2023 Child and Adult Core Set Annual Review:
Meeting to Review Measures for the 2023 Core Sets Day 1 Transcript
April 5, 2022, 11:00 AM – 4:00 PM EST

Hello, everyone. And thank you for joining today's event, the Child and Adult Core Set Stakeholder Workgroup Meeting to Review Measures for the 2023 Core Sets Day 1. Before we begin, we wanted to cover a few housekeeping items. Next slide.

All attendees of today's webinar have entered the meeting muted. There will be opportunities during the webinar for Workgroup members and the public to make comments. To make a comment, please use the raise hand feature in the lower-right corner of the participant panel. A hand icon will appear next to your name in the attendee list. Those who are using the browser app can find the raise hand icon by clicking the ellipsis icon. You'll find the option to raise and lower your hand in the list. You'll be unmuted in the order in which your hand was raised. Please wait for your cue to speak, and remember to lower your hand when you finish speaking, by following the same process you used to raise your hand. Note that the chat is disabled for this webinar. Please use the Q&A feature if you need support. Next slide.

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

Thank you, Dayna. Next slide, please.

Hi, everybody. And welcome to the virtual meeting of the 2023 Core Set Annual Review Workgroup. Thank you to our Workgroup members, federal colleagues, and members of the public for joining us for this virtual meeting. Next slide, please.

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

We have a full agenda and important objectives to accomplish over the next three days. I listed our four meeting objectives on this slide. First, the Workgroup will discuss the seven measures that were suggested for removal and 12 measures suggested for addition to the Child and Adult Core Sets. Second, the Workgroup will vote on the measures suggested for removal or addition, and make recommendations for updates to the 2023 Core Sets. Third, the Workgroup will discuss gap areas in the Core Sets, and areas for future measure development. We'll invite Workgroup members to identify gaps as part of each domain discussion. And on the last day, we'll provide an opportunity for Workgroup members to reflect on cross-cutting gaps and the areas for future measure development.

And, finally, we'll provide multiple opportunities for public comment to inform the Workgroup discussion. I'd like to pause for a moment and note that we are committed to a robust, rigorous, and transparent meeting process, despite the virtual format. That said, we acknowledge that attendees may continue to face challenges working from home. I hope everyone will be patient as we all do our best to adhere to the agenda, and fulfill the objectives of this meeting. Some of you may be wondering why we're not using video for this meeting. We found that some of us do not have enough internet or Wi-Fi bandwidth to support video.

We're also keeping our fingers crossed that there are no storms or high winds that could cause outages that disrupt the meeting. I also wanted to remind the Workgroup members of a few ground rules for participation today. First, we acknowledge that everyone brings a point of view based on your individual or organizational perspectives. As a Workgroup, we are charged with recommending Core Set updates as stewards of the Medicaid and CHIP program as a whole, and not from your own individual or organizational perspectives. Please keep this in mind during the discussion and the voting. Second, we know that spending five hours a day in a virtual meeting can be challenging for all of us. We ask that you be punctual in returning from breaks, so that we can have everyone present for the discussion and voting on the portfolio of measures before us the next three days.

And related to that, we wanted to make sure that all Workgroup members who wish to speak may do so. This platform will enable you to unmute yourself when you want to make a comment or ask a question. If you find that you are unable to jump into the conversation, please raise your hand or contact us through the Q&A feature. And we'll make sure you have a chance to speak before we move on. Finally, we encourage Workgroup members to not repeat comments made by other Workgroup members. And instead, to build on the discussion with new comments. Now, I would like to turn to our co-chairs, Kim Elliott and David Kelley, to offer their welcome remarks. Kim, do you want to go first?

Hi, happy to. Thank you, everyone. So, first, I do want to thank everybody for all of their time, effort, energy and, of course, the passion that each of you, including the Workgroup members, Mathematica staff, CMS, and other federal representatives, have applied in preparing for this meeting, and will, of course, demonstrate during the meeting and any of the follow-up work that may need to be done after we conclude. We recognize that this is a significant and important time commitment, as work that we're accomplishing in reviewing the Core Set measures will affect beneficiaries’ access to care, the quality of care, for both Medicaid and CHIP programs. But more importantly, also identify opportunities for improvement through a better understanding of the barriers and the disparities that are impacting the delivery of high-quality care.

What's also very important about today's meeting is that CMS and states are preparing for mandatory Child Core Set and behavioral health measures in the Adult Core Set reporting by 2024. And those are important things to consider as we work through reporting, feasibility, desirability, and the viability of the measures that are suggested for removal or addition. So, with that, I will turn it over to David. And he can do a strong welcome as well.

Thanks, Kim. And thanks to our committee members. Again, really appreciate the time commitment that all of you have made. I also want to thank our federal partners at CMCS and our other federal partner agencies that have been involved in the process. And of course, want to thank the entire team at Mathematica for all the hard work that they've put into this preparing and providing information for us. As we move forward, we really need to think in terms of looking at quality measurement with a lens of equity. And what I'll also say is that, you know, we need to think in terms of going beyond quote/unquote "the typical medical model," looking at other variables like the social determinants of health.

And also thinking in terms of really focusing on patient experience. And last, but certainly not least, I think we need to continue to think in terms of moving us forward in 2022 and beyond as far as the use of electronic measures. And knowing the challenges of feasibility of many of those electronic measures, but knowing that that is where the future lies. So, a lot of responsibility today. A lot of territory to cover. I think there are seven proposed deletions from the Core Set and 12 proposed additions. So, without further ado, I'm going to turn it back over to Margo and the Mathematica team. Thanks so much.

Thanks, Kim and David. Next slide, please.

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

When we go through the roll call, we ask that Workgroup members raise their hand when their name is called.

We'll unmute you and you can say hello, share any disclosures you may have, or indicate that you have nothing to disclose. When you are done with your disclosure, please mute yourself in the platform, and lower your hand. This will allow you to unmute yourself when you would like to speak during the measure discussions. If you leave and reenter the platform, or find you've been muted by the host due to background noise, just raise your hand, and we'll unmute you. Next slide, please.

On the next few slides, we have listed the Workgroup members in alphabetical order by their last name. When I call your name, please raise your hand, we'll unmute your line, you can indicate whether you are here and whether you have anything to disclose. If you've also muted yourself on your headset or phone, please remember to unmute your line to avoid the dreaded double mute. If you have any technical issues, please use the Q&A function for assistance. So, David, starting with you, please indicate whether you have a disclosure.

Thanks, Margo. I'll disclose several things. Less than four years ago, I was part of NQF's CSAC, where we were looking at measures, new measures and old measures, that were coming up for renewal. I also currently sit, I no longer sit on that. But I also currently sit on the NCQA CPM. And then just recently joined Yale's group that is looking at LTSS measures. That group has not met. But I wanted to disclose that as well. Thanks.

Thanks, David. Kim Elliott?

Hi, this is Kim. And I have nothing to disclose. Thank you.

Thanks, Kim. Richard Antonelli?

Hi, good morning. This is Rich Antonelli of Boston Children's Hospital. And I have nothing to disclose.

Thanks, Rich. Tricia Brooks?

Hi, I have nothing to disclose.

Thank you. Karly Campbell?

Karly, if you are here, please raise your hand.

Okay, we'll move on. Lindsay Cogan?

I'm here. I have nothing to disclose.

Okay, thank you. Lindsay Cogan?

This is Lindsay Cogan. My only disclosure is I also sit on an NCQA group. I sit on the Technical Advisory Group. So, I sometimes will hear about these measures in this context as well.

Thank you. Jim Crall?

Yes, good morning, everyone. Jim Crall from UCLA. And I have nothing new to disclose. I do some consulting for Centene Corporation and its involved dental plans, and with a group at Georgetown University, the Maternal and Child Oral Health Resource Center. And I've been a member of the Dental Quality Alliance for many years, and chair a committee there.

Thanks, Jim. Curtis Cunningham?

Hi, I'm Curtis Cunningham. I guess disclosures would be I am the assistant administrator for benefits and services within the Wisconsin Medicaid program. So, we'll be very significantly impacted by the operational work to get these measures reported. I am on the ADvancing States Board, which is a national board for aging and disability. And they administer the National Core Indicators for AD. And I also sit on their Managed Long-Term Services and Supports Institute. And then, finally, I also participate in the National Association of State Developmental Disability Directors as the DD director for Wisconsin, and sit on their National Policy Work Group. And they also run the NCI IPS surveys. Thank you.

Thank you. Amanda Dumas?

Hi, good morning. My name is Amanda Dumas. I am the associate medical director for Medicaid in the state of Louisiana. And in that role, of course, I help review quality measures. Some of which we're talking about today. And I'm also a member of the American Academy of Pediatrics. Thank you.

Thank you. Anne Edwards?

Good morning, everyone. Anne Edwards. Nothing to disclose.

Katelynn Fitzsimmons?

Katelynn Fitzsimmons, nothing to disclose.

Lisa Glenn?

Good morning. Lisa Glenn. Nothing to disclose. Thank you.

Thank you. Tracy Johnson.

Yes. Hi, Tracy Johnson. I'm the Colorado Medicaid director. And I use many of these measures as a result of my work in that role as Medicaid director. And, otherwise, I don't have anything additional to disclose.

Thank you. Diana Jolles.

Good morning, everyone. Diana Jolles. Nothing to disclose.

Thank you. Next slide, please. Russell Kohl.

Hi, I'm Russell Kohl. I'm the speaker of the Congress of Delegates for the American Academy of Family Physicians. My other two quick disclosures are I'm the chief medical officer of a Medicare Quality Improvement Organization, which obviously helps folks do well on measures. And then, finally, I actually am an independent director on the Board of Blue Cross and Blue Shield of Kansas City. So, those are my only disclosures. Thanks.

Thank you. David Kroll.

Hi, there. This is David Kroll. I'm a psychiatrist at Mass General Brigham Healthcare in Boston. You know, my disclosure is that my spouse has done a lot of consulting for pharmaceutical companies related to cancer therapeutics. And I can just list those companies: AstraZeneca, MorphoSys, Genmab, Insight, Celgene, and Bristol Myers Squibb, Epizyme, Century, Genentech, Regeneron, BeiGene, Mustang Bio, Ono Pharma, Kymera, Kite, bluebird bio, C4 Therapeutics, Allogene, Karyopharm, Novartis, AbbVie, EMD Serono, Roche, Janssen, Humanigen, Bayer, Gilead, Verastem, and Merck.

Thanks David. Rachel LaCroix?

Good morning. This is Rachel. I have nothing to disclose.

Thank you. Jill Morrow-Gorton?

Good morning. I work for a health plan that participates in the Medicaid, CHIP, and MLTSS realm. And we use the measures, but not involved in developing any.

Thanks, Jill. Kolynda Parker?

Good morning. This is Kolynda Parker with the Louisiana Department of Health. Currently, I am the Medicaid deputy director over Program Operations and Compliance and Quality Improvement in Health Equity and Population Health. We do utilize the Adult Core Set measures. And I also assist with identifying measures for the Medicaid program. Other than that, I have nothing to disclose.

Thank you. And we got word that our next member, Mihir Patel, will be about 45 minutes late, and will be joining. Lisa Patton?

Good morning, everyone. Nothing to disclose.

Sara Salek?

Good morning. This is Sara Salek. I am the chief medical officer for Arizona Medicaid. And we use these measures in our everyday quality management system. Thank you.

Great. Lisa Satterfield?

Hi, I'm Lisa Satterfield. And four years ago, I was a measure developer for the American Academy of Otolaryngology Head and Neck Surgery. Though those measures are not in the Adult or Child Core Set here. And currently, I am employed by the American College of Obstetricians and Gynecologists. And I advocate for measures that are consistent with clinical practice guidelines.

Thanks, Lisa. Linette Scott?

Good morning. I work with the state Medicaid program in California as the chief data officer. So I spend a lot of time working on calculating the measures, but not any disclosures related to the development. Thank you.

Thank you. Jennifer Tracey?

Good morning. No disclosures.

Thank you. Ann Zerr? Ann, are you there?

All right, let's move on to Bonnie Zima.

I am a health services researcher. Nothing to disclose.

Thank you. And remember, if your hand is raised, please lower your hand at this point if you can. And Ann, I think you might be there now. Are you able to say hello?

Ann Zerr from Indiana Medicaid. I have no disclosures.

Great. Thank you so much. All right. Well, thank you, Workgroup, for the roll call here. That worked really smoothly with muting and unmuting. And if you could please lower your hand when you are done unless you have another question. And also please mute yourself. Thank you very much. So now we will move on.

Next slide, please.

We are also joined by federal liaisons who are non-voting members.

I'll read the name of the agencies, but not do an individual roll call. Center for Clinical Standards and Quality, CCSQ; Centers for Disease Control and Prevention; Agency for Healthcare Research and Quality; Health Resources and Services Administration; Office of the Assistant Secretary for Planning and Evaluation; Office of Disease Prevention and Health Promotion; Office of Minority Health; Substance Abuse and Mental Health Services Administration; and U.S. Department of Veteran Affairs. Federal liaisons, if you have questions or contributions during the Workgroup discussion, just raise your hand and we will unmute you.

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

Okay. So with that, I'd like to turn now to a special topic at this year's Child and Adult Core Set Annual Review. The topic is Advancing Health Equity Through the Child and Adult Core Sets. As we mentioned at the March 24th meeting, eight measures of drivers of health screening rate and screened positive rate were suggested for addition to the Child and Adult Core Sets. However, these measures did not meet minimum technical feasibility criteria for several reasons. The measures are not fully developed to allow for consistent calculations across states, and to enable production of the measures at the state level. In addition, the measures have not been tested or used by one or more Medicaid and CHIP programs. Recognizing the importance of health equity as a CMCS and state priority, and existing gaps in the Core Set in this area, we wanted to allot time this morning to hear from CMCS and Workgroup members and the public on how to fill these important gaps in the future. This might involve testing of existing measures in Medicaid and CHIP programs, development of new measures for state-level reporting, use of stratification in state reporting, or other strategies. I'd now like to call on Liz Clark from CMCS to start off the discussion. Next slide, please.

Good morning. Thank you, Margo, so much. It's my pleasure, actually, this morning to introduce the director of the Center for Medicaid and CHIP Services, Dan Tsai. Dan joined CMS last July with an agenda to improve access to coverage and advance health equity, in order to best serve the needs of more than 85 million beneficiaries.

Before coming to CMS, Dan worked for the Commonwealth of Massachusetts, where he served as the assistant secretary for MassHealth and Medicaid director. His tenure there focused on building a sustainable Medicaid program that ensured equitable coverage, and reshaped how health care is delivered for two million individuals and their families. He was instrumental there in leading MassHealth's landmark 2016 Medicaid 1115 demonstration, implementing one of the most at-scale shifts to value-based care in the nation, including investing in addressing social determinants of health. At CMS, Dan quickly laid out the strategic vision for Medicaid and CHIP to promote coverage and access, equity and innovation, and whole person care.

This vision is particularly meaningful for the Annual Core Set Review Workgroup, because it's through quality measurement and improvement that we're able to tell and track the story of the health of our beneficiaries and the care they receive. Quality measurement shows us how states are performing in key areas of health equity and health care quality. Without these measures, we would not know where to direct our time and resources, in order to improve how we deliver care and meet the needs of beneficiaries, including addressing drivers of health through evidence-based quality improvement methods. CMS is committed to promoting policies and programs that improve health outcomes and health equity in this country. We recognize that a key strategy for achieving health equity is to address drivers of health that affect different populations in disparate ways. This Workgroup has been aware of these issues for years, including identifying the need to learn how to measure. We appreciate that measure stewards are also recognizing the need for a new way of quality measures that capture drivers of health. And we're glad to see this development underway.

