, we're going to discuss the two measures suggested for removal. Next slide, please.

The first measure suggested for removal is Audiological Diagnosis No Later Than 3 Months of Age. CDC is the measure steward, it is NQF endorsed and it's calculated using EHR data. No measure has been proposed for replacement. Only three states reported on the measure for FFY 2018 and two of the three did not use Core Set specifications. This measure was added to the 2016 Child Core Set. The measure was suggested for removal first due to feasibility concerns. The measure requires matching to newborn screening data, and it is often difficult to obtain the necessary permissions. It also requires matching with EHR data, which has been challenging for states.

Actionability and strategic priority was also a concern with this measure. One Workgroup member noted that newborn screening programs already have protocols in place for a follow-up system for newborns who do not pass hearing screening. It is not known whether adding the Medicaid program into this process leads to better outcomes. A Workgroup member also noted state-level all-payer data from CDC's Early Hearing Detection and Intervention program suggests the overall number of newborn screenings referred with no outpatient follow-up is low. And the CDC data suggests that in some states, all children were followed up. Next slide.

The next measure suggested for removal is PC-01: Elective Delivery. The measure steward is The Joint Commission, it is NQF endorsed, and it can be calculated using

EHR data or the hybrid methodology. No measure has been proposed for replacement. Eight states reported the measure for FFY 2018 and five of the eight did not use Core Set specifications. And this measure was part of the initial Adult Core Set in 2012. It was suggested for removal again due to feasibility concerns. The measure requires EHR data and chart review, and many states do not have the resources for that. The Workgroup member who suggested this measure also felt that it is no longer a strategic priority as rates have decreased, and there's little room for improvement. The Workgroup member indicated that in CMS Hospital Compare the national average for reporting hospitals for early elective deliveries was 2%. So, before we move on to the two measures suggested for addition, I'd like to pause here and discuss these two measures suggested for removal. I'll pass it back to Margo to facilitate the Workgroup discussion.

Thanks, Chrissy. And as Chrissy mentioned, we decided to divide the presentation up today between the two measures suggested for removal, and then, later on after this part of the discussion, we'll turn to the two measures for adults for addition, which are the Prenatal Depression Screening and Follow-Up and the Postpartum Depression Screening and Follow-Up. So, let's open it up for Workgroup comments. And again, remember to unmute your line and say your name before making a comment. Thank you. And just as a reminder, the two measures we're talking about are the Audiological Evaluation measure and the Elective Delivery measure.

Hi, this is Lauren from ACOG. Go ahead.

Oh, no, go ahead, Lauren.

I was just going to say this is Lauren from ACOG, that ACOG is of course supportive of PC-01 as a measure concept but do recognize that as the individual that made the recommendation stated that it is topped out. And when we get to the discussion in this portion about gaps, I do have some ideas to share that, so that we can continue to ensure that the Core Set covers the needs of women, but we as a whole recognize that it's topped out.

Well, may I ask a question about that? This is Gretchen Hammer. Is it topped out across all demographic groups? I mean, I recognize we're talking about Medicaid. But are we confident that the experience of women of different races and ethnicities are similar in this measure?

That is interesting. That is what my suggestion was going to be, I think that that is potentially an area where, as a whole, I think continuing to look at some of the measures stratified by race and ethnicity would do a bit of good for women’s health care in general. I don't know that I have data that - I don't know that it is stratified and looked at that way. But that was going to be my recommendation as a whole if they were to keep it and potentially figure out how to look at outcomes by race, ethnicity, those sorts of things. So, I think we're thinking along the same lines.

Great. Thank you.

Yeah.

This is Diana Jolles from ACNM. I just wanted to weigh in on that concept of it being topped out as well. So, my specialty is research on unwarranted variation in practice, and we do see significant geographic variation in this metric, as well as other metrics related to childbirth, so it functions very well as a measure. One of the reasons this measure was so successful is that it was endorsed and then it became part of the core dataset. Then, state Medicaid tied it to payments. So, there were many levers that work together to make this a successful measure. At this point, you see that it's failing as a measure in that it's feasibly hard to measure, the perception is that we fixed this issue. I think the back-story on that is that we will see resurgence once the disciplinary use of this measure is relieved. So, once you'd stop seeing Medicaid not paying for early elective delivery, you will see it come back. There's still, I'll just say, in Texas, Louisiana, Georgia, there are still issues with this. But whether or not it belongs - whether really should live in the core dataset anymore, I support its removal, I did just want to say that once we remove it, we should expect some quality loss.

This is Linette Scott in California. And I'm just flagging the - one of the key issues is that only eight states have been reporting and that five of the eight did not use the core specifications. So, it's very challenging because it can't be done with strictly administrative data. It has to have an electronic health record, or it has to have chart review or hybrid component to it because of the word "elective" to it. So, while there's been some attempts around running this measure with administrative data to try to get at the "elective" by using from diagnosis codes or procedure codes, it's really hard. So, especially, one of the things in the context right now, the COVID response is the issue in terms of having to go on site to do chart reviews and such, and if we think about how the world is changing in this scenario. If we could have an administrative measure related to this that would be something, I think we could explore. But otherwise, from a feasibility perspective, this one is really hard. Thanks.

Hi. This is Tricia Elliot from the Joint Commission. Can you hear me okay?

Yeah. Tricia, go ahead.

Thank you. And just as I disclosed yesterday, The Joint Commission is the measure steward on this. So, I just wanted to offer some comments, great discussion. We include it in our accreditation program, and we are still seeing significant variability at the hospital level when we collect the data on this measure. I think one of the things that we did this year too is we added a new measure, which was a severe newborn harm measure, which was eased out for the early elective delivery measure as well as the C-section measure was a great kind of balancing measure. We still feel strongly that the PC-01 measure is a strong measure. We understand the challenges that are in place for collecting the information and it is available as an ECQM, as well. So, we've seen many organizations start to submit that way as well. But I just want to add this comment and context from the way we look at it from the organizational perspective.

Tricia, this is Jill Morrow. Can I just ask you a question?

Sure.

It seems like Joint Commission is looking at this and they're looking at it at a hospital level as opposed to thinking about it across the state program.

Correct.

I'm wondering if from the vantage point of making change, is that the better place to be given that we have pockets of differences and the overall numbers are pretty low. Is that a better place or is it that practices within hospitals or regional areas are more driving this and sort of doing intervention at that level, is that a better way to approach this?

You mentioned looking at it from the aspect of change, is that what you mean from higher-level organization versus some of the other comments related to like risk and stratifying maybe to address other gaps?

I think yeah, because part of what the quality measures require is that you're able to improve them. And so, just thinking is the state Medicaid program while they - for the most part or at least half of the - or close to half of the deliveries, is that the right place to put this?

Yeah, great question. When you look at it from a quality improvement initiative, so, we do engage with the organizations to evaluate the opportunities for improvement in care and carve out what those opportunities are for the organization. We're in the position where not only do we develop the measure but we're able to get the information from our organization. So, it gives us a nice look into how the measure is performing. And so, we're still seeing some areas where there's some higher variability in the measure and continue to look for opportunities and ways to engage with the organization to improve it.

This is Rich Antonelli. I've got a comment to make about the Audiologic Follow-Up that I want to say on this measure. Gretchen has nicely led up Day One and Day Two reminding us of our stewardship of the Core Set, recognizing the percentage of all births that are covered by Medicaid throughout the U.S. and that the elective delivery measure is reported by eight states. I feel a bit disquieted to acknowledge or validate the observation that it is "topped out" when we actually don't have some of the stratification. I appreciate the comments from The Joint Commission. I think, Jill, your observation about, would this be possibly more relevant as an intervention at the level institution, I think that's fine. But I, for one, don't feel comfortable validating the observation that this measure has topped out when we haven't really had a presentation of the actual stratification by race and/or SES that we certainly have heard in the discussion in the last few minutes that there is geographic variation. So, I'm not convinced but I haven't heard anything that assures me as a steward of the Core Set that this measure is not potentially a value. And then, if I could beg the Chair's indulgence after we finish this, I'd like to make a comment on the Audiologic measure please.

So, why don't we continue with this measure and then we can come back? And Jennifer.

And Margo, this is Tricia again.

Sure. Go ahead, Tricia.

Thank you. I just want to - my team was able to share with me some of detailed results that we started to drill into. This particular measure is up for re-endorsement in the current re-endorsement cycle with NQF. So, we were able to stratify by age, ethnicity,

and race, and we do not feel that it's topped out based on some of the results that we've seen from the data that we've received.

Tricia, can you be more specific? Do you have any examples?