We're committed to collaborating with measure developers and stewards to help them understand the unique needs of reporting for state Medicaid and CHIP programs. We're confident that someday we'll have a measure that's reliable, valid, and reportable at the state level. It took us years to get there with long-term services and supports measures. And we're confident the field will soon get there in health equity and drivers of health. If we're truly to take a whole person approach to health care in order to ensure equitable access and quality of care, we need to ensure that we're able to measure not only what happens in the doctor's office or hospital, but also what happens in other aspects of our beneficiaries' lives that contribute to their health and well-being. It is CMS's goal to have social determinants of health measures in the Core Sets, just like it was with long-term services and supports. And as measure development continues, the Workgroup might consider having a health equity or social determinants health placeholder on the Core Set, indicating intent to add measures when they are ready and recommended by the Workgroup.

We're hopeful that the upcoming work of different measure stewards will be fruitful regarding these critical measures. Finally, I do want to thank Mathematica, the Mathematica team that worked so hard and so long to make this a seamless process for the Workgroup. And I want to thank all of the Workgroup members for the considerable time and effort you give to this annual review work. You are essential partners to CMS for ensuring the Core Set is relevant, responsive, reliable, and reportable. Thank you.

Is Dan on? Are we ready to welcome Dan?

We don’t see Dan unless he's a call-in user.

Liz, how about if we continue with the discussion. And when he joins, please let us know.

Of course. We'll keep an eye out for Dan. And maybe whoever our next esteemed speaker will be to introduce this topic.

Thank you, Liz. We really appreciate your comments to inform the Workgroup discussion. And look forward to hearing from Dan. Next slide, please. So, at this point, I'd like to open it up for Workgroup members to share their perspectives. We've listed high-level topics to frame the discussion about opportunities to advance health equity through the Core Sets, including use of drivers of health measures that are feasible, valid, and reliable for state-level reporting in Medicaid and CHIP, stratification of measures, and other strategies.

We'd like to start with Rich Antonelli and then turn to Tricia Brooks. Remember to unmute yourself to speak, and raise your hand if you need to be unmuted. And then after Rich and Tricia, we'll turn it over to other Workgroup members. Rich, you want to go first?

Yes, thank you, Margo. And, Liz, thank you. And I'm mindful that I'm sort of jumping ahead of the batting order for Dan Tsai. In my opening remarks, I actually wanted to acknowledge Dan. So, I'm going to pretend that he is at least here.

Actually, Rich, we have word that he is here.

Oh, he is? Then I would be more than happy to get back into the on-deck circle, and let my colleague Dan Tsai jump into the batter's box.

We really appreciate that. Thank you. So, with no further ado, Dan, please join us, and make your remarks.

Thanks, I'm sorry. I'm in the office and was having some technical difficulties signing on with my computer, appreciate it. Thanks everyone for being here and for allowing me to join for a few minutes. The Core Set, and equity, is a really important, exciting topic. So, I just wanted to open up with a few things. So first overall, the Core Set, we really appreciate the immense amount of work from this group. The team, I have a sense of how much detail, and preparation, and technical analysis goes into the very thoughtful discussions around the Core Set and how to make sure it's feasible, it makes sense, it achieves the sort of goals that we're looking for together. And it is really, really important. So, thank you for that.

And I see on the agenda quite a bit of important detailed discussion to come. I think I’m listed on the agenda as part of a discussion around health equity and how we think about drivers of health and social determinants. So, I wanted to say a few opening pieces around that. So, across CMCS, the Center for Medicaid CHIP Services, we've got three major goals. Coverage and access, health equity, and innovation in whole person care. And quality measurement spans across all of that. And when we think about equity, when we think about whole person care, we really do also think about many of the upstream social determinants of health and how we, from a Medicaid standpoint, can be involved from an expectation for care delivery, from a quality measurement and performance standpoint of where we are across the delivery system, and then, certainly also from an investment and accountability standpoint.

And those are all parts of broader discussions we anticipate having with the community around SDOH, social determinants, and Medicaid overall. But especially in the context of this discussion, I know there's been quite a bit of energy and dialogue around how do we ensure that there is momentum towards standardized measurement and tracking of some of the SDOH pieces. In particular, things like screening and incident rates for housing instability, nutritional instability, and the like. All of which we believe are fundamentally important to downstream health outcomes, and also fundamentally important to the discussion around health equity.

And so, I appreciate much of the dialogue that's happened about that exploration of some new metrics. Even discussions with various folks and states in understanding where people are on this topic. I would say one really important thing at the outset is that we are trying to lean into, separate from big questions of what does Medicaid pay for, or even some of the measurement questions we're going to come into, a care delivery expectations standpoint. For all of us down to the provider level, and primary care, and health plans, and kind of how states are thinking about pieces, we really want to move towards a world in which we collectively see as part of the core responsibility of health care delivery, integrating in some of the social determinant components. Which includes screening and assessing for various social determinants drivers of health needs and some of the housing, nutritional, etc. stability pieces. But also, actively thinking about how that is incorporated into the care plan, integrated in alongside physical health care, behavioral health care, long-term services and support needs.

And then where there are actual drivers of health and needs identified, doing something that is both referring and actively connecting people to services and community-based organizations or nutritional programs like SNAP. And I think some of the discussion that I understand this group has had and will be having shortly, includes how do we best measure that in a systematic, standardized way. So that there is collective accountability, focused measurement, and a sense of progress that we're doing around that. So those are really important pieces that we, as CMS, want to lean into in partnership with the community, both from an expectation standpoint of where we would love to go. But then also about a lot of the very important technical work to get to metrics that are standardized and can be used across states, across plans, to work across CMS, including with CCSQ colleagues and CMS Medicare colleagues to really align efforts around this, across CMS from a public payor and broader standpoint. And then to figure out how to address some of the feasibility and other challenges that certainly exist around kind of the maturity of some of the metrics. And even which metrics to use. So that we can move in a direction where discussion around incorporation to the Core Set becomes a very simple one when it comes to feasibility. And we really work together as a community on some of the out-front pieces.

But I wanted to join to note some of those pieces around where we would love to go collectively from a CMS standpoint. And where we want to both help either convene or join with folks in moving towards a prioritized, standardized view of thinking about some of these really important social determinants drivers of health screening, referral outcomes metrics that I know have been up for discussion here. So, that's a little bit of an opener on this topic. And then I would just end by saying thank you to you all again. Measurement, and also being able to stratify how we're doing on quality and outcomes metrics by a range of demographic factors to identify where there are health disparities, and then to really spend time as a community investing, prioritizing, and holding ourselves collectively accountable to closing some of those disparities is really, really important. And none of that would be possible without a strong, very valid, and clearly defined core measure set and work we can do around that. So, thank you again. Thanks for giving me a chance to join you all for a few minutes today at the outset.

Dan, thank you so much for your vision, and insights, and charge. And thank you Liz also. With that we'll turn to the Workgroup discussion. Next slide please. So, Rich now you are up at bat. Take it away.

Thank you, Margo. And Dan Tsai, we miss you in Massachusetts. But I am thrilled to hear your voice. And once again appreciate your vision for what we can do collectively. I'm going to be brief.

Well, I miss you all too in Massachusetts, for the record.

Well, I'm going to keep my remarks brief today. But I specifically want to say thank you to the Mathematica team for allowing me to make some observations. And I'm going to specifically say you're hearing from somebody who's thinking about integration, transparency, and measurement. In other words, the fact that I happen to be a pediatrician is not what I want any of us to focus on. But let's sort of say broadly. So, the work that we put in place in Massachusetts is foundational. But there's an awful lot more that we need to do, including what are the data elements, what are the measures. And moving toward stratification. So, I do not want anybody to think that there's a fait accompli that we can just go to. That's my first point.

Second point, I'm thrilled that this is literally after the intro for our three-day Core Set meeting, we have the privilege of spending substantial time talking about the importance of health equity and the drivers of health. The science here is robust. There's evidence that it makes a difference, poorer outcomes, higher utilization of low-value care, exacerbation of disparities. So, it's clear that we have a burning platform. I am grateful to the Mathematica team for their analysis. Who've done a really, really good job of differentiating what's the work in this space around implementation of measures, and what's the work of how taking the implementation of collecting that data and then doing something with that data that moves it into the domain of measurement. And that's really, really important. So, I want to challenge our group in this moment, but absolutely going forward, how do we go from the experience of implementation into the experience of measurement. And what we do we do with that data?

I'd like to broaden this idea of social drivers of health. And deeply think about race, ethnicity, language, and disability status. I was thrilled to see that there's a standard item now on our measure evaluation sheets. Thanks to the MPR team for putting that together, about race, ethnicity, and language. For every single measure that we put forward into the, for consideration of the Core Set, I would like to know a priori, what's the experience to date of testing a measure for stratification by race, ethnicity, language. And please don't stop, do not forget disability status. We've got some rubrics. The CDC functional limitations being one. Some of the work with NCI, etc. So, I've heard some say well, Rich, we'll get around to disability. but right now, we're focusing on race, ethnicity, and language. The intersectionality for persons with chronic conditions, disabilities, with race, ethnicity, and language is protean.

And so, I want to encourage us to consider the implications for every single measure that goes into that precious real estate we know as Core Sets. For the implications of race, ethnicity, language, and disability status. The issue I think before us today, is what's the work that's been done. How do we get enough testing to move from implementation feasibility into satisfying the technical requirements for Core Set inclusion? I'm not going to burn any more clock time on that. But that is really what we need to do. And then finally to wrap up, I'm so honored to have been able to follow Dan. Dan, you stole about half of my talking points so I won't reiterate, but I will emphasize this notion of whole person care. Imagine people not being thought of as ICD-10 codes, but in fact, as humans who have needs in the social realm and in behavioral health. In addition to the traditional medical thing. So, this notion of integration and approach to the person-centered integration framework that the WHO promotes around the globe and that we're working on in the US around whole person care.

So, I'm excited to think about the notion of integration as a means by which to pull together those important contributors to health outcomes. And then care plan integration, how powerful is that. That person who has housing insecurity, who has food insecurity, who also happens to have diabetes. HbA1c that is stratified to include those other elements would be really, really important. And then finally, this notion that Dan referred to, that I think is exactly right: screening, referral, outcomes, collective accountability. Let's be mindful that collective accountability does not mean that all of the responsibility for a given measure should be that magical primary care provider, which traditionally often is the locus of measurement in the so-called patient-centered medical home. But when we start to think about an approach, the whole-person care and care integration, it can't just be on the PCP. And in fact, it wouldn't just be in the medical sphere. So, we have to think broadly. We have to think about health, not just medical. And I really look forward to discussions around collective accountability. And those are my opening remarks. Margo, I appreciate having a few minutes on the virtual podium.

Thanks so much, Rich. Tricia Brooks, you're next.

Thank you. And thanks for an opportunity to speak up about this topic. In thinking about health inequities and health disparities, and the role that both economic and social drivers of health play in exacerbating those disparities, it would be really shortsighted to not consider the unique role that Medicaid and CHIP play for the nation's children. Based on the most recent CMS data, almost half of all enrollees are children.

And with the COVID-related continuous coverage protection in place, we now cover about 40 million kids in Medicaid and CHIP. That's half of the nation's children. Now children are particularly vulnerable to unmet social needs. The child poverty rate is nearly 1.5 times that of adults ages 18 to 64. And children of color are more likely to experience economic and social factors that negatively impact their health.

The pandemic has further raised this risk level for children, impacting food security for families, disrupting stable housing, and decreasing the availability of childcare and employment. Which is correlated, unfortunately, to an increase in child abuse and neglect. And at the same time, child immunization rates plummeted. Children with unmet social needs are disproportionately at risk of experiencing lifelong negative impacts on healthy development, economic success, educational success, and good health.

And despite increased appreciation that social and economic factors affect children's development, drivers of health interventions led by the health care sector often are driven by an imperative for a short-term financial return on investment. And have generally not focused on children. While drivers of health screening measures make progress in the adult world in Medicare, this Workgroup is a perfect vehicle for advancing drivers of health measurement for the pediatric population. Medicaid and CHIP finance about one in every four births. And now cover nearly half of all children. As we think about measuring and addressing drivers of health, if Medicaid and CHIP are left out, children are left out. I hope this Workgroup, CMS, and all stakeholders can take advantage of the momentum around drivers of health measurement stemming from the COVID-19 pandemic and in Medicare to break down the barriers for Medicaid and CHIP so that next year, drivers of health measurement is no longer a gap. But can be considered as a viable addition to the Core Set. And thank you for the time. I appreciate it.

Thank you for your remarks, Tricia. I see we have a couple of hands raised for our Workgroup members. David Kroll, you have your hand raised. is that from before or do you have a comment now? You should be unmuted. Great, why don't we move on to Jill Morrow-Gorton.

Thank you, Margo. I just wanted to touch real quickly on two points. One, I was struck in reviewing for this meeting the disparities between the Medicaid population and the general population for many of these measures. And that may in fact in itself be kind of a measure of disparity, clearly, related to social determinants. And I think it's important for us to sort of take that into account in terms of including particular topics, particular areas of health in the Medicaid and CHIP Core Set to reflect that. I also wanted to reflect on Rich's comment about people with disabilities. And sort of not leaving them to the next version.

But to think about them now, and up front, as part of the Medicaid population. I think they are a big part of the Medicaid population, both children and adults. They are in the measures now. Those of us that work in the LTSS sphere know that we're measuring all of these things on those disability populations. And I think we need to just begin to look at that data now. And to include them as part of the population, rather than sort of waiting down the road.

Thanks, Jill. I see Michelle Schreiber. You're next.

Wonderful, thank you so much. So, to those of you on the committee who don't know me, I am the Deputy Director of the Center for Clinical Standards and Quality and the Director of Quality Measures and Value-Based Incentive Programs at CMS. And I'd like to speak just a little bit on the Medicare side. Because I think there are certainly parallels to the Medicaid side with what is moving forward in terms of social determinants of health.

Because this is really an extraordinarily important topic. A high level of focus from the administration up to the White House. But also because all of us know how important this is. There are three measures actually that were considered this year by the Measures under Consideration, MUC, Committee NQF on the Medicare side. One is the structural measure that's an attestation to a facility having an equity plan, gathering data, involved in quality improvement, and having governance participating. And two are specifically around the collection of social determinants of health. One is the percentage of patients who are screened for five social determinants of health: food insecurity, transportation insecurity, housing insecurity, utilities assistant, and personal safety, AKA domestic violence. And the second measure there was, of those screened, the percent positivity. I know that both of those measures, which were developed by the Health Alliance, were actually put forward as suggestions for the Core Set but were not moved forward because of perhaps lack of testing at a state level. But we would really like to encourage looking at this. Because those measures may be used across many other CMS programs. And we think that they're important.

In addition, as we look at further, shepherding that measure along to close that loop so that it's not just screening but making sure that there is a plan in place. As many of you also know, there's an NCQA measure around social determinants of health that will likely be coming forward as well. So, we do think there are measures out there that have been used. They've been used in CMMI, they will be used in many Medicare programs probably in the future, depending on what the final decisions are. But they do exist, and I do think that they're possibilities for consideration here.