For example, we're seeing rates greater than one in the race categories of White, African-American, and Pacific Islander for example. So, White is at a 1.77 rate, African-American 1.49, Pacific Islander 1.34, these are based on 2018 discharges. And some of the age categories - the percent for age less than 20, we're seeing a rate of 1.57. It goes down. So, the age goes down a little bit. So, the age ranges in the 20s, so 20 to 29, it ranges from 1.25 to 1.5. But then, it starts to increase for age groups over 30. And then, the over 40 group gets a 3.9. So, we are taking a look at these different categories. And we had 1,616 hospitals submit the data and for these numbers I'm quoting represents almost 140,000 patients.

And Tricia, just to confirm, when you cite those numbers it's like 1.4% of births, 3% of births, so we're talking about percentages, is that correct?

Correct.

Okay. And so, the overall national estimates that you have there around which you shared some of those numbers, what percentage was that?

1.7.

1.7%?

And the standard deviation is 2.8%.

Thank you.

And the range goes from 0%, we have an outlier at 29%, so 0% to 4.8%. And the percentages are of the early deliveries reported to Joint Commission, not all delivered.

Other comments about this measure before we move to the Audiological Evaluation measure?

This is Gretchen. I guess I would - go ahead, Jennifer.

Thanks. This is Jennifer Fuld from CDC, and CDC is not necessarily promoting removing or not removing it. I just want to make a point from our Division of Reproductive Health. So, their perspective is that if CMCS or other organizations are not actively implementing policy changes in support of decreasing early elective deliveries and at the same time decreasing numbers of states that are reporting the measure may be best dropped, but again, CDC is not necessarily recommending that. Also, we would note that rates are low because this has been an area that has been tracked and linked to a reimbursement. And in addition, we would note that PC02-CH and PC-05 are important measures of perinatal outcomes but they are not a substitute for this measure. Thank you.

Gretchen?

Yeah, thank you. I was just going to make a comment that while there is a lot of real estate on the Core Set dedicated to perinatal health and maternal/child health, we I think have agreed that that's reasonable given the role that Medicaid and CHIP play in covering births across the country. The only ones that really get at the birth experience are this one and the C-section rate. So, I would just advocate - although I don't know that I have strong feelings, and there's obviously a lot of discussion. But the experience of birth and how that goes is a significant factor in how families get started and how moms and babies move forward. And so, I just think us acknowledging that there are multiple components in that long prenatal period, the actual birth period, and then the postpartum period, making sure that there are some reflections of the importance of that birth experience makes sense to me as again, a steward of looking across the program.

This is Dave Kelley. And again, we're, I guess one of the few states that has actually looked at this, and we have our External Quality Review Organization actually do this for us. And I will say, I'm looking at our results compared to what I'm hearing of the national benchmarks, and I can say that there are - in the case of Pennsylvania, there's a huge opportunity for improvement. In 2017 across our entire program, we are at about 18%. And in 2019, we dropped down to about 12.6% in our C-section rate for a comparison to vertex, was only about 20.3%. So, our best performing health plan actually was at 8.14%, and our worst performing health plan was at 18%. So, a lot of variation, that's not for sure where it's necessarily topped out. It sounds like we're not topped out in Pennsylvania. And I don't know if other states that have reported this measure where they're at.

Margo, I would suggest we move to the audiology measure just to make sure we give each measure in this section. And I know Rich had indicated that he'd like to talk about it. I'd also like to learn more about why we think it's a good idea to potentially remove it.

Sure. Go ahead, Rich, with your comments.

Okay. Thank you everybody. I'm reminded the discussion that we had yesterday to a certain extent about the depression screen and follow-up, and really at its core, I think it's fair to say that quality measures that require some degree of longitudinal activity. Call it care coordination, call it integration, I think conceptually, we struggle with those measures. And I was really pleased with the results of yesterday's evaluation - just because something is hard to do, it doesn't mean that it's not important. This is one of those measures. There is tremendous scientific evidence to support more optimal outcomes for children that are hard of hearing, the reason we do it as part of the so-called Baby's First Test, the newborn screen, is because the earlier the better. Fortunately, it's a relatively small number of patients by states that are born with loss or hard of hearing but that should not weigh the committee's deliberations about saying, "It's too hard to do." It's not the same thing as hearing loss but let me share with you that four months ago, I was asked to consult on a four-year-old who went completely undiagnosed because of lack of longitudinality with autism, and then, a mother that had been knocking on everybody's doors.

So, the health care system even in high resource environments like Boston for example, much less resource challenge environments, the need to be able to track where these

patients are over time aligning them with the service is critically important. And I want to make a strong argument to keep this in the Core Set because it makes a big difference to intervene early on. Thank you.

This is Anne Edwards. And thanks for those comments. As you point out, this is a tremendous important aspect as early developments that have lifelong impacts. I appreciate the complexity around this particular measurement and how people understand it and have the ability to improve upon it. It really does require a system to work well which is important in this perinatal newborn period into a lot of the measures, to be honest. So, it gives me pause I think that there are other mechanisms that states are looking at this, and opportunities for improvements that are broader. What gives me pause is by removing this, do those other efforts still meet the needs, because as you look at the data, there is significant variation not only geographically but also for different populations, even though the incidence is low. Thanks.

So, this is Jill Morrow. I would echo what Rich said about identification and outcomes. We have been notoriously bad at picking up kids with hearing impairment and the earlier they're identified, the better their outcomes will be. This is one of those that it's perfect, should be a perfect collaboration with the public health people, sort of like the newborn screening, but although I think that that sometimes gets in the way. So, thinking about keeping this may get states to think about, how do they partner better with their departments of public health.

So, this is Margo. This is definitely a very good question or point to share with the Workgroup in terms of whether there are opportunities for working with the EHDI data which I think we've noted is all-payer data. The reason why that data would not be accessible for this measure is that it does not include an indicator of who the payer was for the delivery. So, from a streamlining perspective, if that data source had an indicator of the payer at the birth, that might be a source of secondary data. As the measure is currently specified, it is only an EHR measure so that it does require EHR data to adhere to the specifications. And that's the reason why we have so few states that are actually reporting the measure, even fewer are using the Core Set specifications. I don't know if we have anybody from CDC on the line that might be able to speak to that. Jennifer or one of your colleagues who was involved specifically with this measure? But that is something that when the measure first came into the Core Set, there were some conversations about that. And also, some conversations about would it be possible to develop an administrative specification and that has not happened but certainly it would make it more feasible if either of those two approaches could be taken. Do we have somebody on the line from CDC?

Hi, this is Jennifer Fuld.

Go ahead. Thank you, Jennifer.

Yeah. This is Jennifer Fuld from CDC. Unfortunately, I'm not going to be able to answer that specific question. And I don't think we have any of the subject matter experts on the phone. However, I will say that well, while CDC is the measure steward, we did not recommend the removal of this measure. We think it is an important measure. The question, and others have brought this up, is are there other ways that these data are being reported and whether it's needed in the CMS core measures. So, I would say

we're not taking a particular position other than we do feel it is an overall a very important measure.

That's okay, Jennifer. I think we may have somebody else from CDC. Dr. Deng, are you on the line? And if so, could you press star one to be unmuted?

And Dr. Deng your line's now open.

Hello, this is Xidong. Can you hear me?

Yes, we can. Thank you.

All right, thank you. Yeah. This is Xidong from CDC, the EHDI team. So, we are the steward for this measure. Yeah. So, when the measure was first added to the Core Set in 2016, we were trying to - at that time, the measure was defined as using the EHR data. Well, actually, strictly speaking it's not like that came directly out of the EHR and the measure was not a CDC measure, it's basically just from the audiologist provider's chart. So, the CDC collected data for all populations. And we gather data from the state, the audio hearing protection and prevention system. And back when the measure was first added to the Child Core Set, we once tried to come up with a specification using the administrative data. But at that time because there were some certain complexities involved in the codes used and some data definitions. And also, one of our subject matter experts left our team. So, that effort was halted at the time, so the measure was just using the EHR definition; the administrative definition never got implemented, so that's the history of that. So, we do understand like we get for this measure, the Medicaid population there is no - only a few states. The EHDI program, when they collect the data, the hearing screening or the audiology data, only a few EHDI programs were able to get the payer information. So, some states, they may be able to get - when the child was born in the hospital, they may be able to get the payer information for the delivery. But for the audiology service, the diagnostic service, many of the states, they don't collect that information. So, but we do know there are a few states they can do it. But also, that also varies from state by state, the level of collaboration between public health and the Medicaid program. So, that is the current situation.

Thank you. Other questions or comments on this measure?

Hi. This is Linette Scott from California. I also want to flag the same thing on the PC-01 is the case with this one. The measures have been on the Core Set for quite a while. States have looked at them. We have not been reporting them, less than 10 states on each are reporting them and it's a feasibility issue. It's not a matter of whether we think it's important or not. It's not whether or not we think there's room to improve or not. It's simply feasibility. States have not been able to do it. We are not ready to get data from EHRs. We all would love to be. We have some states that are leading edge in states like Oregon and some others, that have actually been doing this. But the majority of states have not been able to go in this direction yet. Again, not a lack of willingness, not a lack of importance, but it's a resource issue. And given that these measures are going to be required in a couple of years, it's putting a lot of strain and concern around how that would happen given that we have not been successful at this yet. That doesn't mean that if they were removed, we couldn't still work towards that in the future, we're certainly working towards the idea of getting data from electronic health records. But I suspect my

other colleagues sitting in the Medicaid programs have had the same issues around just simply feasibility. And so, I just want to highlight because that was one of the major criteria we were asked to consider as we look at measures for removal and addition.

Thank you.

This is Lindsay from New York. So, we are actually trying to work with the hearing screening data as a part of our Performance Improvement Project with managed care plans right now. And what we're finding is not necessarily, we're encountering some challenges of how this measure is designed. So, what we're finding is we're trying to share information with health plans to actually move back and ensure that that loop is closed and that the child did have follow-up. And what we're finding is the plans - they're chasing down children who actually already had follow-up, but the record never made it, or the follow-up never made it back into the hospital record. So, it's a lot of chasing dead ends. The children were actually followed up on and referred, but it never got linked back. So, that's been a challenge with trying to work on this and then bumping up against other efforts for outreach and follow-up and duplicating that service when there's other public health folks that are also trying to do the same thing. So, I'm just curious to know if other states have actually tried to use this information for that type of quality improvement and if they found benefits to it because no one is saying that it isn't important. But if the data that we're getting out of this measure is not actually helpful to do the quality improvement work, what would be? And I don't know if the CDC can comment about the results that they find as far as children who do not receive follow-up.

So, for the follow-up, that's the problem that we have been trying to deal with for a long time, the lost to follow-up. Or on the other hand, the loss of documentation issue. So, actually, we think it's very unfortunate that the measure if it's removed from the Child Core Set. Because of the EHR system were not very mature, like the feasibility issue we just talked about - kids, they did get the follow-up, it's just the hospital never received the data, and the state health department never received the data, or it's just simply because the doctors are too busy to put the data in the system and send it out. So, it's really hard for the state people to actually differentiate between true lost to follow-up and just the loss of documentation. So, that's the problem that the EHDI program has been trying to deal with for a long time. And we have thought like even the Child Core Set, the Medicaid system can actually help the state's public health program to look at this problem because if we have - if we were able to actually get using some administrative data then - so that it can crosscheck the data - because if the kid gets the service, and they will have the data from the reimbursement, from the payment system. So, that's a way they can actually check if the kid is really lost to follow-up to the service, or it's simply just the data is not recorded in their EHR or not recorded in their state's health information system. So, that's one way we can try. We can use this measure to help with the lost to follow-up issue. And the other thing is, even though the Medicaid system that's not - like address the entire population, but we all know that the Medicaid population actually have the higher risk of being lost. And from all our data, we look at the demographic, the socioeconomic status data, we have been found that that's always the case, that the lower socioeconomic status population has the higher risk of being lost. So, that's and -

Thank you.

Yeah. We do know there are a couple of states that we've been working with. One of the very rare cases where the state public health department has a very good working relationship with the Medicaid system. And actually, one of our EHDI programs, they are currently doing that if that they established some data access exchange channel. And they were able to actually go into their Medicaid system to check. Because if they found several of the kids, they got the screening, they failed the screening, but they don't have any documentation showing that they got an audiology diagnosis, they'll actually send their names to their Medicaid system or they'll go into their Medicaid system to check if those kids actually get audiology diagnosis. So, in that way -

Thank you so much for your comments, that's very, very helpful to provide feedback on the program and connections with Medicaid. With that, I wanted to check whether we have any further comments on Audiological Evaluation or Elective Delivery before we move on to the other two measures. Okay. With that, I'm going to turn it back over to Chrissy to walk us through the other two measures in this area. Thanks, Chrissy.

Okay, great. We can go ahead two slides. Okay. So, we're going to start off with the Prenatal Depression Screening and Follow-Up measure. NCQA is the measure steward, it is not NQF endorsed. It is calculated using the HEDIS ECDS methodology. It measures the percentage of deliveries in which women were screened for clinical depression while pregnant and if screened positive, received follow-up care. Two rates are reported: the percentage of deliveries in which women were screened for clinical depression using a standardized tool during pregnancy, and the percentage of deliveries in which pregnant women received follow-up care within 30 days of screening positive for depression. Next slide.

Here, you can see the more detailed numerator information, and it's also on the measure information sheet. The measure information sheet also contains the details about which screening tools are allowed and what counts as a positive screen. A Workgroup member suggested this measure for addition because the health care system struggles with depression screening and access to appropriate care following a positive screen. This measure should drive improvement in maternal and child health and add focus to the need for health care systems to be responsive to positive depression screens.

The Workgroup member also indicated that many states are already focused on maternal depression, and this is likely to increase with the recently announced Integrated Care for Kids and Maternal Opioid Misuse demonstrations. States have the ability to drive improvement by establishing this measure as a priority in performance improvement plans and by putting value-based payment arrangements in place. The Workgroup member also noted that all states are required to provide Medicaid coverage for pregnant women and in many states, Medicaid covers the majority of births. Women who are enrolled in Medicaid have low incomes by definition and the data on depression show a link with life stressors such as resource constraints. Therefore, Medicaid and CHIP are uniquely positioned to bring focus to and improve treatment for prenatal depression. Next slide.

The next measure is Postpartum Depression Screening and Follow-Up. Like the previous measure, NCQA is the measure steward, it is not NQF endorsed, and it's calculated with the HEDIS ECDS methodology. It measures the percentage of deliveries in which women were screened for clinical depression during the postpartum period, and

if screened positive, receive follow-up care. Two rates are reported for this measure as well: the percentage of deliveries in which women were screened for clinical depression using a standardized tool within 84 days post-delivery, and the percentage of deliveries in which women received follow-up care within 30 days of screening positive for depression. Next slide.

And again, you can find more detailed information about the numerator and measure specifications here and in the measure information sheet. This measure was suggested for addition for many of the same reasons as the prenatal depression screening measure. In addition, the Workgroup member indicated that the postpartum depression measure will address effective delivery of care because it is focused on a period when women often have a disruption in care following the delivery of the child and at a time when care for women is often limited by a focus on the needs of the newborn child.

I did also want to provide some information around the field testing of the perinatal depression measures. NCQA has tested those measures at the health plan level in Washington D.C. and Hawaii and at the provider organization level in New York and Colorado. Pennsylvania Medicaid is requiring Medicaid health plans to report the measures beginning in 2020. The HEDIS prenatal and postpartum depression screening measures will be reported by commercial and Medicaid health plans for the first time in June 2020, and NCQA will then analyze first year performance data. Next slide.

So, now, I'm going to turn it back to Margo to facilitate the discussion around these two measures.

Thanks, Chrissy. And I'd like to open up the lines for members to discuss these two measures.

This is Gretchen Hammer. I will begin. And I will disclose that I was one of the Workgroup members or perhaps the only Workgroup member that suggested this for addition. You may recall from our conversations last year on this that they were just endorsed by NCQA. And I think the pending, the decision about whether or not to include them in HEDIS was - and so, I think we had a reasonable discussion about how they may not be ready for primetime. But I guess I would submit that perhaps we would be more ready this year. There are a couple of real benefits to these measures. One is the improvement hopefully in the quality of care and services available to women. Second, these are electronic measures. And so, given some of the constraints we talked about with other kinds of measures, this moves us in that direction. And I also think these measures do what we've also talked about, which is they include both the screening and the connection to follow-up care which is the direction again we wanted to move. And so, I would just submit that I think we had a great discussion last year, it was very understandable how the committee didn't think that these were quite ready. But I would submit that perhaps we'll be more ready this year.

And I'll jump in here. This is Tricia, Georgetown. I completely agree with Gretchen. These are critical measures. They have, particularly postpartum depression, such an impact on moms' bonding and kids' early outcomes. I just think the time has come for us to be collecting these data.

This is Jill Morrow. I would just like to add to that that, at least for the Postpartum Depression Screening, I know that at least Massachusetts has been using the Edinburgh, and paying pediatricians, or starting to think about paying pediatricians to do that screening, so that there are other ways to get it done other than the OB follow-up which is sometimes a problem when prenatal coverage ends at 60 days after delivery.