The other thing is the approach to equity beyond just measure development. But it's the collection of data which, you know there are initiatives for all of these ongoing across CMS, the stratification of data. So already we're looking at what are the most appropriate measures for stratification. And more importantly, what is the stratification approach? Because it ranges from everything considering race and ethnicity, to low-income status, to dual eligibility, to disability status. I will say that has specifically been discussed and called out. To using area deprivation indices or the ARC or CDC social vulnerability indices. So all of these are under consideration for what we use for stratification of measures. And we're hoping to come to sort of an aligned approach across CMS. And then using it for, probably starting with confidential feedback. And then public reporting and frankly tying the payment programs to performance here. So there's a lot of work going on. There is also work going on looking at health equity index. Again, a standardized way of not only stratifying, but looking at some of the program. So we will really hope Medicaid will at least have a placeholder for this. And will be hopefully proposing some of these going forward. Thanks.

Thank you, Michelle. Very much appreciate your comments. I see we have a couple people with raised hands, or interested in speaking who are part of the public. We will have a public comment period after the Workgroup has a chance to speak. And we'll allow a fair amount of time for that. So, if you could lower your hand for now and we will get back to you in public comment. And we appreciate that. So, other Workgroup members who would like to speak.

Curtis, you're next.

Hello. Thank you. As the first time on this Workgroup, I just have a lot of thoughts about like thinking of the measures and what is the logic model for each of these measures in a longer construct. From everything from the process measures to the outcomes. I think that's really important. And the second comment I'd make from a Medicaid perspective is that really, we look at people as holistic and as people. And so, for example, in our long-term care program, which is 40% of our Medicaid spend, there are people with developmental disabilities, frail elders, intellectual disabilities, and physical disabilities. And we look at how their person-centered outcomes come to fruition. And those may be very different. So, I just caution about, at a high-level measure, looking too much at specific populations instead of the overall experience of and outcome of every individual that we're serving in the Medicaid program. Stratification can then come in to look at various populations. But that's something that's on the top of my mind right now. Thank you.

Thanks, Curtis. Who else would like to speak for the Workgroup? Jim Crall.

Yes, hello. Thank you, Margo. I'm just thinking and reflecting on having worked with many federal agencies over time. And actually, working within on a short, limited basis a couple of federal agencies over time. And perhaps this will be a discussion for our third day. But I think it's really important just to be thinking about mechanisms of aligning any type of measurement across a wide variety of programs that are supported through DHHS agencies, as well as other federal agencies. When we're talking about Medicaid, we then introduce the whole realm of state input and design in terms of programs and administration of programs. But I think we can't start too soon thinking about ways to help standardize measurements, particularly in many of these complex types of issues such as social determinants, health equity, to start thinking about how that gets aligned across a variety of federal programs.

Thanks, Jim. Other Workgroup members who want to speak? Jennifer.

Thanks, Margo. Just building on a couple of comments. I think you know, we all know, the research really shows a link between the drivers of health and health and well-being for individuals, their children. And particularly young children. And I think you know, the impact that they face is obviously magnified because they're not only experiencing drivers of health themselves. But also, they're experiencing it through the lens of their caregiver. So obviously, things that can directly impact their social emotional health, attachment, long-term development. And so, thinking with that lens, I think, you know, this Workgroup, I know we all appreciate the high bar that has been established over the years for new measures that get added to the Core Set. And it feels like even rightfully so this year the bar was even higher as we think about mandatory reporting and moving forward. So, I think, you know, that's obviously necessary, it's important as we think about how states gather, report data, what's feasible. But it's also been on my mind that it really limits the ability for the Core Set Workgroup to think about being innovative and flexible. About maybe emerging issues that we know are impacting Medicaid and CHIP populations. And sadly, I think we all agree that, you know, social drivers of health are not an emerging issue. I think the science around measurement still has a lot of work. But I was just thinking about is there some way that we could think about the possibility of a potential parallel track, or a continuum, where we could suggest or offer up new measures for maybe states to explore, vet, test. Or measures aren't mandatory but could eventually have the potential to rollout more broadly to states. So, almost running parallel to the Core Sets.

You know, policymakers, payer, states, they look to our Workgroup for guidance as to areas they should focus on. And the SDOH area, obviously is something we've talked about for years. As we've all heard from a wide variety of super, super experts this morning. There's a whole lot of issues why we haven't arrived on the measurement standardization. But I also keep thinking, you know, there has to be a way maybe for us to help play a role in promoting new and innovative approaches for measurement that can help send a signal to maybe payers, beneficiaries, policymakers that we're not out of touch with critical issues that are impacting beneficiaries. And just, you know one final comment, just thinking about is there a role that the Core Set Workgroup can play moving forward in trying to highlight and elevate potential new measures for states to think about and explore.

Thanks, Jennifer. Who else would like to speak from the Workgroup? Anne Edwards.

Thank you. So, I just want to pick up on a couple of recent comments. One, really around alignment and thinking across programs. Really thinking about how this is going to take a collective community to really address some of these factors. But I think of this in the space that yes, it's important in process measures. But particularly important as we move to outcome measures. Certainly, I think many of us have experienced where sometimes if the programs' measures are not aligned, that's a particular challenge. But even worse, sometimes they're actually competitive. So, I think some intentionality around that on a state level could be of particular importance. I also, wearing my hat as a pediatrician, to think of the context where children live and learn from caregiver settings but also in communities, and experience health holistically. Certainly, that's similar in the adult population too. But of particular importance in the pediatric population. So, there is a complexity there that should not be a barrier. But just recognized. Many times, it becomes a little bit more complicated. But I would challenge us to say, we can work through that. And then I would be remiss to say that sometimes when we move into this space, this ROI, which we know is a little bit longer trajectory certainly, will be important as we consider this space, to continue to have that longer lens as well. And then I think someone said patient experience. But this does seem like an area that it's of particular importance that we engage communities. That we engage those that may be impacted by any measures in this space. And really that that is always important for us. But in particular, that we assure that as we address equity issues, that we involve the people that would be most impacted by who live in this space. Thank you.

Thanks, Anne. Who would like to go next?

Do we have any other Workgroup members that wish to speak?

This is Linette from California. I think I would just add that health equity is certainly something we've really focused on. COVID-19 has revealed a number of inequities throughout our environment, our society, our programs. And so, we have been looking at how we incorporate that into various ways that we measure, as well as report and target resources, right. So, looking at where there’s inequities to do so. One of the things about doing the stratification piece, just to flag as a consideration since I wear the Chief Data Officer hat, is that data collection around some of the stratification fields like race, ethnicity, etc. may have issues in terms of how the data is collected, people's willingness to provide the data. We often have unknowns of different percentages depending on the program or the dataset in terms of the different categories. So, I know that's something we get asked about from a data quality perspective. But it's something that gets recorded in a voluntary way. And so, as we think about how to address equity and how to incorporate stratifications, I wonder if there's an opportunity to also provide public education or educational materials that help people understand how the data is used in terms of being a statistical analyses to help support populations and improve health. And that it won't be used for negative consequences. I just think it's important for us just to make sure we keep those areas of balance in mind as we think about the data process.

Thanks, Linette. That's a great point. Something else I wanted to mention for the Workgroup to consider is that going forward, 2021 Core Set and beyond, there are optional stratifications of Core Set measures for race, ethnicity, sex, language, disability status, geography, and ACA expansion status. So I think the Core Set is moving in that direction. But Linette, to your point, we know that there are some data quality, data completeness issues. And there's still work to be done to standardize some of the measurement. But I did want to mention that because I think that is an important future direction for the Core Set. And we'll be wanting to engage with states in that as well. So, thank you, Linette.

And Curtis and Anne it looks like you still have your hands raised. Do you have other comments? And Jill Morrow-Gorton as well, other comments you wanted to make? All right. Are there other Workgroup members who would like to speak? Rich Antonelli.

Thank you, Margo. I wanted to reflect back a year or two ago when this group recommended the removal of the audiologic screen follow-up diagnosis measure. Not because it wasn't a good measure. Not because it wasn't focused on a particularly vulnerable population but because of the sample size. So, I want to call this out in the context of a discussion around health equity. There are conditions like congenital hearing loss, like sickle cell disease where the numbers are relatively small. And that often means that we have a reason to exclude important quality measures. And so, you know the answer isn't necessarily well let's just put it into the Core Set because it belongs there. I'm inspired by the commentary from CMS today. The several folks that spoke about the dedication to equity. And so, I want to make sure that we aren't removing important quality measures for at-risk populations, simply because of small sample size. Unfortunately, there is a disproportionate representation for sickle cell, obviously, people of color. So, I want to keep that in mind as a mechanism by which we assure equity for populations. It could be that a relationship with state Title V programs, for example, with data sharing agreements could be a way to go. Thank you.

Thanks, Rich.

Also, a reminder that the Q&A is disabled for comments. If you have a comment to make, please make it verbally, whether through the Workgroup comment or public comment. Other Workgroup members who have comments to make? Other comments about stratification or other strategies?

Let me ask David Kelley and Kim Elliott as our co-chairs whether you have anything to add at this point?

This is Kim. And I think that, I've been on this Workgroup for quite a long time. And the work that we do is really, really important I think that it really does set the tone, set the direction for how we really think about measurement, and what we really view as actionable. And health disparities, health equity, social determinants of health, it's been kind of a constant theme and consideration each year as we work through the Core Set review process, really almost since the inception of the Workgroups. And a lot of the measure discussion often also focuses on measure stratifications that would allow interventions or quality improvement efforts to really address disparities in a more meaningful way.

So, I often see Workgroup members suggesting measures for addition to the Core Sets that have potential for stratifications, but we don't see sometimes from the measure stewards where that kind of testing has really occurred to ensure that the results we get from that measurement are meaningful, actionable, and really produce some valid and reliable information for us to really take that turn and make that change from a quality perspective. And that's, I think, what we really are striving for here in the Core Measure Review Workgroup, is define these measures that will result in real improvement in addressing things like disparities and the social determinants of health. And I think we also recognize that a lot more does need to be done in this area if we really want to improve overall quality from a national perspective, state perspective, health plan perspective, whatever perspective you're coming from. I think a lot more does need to be done.

And even if the measure isn't allowing for that stratification now, how do we get there to make sure that that stratification is available with the best data that we have. We know that there are always problems with different data sources including what's filled out on applications or not filled out on applications for Medicaid. So, I think what we're really looking for are things that will result in actionable interventions and real meaningful improvement in this domain and other domains as well. So, I think some of the central considerations related to this topic may include not only the measurement stratification, but how we're looking at the different demographic factors.

And not just race/ethnicity, but lots of other things that are really impacting the Medicaid members, or the populations and officiaries from really advancing from a health perspective. So even when we think about disabilities and how we're thinking about what's included in disability and how we stratify that, such as chronic diseases as a disability, or mental health as a chronic condition. And then how we really address the social determinants of health in relation to these. And then moving really towards that whole person care. I think that we talk each meeting as well about balance, and how the core measure set really needs to reflect the population that's being served by Medicaid, and making sure that we're addressing things in each of the domains that are priority domains. And it goes beyond just the medical sphere of course. So, I think that's about all I have to say on it right now. David, do you have anything?

Thanks, Kim. I would just add that again, I agree that it's not just being able to stratify and measure, but actually doing interventions that are meaningful, and sometimes meaningful at a community or even a neighborhood level. Interventions that work in Philadelphia don't work in Potter County in Pennsylvania. So, you know, being able to think in terms of what are interventions that we can move the needle when we're looking at identified health inequities. I would say the other thing that has always been curious to me, and we've been stratifying measures in Pennsylvania since I think 2007 or '08, and working with our plans to do interventions. One thing that has always been of interest to me, and I haven't really seen this developed yet, is really kind of the perception of health providers and health systems from a, I'll call it a level of suspicion or a perception of the validity of the health system. And I think the COVID pandemic and some of the issues around getting folks vaccinated or not vaccinated, I think has really borne this out that we need to have a better understanding of why people perhaps don't want to have certain preventive services done, or they don't access health care even though there is, you know, readily available access to care. So, I think, thinking in terms of getting into, going beyond basic stratification, but actually trying to delve into from a survey and a patient experience standpoint of how they perceive health care providers and how their health care is delivered. And what's related to that also I think is being able to look at provider networks and provider workforce that speaks the language of individuals, and perhaps is of the same race and ethnicity as individuals. I think that's an important aspect to overcoming some of these barriers.

So, I think we need to look, you know, go way beyond just looking at stratification. And the last, I think, key thing is really the ability to communicate in the language that you're comfortable with, with a provider so that they will understand you. And the ability to do that and to be understood. And you know that there's adequate communication. So those are some of my thoughts. As I said, I think doing just basic stratification is not enough. I think we need to delve into patient experience and patient perception of the health care system. I'll turn it back over to you, Margo.

Great. Thanks, David. And I see we have Russell Kohl queued up next.

Great. Thank you. It's been a very interesting discussion thus far. You know, the couple things that jumped out to me that I wanted to highlight or keep in mind, I think, are, you know, around the idea of an outlier methodology as we look at health equity. And you know, almost the idea sometimes geography as a consideration of a social determinant of health. Certainly, you know, what a practice looks like in Manhattan, Kansas versus Manhattan, New York is significantly different. I think one of the things that was alluded to earlier that certainly is a challenge for a number of family physicians as we look at the measurement and those sorts of things around this is the role of patient autonomy. Certainly, the last two years have shown us some interesting aspects in our patient communities where the way that we evaluated the data and the recommendations that we made may or may not change the patient's actual decision. And so I think the idea of collective responsibility or collective accountability is certainly a great one. But I think one of the things to keep in mind as we look at these measures is what if the measures are truly of value to the patient? That it's great from a health care perspective we look and say, okay, this is really important. But if we're not able to make that same argument at the patient level that a patient would value this individual item, and then certainly that creates some challenges for us in identifying those sorts of the outliers and what almost could be a sort of purposeful inequity. So just that's something to keep in mind as we look through the different measures and think about them.

And next up, Jill Morrow-Gorton.

I wanted to sort of emphasize David's comment regarding rural populations versus urban populations versus suburban populations. I think that we don't always think about health equity in terms of where people live. And I think there's significant health equity issues depending on where you live, both access to care, but also what Russell was talking about in terms of people's approach to health care and how they think about health care. But I think it's also important because understanding the differences and being able to measure the differences will help identify what are some of the solutions to meeting the issues and meeting the problems. And then I think the other thing that came to mind was the concept of health literacy. And by virtue of having difficulties with social determinants of health, low education, etc., the Medicaid population often has low health literacy, and the Medicare/Medicaid dual population does as well. And that is something that can be addressed. But I think it's important to recognize. And I don't know that there are good measures of health literacy that are easy to do, but that again might be something to think about in terms of a way to identify disparities, but also how to address them.

Thanks, Jill. Curtis Cunningham, do you have another comment?

Yeah. I was just going to mention the definitions, I'm hearing a lot about SDOH in different populations. And you know, I just want to point out from a standard definition perspective, you know, we don't even have consistent definitions of determining DD status across states, or rural and urban or, and you know, race, ethnicity, language, there are no consistency standards. So, as I listen to the conversation, and within the Medicaid program, I do think there needs to be a lot of work on thinking about if we're going to stratify and if there's going to be these conversations, where is the standardization or ways to create definitions around where these various stratifications come from? And then I want to reiterate again, looking at whole person. You know, there's elderly people with DD. There's behavioral health with, you know, co-occurring medical conditions. So, as we look at these measures and just want to keep an eye on, you know, looking at one thing within a person's life might not be adequate in assessing whether the Medicaid program is addressing those needs. And in regard to social determinants of health, I do think that they are important. But again, that's right now when we look across the states, it's a very difficult thing. And those are just, you know, really conversations in their infancy of how Medicaid and what Medicaid's role is addressing social determinants of health. Thank you.