This is Jennifer Tracey. I think on that especially the postpartum side, given that over half of the States currently are allowing for postpartum screenings to be billed under the child Medicaid ID number. These measures are really important, and they are definitely in line of course with the previous CMS guidance and flexibility that was opened up to states. I think at least on the postpartum side, it's really aligned with some of the social, emotional health needs that we were speaking to yesterday about young children. And then finally, I think a gap that we have currently in the measure set and across measures in general are around dyadic services for caregivers and their young children. And since we know that all babies and young children come with caregivers, whatever is happening to the caregiver is also happening to the infant. Both of these measures are really critical I think to starting to open up and look at the impacts of dyadic services on the entire family unit.

Hi, this is Lisa Patton. I just wanted to say in my recollection of our last conversation on these measures is very similar to Gretchen's. And in terms of the Postpartum Depression Screening and Follow-Up with what we know about maternal morbidity and mortality rates in the country and the push really across the federal government to begin to be better at addressing some of that. This certainly will get at a component of that and also enable us to support better self-care in that critical period after giving birth.

Hi, this is Carolyn Langer from - sorry, go ahead.

No please, go ahead.

Hi, this is Carolyn Langer from Fallon Health. And I do agree, this is a really important measure. I just have one question for the proponents of this measure regarding the follow-up on the positive screen. Is there any concern since this relies heavily on proper coding of a diagnosis of depression or a related code, is there any concern about the ability to effectively measure this? Curious what other folks' experience has been - because we do, as Jill said, have pretty widespread depression screening and allow pediatricians to do that. I was just more curious about the second piece, the follow-up. And whether or not that would be easily captured -

This is Dave Kelley. In Pennsylvania, we actually have been measuring both of these for, I'm going to say, almost a decade by using administrative and chart review measures that our own EQRO developed with us. And I will say that we have been able to capture those follow-up codes even in a carve-out state. We've been able to capture those follow-up codes for visits, pharmacologic interventions, et cetera. So, we have been able to do that using administrative claims supplemented with chart review. And I think this is an ECDS measure. I'll also say that over the past decade we've seen - since we started measuring this, we've seen marked improvement in the screening for the prenatal and postpartum depression and also marked improvement in the actual follow-up.

Great. Thank you.

This is Lauren from ACOG. I think echoing a lot of what has already been said, so I'll keep it brief. But ACOG is of course supportive of these measures particularly the piece, as people have noted, on the follow-up being that it's not screening alone, not exactly, and to give us the results that we're looking for that it's connected to an action. So, just that we are supportive of both of these measures.

This is Rich Antonelli. I just want to call out that for quite some time the evidence has supported that the pediatrician was more likely to see the mom postpartum than the OB for their typical six-week follow-up. And so, and I know this was raised, but I really want to make sure this gets captured in the discussion of, please, that the way that the measure can be tracked wouldn't - the appropriate flagging event of the screen and then the hand-off. Because I'm mindful of yesterday that we were struggling a little bit with operationalizing the depression screen and follow-up, which potentially could have just been with the same PCP. But here's a place where that's not going to be the case. The screen may happen in the pediatric office. The hand-off could go to a behavioral health provider, could go to a state-level program like we have in Massachusetts, our so-called MCPAP and MCPAP for Moms, and/or into the OB office. So, I just want to make sure as the Medicaid agencies think about this, that they're doing that. And then, David, to the extent, is Pennsylvania - have you cracked that nut yet with being able to look at your observation that you're able to pull some claims, does that include pediatrician screening and OB taking over for the follow-up care?

I'd have to go back and look at that specification. But I know, I believe so. Because I think as a state, we've offered coding guidance, I believe, for postpartum screening done as part of a well-child visit, without getting into the details of our spec. I have to go back and verify that. But I believe that has been added, but I'm not 100% sure.

Yeah. And Rich, this is Gretchen. In our conversations both in Colorado and then just in my continued professional work in this space, what's also interesting is sometimes women in the postpartum period who are diagnosed with depression, nobody really wants to care for them. The pediatrician is like, "This is outside of my scope." Their OB is like, "I made sure you had a healthy baby and you know, support you but I don't really know how to treat your postpartum depression either." So, in some ways, I'm hopeful that this can start to drive delivery system change in a way that there's a better path of care developed. And that is certainly not the case in every community, but we have heard very specifically from both provider groups that neither one of them feel particularly well-positioned to support a mother who's screened positively, and although they want to, right, it's just that they don't feel well positioned to do that. So, I think your point is really well made. And again, to the extent that we hope that these measures drive a conversation and a clinical improvement like the audiology conversation we were just having, I think that would not be a bad outcome.

Yeah. I totally agree as you guys know thinking about integrated care almost all of the time that the notion of when you have multiple entities accountable for something, that often means nobody is accountable. So, that's why I want to make sure that as this gets specified and moves forward, and I'm not questioning against the measure by the way, this is profoundly important. I just want, there would be a contribution of the pediatric community, there would be a contribution of the behavioral health community, there'd be

a contribution of the OB community, et cetera. So, I just want to make sure, Gretchen, that where we land enables that multipronged process so that ultimately, there's an accountable entity and how that is passed across those different settings and sectors happens efficiently enough that we can actually measure it.

Yeah. That perspective makes a lot of sense to me.

I just have a general comment about this measure and the screening for clinical depression. So, when we look at the results of the screening, the clinical depression and follow-up, this is Lindsay from New York, I'm sorry. When we look at the screening for clinical depression and follow-up, it's largely being driven by women and OB providers. So, there is a level of overlap between these two measures and it's a critique I have that I just want noted. And I've sent it to NCQA as well that there should be some harmonization between these two measures because there's a little bit of a danger that we're measuring similar constructs in a little bit of different way. And I understand that the prenatal and the postpartum is anchored around the delivery date. But I just want to note that when we actually look at who is coming in under that screening for clinical depression involved, it's largely women and it's being driven a lot from OB providers.

This is David Kroll from -

Oh, go ahead, David.

Thanks. I just want to respond with this point. And I think that's a point that's very well taken. I think that one of the tricks around this is that perinatal depression or prenatal depression is a pretty distinct problem compared to postpartum depression. It's a timing that's really what’s so close and gets so tricky. And so, I think that as the measure stewards start to increasingly help them work together, I think that that's just making that distinction that the timing is what can trip people up and conflate the two, they are two very different problems.

This is Linette Scott of California. I just was wondering, I think this was mentioned in the conversation but I'm not sure that there was a resolution per se, that the postpartum measure runs through 84 days post-delivery but there may be many Medicaid agencies or many individuals within Medicaid agencies who have pregnancy only coverage and the coverage runs out at 60 days postpartum. Is there a recommendation on how to deal with the 60 days versus 84 days? And would the people who only have 60 days postpartum coverage not be included in this measure?

This is Gretchen. NCQA may be able to answer that technical question. It is my understanding from reviewing the early states that tried this that there was that recognition of the ending of coverage in many states at 60 days postpartum and that was accounted for in the final development of the measure. But NCQA may be able to speak to that more effectively than I am.

This is Margo. I can answer in terms of the specification that the continuous enrollment period is the delivery date through 60 days following the date of delivery. And you are correct though that - yes. And do we have somebody from NCQA in the queue?

Hi, yes. This is Lindsey Roth from NCQA, can you hear me?

We can.

Okay. Great. Yeah. I think I will talk about this a little bit more because this was an issue that we looked at pretty extensively during measure development. So, and I can explain how we arrived at the specification. So, yes, as everyone has been saying that across all states, Medicaid women who are pregnant would cover them at a minimum of 60 days postpartum and that in some states, Medicaid covers them beyond that - the Medicaid expansion, so it really varies across states. And so, what we had decided to do after getting a lot of stakeholder feedback was to specify that members would need to be enrolled a minimum of 60 days postpartum to be in the denominator then spend the minimum time period that women will be covered. And if we were to make it longer than that, there's a lot of concern that we've just been missing a huge portion of the Medicaid population. But then, some women in some states might be covered beyond that 60 days, the numerator would allow the depression screen to be conducted up to 84 days postpartum and so to align with the clinical guidelines from ACOG and other organizations that they can be screened out to that time period. So, that was our thinking behind how we would specify the measure, and we've received a lot of stakeholder feedback on that issue.

Thank you. Are there any other comments before we move to public comments?

Gretchen and David, anything else you wanted to add?

No. Thank you for the robust discussion on all four of these measures.

Likewise, I agree. I have nothing to add and it's been a great discussion.

Great. So, now, we'd like to provide an opportunity for public comments. And if you would like to make a comment or ask a question please press star one, that's star one to enter the queue. And please remember to say your name and affiliation before you make your comment. Operator, do we have anybody in the queue?

And we do not. As another reminder, star one if you have a comment, star one. And there are no public comments at this time.

Just a reminder, we're taking public comment on all four measures. Operator, anyone at this point?

We do not. Again, star one if you have a public comment, star one on your phone.

All right. Well, with that, I think we are ready to turn to voting. So, Dayna it's all yours to vote on the four maternal and prenatal health measures we've just discussed.

Great. Thanks, Margo. Next slide. Okay. For our first vote, the question is, should the Audiological Evaluation No Later Than Three Months of Age measure be removed from the Core Set? The options are yes, I recommend removing this measure, or no, I do not recommend removing this measure. And voting is now open. Okay. We have 23, we are waiting on just a couple more. Thank you. Okay. We are waiting on just two more votes. Have we received any other Workgroup votes through the Q&A?

We have not.

Okay. Again, if anyone is having issues submitting their vote, please do let us know.

This is Dave Kelley. I'm having technical issues. I'm going to have to reboot my computer.

Can you send it to us here on the chat?

Unfortunately, I'm locked out of the internet right now. I have to reboot my computer. So, I thought I was logged in to the voting but apparently, I'm not and I got booted off of the chat function, so.

Thanks for holding with us folks. We're resolving the last couple of votes, and then we'll have results for you.

And thanks everyone for your patience as we navigate the internet challenges today. Again, stand by as we're sorting this out.

Hi, Margo. This is Dave Kelley. I did send you my vote via e-mail to your personal e-mail. I'm just going to try and reboot my computer.

What I'd like to suggest is that we move forward with the vote. And what we will do is when we have time during the break, let's figure out who we have voting - oh, we think it might be Carolyn Langer. Carolyn, do you know if you submitted your vote? Can you tell?

Oh, you know what, let me just make sure it went through, sorry.

Okay. And thanks everybody for bearing with us.

Okay. I think I'm good.

Okay. It looks like we got your vote now.

Yeah. Thank you. Sorry, I had some connectivity issues.

That's no problem.

Okay. With that, I think we have all of our votes in. So, I'll go ahead and lock the poll. Okay. Thanks for your patience everyone. So, the two-thirds threshold for this measure is 17 yes votes to pass. We received 10 yes votes. That does not meet the threshold for recommendation. So, the Audiological Evaluation No Later Than Three Months of Age is not recommended by the Workgroup for removal. Next slide.

Sorry. Just to note that Carolyn is also from Boston. So, I think we're narrowing bandwidth issues to Boston again. All right, keep going. Sorry, Dayna.

No problem. So, the next question is, should the PC-01: Elective Delivery measure be removed from the Core Set? And the options are yes, I recommend removing this measure, or no, I do not recommend removing this measure. And voting is now open. Okay. We are almost initially, now, one more result. And David, were you able to vote on this one?

I just sent Margo an e-mail again. I'm still in the process of trying to reboot. So, I apologize -

No problem -

I am sending her e-mails via my iPhone, so I have my backup.

Thank you. Thank you so much.

It has not come through yet. David, can you check that it went out of your mail? It still has not arrived in my e-mail.

It's in my sent box.

I just got it. Thank you.

Okay. So, results are all in. Thank you for bearing with us. The two-thirds threshold for this measure is 16 yes votes to pass. We received 11 yes votes. That does not meet the threshold for recommendation. So, the PC-01: Elective Delivery measure is not recommended by the Workgroup for removal from the 2021 Core Set. Next slide.

Okay. The next question is, should the Prenatal Depression Screening and Follow-Up Measure be added to the Core Set? The options are yes, I recommend adding this measure, or no, I do not recommend adding this measure. And voting is now open. Okay. Most are in, we're just waiting on two more.

David, were you able to vote?

I just sent it through the chat, Margo. So, hopefully you saw that. I've rebooted and I'm going to try and get to the voting website.

Okay. Thank you. We did get that.

Okay. So, with that, I will go ahead and close voting. As a reminder, the two-thirds threshold for this measure is 17 yes votes to pass. We received 14 yes votes. That does not meet the threshold for recommendation. So, the Prenatal Depression Screening and Follow-Up measure is not recommended by the Workgroup for addition to the 2021 Core Set. Next slide.

So, the final question in this domain is, should the Postpartum Depression Screening and Follow-Up measure be added to the Core Set? The options are yes, I recommend adding this measure, or no, I do not recommend adding this measure. And voting is now open. Okay. I believe we're waiting on one more. It looks like we just got that in from David this minute. Okay. With that, I will close voting. As a reminder the two-thirds

threshold for this measure is 17 yes votes to pass. We received 22 yes votes. That does meet the threshold for recommendation. So, the Postpartum Depression Screening and Follow-Up measure is recommended by the Workgroup for addition to the 2021 Core Set. And now, I will turn it back to Margo to facilitate a discussion of gaps in the Maternal and Perinatal domain.

Okay. So, here we are again to talk about gaps in terms of measures or measure concepts that are missing in the Core Sets. Are there other existing measures to fill the gaps, would a new measure need to be developed? And I think Lauren, you had already mentioned that you wanted to speak to gaps, so maybe I'll turn it to you first.

Yeah, sure. And I mentioned a little bit of it when we were discussing previously. But yeah, I think just looking at the outcomes in maternity care, specifically by race and ethnicity since we know that there's a significant racial disparity in the U.S. with Black women being three times more likely to die in pregnancy than white women. So, I'm just recognizing that in order to solve that problem, we need to understand it. So, I think we had a lot of conversation around this when we were discussing the measure previously. But just we'd continue support, or have continued support of stratifying the measures by race and ethnicity and other categories to better just understand the data that we are collecting.

And then secondly, I just wanted to share something, not really specific measure yet at this point, but, that ACOG has made a recommendation to CMS about a different style of measure around participation in a quality improvement program at the hospital level, around a maternal health quality improvement program, including the engagement in something like a Perinatal Quality Collaborative, that data is being collected and reported on, and that the hospital is actively implementing a quality improvement project to help improve outcomes in maternity care that can include something like implementation of one of the patient safety bundles through the Alliance for Innovation on Maternal Health program. That is something that we're working through. So, I just wanted to make the committee aware of that and just to encourage us to, in the future, consider measures that are maybe a little bit different than what we're used to traditionally but will continue to improve the quality of the Medicaid programs. And that is all.

This is Gretchen Hammer. During our earlier conversation this morning in relation to oral health and the lack of adult measures of oral health, I did wonder if there was not an opportunity to look at a measure that might be related to access to oral health services for pregnant women. As again, that would ease some of the concerns about coverage because of the more universal nature of coverage for pregnant women. And I think that there's good enough clinical evidence, I'd defer to the clinicians on the phone, that that's an important component of a healthy pregnancy and a healthy beginning of life for a baby is the oral health status of the mother. So, I would just raise that up as something that would be an adult measure related to oral health but maybe not the entire adult dental benefit as we discussed.

This is Bonnie Zima. Can you hear me?

Yes, we can.

I just want to make a comment on the Postpartum Depression Screening and Follow-Up measure that just passed. And I think that there should be some standardization so that when we look at follow-up for behavioral health that within the specifications, there is the option to count telehealth. I didn't see it in it. I know we didn't - we need to vote as specified, maybe that's tucked in. But as we go through the COVID epidemic here, it might be a double check we need to do to always make sure there's that option.

Margo?

Thanks, Bonnie. Yes, go ahead.

Yeah. Hi, this is Jim Crall here. Just picking up on Gretchen's comment about an oral health measure that relates to pregnant women. I think clearly, we in the oral health community would support that, I don't speak for everyone. But I can mention that we actually included among the Core Set that we've recommended, the work we're doing with Georgetown University, the Maternal/Child Oral Health Resource Center and the DQA, a PRAMS measure that looks at this. Of course, one of the challenges that appears to us is always the ability to identify a woman during pregnancy is - identify they're pregnant. They have this denominator to then look to see whether or not oral health services are being provided. So, recognizing that other measures being proposed that focus on the pregnancy, if there are some methodological things we can learn about that to help to create a better measure that wouldn't just rely on survey data, could be perhaps based off of administrative data that I think we certainly be interested in working to pursue development in such a way.

This is Richard Antonelli. I want to thank the committee and have a little bit of a fist bump here for the Postpartum Depression Screening Follow-Up moving forward. I wanted to take a step back and take a longer view, though. We still have a - in my view, a glaring disparity issue of maternal mortality. And there's lots of factor that feed into that, the component clearly with the narrowly defined depression. Other parts are explicitly related to race, poverty, substance abuse and dependence. So, I'd like to think as we define the gap area of not just thinking narrowly of depression as a component of behavioral health and social risk factors, but in fact to call out that there are other things that we need to be thinking about in the measurement space to begin, to take a run at reducing those gaping disparities between women of color and Caucasian women for perinatal and particularly postpartum mortality. That latter comment pushes the envelope a little bit with Medicaid recognizing that the higher risk of maternal mortality actually doesn't abate until they're 12-months postpartum. But since we are discussing gaps and in the context of thinking about advancing health and equity, I'd like to call that out to the group as an area that is right for further investigation in measurement.