Thank you so much. And a reminder, we will be getting into public comments soon, so I will let you know when we get there. Other Workgroup members with comments?

I also did want to mention that Mihir Patel has joined. And welcome. Could you introduce yourself and also indicate whether you have any disclosures?

Sure. Good morning, everyone. Mihir Patel, VP of Pharmacy here at PacificSource Health Plans. I don't have any disclosures. I am happy to be here.

Okay. Did you have any comments that you wanted to make at this point?

No comments at this time. Thank you.

Okay. All right. Thank you. Other comments from Workgroup members before we move into the public comment period? And a reminder that on day three when we talk about gaps in other cross-cutting issues, we'll certainly be able to revisit a lot of these topics.

All right. So, with that, let's move into public comment. Next slide, please. And Eliot Fishman, I see you have your hand raised.

Thank you very much both, for the opportunity to comment, and this is such an important discussion, so much at the heart of the future of the Medicaid program. So, my request is for the Workgroup, and ultimately the agency, to move forward aggressively and expeditiously both in terms of stratification and in terms of drivers of health. I guess I would take issue with the idea that state implementation is in its infancy. While certainly it's a very fluid situation, we now, I think, know enough to know that this is really where the field is going. I think it would be hard to find a state 1115 waiver application or state Medicaid managed care procurement that doesn't touch on drivers of health as a theme. But certainly, an overwhelming priority not just in CMCS, but across CMS with the new administration. I happen to sit on the NCQA Standards Committee. I can say in that context, it's very much where the field is going. And while there are certainly going to be implementation challenges, the state Medicaid experience in states that have pushed this agenda forward has been that it's critical to have the commitment to start measuring and incorporating both stratification and drivers of health into quality measurement in order to resolve those feasibility questions. And in this area in particular, it's unrealistic to expect to nail down the implementation and data gathering challenges first, and then move ahead with the commitment to measure, that the sequence has gone, to my knowledge, at the state level generally in the other direction. So again, thank you for the opportunity to comment.

Thanks, Eliot. So next, we have Ned Mossman. Can you please say your full name and affiliation?

Thanks. I'm Ned Mossman, the Principal Social Determinants of Health Lead with OCHIN, an international nonprofit health organization in the research network that was established 20 years ago. Just for context, our members are across 45 states, include over 1,000 local-controlled community-based clinics with 21,000 providers and serving nearly 6 million patients who are among the nation's most medically and socially complex and rural other underserved communities. And over 50% of these patients are covered by Medicaid. Our members have collected the nation's largest EHR-based dataset of drivers of health screening data in the safety net, including over a million individual screenings, and the pace of that screening continues to grow every single month, with nearly 50,000 screens performed in the last month. We strongly urge the Workgroup to include drivers of health screening and positivity measures in its recommendation. These measures are essential moving forward to advance structural equity. And further, we know the implementation of these measures is technically feasible even for Medicaid and the safety net clinics. Together with our clinics, our experience demonstrates that it's entirely possible to implement the measures and that the tools and resources to do so, such as the CMS Accountable Healthcare Community's tool, are widely available even to the safety net providers. In moving these basic drivers of health measures forward allows for a phased implementation of further foundational health equity measures in a pragmatic and stepwise fashion. Currently, our members continue to be penalized as they undertake these screenings, which can drive quality care without the associated benefit that other, better resourced providers and specialists receive from the applicable quality measures that are targeted to their practices. Finally, the existing lack of drivers of health measures also limits efforts that identifies sustainable pathways to value-based payment. And I thank you for the opportunity to comment.

Thank you. Next up, Julia. Can you please state your full name and affiliation?

Sure. Julia Skapik. I'm the CMIO at the National Association of Community Health Centers. I'm also a part-time primary care provider at an FQHC in northern Virginia. And NACHC is the co-owner of the PRAPARE tool, which is an SDOH screening tool. I'm pleased to hear from Ned.

Note OCHIN is one of our excellent partners, and overall NACHC helps to serve over 1,400 member FQHCs across the US and its territories, and that includes partners like OCHIN and the State Primary Care Associations. Just a few comments. It's unfortunate that we're not having a discussion about moving forward on these measures. It seems, I agree with Ned, they're very feasible, they're process/processes measures. The answer is really a binary kind of, "Yes or no, I did something." I would argue that that's not really strongly advancing where we need to go with this area, which is creating interoperable SDOH assessments that lead immediately through decision support to actual social interventions. And I know that NACHC has a PRAPARE tiger team that work with organizations that have implemented the PRAPARE tool. Some of the feedback that we get includes that both patients and care teams don't feel that it's really useful to only ask these questions if there's not going to be an obvious next step. So, I would strongly encourage CMS, if they're not moving right now on the follow-up actions to support social needs, that they really rapidly move to that. I really appreciated some of the comments of the panel, which is that the speed at which we're moving and advancing these measures is really incredibly slow. It evokes the 17 years it gets for research to get to the bedside kind of pace. And I would suggest that CMS invest time and energy in something like a measure accelerator or innovation sandbox, or very rapidly select organizations like OCHIN and others that are ready to move rapidly on this and to incorporate some of these more patient-centered outcomes into the way that they implement SDOH assessments. The whole field doesn't need to be ready for that for us to start advancing models that support it.

Another comment I'll make is about alignment. I heard some great comments about data quality and some of the stratification metrics, but also the measures that are pointed to here are very broad and say, "Do any kind of assessment." And I think it's important to think about how do we normalize the data from different assessments? Are those data equivalent? Are we able to create scoring for those things, and what are we going to do with those scores again? And then the last comment, you know, I just really want to come back to this shared accountability comment because we can't continue to load things onto primary care and not create mechanisms for accountability of payers and other care teams that participate in the patient's care. We can also support the patient through better health and digital literacy services, and I know CMS is in a good position to advance payment for an evaluation of health and digital literacy. So, we appreciate listening to our comments today, and happy to continue the discussion if desired.

Thank you, Julia. Next up, Allison. Please introduce your full name and affiliation.

Allison? Can you hear us? All right. Why don't we move onto Kelly Crosbie, and we can try to come back to Allison. Kelly? Kelly Crosbie are you able to speak? All right. Why don't we move onto David Perlstein?

Thanks for giving me the opportunity to talk. I'm David Perlstein. I'm a pediatrician by training. I practiced in the Bronx for a long time, and currently the CEO of SBH Health System. We're an independent community-based safety-net anchor, which includes a 40-bed hospital, large ambulatory network, and we deliver primary and specialty care, as well as significant behavioral health to our Bronx neighbors. We also have a fairly heterogeneous population, diverse population, but they're all connected by poverty. We have been working in the realm of social determinants of health for a long time now, which is something that we have to do because we are taking care of a population whose average income for a family of four is about $13,000 per year, which means the majority of them are living in poverty. The Bronx has worse health outcomes, high mortality rates, chronic disease rates, a high prevalence of obesity, asthma, diabetes, and heart disease. Poor access to care in the Bronx. We have fewer hospital beds per 100,000 patients, per 100,000 population, compared to other areas of New York. As you probably are well aware, COVID has been just devastating to our community. It's exacerbated preexisting health and socioeconomic disparities from which we are not going to quickly recover. Unfortunately, most of our community members also know someone who was either hospitalized or died from the disease, and it impacted the general sense of well-being that was already low. We have the highest unemployment rate in New York, highest food insecurity rates. Thirty-eight percent of Bronx residents don't have broadband access, which means we've exacerbated the educational inequality for our populations. And we haven't been able to fully utilize telemedicine because of that disparity.

As I said before, we have a deep commitment to addressing social and economic drivers of health, and we know we cannot make our community healthier without doing so. As an anchor institution, we have significant experience in this area. We led Bronx Partners for Healthy Communities, which is a New York State District PPS collaborating with over 200 Bronx community-based organizations and we improved health care and delivery outcomes during that period. We are also a founding member of Bronx Accountable Care Network, and one of the largest providers of mental health services and addiction services in the Bronx. In addition, we recently partnered to build 314 units of affordable housing, 95 reserved for former homeless individuals, which we opened in 2019, which also included a central 50,000-square-foot health and wellness center. We offer fitness facilities, nutrition classes, teaching kitchens, rooftop farm, a community meeting space, as well as clinical programs that service to women and children. Yet as proud as we are of these efforts, they're grossly inadequate to meet the needs of our community. And unfortunately, we're pretty limited by the fact that what we report, what we measure, what we pay for, and what we get paid for is blind to the extreme complexity of our patient population.

If we're going to try to improve health and wellness, we have to be able to identify health-related social needs impacting our patient population in a more standardized and validated way. Only then can we systematically align our interventions and payments so that can be addressed in an effective and sustainable way also can be scaled up. We have to be able to develop evidence-based interventions to improve our collective ability to learn from one another. The first step in this change is through measurement. Specifically we have to create standard reporting of SDOH screening and positive screening rates. And as I understand, this is the third year in a row that this Workgroup has identified the need for this reporting. But I do believe also it's a critical gap in our Medicaid and CHIP reporting systems. Until CMS requires standardization of these measures across this program, including the Medicare, Medicaid, and CHIP, we're going to struggle to accurately understand or quantify the impact of these risk factors on health disparities. It also ultimately allows us to strategically implement programs aimed to measurably improve the health and wellness of our patient populations. I believe it's important for us to commit to these conversations about determinants of health into action by exerting the federal leadership necessary to advance standardized measures within the next year. I happen to agree with the former speaker that we're just moving too slowly here. We're well aware of what the impacts of social determinants are, and I believe it's an effective approach to begin mitigating the impact of the past policies which contributed to the devastating impact that COVID had on our community and others. Thank you.

Thank you. Dawn Alley?

Thank you. Hello. I'm Dawn Alley. I'm faculty in the Milken Institute School of Public Health at the George Washington University. And I previously served as the chief strategy officer at the CMS Innovation Center, although I provide comments today in my personal capacity and not representing any current or former employer. A key lesson from the CMS Innovation Center's Accountable Health Communities Model has been the value of systematic social needs' data collection for Medicare and Medicaid beneficiaries. Only one full evaluation report has been released, but in that report more than 330,000 Medicaid beneficiaries had been screened, and among members who had two or more emergency department visits in the prior year, and at least one health-related social need who were eligible for navigation services, 84 percent of those members were Medicaid beneficiaries. This speaks to the same issues that we've seen feasibility that many of the previous commenters have noted. And in some ways, this should come as no surprise because Medicaid members definitionally have limited incomes that are at high risk of food insecurity, housing instability, and transportation barriers. But notably CMS saw, again and again, the ways in which systematic collection of health-related social needs can lead to insights, both at the clinical level for individual patients and at the population level. I'll share two examples.

AHC sites heard from care managers who said, I've been working with this member with diabetes for years, and I had no idea the struggles that he was having related to issues like food insecurity and utility shut-offs. At the population level, CMS heard from the state Medicaid director who had a site in her state and shared that her department had thought that the most common issue was going to be housing but was surprised to learn just how prevalent food insecurity what in that state's Medicaid population. Important questions remain about how to best measure health-related social needs screening, and I particularly appreciate the comments from the earlier commentor from the National Association of Community Health Centers that screening is just the first step. And I would also argue there is real value in doing this systematically. And CMS appears to believe this as well because it proposed requirements for D-SNPs to assess health-related social needs, and is requiring health-related social needs screening in the new ACO REACH Model.

There's a real opportunity here for standards-based data collection that facilitates interoperability across providers and programs while minimizing patient and provider burden. I'll note that systematic data collection does not necessarily mean that everyone needs to use exactly the same screening tool, and that the AHC screening tool was not designed to be the be all and end all approach. It was specifically designed to meet CMMI's model evaluation needs. And this poses a challenge for measure developers. How do we provide enough standardization to ensure that measures drive meaningful improvements without so much specificity that providers and plans that are already collecting this information need to update all their tools? But I would encourage us to prioritize this and accelerate our focus on this as we've heard from many of the other commenters to continue developing and testing, and to take advantage of the evolving literature in this area because collection and use of this kind of social need data is a critical part of addressing health equity. Thank you.

Thank you. Sepheen?

Hi. This is Sepheen Byron from NCQA. I am the assistant vice president of performance measurement. And I just want to mention that NCQA, which is the National Committee for Quality Assurance, does support moving towards measurement of social needs. It was mentioned earlier that we are working on a measure that we hope to release for measurement year 2023 that looks at screening and referral to services for unmet food, housing, and transportation needs. And these domains were chosen based on the maturity of electronic data standards, so I absolutely agree with the statements that, you know, these things come hand-in-hand. And now just, you know, some comments from me as an individual, as a public health professional, I absolutely agree with previous statements that the pace feels slow. I know I've mentioned in past meetings that there is a chicken and the egg problem where we cannot do measurement unless we have the data, but the data people are not incentivized to collect the data in the right way unless there are things such as measures that are incentivizing people to do this work. So, you know, I agree with the statements of something that can break the cycle, like an innovation center, or you know, a parallel set of measures that are not required, but give people an opportunity to play in the sandbox, and really try and make movement on this area. So thank you for the opportunity to comment.

Thanks, Sepheen. Jeff, you're next.

Thanks, everyone, and it's a pleasure to be able to make a public comment. I am Jeff Schiff. I am a senior scholar at the Evidence-Informed State Health Policy Institute at AcademyHealth, where the Medicaid Medical Directors Network and the Medicaid Outcomes Distributed and Research Network are housed. I'm also a former Medicaid medical director for the state of Minnesota, and I've been involved in the Core Set for quite some time. Along the lines of the importance of this, we, from our data in Minnesota are releasing a report that shows that individuals who had availability of SNAP food assistance from the adults without children population had decreased health care costs. And I'm sure our report is not the only one. But I want to address one thing as an individual, and these are comments I suspect my colleagues at AcademyHealth would agree with, but they’re my personal comments. I believe we would almost answer in the affirmative to the premise that measures should be designed to improve implementation as well as accountability. And that requires that we consider that these measures impact those who have the most control over implementation and the funding of implementation after the state programs, the system, managed care plans. As we consider the social risk factors, please consider how these measures affect the flow of funds in the health care system, the implementation of screening and integration of referral for social risk. Who would be the accountable entity, including how to get resources to communities to do screening and intervention? How and which of these measures would roll up to managed care contracts, and to the managed care, the Medicaid managed care Quality Reporting System? I think it's important that we understand that we have very dedicated providers, many of whom are on this line, these lines today, and making comments, but we need to have the opportunity to have the resources flow to them so that they can do the screening and intervention. Thank you for the opportunity to comment.

Thanks, Jeff. Richard, you're next.