Other comments on gaps before we move to the break.

So, this is Jill Morrow. I just wanted to move to the audiologic evaluation for newborns. It seems that that measure would be more easily measured as an administrative measure, it should be capturable in claims. But the other thing to think about is like developmental testing is yes, referral for follow-up, but then do referrals happen for early intervention and those kinds of things. And again, that's looking at a trajectory and a linear path of care but just to put that in the mix.

And this is Linette. Just to echo that. Even though some of those measures were not recommended for removal, the feasibility issue is still very real. And so, looking at comparable measures that can be done administratively would be, I think, a gap that needs to be filled. And/or a really concentrated effort around how to interface with EHRs. The new interoperability rules that came out are going to certainly move us in that direction but just being aware of timing and how that all fits together too. So, a gap maybe not in the measure but in the structural infrastructure to support the measure.

Yeah. This is Margo. Linette, I'd like to follow-up on that point and give a charge to the Workgroup to be thinking about that overnight for when we come back tomorrow. But before we wrap up, we are going to be talking about elements related to moving towards mandatory reporting. And I think Linette what you're alluding to is a big part of that is the AUD measure is in the Child Core Set. And what can we do to make that more feasible for states? So, thinking a little bit more about that and reflecting on that tomorrow about technical assistance and other improvements as we move towards mandatory reporting, and just in general, trying to improve the completeness and accuracy of data in the Core Set. So, charge to the Workgroup overnight. Other comments? Gretchen and David, anything you want to wrap up at this point, on this area?

Nope. I think since we're running a little behind time, I have nothing to add.

Same here.

All right. So, we had planned for a 10-minute break. Let's stay with the 10-minute break, be back at 2:45, so 9-minute break and then we'll move into Experience of Care. So, again, please do not disconnect and we'll talk to you at 2:45.

BREAK

All right everybody. Welcome back from the break. This is Margo. I am now going to review the two Experience of Care measures in the Child and Adult Core Sets both of which have been suggested for removal. Next slide.

The Child Core Set includes the Consumer Assessment of Healthcare Providers and Systems or CAHPS Health Plan Survey 5.0H Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items. For FFY 2018, 39 states reported collecting CAHPS data.

The Adult Core Set includes the CAHPS Health Plan Survey 5.0H Adult Version for Medicaid. And for FFY 2018, 32 states reported collecting CAHPS data. I'd like to point out that CMS has not collected raw data from states about their CAHPS survey results. Instead, states indicated whether or not they conduct a survey and whether results were reported elsewhere, such as to the AHRQ CAHPS Database. As I noted yesterday when discussing the context for the 2021 Core Set Review, CMS and AHRQ are collaborating on an effort to compile results reported to the AHRQ CAHPS Database to produce state-level rates on consumer experience in Medicaid and CHIP. Submission to the AHRQ database by states and health plans is voluntary. AHRQ indicated that for the FFY 2019 reporting cycle, state-level results are available for 29 states for Adult Medicaid and 33 states for Child Medicaid. CMS anticipates conducting a dry run of state-level reporting

with states later this spring. The goal of this effort is to streamline state reporting information for the Child and Adult Core Sets. Next slide.

This slide provides additional information about the Child CAHPS Survey. The measure provides information on parents' experiences with their child's health care and gives a general indication of how well the health care meets their expectations. Although reporting the Child Core Set measure is currently voluntary, CHIP programs are required by statute to collect CAHPS data. This requirement was enacted under the CHIP Reauthorization Act of 2009 and became effective as of December 2013.

NCQA is the measure steward, and the measure is not endorsed by NQF. Note however this measure is adapted from the AHRQ CAHPS 5.0 measure, which is endorsed. The survey includes parents and guardians of children ages 0 to 17 who were continuously enrolled in Medicaid or CHIP in the last six months of the measurement year and who are currently enrolled at the time of the survey. Next slide.

The survey includes four global ratings of overall health care, the child's health plan, the child's personal doctor, and the specialist seen most often. In addition, four composite measures summarize experiences with Customer Service, Getting Care Quickly, Getting Needed Care, and How Well Doctors Communicate. And question summary rates are available related to coordination of care. I will now describe the Adult CAHPS Survey and then the reasons these measures were suggested for removal at the end since the reasons are the same for both measures. Next slide.

Similar to the Child CAHPS Survey, the Adult CAHPS Survey provides information on the experience of adult Medicaid beneficiaries with their health care and gives a general indication of how well the health care meets their expectations. NCQA is the measure steward for the Adult CAHPS Survey, Version 5.0H, and the measure is not NQF endorsed. The survey includes beneficiaries age 18 and older who are continuously enrolled in Medicaid the last six months of the measurement year and who are currently enrolled at the time of the survey. Note that two other Adult Core Set measures are derived from the Adult CAHPS 5.0H Survey, Flu Vaccinations for Adults Ages 18 to 64, which was discussed yesterday, and Medical Assistance with Smoking and Tobacco Use Cessation, which will be discussed tomorrow. Next slide.

This slide shows the ratings and composites from the Adult CAHPS Survey similar to those for the Child CAHPS Survey. Now, I'd like to review the reasons that the two CAHPS surveys were suggested for removal from the Child and Adult Core Sets. The Workgroup member noted that CAHPS is expensive to field and that response rates are low and decreasing. The Workgroup member also noted that responses vary widely across cultures, age groups, and other demographics. And as a result, the measure does not allow for consistent calculations across counties and states. The Workgroup member also noted that the measure does not contribute to estimating overall quality of health care in Medicaid and CHIP because of these limitations. As a result, the Workgroup member indicated that the measure does not accurately portray the unique and complex views of health care satisfaction or experiences across beneficiary demographics. Finally, there is a concern about trending the results over time because of decreases in completed responses. Next slide.

So, again, it's time for Workgroup member discussion. We'll now invite comments and questions from the Workgroup members on CAHPS measures. Please unmute your line if you wish to speak, and please say your name before making your comment.

Margo?

Yes?

Yeah, thanks. This is Jim Crall. Could you briefly just explain that NCQA is the steward for this and it's noted that the CAHPS surveys that are used are adaptations from the 5.0 CAHPS which is endorsed by NQF? What's the nature of the adaptation? Can you just briefly comment on that?

If NCQA is on the line, perhaps they can comment on this as well. But I will say that for example, the two measures that are in the Core Set based on the flu vaccination question as well as the smoking cessation measure, those are in 5.0H and not in 5.0. So, there are some extra questions that have been added to the NCQA version. Janet or someone else from NCQA if you're on the line, you're welcome to make a comment at this point. And please press star one. So, why don't we keep going with discussion and if someone from NCQA joins, and is able to make their comment, we'll come back to that if that's okay.

This is Lindsay from New York State. We have a couple of concerns as they relate to CAHPS and our dwindling response rate. So, we understand that measuring the experience of care is an incredibly important dimension, for particularly this vulnerable group, but we are really concerned about our response rate especially this year. I mean, we're starting to get close to single digits here in our response rate. And we reached out to CAHPS and really didn't get a response that I would say echoed our concerns. We've tried alternate sources of data collection, different ways, different modalities - from mail, to phone, to providing a one-time text to link to a survey online. And so, I do echo some concerns with the use of CAHPS. I don't have a really good solution to what to do and would welcome responses from other states. But this is an area that we are continually monitoring as it relates to response rates and generalizability to the whole population.

Hi Lindsay. This is Linette from California. And the response rates to surveys are a problem across the board. So, every large survey is having the same issue. And so, there's different things being done to try to experiment with how to get responses, probably the changing population, the way the population interacts with phone contacts, the mail contacts, some options around using web-based or text-based responses to surveys. So, there's a variety of things that folks are taking a look at. So, I mean, in that context, I wonder for the CAHPS survey, if the CAHPS survey in particular is doing anything related to looking at additional modalities or other ways to try to address the response issue. Because depending on what the response issue is, doing that can create a significant amount of bias in your results as well. So, if that's not being adjusted for, so, sharing your concern.

So, we do have some folks from NCQA on the phone, Janet or Sarah. Operator, can you unmute Janet's line.

And Janet, your line is now open.

Janet, if you're speaking perhaps, you're double muted.

Hi. This is Janet Holzman, can you hear me?

Yes. Now, we can.

Thank you. So, just to go back to the earlier question about the difference between the NCQA version of CAHPS which is the HEDIS version of CAHPS versus the AHRQ CAHPS. The HEDIS designation refers to a standardized protocol that NCQA has adopted for the administration of CAHPS surveys as well as the administration of those HEDIS surveys through the use of an NCQA certified survey vendor. So, the adaptations are in large part a standardized protocol, as well as an oversight process that we apply to the service. And then I think it was Margo who mentioned that there are some additional NCQA-developed measures, specifically the smoking measure and the flu measure, that are also part of the NCQA version. In terms of the issue of response rates, that is response rates are absolutely declining, the problem is across all surveys. We still find that the majority of our responses have come in from mail; for the Medicaid population phone remains an important avenue of responses. We've had less success with say e-mail surveys because health plans are either unable or unwilling to provide e-mail addresses. And so, we are still for the most part, although we offer an internet enhancement, we are still relying predominantly on mail and phone.

This is Gretchen Hammer. I would just reflect that I really appreciate the perspectives of New York and California and recognize that there are methodologic issues. I would just advocate that it would leave a significant hole in one of the core areas that I believe we want to continue to drive quality, which is the experience of care. So, I recognize those unless there was a replacement measure already on deck, I just don't know that I would be able to vote to remove these measures. And when I was Medicaid director in the State of Colorado, I absolutely looked at these data to help us understand the experience of care in addition to other ways that we found. Right, so it's not our only glimpse into that, but it's one that is comparable and one that is important. So, I would just offer without a replacement option, it's difficult for me to imagine we would leave this hole.

This is Richard Antonelli. I'd like to provide commentary as well. I very much appreciate the methodologic challenges. I think that we can send a profound message to the folks about the measures, the fact it's undergoing debate about whether to be removed from the Core Set I think is significant. I, however, agree with Gretchen. I don't feel comfortable removing these especially since there isn't something that is an improvement on it, it would send the wrong message. So, I would like very much so to send - the outcome of this debate should be very much a profound methodologic refinement to the measure stewards and the implementors to make it meaningful. But otherwise, I cannot support withdrawing either of these measures.

Hi. This is Lowell Arye. And I'm speaking both as someone who was Deputy Commissioner in New Jersey's Department of Human Services. But also, served on the MAC for six years as Vice Chair while I was in the advocacy community. And I just want to reiterate everyone else's view. In New Jersey, we actually had many discussions at the MAC specifically as to how we could increase the numbers of individuals who

responded, and it is always a vibrant discussion. We also used it significantly both myself as an advocate but also within the state to take a look at experience of care for beneficiaries, and sometimes with the over sample for certain parts in our population because we were only getting some very minimal information specifically by managed care organizations on specific areas such as durable medical equipment. So, it's an important thing. And I certainly would not recommend to remove this from the Core Set.

This is Dave Kelley. I just want to add to the commentary that I think the CAHPS survey is very important. I know that there are method challenges to getting respondents but at least within Pennsylvania, we've encouraged our managed care plans. They all have consumer advocacy groups, workgroups. We also have a statewide consumer subcommittee as part of our advisory committee. So, we certainly worked with them to get the message out that this is an important component of evaluating our managed care plans. We place our CAHPS results online, and it's also part of our consumer report card for this - there are one or two measures, for adults and for kids. So, we think it's a very important component of being able to measure what's happening within our program, our health plan, and statewide.

Margo? Yes. This is Jim Crall.

Go ahead, Jim.

Yeah. Thank you. I have been and continue to be a great supporter of the consumer voice and making sure that that's part of the mix as well and have even looked to develop a pediatric dental CAHPS survey that the CHIP program in California used on a number of occasions. And I know that there's incredible scientific rigor that has gone in over decades to developing CAHPS to be a valid and reliable method, but at the same time, I'm really bothered when I start to hear about response rates that are approaching single digits, and can't imagine that the scientific community would consider that to not be a potentially biased representation of the actual concerns of the consumer. So, I don't know what it's going to take to force a better method or happier medium or an alternative data collection strategy but to me there's a real tension here between the desire to want to include the consumer perspective. A methodology that at one level is highly defensible from a scientific standpoint. But then, when you introduce the response rate, really calling into question about both the validity of what's actually being represented and just a whole methodology of collecting the data. So, I think this is a big dilemma that we need to be working to try and solve.

Hi. This is Linette again from California. And just to echo what Jim was saying, because I'm probably the one at fault for helping us have this conversation every year. But and other than that, I'm not sure how do we push this boundary? And so, this goes into the gaps conversation a little bit recognizing that absolutely consumer voice is critically important, but it needs to be a valid consumer voice. I mean, so going to the methodological issues that are coming up and especially around surveys and response rates every year is worse. We're not getting better, it's getting worse. So, how do we do this? How does this get broached? How do we get to a point where we have another option to put into play? So, just really want to voice that, and especially a culturally sensitive option, because we really see this significantly in California probably because of our diversity, there are certain plans that do not perform well because the populations they serve do not score high. And it doesn't mean they're less pleased with their care

than somebody who scores high. So, there is bias in the survey in terms of response not being equivalent depending on what your underlying population is. And that's not taken into account in looking at the results. So, I really want push on that, and I'll say it again in the gap section. But we need to look at how we address the issues that affect CAHPS while making sure we really do get that consumer voice heard in a valuable way. So, thank you.

So, I'd like to respond to that given my almost 20 years of work in New Jersey. New Jersey certainly does not have the population size that California has, but it really is one of the most diverse states in the nation. And I understand what you're saying, and yet at the same time, I think that there are ways to deal with it. And I think I would agree it's a gap, but I wouldn't say that this is why we should be removing CAHPS from the Core Set.

Are there Workgroup members who wish to comment?

Are there any other comments from NCQA? Sarah, did you want to say something or Janet, anything to add?

This is Sarah, can you hear me?

We can.

Oh, thank you all. We really take these comments very seriously. We appreciate your input. We'll go back, it's something we've been reviewing internally. As you may know, the CAHPS really was developed by AHRQ, and there is a research team at AHRQ that owns that content, so we've spoken with them about the decreasing response rates and the concerns about relevance and timeline. So, we appreciate this concern, and it's something we've been trying to figure out what would be the best way to respond. So, we look forward to reaching out to members of the committee if that's okay to hear more about whether you have suggestions for other considerations that might guide the improvement of this type of tool and protocol.

Thanks Sarah. Other comments from the Workgroup before we wrap up for public comments? Gretchen or David, anything to add? Oh, sorry. Go ahead.

Was that Sarah from NCQA?

Yes, it was.

So, I'm just wondering, are we talking about a long-term discussion? When Lindsay Cogan says we reached out and didn't get a satisfying answer, for me that's a bit of a bellwether. I'm especially mindful that the Core Set on the pediatric side will be reported beginning in 2024. And so, I just want to make sure that whatever Sarah is going to be bringing back that there could be a relatively timely response because the clock is ticking on mandatory reporting. And when folks that have the degree of skill that Lindsay and her team has are getting less than satisfying answers, I would like to have a timely response. So, are we -

Oh, just to clarify Rich. This is Lindsay. It was not a response from NCQA that we count to be inadequate, just to clarify it. It was when we reached out to AHRQ that the response was not exactly what we were hoping for. Not NCQA.

Okay. Yeah. Thank you for the clarification. But I guess I'm still concerned, Lindsay. You have need or the California colleague has a need and those aren't being met. So, back to the statement I made an hour and a half ago, multiple entities that are accountable can often mean that there is nobody accountable. So, I just want to get a read from Sarah. Does she take that this is something that is addressable in a timeframe, so that when this group convenes next year, we're not going to be hearing the same thing.

Well, I think what we've heard loud and clear is the urgency that you've presented in this case. So, thank you for that.

And Rich, I'd like to also suggest that this is something that we've heard as part of the review of the Workgroup and it'll be reflected also in the report.

Any further comments? Gretchen, David, any comments before we turn to public comments?

Nothing for me.

I have no further comments.

All right. So, now, I'd like to open it up for public comments. And if you would like to make a comment or ask a question, please press star one to enter the queue. Operator, do we have anybody in the queue?

And we do. We'll go first to Sara Toomey.

Hi. Can you hear me?

Yes, we can.

Great. Hi. I'm Sara Toomey, I'm from Boston Children's, and actually I have two roles that are important I think to this conversation. I'm Chief Experience Officer for the hospital, and I'm also the PI of one of the CMS- and AHRQ-funded Centers of Excellence for Pediatric Quality Measurement. And I should disclose I guess before I start that I'm one of the co-lead developers of the Child Hospital Consumer Assessment of Healthcare Providers and Systems survey, Child HCAHPS. And I appreciate your listening to me. And I appreciate this conversation. I share with Sarah Scholle certainly the importance of what you're all bringing to the forefront. And I think it's fair to say that, from the meetings that I've been at with AHRQ and with others in the CAHPS consortium, that they certainly have heard these concerns. And I will say that I am certain that they are actively pursuing different testing regards in particular to the low response rates. I've also looked at NQF and the work that they've been doing more generally with quality measurement in regard to the socio-demographic issues that were brought up.