Hi. I'm Richard Thomason, Policy Director for Blue Shield of California Foundation, whose mission is to achieve lasting and equitable solutions to make California the healthiest state and end domestic violence. For over a year, Blue Shield of California Foundation has joined with the Commonwealth Fund to support an initiative called "Investing in Health" to generate new ideas for how federal programs can better address the social and economic drivers of health that impact much of health outcomes and disproportionately affects communities of color. So, through this work, you know, we've come to understand how important it is to create more a standardized driver of health measurement or payments and structural reforms that are needed to improve health and health equity. So, we're another voice for addressing drivers of health through measurements and for picking up the pace. It's we really need to see some movement as a nation on this matter. We are pleased that CMS issued guidance last year encouraging states to incorporate drivers of health into Medicaid and CHIP. We see that more than 20 states already require managed care organizations and their contracted providers to conduct driver of health screening, but they lack standardized ways to import whether those screenings happened or what they found. We've seen through the Accountable Health Communities Model and CPC+, that CMS has years of data and learning across millions of beneficiaries and thousands of practices in clinical sites demonstrating that implementation of drivers of health screening can be done reliably and consistently over time. But we think there's an urgent need for meaningful measures that can underpin sustainable systematic efforts to address drivers of health and action to ensure that we will not find ourselves in the same position next year. So, we call on CMS to engage with states that are interested in contributing to measure development to further test and refine reporting processes, and leverage CMS authority and resources to promote standardized and measurable DOH screening and reporting practices across Medicaid and CHIP, as we're seeing some movement on these measures across Medicare programs. Thank you.

Thank you. Kathleen, you’re next.

It's Kathleen Conroy. Thanks for the opportunity to speak. I'm a pediatrician at Boston Children's Hospital and the clinical chief of our primary care center. And today I just want to speak out with many of you to ask you to address this gap this year so that we don't perpetuate this cycle of insufficient testing of these measures. I want to speak very briefly about our experience of having measurement required and the difference it makes. So, I run a large pediatric practice. We cover about 23,000 patients. And we've been screening and addressing social determinants of health for over a decade. Our current screening measures meet the demands and requirements in these measures that failed this year. Like many pediatricians, we adopted this practice because of the overwhelming evidence that screening is acceptable to families, and because it helps facilitate the connection to needed social resources. But more recently at the behest of the CMS, the Massachusetts Medicaid program introduced two quality measures that ensure that we screen and report out on needs. So again, very similar to the measures that did not go through this year. This had some interesting effects. So, in practices like mine, where we were already doing this work, we were forced to look at it, in a sort of meaningful way, at our actual completion rate on the screening, and also to set up reporting mechanisms that allowed us to understand whether our systems of screening and response were unintentionally inequitable. And so, this knowledge has become a foundation for disparity-focused quality improvement programs, and also the impetus for creation of new community partnerships to better address the needs of our populations.

In other practices in our network, serving similar populations, who were not yet formally screening for these needs, they of course, in response to these new requirements, began screening and also addressing these needs. So in short, kind of regardless of where people were in the process, learning occurred, and families' needs were met. I don't think the irony is lost on anybody here that Medicare provisionally approved adoption of these measures, and that Medicaid, a program set up for low-income families who by definition are more likely to experience drivers of health, isn't yet there. And so just my role as a pediatrician is to remind you, as others have, of the urgency. The impact of living with food and housing insecurity in childhood changed not only developing bodies, but the developing brain in ways that affect health now and affect health in the long-term. Measuring alone certainly doesn't address these needs, but as others have said, it becomes a pathway to financial incentive to address these needs. So please do what you need to do this year in order to make these measures a reality next year. I think it's time. Thank you.

And next, Kelly? Are you able to unmute? Kelly, can you unmute yourself?

Is it working? Can you hear this?

Now we can hear you.

Oh, thank you so much. Sorry.

Sure.

I apologize, and I thank you for giving me another opportunity. Hi, everyone. My name is Kelly Crosbie, and I am the Chief Quality Officer at North Carolina Medicaid. And I wanted to speak particularly about the DOH measures. So, while North Carolina was an early adopter of efforts to address DOH, after experiencing COVID, it's even more clear that we can't achieve our health improvement, health equity, or value goals without understanding and addressing health-related social needs of the people we serve in Medicaid and CHIP. We don't feel at all in North Carolina that we're alone in recognizing the importance, obviously as this committee recognizes, as well as all the public speakers. We're among more than 30 states that currently require screenings for DOH by our health plans or by our providers. We think it's a common practice and its value is well-understood. We also know that it's possible for states to measure DOH screening rates to ensure that required screenings are performed, and it's helping us to much better understand levels of need. We're doing that in North Carolina right now. And of course, a barrier to broad reporting and action on a lot of these measures is the lack of standardization. As states, we embrace innovation, and we are proud of our commitment to ensuring that Medicaid dollars buy health and not just health care. But we can't really be expected to independently develop national standards for DOH reporting. And this is the third year in a row that the Workgroup has identified DOH as a gap in Medicaid and CHIP. So, we think we're at a really critical moment, and I agree with all the other speakers today. And we would ask that CMS would work with states to develop measures around a common set of essential screening domains, like housing, food, transportation, utilities, interpersonal violence, and safety, that align across Medicare and allow North Carolina as well as other states that are already active in this space, to build on and get more value from what we're already doing today. States are really leading the way on these efforts to address drivers of health. And we don't want to be left behind, to lag behind Medicare or other payers in our ability to gather the standardized reporting that we need to inform our improvement efforts. Thank you so much for letting me have a second chance to speak today. I appreciate it.

Thank you for your comments. Well, we are just about out of time before the break. Do we have any last comments?

All right. With that, let's proceed to the break. We are going to take about 30 minutes. Very much appreciate this robust conversation that we just, oh, I see Allison Bryant. Before we do that, Allison, are you able to unmute? I know you wanted to talk earlier. Allison, are you able to speak?

I hate to keep you from your break. I will keep this brief. But I am Allison Bryant, the senior medical director for Health Equity at Mass General Brigham Health System in Massachusetts. I am also a practicing maternal fetal medicine specialist at Mass General Hospital, and have the privilege of chairing the Massachusetts Maternal Mortality Review Committee, which is a process that relies heavily on understanding the drivers of health. And I'll just echo what other folks have said, which is that those of us who have the privilege of delivering health care know that all the things that we say that we want to and should do, like building relationships with our patients, achieving health equity, reducing costs, addressing staff well-being, depends so much on our recognizing the reality of the lived experience of our patients outside the proverbial four walls of our institutions. At MGH, we are committed, as others are, to committing to screening for and addressing health-related social needs, but as committed as we are to this work, we're doing so without the benefit of any standardized federal SDOH measures.

We are screening for drivers of health among our Medicaid Accountable Care Organization patients, as well as under our United Against Racism Campaign, where we scaled up these efforts in a payer blind way in 23 communities with greatest need. And we really are at this point leveraging a fantastic and expert workforce of community health workers to assist our patients in SDOH needs. So, I just would like to echo that it's really critically important that both rates of screening and rates of positive screening are critical to make visible the impact of these issues on the lives of our patients and the inequities that they perpetuate.

And given disproportionate impact of SDOH on people from historically marginalized communities, the equity agenda for us is super clear. And we have to recognize providers and institutions for screening their patients and reporting their screen positive rates. And I will last note that I made similar comments earlier when these measures were under consideration for the MIPS and hospital IQR a few months ago and was very heartened to learn that those measures were adopted for approval in two important Medicare programs. And so just lastly, that step makes it so much more important that state Medicaid programs are included in this process, and that providers and managed care organizations can work from a common, or at least a consistent, set of care standards. So, I'll thank you for your time, and again apologies for the earlier mishap. Thank you.

Thank you, Allison. And with that, we will move toward a break. Thank you for such a robust conversation. Workgroup members, we will be doing some live test votes after the break. So please take a few minutes during the break to log into the polling platform and make sure you can see the question we posted. If you have any issues, please reach out to us through the Q&A or our mailbox during the break and we'll work to resolve your issue. So, with that, we will return from the break at 1:30. Thanks, everyone. Have a great break.

BREAK

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

I'm going to go rather quickly through this recap, as most of us were together just two weeks ago in the last Workgroup meeting. But for folks who might be seeing this for the first time, the slides and other background materials are available on our website. As discussed before the break, the Core Sets are a critical tool for understanding and advancing health quality, equity, and access in Medicaid and CHIP. The Core Sets help CMS and states identify disparities in care, and to develop targeted quality improvement efforts to advance health equity. Our charge over the next three days is to assess measures for removal from and addition to the Core Sets, in order to strengthen the Core Sets. Next slide, please.

Our goal in assessing the measures for removal and addition is to optimize these three elements. Technical feasibility of collecting and reporting the measures, particularly in light of mandatory reporting beginning in 2024. And I want to emphasize reporting at the state level. Earlier, when we had the health equity discussion, lots of comments about feasibility, but where we focus on the Core Sets is feasibility for consistent and reliable state-level reporting. Also, desirability for stakeholders, which relates to the actionability and strategic priority of the measures, and financial and operational viability, which ties back to considerations like alignment across programs and state capacity for reporting. Next slide, please.

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

Since Workgroup members discuss the measures for removal and addition in the context of the whole Core Set, we've shared here some basic information about the Core Sets. The 2022 Child Core Set includes 25 measures, and the Adult Core Set includes 33 measures. CMS does not have a target number of Core Set measures, either minimum or maximum. We encourage the Workgroup members to consider each measure on its own merits according to the criteria. In terms of reporting on the Core Sets for FFY 2020, which is the most recent cycle for which data are available, states reported a median of 19 out of 24 measures in the Child Core Set, and 22 out of 33 measures in the Adult Core Set. As you would expect, the most frequently reported measures are those that states can calculate accurately using claims and encounter data. Less frequently reported measures include those with medical record extraction, electronic health records, or survey data collection. And not surprisingly, it often takes a year or two for states to ramp up when reporting new measures. Next slide.

This slide lists the seven Core Set domains. We want you to keep in mind that CMS will assign the domains in updating the Core Sets for 2022, and we will not be focusing on domain assignments during the meeting. We also wanted to note that some measures cut across the Child and Adult Core Sets, and CMS decides which Core Set to assign the measures to. Next slide.

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

And, finally, I'll wrap up with some additional context for this year’s review. As you know, we are quickly approaching the mandatory reporting of all Child Core Set measures, and behavioral health measures in the Adult Core Set in 2024. These measures will need to be reported by all states for all their Medicaid and CHIP populations. This includes managed care and fee-for-service beneficiaries, as well as dually eligible beneficiaries. As we mentioned previously, CMS has asked us to notify the Workgroup that due to rulemaking and mandatory Core Set reporting beginning in 2024, the potential changes recommended by the Workgroup this year could apply to the 2023 Core Set, the 2024 Core Set, or both Core Sets. Due to rulemaking, CMS isn't able to elaborate more on this. They are working to issue a final rule in a manner designed to give states adequate time to implement mandatory reporting. Second, CMS is continuing to explore the use of alternate data sources, to support calculation and public reporting of current Core Set measures. The goals are to reduce state burden and improve the completeness, consistency, and transparency of measures. Pilots are currently underway to use T-MSIS to calculate selected measures, and to use the AHRQ CAHPS database to obtain Medicaid and CHIP CAHPS survey results. In addition, two Child Core Set measures will be calculated for all states using state vital records data compiled by the National Center for Health Statistics as part of CDC WONDER.

And lastly, increasing emphasis on digital measures and supplemental sources. We have a whole discussion set aside tomorrow about opportunities for digital measures in the Core Set. So, we look forward to thinking more about this tomorrow. Now I'll hand it over to Dayna to talk about the criteria for reviewing measures, and to share the voting logistics.

Thank you, Margo. Next slide. And next slide. Great. So, in each meeting, we always come back to our criteria for assessing measures. So, for those who have seen this many times before, humor me. They are just such a critical part of our discussions over the next three days. The first category is our minimum technical feasibility requirements. All suggested measures must meet these requirements. So, the measures we'll discuss today have passed through Mathematica's initial screen based on these criteria. And what this means is that the measures up for discussion should be fully developed, and have detailed technical specifications for producing the measure at the state level, have been tested in or are in use by at least one Medicaid or CHIP program, have an available data source or validated survey that includes an identifier for Medicaid and CHIP beneficiaries, and their specifications and data source allow for consistent calculations across states. CMS also requires that the measure must include technical specifications, including code sets, that are provided free of charge for state use. But Workgroup members do not need to consider this criterion. Next slide.

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

Finally, a few other criteria to consider. Is the prevalence of this condition or outcome sufficient to produce reliable and meaningful results across states? Is this measure aligned with those used in other CMS programs? And will all states be able to produce this measure by 2024 for all populations? Next slide.

When Workgroup members are considering measures for removal, we ask them to consider whether the measure no longer meets the criteria for addition. So, for example, we asked the Workgroup to consider: is the measure no longer making a significant contribution to the Core Set's purpose of estimating the national quality of health care? Are states unable to access the data needed to calculate the measure? Or is the data source leading to inconsistencies across states? Is the measure unable to be used to assess improvements in state Medicaid and CHIP programs? Is there another measure that is better aligned with other CMS programs? In looking ahead to mandatory reporting, will some states be unable to produce this measure by 2024? Of course, this is not a comprehensive list of reasons for removal, but a few key considerations. Next slide.

And, so, now with those criteria in mind, here's an overview of the voting process. Voting will take place by domain after both Workgroup discussion and public comment and will be for Workgroup members only. Federal liaisons and other attendees of today's meeting are not eligible to vote on measures. Each measure will be voted on as it is currently specified. When we vote, if a measure is being considered for addition, a yes vote means "I recommend adding this measure to the Core Set." And if a measure is being considered for removal, a yes vote means "I recommend removing this measure from the Core Set." Measures will be recommended for removal or addition if two-thirds, or at least 67 percent, of eligible Workgroup members vote yes. Next slide.

So, are there any questions from Workgroup members about the criteria or voting logistics, before we move along to a couple of practice votes? And a reminder, if you have a question, please raise your hand. Anne Edwards, you still have your hand raised. Is that from earlier, or do you have another question? Great. All right, Dayna, I think time to move on.

Okay, great. So, next slide.

As a reminder for all attendees, voting will be for Workgroup members only. Workgroup members, please make sure that you're logged into your voting account, and have navigated to the Core Set Review Voting page. You can remain on this page for the duration of the webinar and new voting questions should appear as we make them available. If you don't see the new question, just refresh your page and, hopefully, it should pop up for you. If you need any help, please refer to the Voting Guide we sent along last week, or send us a chat through the Q&A. And make sure you address that to all panelists. And the second page of the Voting Guide does have an FAQ section that answers most of the common problems we've seen in prior years. During voting on measures, if for any reason you're unable to submit your vote, please send us your vote through the Q&A, or to our email address if you aren't able to access WebEx. Your votes will only be visible to the Mathematica team. Okay. So, with that, I will go ahead and share the first question.

Okay. So, the first question is, "Do you prefer thin crust pizza over thick crust pizza?" I see votes are already coming in.

We have 18 results in for Workgroup members so far. Workgroup members, if you're having any issues, please just send us a chat through the Q&A. Okay. We have 20 results in. We're just waiting on a couple more votes. So, I'll give our team some time to troubleshoot with folks who might be having issues accessing the voting. Okay. So, it looks like we might still be missing a couple folks. Amanda Dumas, Curtis Cunningham. And possibly Ann Zerr and Bonnie Zima as well, if you have not put in your responses yet, either troubleshoot with us in the Q&A, or send us a chat with your vote. And I'm seeing that a couple of folks might be having issues seeing the poll. If you are having issues seeing the polls, and you are not on the Core Set Review Voting page, which means you don't see the Core Set Review logo and our Waiting Room text, I would ask you to go back to the Voting Guide and make sure you have navigated to our voting page specifically. Okay. Well, why don't we move on from this one for now, for the sake of keeping things going. We'll see what our responses are.

So, it looks like we have 68 percent of folks preferring thin crust pizza. That's knocked down to 65, so someone else got a vote in. At 65 percent this would not pass Workgroup recommendation if we were recommending pizzas. So, I'll take us to the next vote.

Okay. So, we're all about balance here. So, the next vote is, "Would you choose a Caesar salad over a Greek salad to go with your pizza?" Options are "Yes, I choose the Caesar salad," or "No, I'd prefer the Greek salad." The votes are coming in. Much faster this time, it’s always a learning curve. Okay. And it looks like we're missing Ann Zerr and Curtis. I think Bonnie's sending her vote through email. So, we'll work with you, Bonnie, after this to get that resolved. Okay. Well, I think we have almost all the folks. So, I'm going to go ahead and move us along, for the sake of time. But the one or two folks who are still working on resolving their issues, I think that's Ann and Curtis, talk with us in the Q&A, and we'll get you up and running. Let's share the responses to the salad question. We have 67 percent preferring the Caesar salad. So, if we were voting on this as a measure, Caesar salad would be recommended by a narrow margin.

Okay. With that, I will transition us back to the slides. Okay. I'll move us into the Behavioral Health Care section. Okay. So, thank you all for testing the voting, and bearing with us as we go through that process. It just gets easier from here. So, moving into Behavioral Health Care. Next slide.

Great. So, I will start with the current 2022 Core Set measures in the domain. There are six Child Core Set measures and 12 Adult Core Set measures. And note that all of these measures will be subject to mandatory reporting in 2024. I'm just going to read through the measure names. But these slides also show whether the measure is NQF endorsed, the data collection method, and the number of states reporting the measure for FFY 2020, the most recent year of public reporting.

The six Child Core Set measures are: Follow-up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication; Follow-Up after Hospitalization for Mental Illness: Ages 6 to 17; Metabolic Monitoring for Children and Adolescents on Antipsychotics; Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics; Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Ages 13 to 17; and Follow-Up After Emergency Department Visit for Mental Illness: Ages 6 to 17. And note that these last two measures were newly added to the 2022 Child Core Set. Next slide.

And here we show the first handful of Adult Core Set measures. The first measure is Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment. The second, Medical Assistance with Smoking and Tobacco Use Cessation has been suggested for removal. And I'll give a brief overview of that measure shortly. Next, we have Antidepressant

Medication Management; Follow-Up After Hospitalization for Mental Illness: Age 18 And Older; which is the same as the measure in the Child Core Set, but with an older age range; Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications; and Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c Poor Control (>9.0%). This measure has also been suggested for removal. Next slide.

And here are the remaining six adult behavioral health measures. The first two have been suggested for removal: Use of Opioids at High Dosage in Persons Without Cancer; and Concurrent Use of Opioids and Benzodiazepines. The other measures are Use of Pharmacotherapy for Opioid Use Disorder; Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence; and Follow-Up After Emergency Department Visit for Mental Illness. And note that these two measures are the same as the measures in the Child Core Set again, but with an older age range. And, finally, Adherence to Antipsychotic Medications for Individuals With Schizophrenia. Next slide.

So, we'll now move on to discussion of the four measures suggested for removal in this domain. I'll share some baseline information on all four measures. And then we'll discuss each measure separately. Voting on each measure will take place at the end, after we've heard public comments. So, the first is Medical Assistance with Smoking and Tobacco Use Cessation. It is an NCQA measure. It's no longer NQF endorsed and it is calculated using data from the CAHPS 5.1H Adult Medicaid Survey. Next slide. This slide contains information about the denominator for this measure. The measure has three components, and the denominator for all three is the number of beneficiaries who indicated in the survey that they were current smokers or tobacco users, and who responded to the individual survey questions about each component. Next slide. And this slide contains information on the numerator for each of the three components of the measure, based on responses to questions in the survey. As you can see, the numerators are related to the number of beneficiaries who reported their providers advised them to quit, discussed cessation medications, and discussed cessation strategies. Next slide.

Twenty-eight states reported the measure for FFY 2020. Data were suppressed for one state due to small cell sizes. And the measure was publicly reported for the first time for FFY 2020. The Workgroup member who suggested this measure for removal noted that states report challenges obtaining the data for this measure, as this measure is based on the CAHPS Health Plan Survey. Given that states will be required to report on all behavioral health measures in FFY 2024, the Workgroup member expressed concern that conducting the survey on an annual basis for the purpose of reporting this measure may result in administrative burden and fiscal capacity issues for states. Next slide.

So, the next measure suggested for removal is Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c Poor Control (>9.0%). This measure assesses the percent of beneficiaries ages 18 to 75 with a serious mental illness and diabetes, either type 1 or type 2, who had hemoglobin A1c in poor control. It is an NCQA measure. It is NQF endorsed, and the data collection method is administrative or hybrid. Next slide. Seven states reported the measure for FFY 2020, with one of these reporting substantial deviations from the Core Set specifications. It was suggested for removal because many states do not have access to the data needed to calculate the measure, due to lack of CPT codes in claims data, or lack of lab data. One Workgroup member also noted that not all states have an integrated data warehouse that provides access to the behavioral health claims necessary to identify the population with serious mental illness, and, therefore, need to perform medical record reviews.

States cite confidentiality concerns, given small denominators in many states, which may also limit measure reliability. Next slide.

The next measure suggested for removal is Use of Opioids at High Dosage in Persons Without Cancer. This measure assesses the percentage of beneficiaries age 18 or older who receive prescriptions for opioids, with an average daily dosage greater than or equal to 90 morphine milligram equivalents, over a period of 90 days or more. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospital or palliative care are excluded. It's a PQA measure. It is NQF endorsed, and the data collection method is administrative. Next slide.

Thirty-three states reported the measure for FFY 2020, with five states calculating the measure using non-Core Set specifications. Note that there is a similar HEDIS measure, Use of Opioids in High Dosage. And five states reported the HEDIS measure instead of the PQA measure for FFY 2020. The Workgroup member who suggested this measure for removal noted that the measure may not be driving improvements in quality of care or outcomes. They noted that the opioid epidemic is no longer driven primarily by prescription opioids. And the AMA and other stakeholders are calling for a shift in focus. The CDC and FDA have acknowledged that opioid tapering and discontinuation for chronic users may put patients at risk, particularly for patients with mental health conditions. Next slide.

And the final measure suggested for removal in this domain is Concurrent Use of Opioids and Benzodiazepines. It measures the percentage of beneficiaries aged 18 and older with concurrent use of prescription opioids and benzodiazepines. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospital, hospice, or palliative care are excluded. It’s a PQA measure, it is NQF endorsed, and it uses the administrative method. Twenty-seven states reported the measure for FFY 2020, all using Core Set specifications. It was suggested for removal out of concerns that some of the actions providers may take to improve this measure put their patients at risk. The Workgroup member noted that providers may be hesitant to serve chronic users on this combination, or discontinue or taper the medications too abruptly, leading to negative outcomes for patients. Next slide. Okay. I will now pass it back over to Margo to facilitate the Workgroup discussion.

Thanks, Dayna. Ann Zerr, I see you have your hand raised. Did you have a question about voting, or a comment for this discussion?

I'm so sorry. I am unable to access the Voting page. So, if somebody could send that to me. I sent it in the chat, but I'm not sure I did it correctly.

Okay. We will definitely work with you offline to make sure that you get to vote.

Thank you, thank you.

Thank you. All right. So, now we are ready for the Workgroup member discussion of these measures. The way we'll do this is to go measure by measure, since they're all rather different and we want to have a chance for everyone to speak about the measures. So, the first measure for removal in this domain is Medical Assistance with Smoking and Tobacco Use Cessation. As a reminder, you may unmute your line if you wish to speak. And please remember to say your name before making your comment.

Do we have any comments or discussion about the Medical Assistance with. Jill Morrow-Gorton.

So, I actually think that from the vantage point of a Medicaid population, smoking is a significant issue. It affects health more than medical care, if you look at all the behavioral health, or the effect of behaviors on health. It is one of the 6 conditions with 18 effective evidence-based treatments from the CDC 6|18 Initiative. And a good sort of public health Medicaid partnership, in terms of addressing. As an LTSS practitioner professional, I see lots of end-stage lung disease and heart disease related to smoking. I think this is a significant clinical issue. I recognize the difficulties with gathering the data. But I do think it's a significant clinical issue.

Well, thank you. Lindsay. Lindsay Cogan.

Yes. Hi, this is Lindsay Cogan from New York State. So, and I apologize because I missed the prep meeting, but in years past when we talked about the removal of a measure, we would often give people a heads up if there's a replacement being put forward. And I don't know.

Yes, there is no replacement moving forward for this.

I understand what the issues with our CAHPS measures are. I mean it's definitely an issue with declining sample size, representation. But this is a measure that we in New York State do incentivize and use across many of our pay-for-performance programs. We do feel like it's an important measure, especially for folks enrolled in our specialized plans for behavioral health. We just see incredibly high rates of smoking. So, I think it's an important topic. There are other measures that we could think about replacing this with. I just don't know what the timeline would be to bring some of those up to fruition. But if other states have experience working with measures that get at the same content, I would be interested in hearing more about that.

Thanks Lindsay. Other Workgroup members?

Curtis Cunningham.

I’m curious about using the CAHPS survey. One, is it to a statistically significant for the entire Medicaid population? Because I know, and then also when we look at the states that are reporting, is it just their managed care lines of business, is it their long-term care, it is, you know, and other, because I'm struggling to think that many states are doing this for their entire Medicaid population, which would be I think the goal for these measures or at least one of the goals. Do we have, you know, of the 28 states reporting, do we know, is that for their entire populations, or is it a sub-portion of their Medicaid population?

Curtis that's a great question. We do know that in many of the states it is for a subpopulation, people in managed care. But as you know, it is a goal for it to include the full Medicaid population for it to be representative. And keeping in mind that is based on a sample of responses for, to the survey. So, the goal would be that samples in the future would include the full Medicaid population for representativeness.

Thank you.

Sure. Russell Kohl.

I would say certainly recognize and understand the clinical importance of the topic. But I think it's important to recognize the challenges around the measure itself. I have some degree of concern about the fact that it's no longer an endorsed measure from NQF, which I think certainly plays into the discussion. But I would also encourage us to think about the fact that, how does the measurement of this drive activity? And I would put out that, you know, at this point in medical care I think it would be sacrosanct to believe that simply removing this from the Core Set would stop the entire medical community from screening for and still dealing with smoking cessation. I think that we have to have a limited number of measures for the reality of the administrative burden associated with it. I think that this one makes perfect sense as one that could be removed without losing any sort of positive impacts on patient care.

Thanks for those comments, Russell and I would certainly invite other Workgroup members to comment on that. In terms of the implications for driving improvement.

Linette Scott, you're up next.

Thank you. Linette Scott from California. I know we've talked about this measure for the past several years. And part of the challenge is again a really important health condition, a really important issue in our Medicaid communities. The question though is, is the right way to collect the data and is the data actionable. And so, I mean one of the things I would put out for the Workgroup to think about is, again, it’s going to be required in 2024, right. And we have just over half the states currently reporting. Survey data, as we talked about in the last few years, response rates have been a real challenge. Lots of difficulties there. The other thing about smoking in particular is that there are a number of surveys that do this kind of data collection. So, there's BRFSS, other, sorry, Behavioral Health Risk Factor Surveillance System under the public health side. Many states I think have other ways of doing surveys. In California we have the California Health Interview Survey. And so, the question becomes, how actionable is this particular measure, to piggyback on the previous speaker. And how do we look at alternatives?

So, again another way of thinking about alternatives, we’ll be talking about e-clinical quality measures, I think tomorrow. And this would be a prime item to perhaps look at exploring because it's been a key measure in the Meaningful Use conversation about electronic health records. So, while there wasn’t a replacement suggested this year, it may be an area especially given the fact that it's going to be required that maybe we think about letting this one go for now, but then really put a focus on the tobacco cessation, in the context of e-clinical quality measures as we move forward. So just some thoughts for consideration. Thank you.

Thanks Linette. Lindsay Cogan.

Thank you. And Linette, you made me think of an interesting idea. So, using the BRFSS to supplement or have that serve as an additional source would be a way to, and I don't know how many states do a comparable BRFSS and have that question in there. But it is stratified by Medicaid. So, it would at least give us some insight into smoking, the smoking cessation among this population. I worry about alternative measures right now because the states are currently required to complete the CAHPS. And as long as those questions are still in the CAHPS, it's kind of you're building into an existing workflow. It's fine to think about alternative measures, but then that becomes additional burden on the states because, I don't hear anyone saying that the CAHPS survey is going to be going away anytime soon.

So, it's just kind of balancing those, those workflows. But thinking about an alternative data source for the type of information is interesting. And one I hadn't thought of for smoking, understanding smoking prevalence, as well as cessation. So, I don't know if that could be an action item to have Mathematica take back to look at whether this is one of those measures that we could use an alternative data source to still provide insight. It would lift burden from the states and allow us to continue to work on improving care, as well as have that flexibility to fold in additional measures.

Lindsay, thanks for that comment. In terms of the BRFSS I think, it sounds like New York does require health insurance as a stratifier, so having an indicator of Medicaid or CHIP. We have explored this over the years and not all states require that, in some states it's an optional item. So, I think that is something that the Workgroup could consider recommending that BRFSS be including the Medicaid indicator to facilitate those kinds of analyses. But that has come up in the past, and I think it's something that could be discussed again on the third day as a gap. So, thank you for that. I see Michelle Schreiber; you have your hand up.

Hi, thank you. I just have a question. If we're removing these tobacco metrics, are there any smoking measures that remain on the Core Sets?

There are not.

And I guess the question then for the Workgroup is, given that this is such a public health issue, is that something that people want to do, is not having any smoking metrics on the Core Sets?

So, I’ll leave that up to the Workgroup to comment on, thank you Michelle. Any other comments before we, thanks. Okay. We have a lot of other people queued up here, so Lisa Patton you're next.

Thank you. Yeah, and I mean the last speaker that was sort of where I was going, like in alignment with Lindsay's comments, you know, this is data that is being collected, you know, to a certain degree. And, you know, given that we have to vote and look at the measures as they are before us, I hesitate to pull that off without another measure being available. And while I agree we can do a better job with it and perhaps find alternative data sources, I think it's important messaging to retain the tobacco cessation focus, you know, in this very limited real estate that we have available to us. So, I would vote to preserve it for now with an acknowledgment and an emphasis on finding better ways to collect it moving forward.

Thanks Lisa. David Kroll.

Hey everybody. I also agree with everything that has been said so far. I think the one thing that I would also put out there is that we are increasingly finding with behavioral health measures across the board, and some of the ones that we'll be actually discussing today as well, that it doesn't just matter whether or not you talk about something, or screen for something, or provide some certain kind of education. But actually, how you do it. And what we're seeing across like depression screens and, you know, suicide risk assessments, etcetera, is that increasingly there's an expectation that high-quality care goes along with following a standardized approach to doing something. So, you know, the issue with any of these measures that are currently out there around tobacco cessation are, in part that it's this crude measure of really whether or not a discussion took place and not really a measure of whether or not that discussion followed any kind of evidence-based protocols, or sort of validated standard approaches. I bring that up mostly to think, actually to really reinforce what Lisa had just said, which is that, you know, we don't necessarily have an easily trackable standardized approach to smoking cessation management that can adapt itself to a measure right now. But I think that ultimately that's where we should be headed. And unless we necessarily have something like that on the line, I don't necessarily know it that it makes sense to sort of chuck this one right now. But instead sort of think about this as sort of a placeholder as we work towards a measure that hopefully would include some assessment of whether or not this information was shared, or used, or sort of the treatment was given along a standardized or validated protocol.