And I agree looking at differences in populations across quality measures can often be very challenging, and it's something that we all need to be thoughtful about as we make those comparisons across groups. I do want to just go back to the importance of patient experience. I think it is extraordinarily important in our current health care system. And we know that there are disparities in experience, in particular, we look at socioeconomic differences. And we've also been able to show that by measuring patient experience that we are able to lead to improvement through interventions. And so, it certainly seemed this has been useful to measure over the past years. But I share your concerns about the decreased response rates. As the Chief Experience Officer of Boston Children's, we are certainly wrestling with that every day.

I guess the last thing before just to go with also just to say in the context of pediatrics, I would say having this in the core measures that for Medicaid and CHIP has been really extraordinarily important. On the adult side, the adult age CAHPS survey is mandated by CMS through Medicare. But for children, this is really the only way which we have any sense of what's happening at a state level in regard to patient and family experience. So, I just want to also make sure that that point got raised. But I do think that it's important while I do understand it's flawed, and certainly, very hopeful that we will be making improvements over the coming years. Thank you.

Thanks, Sara. Operator, anyone else in the queue?

And once again, it's star one if you like to make a public comment at this time, star one. And at this time, we have no one else in queue.

All right. Well, with that, I think I'll turn it over to Dayna for voting on these two measures.

Great. Thank you, Margo. Next slide.

Okay, great. For our first vote the question is, should the CAHPS Health Plan Survey 5.0H Child Version Including Medicaid and Children with Chronic Conditions, Supplemental Items measure be removed from the Core Set? And the options are yes, I recommend removing this measure, or no, I do not recommend removing this measure. And voting is now open. Okay. Almost there, waiting on just one more vote. Perfect. So, we are expecting 25 votes and we do have 25 at this time, so I'm going to go ahead and lock the polling. Voting is now closed. As a reminder, the two-thirds threshold for this measure is 17 yes votes to pass. We received six yes votes. That does not meet the threshold for recommendation. So, the CAHPS Health Plan Survey Child Version is not recommended by the Workgroup for removal from the 2021 Core Set. Next slide.

The next question is, should the CAHPS Health Plan Survey 5.0 Adult Version measure be removed from the Core Set? And the options again are yes, I recommend removing this measure, or no, I do not recommend removing this measure. And voting is now open. Okay. We are expecting 25 votes and we have received at this time. I'm going lock voting. Okay, voting is now closed. The two-thirds threshold for this measure is 17 yes votes to pass. We received six yes votes. That does not meet the threshold for recommendation. So, the CAHPS Health Plan Survey 5.0 Adult Version is not recommended by the Workgroup for removal from the 2021 Core Set. And with that, I will turn it back to Margo, so we can discuss gaps in the Experience of Care domain.

Thank you, Dayna. And that's our last vote for today. So, I think we'd like to hear a little bit more about gaps. We've already started that conversation but let's hear more about measures, measure concepts that are missing, or other measures that could fill the gap, or measures that need to be developed. So, open it up for the Workgroup.

Hi. This is Linette from California. And I mean, to follow on what we started earlier if there were some sort of a workgroup or something that - or just outreach or data gathering, I'd be happy to follow-up with AHRQ or NCQA around those kinds of things. I'd also point out that there's some really good folks with survey and survey response, survey bias at National Center for Health Statistics that might be good to chat with. And the California Health Interview Survey in California has done a bunch of work in terms of looking at modalities around other alternative modalities for collecting information to try to respond to the decrease response rate. And they've had some good results with that. So, those would be some other things to take a look at in this area.

This is Jill Morrow. I would echo that, having sat with somebody who tried to fill out the CAHPS, who asked very good questions, about the questions. I think the other thing that we have to take into account is that everybody and their brother has a survey that they ask. You go to the grocery store you get a survey. You go to Kohl’s you get a survey. And so, I think people are a little surveyed out. And so, thinking about other ways to gather the information, thinking about being very strategic about what to gather would be important. And the other side is, does all of the information need to be gathered for everybody. Again, you have to look at statistics and whatnot, but I think it's probably ripe for an overhaul in terms of thinking about how to get this valuable information.

This is Bonnie Zima.

Jim Crall again. Let me just mention for -

Okay. I think Bonnie wanted to say something.

Oh, I'm sorry.

Sorry.

I'm sorry.

It's okay.

Thank you, Margo. I just wanted to make a last comment to move a bit farther and say, yes, Linette, I'd be happy to work with you on this. I think it's an important direction. And also, that in this deliberation we explore things like item response theory to reduce burden on respondents.

Jim?

Yes. Thanks, Margo. Yeah. I would just add just so with - it's part of the information that dental care really isn't a part of the CAHPS survey other than there is an adult survey that is a bit dated now, so it actually had - it was supported by I believe the Department of Defense and the AIR group in North Carolina work to develop that using CAHPS

methodology and to get it approved through the AHRQ channels, but that's for adults. And there isn't anything for on the pediatric side, I would definitely be willing to speak with someone about the overall challenges that have been expressed to see if there's some way with different methodologies of getting information that we could at least also get some information related to their use of dental care. And I guess we would start with kids given the earlier discussion about the state coverage for adult dental benefit. But I think that some way to make sure that we've got that covered without adding extensively to an already existing problem of ways of collecting data.

Thanks, Jim. Other comments?

This is Rich Antonelli. And while we're talking about experience, I want to loop back to the conversation that we had yesterday about LTSS. And want to make sure that there's an opportunity here, I think, to possibly harmonize some of what gets measured across these areas, populations.

Rich, can you say a little bit more?

I'm mindful that we had a couple of measures under consideration for LTSS that didn't advance. And I'm mindful that as we consider, in the current conversation, we're talking about what else beyond CAHPS or at least optimizing response rates, for example with methodologic adjustments, will that be sufficiently reflective of the experience that folks with disabilities and chronic conditions have? So, I just wanted to call that out as an opportunity to either do work that touches both of these potential domains. In fact, I'd actually prefer that there be an opportunity that were to improve in the patient reported outcome experience based had actually been quite relevant to LTSS experience reporting as well.

Other comments on gaps? Gretchen and David, anything before we move on to the wrap up?

I have nothing now.

Nope.

All right. Next slide.

Okay. So, here we are in the homestretch on Day Two of the Stakeholder Review of the Child and Adult Core Sets. Thank you everyone for another day of robust discussions. And thank you for powering through all the measures and the voting. We appreciate everyone's contributions today. So, now, I'd like to preview the agenda for tomorrow. Next slide.

Tomorrow, we will discuss measures for removal and addition in the two remaining domains: Behavioral Health Care with three measures suggested for removal and Care of Acute and Chronic Conditions with one measure suggested for removal, and there are two measures suggested for addition. We'll also provide a recap of the meeting and discuss future directions including further discussion of gaps and areas for measure development. And we'll also discuss next steps in the Stakeholder Review process. We'll

begin promptly at 11:00 A.M. again tomorrow, and we ask Workgroup members and others to sign in early.

Gretchen and David, any final wrap up comments before we break for the day?

I guess just in the spirit of us when we were all together, we shared some laughs, et cetera. But I am just expressing my gratitude that we do not have 45 measures to be reviewing. I thank you for doing a great job - Mathematica again, you've been so well prepared, the slides are so clear, the voting is easy. The conversation has been great. But it is hard and long, and I just want to acknowledge that for us as a team. And again, just express gratitude that we don't have twice as many measures like we went through last year. But I'm really appreciative of the due diligence that we're providing to the process even though it is in these extraordinary times and under the extraordinary circumstances. I think the conversation is equally as robust. I'm just thankful that there's fewer things for us to talk about.

And likewise, I'd like to thank the committee members for your due diligence and great discussion today. Also, I'd like to thank Mathematica for really keeping things on task and all the backup support has been absolutely fantastic. Lastly, also I'd like to thank our federal partners for their participation, their comments and their guidance, I think that's been very valuable as well as the public comments that we've received. So, this is really important business at hand here. So, I really look forward to tomorrow's discussion, and thanks again for everybody for all the hard work and the preparation.

And I just like to offer thanks to the Mathematica team behind the scenes, you have no idea how many chats we've exchanged today - Brice Overcash, Grace Reinders, Lindsay Zelson, Dayna Gallagher, Chrissy Fiorentini, Brian Willis, Crystal Stone Valenzano, Alli Steiner, Patricia Rowan, and I just appreciate everything that you all have done to make this go smoothly. And thanks to everyone for their patience with the bandwidth and internet issues that we seem to have struggled with a little bit today. But all things considered when we're all virtual and in makeshift home offices, thanks to everyone for everything that you've contributed. We wish everyone a good rest for the day. Stay well. And this concludes day two of the 2021 Child and Adult Core Set Annual Review Meeting. Take care, everybody.

Thank you.

Thanks.