Thanks David. Do we have any other comments about this measure before we move on to the next one? Lindsay, do you have, oh Jill Morrow-Gorton.

Yeah, I just wanted to add real quickly that there are in fact some other measures, some of which look like they're hybrid measures, but that are not survey-based. Margo, I will send you this reference so that maybe we can share it with the group.

Sounds good, thank you. And Lindsay it looks like you still have your hand raised, do you have another comment? Do we have any other Workgroup members who have comments about this measure before we move on to the next one? Great, well why don't we talk about the Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c Poor Control. Do we have Workgroup members with comments?

Jim Crall, did you have a comment on the previous measure?

Yes, thank you Margo. Yeah, I was just saying that I, my thinking is in line with many of the Workgroup members’ comments. I've found that this is really a very important area that cuts across a wide variety of health conditions. And it's all we have at the moment. I also, I'm sympathetic to the, some of the comments and concerns about the use of survey measures for this. But since our real context is performance of Medicaid and CHIP programs, I guess without having spent a lot of time involved in the whole measure development and assessing measures related to this, the activities that we're looking to encourage and drive improvement on, I'm really sort of mystified that, or what, my level of understanding of what these measures are seeking to capture. That we aren't using some type of a more direct means of assessing provider activity. And here, again, even administrative claims data. Because if programs are not paying for this service, then, if that's the reason why we can't capture it in claims, then I think we have even a more fundamental problem. But, suspecting that programs are paying for services that could be identified through procedure codes for the services and linked to diagnostic codes, it seems to me like that's where we ought to be going in the future, is a much more direct assessment of, you know, program performance, maybe plan performance in this area. Rather than taking the survey approach, which has lots of limitations that we've discussed over the years.

Thanks Jim. I see a couple of other people queued up that might be wanting to speak to the tobacco measure first. Erin Abramsohn. Are you looking to speak to this measure or the next one?

Hi. Yeah, it was the tobacco measure and I just wanted to make sure that this was the appropriate time as a federal partner, is this correct?

It is. That's great, thank you.

Thank you and I'm sorry for not jumping in earlier. So, from CDC, we do strongly oppose removing the Medical Assistance with Smoking and Tobacco Use Cessation measure from the Adult Core Set without having a suitable substitute measure to assess delivery of clinical treatment for tobacco use and dependence. We agree with the other, the comments that others have provided. While we prefer this measure as a more detailed measure, if a change in the tobacco treatment related measure is necessary, we would recommend adoption of NQF #0028, all three parts which would align with HRSA required clinical quality measures. It's credible to maintain tobacco cessation related quality measures to address the leading cause of preventable disease and death and related health disparities, to encourage and incentivize health care providers to deliver treatment for tobacco use and dependence, particularly among adult Medicaid enrollees, and to track providers' performance and treatment delivery. And the availability and delivery of treatment for tobacco use and dependence is particularly important for Medicaid enrollees, as I've said. So, this includes comprehensive coverage for cessation treatment and quality measures to track treatment delivery. We know that Medicaid enrollees have a disproportionately high prevalence of smoking. In 2020, 22.7% of adult Medicaid enrollees currently smoked cigarettes, compared with 9.2% of adults with private health insurance. And smoking related disease is a major driver of Medicaid costs. And Medicaid enrollees are less likely to be successful in their quit attempts compared to privately insured adults. So, tobacco use remains the leading cause of preventable disease, disability, and death in the U.S. And quitting smoking reduces the risk of premature death, improves health, and enhances quality of life. We wanted to just note that if this measure is removed, again we recommend replacing it with NQF #0028. And, yeah, I think that that is the end of our comments. Thank you I really appreciate your time.

Thank you, Erin. So, turning now to the HPCMI measure, Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c Poor Control. Linette did you have a comment about this measure?

Yes. That's what I had raised my hand for this, the diabetes measure. And I think we may have talked about this before as well. But, you know, this is a measure that is being done more broadly as part of the adult measures. So, folks could stratify by the population that's specific to this measure, in terms of those with serious mental illness. But the challenge with this measure right now is that there are very few states reporting and we know that there's new, California's currently reporting, so we don't have a problem reporting it. But I know a number of states have expressed issues around availability of data, data integration, small counts for the smaller states, and such. And so given that this would be a required measure, it doesn't seem like it really passes some of the feasibility requirements that we have for measures that we add now. This is a measure I think that's been in the Core Set for quite some time. I'd encourage us to think about perhaps removing this measure at this time, given that the measure for the whole Medicaid population is still part of the measure set. Thank you.

Thank you for that, Linette. Sara Salek. Why don't we move on to Jill Morrow-Gorton.

I think this measure does a lot of things in the sense that when it clinically and topically it's a really important topic, it's a disparity issue. And it is the integration of behavioral health and physical health. All that said, it's really disappointing that only seven states are reporting it. Especially given that the other diabetes measure is much more readily reported I believe. And if states could stratify by serious mental illness, then that would essentially create this measure through stratification. I wanted to ask, at our, with our conversation last year, it sounded like CMS wanted to keep this measure in and to look at whether or not there was a more feasible way for states to have this done. Did anything happen around that?

Jill, that's a good reminder, yes that was one of the reasons for keeping the measure, to be able to explore the use of electronic health records through a health information exchange. But that has not been fruitful at this point. And so, I think that's not, that's not something that has come to fruition. The one thing I would encourage the Workgroup though to consider is that, as we think about whether to remove this measure or not, the current measure, hemoglobin A1c poor control, is not currently specified for stratification. So, that's certainly something that could be explored in the future, but I think in terms of the technical specifications for that particular measure, there is not a stratification. That's not to say that a state couldn't do that, but as you're thinking about the importance of the HPCMI measure, we should not be necessarily assuming that the technical specifications would be adapted or revised to allow for stratification.

I see Lindsay Cogan's hand raised and Sara Salek wanted to speak, can either of them unmute, or Derek can you help them to unmute?

Great, thank you Derek. This is Lindsay Cogan from New York. So, I just wanted to comment on, so we as a state have been providing this information year after year as a stratification of the original measure. We actually stratify all of our measures to look at this particular population. So, while I agree that we're not going to change the specification for poor control among diabetes, CMS does host, or they have the ability to specify what they want the measures stratified by. So that stratification, in those stratification instructions are separate from the measure specifications. So, just a thought, CMS could do that. And since most states are reporting this, the global measure, which includes those with serious mental illness, that might be one way of thinking about increasing the usability and feasibility of doing some of these measures. It's just adding a stratification to that or looking at member demographic characteristics in our stratifications. They could look at something like a diagnosis code stratification, so I continually bring this up every year. It's not that we don't agree that this is important, and I think folks have expressed concern that, you know, with medications around mental illness, that anything having to do with diabetes is important, I agree with that. I believe there are other measures on the Core Set that look at integration of physical and behavioral health. I don't think that taking this off would be then leaving us completely without any measures that look at coordinated care. I do think it's an important outcome measure. But I think there's a way for us to obtain this measure without the added burden. Right now, it's duplicative, you know, states are going out there and asking for a separate sample, doing all of the analytics and medical record review that go with this and it's incredibly burdensome and costly. And then to what end, right? So, just something to think about as far as your comment, Margo, made me think about the stratifications.

Thanks Lindsay. Sara are you able to unmute now? Sara, can you try your audio again and let's see if we can hear you.

Well, I think in the interest of time, we should move on. And Sara, if you're able to unmute yourself, we'll come back to you to give you a chance to speak about this measure. So why don't we move on to the two PQA measures next. The first one being Use of Opioids at High

Dosage in Persons Without Cancer. Do we have any Workgroup members that would like to speak about this measure?

Lisa Patton.

Hey, Margo, apologies. Can you all remind us of the current set of opioid measures on the adult set if that's possible?

Sure, what I'd suggest is that we go back in the slides to the list of measures in the Core Set.

Yeah. I just think for the good of the discussion, it could help if everyone could see the full portfolio. Thank you.

Sure. If you go back one slide, I think we might have. So, yeah. Here you can see Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment. And that does have opioids as one component. And then, next slide please. And here you can see the two measures that are being considered. Use of Opioids at High Dosage in Persons Without Cancer. Concurrent Use of Opioids and Benzodiazepines. Use of Pharmacotherapy for Opioid Use Disorder. We also have Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence. So those would be the measures currently.

Lisa, did you have a comment?

Yeah, I understand the rationale from the person who nominated this one for removal had to do with you know a lot of the challenges with opioid misuse are not occurring because of prescriptions. But you know, at this point, particularly in light of the significant increase in overdose and death that we saw during the pandemic, you know, we had started to at least get a leveling out of overdose and deaths around opioids pre-pandemic. And now our numbers are skyrocketing again. So, I just have concerns about removing this one at this point. Particularly since we do have great uptake by the states. And you know, I can't recall exactly when we put this one on, but I don't think it's been on for too many years at this point. I'd feel more comfortable removing the concurrent use opioids and benzos if we sort of had to choose.

Thanks, Lisa. David Kroll.

Hi everyone, Dave Kroll. So actually, this comment really applies to both of these measures. I think that one of the problems that I have with the arguments to remove these measures is that they really conflate really all of the problems associated with high-dose or excessive controlled substance prescribing with the opioid epidemic and opioid abuse and diversion.

And the truth is that what these measures are really looking at is not necessarily abuse per se, but rather, what’s frankly bad care. You know, we know that prescribing high doses of opioids is associated with worse health outcomes across the board. People develop all sorts of complications. They develop hyperalgesia, they can develop gastroparesis, and sometimes they can even die in their sleep, even when they're not necessarily abusing the substance per se. And so, I think it's pretty well accepted that prescribing opioids at higher doses and combining opioids carelessly or excessively with benzodiazepines is just bad care. And this is really a measure of whether or not the clinicians involved in the program are really providing higher quality care. I think there's also, you know, one of the arguments that the Workgroup member included was that, well if there's more of a stigma, or somehow this set of measures attaches a stigma to this kind of prescribing, then patients are going to be put in the position of going to see new prescribers, and then the prescribers may refuse to take on their care. Or they may be overly stigmatized, or they may terminate their care. And I actually don't think that's a fair argument either.

I think as any clinician knows, it's common to inherit patients who are currently receiving a bad treatment plan and expect that bad treatment plan to be continued. It's one of the more challenging things about providing clinical care. But all of us who do this work expect that's going be part of the work of being a clinician some of the time. And if we are providing high quality care, we have the skill set to handle those situations. And to be able to address changes in treatment plan that need to be made without necessarily shifting the burden or overly stigmatizing the patients. You know, some of the stuff about, you know, patients potentially being unfairly tapered on these medications, and sort of pressured to come off these medications. While that is probably true, that there's going to be, out of the hundreds or thousands, or hundreds of thousands of patients who may be impacted by this measure or by clinicians attempting to sort of follow along with this measure. There may be some handful of patients who end up on lower doses than what otherwise would have been optimal. But I think far more patients are going to be protected from having doses that are too high, or too high risk. And as a tradeoff for having this measure in place to really set that tone and set that priority is well worth it.

Thanks, David. Linette Scott?

So, I really appreciate those comments. I mean from a general reporting perspective. You know as we move towards again, required reporting, right now we have about 1/3 of the adult measures are behavioral health. Of those we have three or four that relate to opioids. So, I guess I would challenge the group to say of these, which are the most important and which give the most benefit in terms of providing action to improve how we address opioid use disorder. I mean these two measures in terms of high dose and opiates and benzodiazepines, because it's based on pharmacy data, it's relatively straightforward in terms of being able to calculate a report, which is why there's good reporting for it. But one of the concerns that we've seen in California is this shift from the prescription medications to the street medications. So, the fentanyl, the heroin, the other things that are being used to substitute the prescription medication. So, that's part of what raises a concern about having a focus on these measures in particular. Thanks.

And Linette, just to confirm were your comments about both of the measures?

Yes, I mean they basically apply to both.

Great, thank you. Jill Morrow-Gorton.

Yeah, I'd like to echo David's comments. I don't think this is a measure about opiate use disorder. I think this is a measure of appropriate pain management. While use of opiates may have shifted to using street, getting them on the street, one of the pathways to addiction is using too high doses of prescription opiates around an acute injury, or whatever. And so, I think from that vantage point, this is a very different measure than measuring something in a population of people with opioid use disorder. I also think that this is really a measure that measures the integration of pharmacy providers and providers. There's been a lot of work in a lot of states about sort of crafting ways to support this. Pharmacists do a lot of outreach around opiate use, other possibilities in terms of managing pain, especially acutely. There have been a lot of changes in how EDs approach acute pain management that should be time limited. And I just think this is a valuable measure to sort of get appropriate care for people and not inappropriate pain management.

Thanks, Jill. Sara Salek are you able to talk now?

Oh my goodness, that was difficult. I'm not sure what the technical glitch was, but oh, it feels good to talk. All right so I have comments on both measures. I really wanted to speak, as you know, I was persistent, Margo, on hemoglobin A1c for our members living with serious mental illness. I think Arizona, actually Medicaid, has a lot of experience with this, as we actually moved toward integration of both behavioral and physical health services for members with serious mental illness back in 2014. And so, like eight years of experience. And the reason why we did that is actually, the core components that were discussed at the opening remarks in regard to addressing health care disparities. And so, we know individuals with serious mental illness are at a higher risk of morbidity and mortality. And so much impacted by social determinants of health including living in homelessness. And so, you know when this measure came up for removal, it definitely sparked interest and concern in my eyes because the reason why we've moved toward integrated care in Arizona is because our members living with serious mental illness were dying 20 to 30 years earlier than their counterparts. And of course, there's you know overlap with the tobacco discussion we just had. But when it comes to hemoglobin A1c and poor control, we know that our members with serious mental illness on prescribed medications, including atypical antipsychotics, are at a much higher risk for metabolic syndrome, including diabetes. And so, we have found, you know, ways of course we have integrated care that helps us. Because we have the same care, so we get those claims. But you know this is a hybrid measure where you're also doing chart review to see what those lab values are. We're also leveraging our health information exchange to get the lab-based data as well. So, I think it's absolutely feasible. And I think we'd actually be going in the opposite direction of what our real plan was as far as addressing health care disparities, and also addressing integration by removing this measure from the Core Set.

And then, in regard to the actual opioid measure, I commented this in years past. And what I have mentioned is it is really a reflection of the concern we have had historically around opioids being prescribed for pain. And the number of people we're still losing to this epidemic, the opioid epidemic, including what my colleagues have referenced in regard to getting out fentanyl, illicit fentanyl on the street. Having said that, you know it is something that we need to continue to monitor. And what I had proposed, it's not a measure of behavioral health services. Because as individuals start using opioids and then hopefully, we're transitioning them to medication assisted treatment to help in their recovery, they're accessing medication assisted treatment through the behavioral health system. So, I think this measure, what I had mentioned in previous years, is that this is really more a physical health measure so to speak, because we're looking at the concerns that we've seen through pain management, through primary care. And so, it's not a good reflection of behavioral health, but rather physical health. But what was discussed is that that was not before this Workgroup to discuss if it was to move to another area within the Core Set, in this context, the physical health section. So, that's all my comments.

Thank you, glad you could get unmuted. Kolynda Parker, you had a comment before.

This is Kolynda Parker from Louisiana. And I just had a comment on the diabetes care for people with serious mental illness poor control. And I wanted to report that for the last several years, the state of Louisiana did not report on this measure. And that was because there was a requirement of chart review. One of the comments I always added to any discussion regarding reporting is that taking into account states that may not have those capabilities to report chart review data on our health, a consolidated EHR that makes measures such as this difficult to report. So, I'm not opposed to removing a measure, and being that a low number of states report on this measure anyway, I don't see any objection to the removal of the measure. Also, I noted that the measure under the care of acute and chronic conditions, this measure is still listed. So, it's not like we would lose reporting of these measures, totally. So, that was my comment.

Thanks, Kolynda. So, we're coming to the end of the Workgroup discussion on these four measures. Do we have any other comments on the four measures before we open it up for public comment? Linette, you have your hand raised, do you have another comment?

No, sorry.

Thanks. Lindsay, do you have a comment? Lindsay Cogan. Rich Antonelli, looks like you might have a comment.

Yeah. Thank you, Margo. I appreciate the conversation up to now, in particular, David, your observation that these really have to do with measuring providing the right care. But I want to call something out, we're potentially defending keeping measures in because we don't yet have a robust way of stratifying existing measures. And I just want to call that out. I can't think of any condition that is not exacerbated by having a serious mental illness and sort of floating that out there. So, this loops back to the conversation that we had at the beginning of the day today. So, my hope is that as we go forward and really embrace having appropriate stratification by disability status and behavioral health, behavioral health, behavioral health and developmental disabilities would be my top four priorities in that bucket. But I just want people to be aware of that. The other observation that I would like to make, or comment, is the level of accountability so that this data actually is actionable. And so, if it's in the Core Set and it's reported to the state Medicaid program, is that data going to be actionable at the level, say of the delivery system. And so, I don't know if that's an answerable question, Margo, or whether I can leave it as a comment. But if we keep something in the Core Set, does that find its way automatically into accountability, say at delivery system level, which is really where the actionability would come from in my opinion. Which aligns with measuring appropriate care. Thank you.

Thanks, Rich. I think those are good context for the voting that we'll be doing and for further conversation the next couple days. All right. With that, let's turn to public comment. And so, if you have a public comment, please raise your hand and we'll call on you and unmute you. And Rich if you could lower your hand.

So, I see Anne. Could you please unmute Anne and could you introduce yourself and your affiliation?

Hi, my name is Anne DiGiulio and I'm with the American Lung Association. And thank you just very much for the opportunity to speak with you today. And I'd like to ask you to vote to keep the Medical Assistance with Smoking and Tobacco Use Cessation MSC-AD as part of the

Behavioral Health Core Set for 2023. As has been said, smoking is the leading cause of preventable death and disease in the United States. We know that more must be done to help smokers quit and the data provided by this measure will help identify those gaps in treatment. We know that Medicaid enrollees smoke at a really high rate. The overall smoking rate, nationally, is 12.5%, while Medicaid enrollees smoke at a rate of 22.7%. And some data shows that smoking rates in some state Medicaid programs is as high as 50%. Not surprisingly, smoking related illness accounts for approximately $39 billion annually in the Medicaid program. And helping smokers quit just makes sense. It will save both lives and money. Additionally, individuals with behavioral health and substance abuse disorders also smoke at high rates compared to the general population in the United States. For example, approximately 34.6% of adults with mental illness smoke. And these individuals we know are heavy smokers. Individuals with behavioral health conditions, accounting for approximately a quarter of the population, consume 40% of cigarettes in the United States. And unfortunately, people with behavioral health conditions that smoke, die on average 15 years earlier to their counterparts with behavioral health conditions that do not smoke. The 2020 Surgeon General's report on smoking cessation found that 4 out of 9 adult cigarette smokers who saw a health care professional in the past year did not receive advice to quit smoking.

However, data has consistently shown across demographics that we know most smokers want to quit. There's a saying, what gets measured gets done. There's clearly a need for more tobacco cessation. The current measure in the Behavioral Health Core Set has its limitations and problems associated with it. But I'd encourage the committee not recommending throwing it out, but to work on improving it. There's clearly a sufficient number of smokers in the Medicaid program from which to gather a robust data set, you know, so the data collected in this measure is important. The measure encourages smoking cessation and identifies gaps in patients getting screened and getting treatment. The Lung Association strongly encourages the committee to vote to keep this measure as part of the Behavioral Health Core Set for 2023. Thank you so much. I appreciate the opportunity to provide comment.

Thank you. Other members of the public with comments, please raise your hand.

Any other members of the public with a comment on these four measures before we turn to voting. Are there any federal liaisons that have any final words?

All right, so with that next slide please. I'm going to turn it over to Alli and Dayna for voting.

Great, thank you so much, Margo. Next slide and we'll get the vote up on the screen.

All right. So, for our first vote the question is, should the Medical Assistance with Smoking and Tobacco Use Cessation measure be removed from the Core Set. And the response options are yes, I recommend removing this measure. Or no, I do not recommend removing this measure. And voting is now open. Looks like we've already gotten a lot of results in. Thanks, everyone. Looks like we're waiting for a couple more votes to come in. All right and it looks like we've reached the expected number of votes. Sorry, folks just give us one second here. Just doing a bit of troubleshooting. We're at the expected number of votes now. So voting is now closed.

All right, and so the responses show that 67% of Workgroup members voted no, I do not recommend removing this measure from the Core Set. So, this measure is not recommended by the Workgroup for removal from the 2023 Core Sets. Next slide please.

The next vote is should the Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c Poor Control 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 open, and the results are starting to come in. Looks like we're waiting on one more vote to come in. Okay, thank you so much everybody.

So, for the results, 63% of Workgroup members voted yes. And that does not meet the threshold for recommendation. The Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c Poor Control measure is not recommended by the Workgroup for removal from the 2023 Core Sets. Next slide please.

Next we have should Use of Opioids at High Dosage in Persons Without Cancer be removed from the Core Set? The response options are yes, I recommend removing this measure. Or no, I do not recommend removing this measure. Voting is open. Thanks everyone, we have the expected number of results.

Okay so for the results, 44% of Workgroup members voted yes. And so that does not meet the threshold for recommendation. The Use of Opioids at High Dosage in Persons Without Cancer measure is not recommended by the Workgroup for removal from the 2023 Core Sets. Next slide please.

Now we have should the Concurrent Use of Opioids and Benzodiazepines 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. That's the expected number of votes for this particular measure.

And for the results we have 27% of Workgroup members that voted yes. And again, that does not meet the threshold for recommendation. The Concurrent Use of Opioids and Benzodiazepines measure is not recommended by the Workgroup for removal from the 2023 Core Sets.

And so now at this point, I'll turn it back to Margo to facilitate a discussion of gaps in the behavioral health care domain.

Thanks, Alli and Dayna, and thanks Workgroup members. So now we would like to hear from Workgroup members on gaps in the Behavioral Health Care Domain for the Child and Adult Core Sets. Please keep in mind that measures in this domain are subject to mandatory reporting in 2024. What suggestions does the Workgroup have for further strengthening the Core Sets? What types of measures or measure concepts are missing in the Core Sets? Are there existing measures to fill the gap, or would a new measure need to be developed? Again, please remember to say your name before making your comment. I know we've heard some things in the previous discussions, and we'd love to hear a little bit more about opportunities for strengthening the Core Set in the future.

So, I see Mihir, do you have a comment? You are currently muted, can you unmute?
Why don't we move on to Linette and come back to Mihir? Linette, are you able to unmute?

Linette Scott from California. I mean I guess as you mentioned, Margo, some of this we've already talked about but just to kind of put it on the recording for this section, I would say a gap is a tobacco use measure that’s not a survey. We’ve talked about it for years. And I think that's something that really needs to be focused on so that we can address that issue using data that's going to have better representation across the populations that we serve. And then be actionable. I would identify that as a definite gap. And then the other thing, I really appreciated the comment earlier about the high-dose opioids and concurrent use of benzos perhaps being in the wrong category. And that perhaps they should be under chronic disease because that's how they're being used in that case, as opposed to behavioral health. So that's kind of an adjustment as opposed to a gap, per se. But again, a third of the measures are in the behavioral health category at this point for the adult measures. And so, I think we need to be really strategic about if we're going to add measures what are we going to take away, just in terms of reporting burden and making sure we’re really focusing on actionable activities. Thank you so much.

Thanks, Linette. Other Workgroup members including federal liaisons? Peggy O'Brien. Can you introduce yourself?

I'm Peggy O'Brien, I'm with SAMHSA. And I have three kinds of general comments about gaps. The first involves achieving balance in the child core measures. As you're aware, the 2022 measures include six child measures, of which only one relates to substance use disorder. We suggest the addition of the initiation and engagement child measure to the Core Set to better understand and enhance overall quality of SUD services for adolescents, and to capture the critical elements of initiation and engagement, and SUD treatment for adolescents. It's already endorsed by NQF for those ages 13 and older. We also suggest the addition of a couple of additional measures to the adult group. And these are Continuity of Pharmacotherapy for OUD and Query of Prescription Drug Monitoring Programs. These represent critical components of treatment and prevention, respectively. We know that retention and treatment for OUD is critical for recovery and associated with multiple improved outcomes. Similarly, routine query of state PDMPs is an essential part of appropriate prescribing practice for controlled substances. And it's worth noting that I think since the measure was last considered in 2020, all states have now adopted PDMPs. Which was not the case in 2020. And then lastly, I'd like to talk a little bit about multi-substance use disorder. We have the measures of concurrent use of prescribed opioids and benzos. This doesn't really capture the very real and growing threat that's associated with polysubstance use and more amenable to measurement, multi-substance use disorder. We recognize that the core measures are designed to measure use of services and that a measure does not exist specific to treatment for multi-SUD. But we believe that this could be rectified and suggest that one approach might be to explore stratification by substance, and possible modification of diagnostic fields in the follow-up after ED for substance use treatment or the IET measure to encompass additional diagnostic fields. This would only capture diagnosed and coded SUDs and would not indicate that appropriate treatment is being provided. But it would indicate better if any treatment is being provided to those with multiple substance use disorders. And those are my only comments.

Thank you very much. Jill Morrow-Gorton.

So, thank you. You actually covered a couple of the things that I was going to suggest in terms of looking at longer-term outcomes. I've seen ways to look at sort of the amount of time that people spend in SUD treatment. So how long they have been engaged, something like that might as well give us a longer-term picture. I was looking at our measures and they’re follow-up after hospital, or they’re engagement. And we don't have a lot, there are a couple, but not a lot, around longer-term management. And I think this is also kind of a right place for looking at social determinants as a measure of outcome, in terms of stability. Because people with serious mental illness, people with substance use disorders, in treatment have better outcomes and you know thinking about can we look at housing and employment and those kinds of things as a valid outcome of the success of treatment.

Thanks, Jill. Linette Scott.

Sorry, I keep forgetting to put my hand down.

Curtis Cunningham.

Hey, I just want to comment on kind of the inherent conflict I'm seeing in some of the conversation of the ability to want to require all states to report on these measures while also wanting to acknowledge the importance of various measures to meet end goals. And so, I mean when I think about you know only seven states reporting a measure and then, you know, wanting to move forward with Core Sets being reported by all states in 2024, I struggle with how to reconcile some of these foundational assumptions in the conversation going forward. So, I don't know, maybe more of an observation to maybe pass onto CMS as they're you know thinking about future policy. But I think this is going to be very difficult to reconcile these two dynamics at play. That's my comment. Thank you.

I think another thing that could be very helpful here to think about that tension is what kinds of technical assistance could be valuable to help states move toward mandatory reporting. So, if you have any suggestions about that. We did have four removals, none of them were recommended for removal. So, to the extent that there are opportunities for technical assistance, we'd certainly welcome some comments on how to fill those gaps with the current measures and support states as we move toward mandatory.

Mihir, did you have a comment before? Are you able to unmute yourself? Are there any other Workgroup members that would like to speak about gaps in the Behavioral Health Care Domain? We're kind of winding down the end of Day 1. It's the last call for comments before we move on and wrap for the day. All right, next slide please. So, that brings us to the end of our measure discussion today.

I want to thank everyone for a robust conversation. And everyone's contributions during both the health equity conversation this morning and the behavioral health measure review this afternoon. There was definitely a lot to takeaway, particularly from the health equity conversation. Certainly, a sense of consensus on the importance and the urgency of measures. A sense that there's lots of screening underway already. But we also heard about the need for further standardization, assessment, and feasibility for state level reporting. I think as we all have talked about, that state-level reporting for Medicaid and CHIP is different from Medicare, which is more of a provider level. So, thinking about how you aggregate up to the state level. And then also opportunities for partnership between CMS, states, measure stewards to keep moving forward. So, thank you all for those wonderful comments this morning both from Workgroup members, from federal liaisons, and then also from members of the public. And likewise, the behavioral health measure review this afternoon was, I think very informative about perspectives on the Core Set measures as they exist and gaps that could be filled in the future. So, thank you for all those comments. So, now I'd like to preview the agenda for tomorrow. Next slide please. We'll start off by discussing strategies for including digital measures in the Child and Adult Core Sets, a special topic. And we hope that we'll have lots of participation from Workgroup members, from federal liaisons, and also from members of the public. We'll then discuss measures for removal and addition to two domains. Primary Care Access and Preventive Care, with two measures suggested for removal and four measures suggested for addition. And Long-Term Services and Supports, with three measures suggested for addition.

We'll begin promptly at 11 a.m. Eastern again tomorrow. And we ask Workgroup members to sign in about 10 minutes early. So, with that, we'd like to turn to our co-chairs, Kim and David. Do you have any final remarks to close out the meeting today?

Thank you, Margo. This is Kim and I just want to thank everybody for their very active participation in Day 1 of the Workgroup meeting. And Mathematica, you just did a phenomenal job of course of organizing the meeting and executing the meeting today. So, we appreciate that of course. And I especially appreciate all of the information that was shared by federal partners and Workgroup members throughout the discussion on each of the measures and the different topic areas that we had on the agenda today. I think it really lent itself to a very thorough discussion of different topics that I think led to perhaps really good outcomes for Day 1. And we also had a very prolific discussion on the social determinants of health, health disparities, health equity. And I think that gave all of us a lot to consider and think about as we do review these measures. And I'm confident that the discussion tomorrow will be just as strong, and we’ll consider all of the discussion that we had and the social determinants of health. So, I think it was a very good day and very active participation. And I'm looking forward to tomorrow's discussion, which should be equally active on the strategies for advancing quality or performance measurement to digital measures and the impact that that might have on the Core Sets. David.

Thanks, Kim. I'll echo thanks to our Workgroup, our federal partners, and Mathematica, and my co-chair. Really, I think that we've had great robust discussion. I think that there was really excellent points around, you know certain gaps that exist and certain measures that are on the Core Set that are underreported. Again, I think technical assistance is going to really be vital. I think that specifically the diabetes hemoglobin A1c control and the tobacco measures quite honestly, in my hopes and dreams they will become digital measures. So that will segue hopefully into tomorrow's discussion. But you know, we really need to keep pushing the need for e-metrics and those are two prime examples where you could certainly gather that information in a very different and probably more efficient way. So, thanks again to everyone for their participation and active engagement today. This has been very enlightening. Margo, back over to you and the Mathematica team.

Thanks, Kim and David. And thanks, everyone. We wish everyone a nice rest of the day. This concludes Day 1 of the 2023 Child and Adult Core Set Annual Review Meeting. We are adjourned for the day. Talk to you all tomorrow.