2023 Child and Adult Core Set Annual Review: Meeting to Review Measures for the 2023 Core Sets Day 2 Transcript
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Hello everyone. And thanks for attending today's event, the Meeting to Review Measures for the 2023 Core Sets Day 2. Before we begin, we want 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 ellipses icon. You'll find the option to raise and lower your hand to the left. You will be unmuted in the order in which your hand was raised. Please wait for your cue to speak, and remember to lower your hand when you finish speaking by following the same process you used to raise your hand. Note 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 to the Q&A function located on the bottom right of your screen. And if you're on the browser app, please look for the question mark icon. If you're having issues speaking during the Workgroup discussion or public comments, please make sure you're not also muted on your headset or phone, and we found that connecting the audio using computer audio or the “call me” feature are the most reliable options. The instructions for adjusting your audio are available on this slide. And with that, I will turn it over to Margo Rosenbach from Mathematica. Margo, you have the floor.

Thank you, Dayna. Next slide, please. Welcome back to Day 2 of the Meeting to Review Measures for the 2023 Core Sets. I hope everyone had a nice evening. We had a very productive day yesterday. We started off the day with a discussion of opportunities to advance health equity through the Core Sets.

There was clear consensus on the importance and urgency of doing that, and also evidence of a lot of screening that is currently underway. But a lot of discussion about the need for further standardization of measures, and also development of measures that are feasible for state-level reporting. So, there's definitely a lot of screening underway, but how does that get captured for purposes of state-level reporting of drivers of health?

Clearly, strong support for partnership between CMS, states, and measure stewards to move forward with developing and testing measures for the Core Sets. Also, a lot of conversation about the importance and utility of stratification to identify disparities and to measure the gaps and narrowing of gaps in disparities. I'm sure those conversations will continue today, and tomorrow as well.

We also reviewed four measures in the Behavioral Health Care domain. There were four measures suggested for removal and lots of robust conversation about the strengths and limitations of those measures. With the four votes that were taken, none of the measures were recommended by the Workgroup for removal. So, with that, we're looking forward to another day of discussions about updates to the Child and Adult Core Sets, as well as a focused discussion on digital measures.

Before we begin, I'd like to turn to Kim Elliott and David Kelley, our two co-chairs, for some brief welcome remarks. Kim and David.

Thank you, Margo. This is Kim, and I just want to welcome everybody back again to Day 2 of the Core Measure Set Review Workgroup. We're very excited to be here, and I'm sure all of you are as well. And as we review today's measures that are focused primarily on primary care access, preventive care, and long-term services and supports, we still want to consider factors discussed yesterday, including advancing health equity or diversity in the measurements, and how the measures advance health care quality at the local, state, and national level, and whether measuring the topic area is actionable by implementing actions that will improve access to or improve the quality of health care.

I'm particularly excited today about our discussion on the strategies for including digital, or they're sometimes referred to as ECDS measures in the Core Sets. And digital measures really do provide us an opportunity to help IT to increase sufficiency of quality reporting, while also incentivizing electronic connections to data sources, such as registries, public health data, and other data currently described as supplemental data for the purposes of performance measure reporting. And I think once we start moving in that direction and start implementing some digital measures, it hopefully will start to reduce some of the burden of reporting performance measures for providers and care organizations and, of course, for states. So, with that, I'll turn it over to David for an opening.

Thanks, Kim. And thanks again to the Workgroup for all of the hard work and great discussion yesterday. Really had a lot of interesting public comment as well, that I think was really vitally important. As we move forward, obviously, I think we're starting with a digital measure discussion and hopefully, some day we will get there. I'm thinking back ten years when ARRA HITECH was passed, where providers complained that they really didn't have electronic health records, and I think that in 2022, the electronic health record systems, while not perfect, certainly have come a long way in the last decade, and I hope that that technology is going to really better enable us to collect digital quality measures more real time that are much more actionable. It really is the wave of the future.

I think Michelle Schreiber at CMS has talked about, repeatedly, CMS's goal to really move towards digital measurement. And I think within the Medicaid program, we really need to be thinking of aligning ourselves with our colleagues at CMS on the Medicare side of the fence. So, hopefully we'll have a really great enlightening discussion around digital measures. I'm always in favor of pushing the envelope and really trying to move things along.

Here in Pennsylvania at least, we require our plans to report several digital measures every year. But, again, knowing full well that states are in a very different place, we really need to keep in mind the feasibility of some of the digital measures and some of the challenges there.

Also, look forward to the discussion around the LTSS measures. In Pennsylvania, we have three LTSS MCOs, and we are using quite a few of those LTSS measures, so hopefully it will be an excellent discussion. I know that this is also an area where there have been a lot of identified gaps in the past, so really look forward to today's discussion. Margo, I'll turn it back over to you.

Thank you both for those great comments to frame the day and really start setting the scene for what we're going to be talking about today. Next slide, please. So, now I'll conduct the rollcall of the Workgroup members. Next slide.

We ask that Workgroup members raise their hand when their name is called, and we'll unmute you, and you can say hello. After you are done, please mute yourself in the platform and lower your hand. This will allow you to unmute yourself when you would like to speak during the measure discussions. If you leave and reenter the platform or find you've been muted by the host due to background noise, just raise your hand and we'll unmute you again. Next slide.

Okay, so with that, on the next two slides, we’ve listed the Workgroup members in alphabetical order by their last names. We've already heard from Kim and David, so next, Richard Antonelli. .

Good morning. I'm here.

Tricia Brooks?

Good morning. I'm here as well. But I did want to make note and apologize to the Workgroup that I will miss tomorrow's meeting. When I committed to doing this for another year, it was based on the original dates that we had planned for this meeting, and, unfortunately, I have a conflict with MACPAC, where I serve as commissioner tomorrow. So, this will be my last day with you all today, so thank you.

Well, thank you, Tricia. We appreciate your contributions. Karly Campbell? Is Karly here? All right, we'll move on. Lindsay Cogan?

Hi. This is Karly Campbell. I'm glad to be here.

Great. And Lindsay Cogan?

Hi. Lindsay Cogan is here.

Great. Jim Crall?

Yes, good morning, everyone.

Curtis Cunningham?

Hi. Good morning. Here.

Amanda Dumas.

Good morning. I'm here.

Anne Edwards?

Good morning, everyone.

Katelyn Fitzsimmons?

Yes, present. Thank you.

Lisa Glenn?

Good morning, everyone.

Tracy Johnson?

Yes, good morning.

Diana Jolles? Is Diana here?

I believe Diana is having some tech issues and is still getting connected.

Okay. Great. Next slide, please. Russell Kohl?

Good morning.

David Kroll?

Hi, everyone. Good morning. I'm here.

Rachel LaCroix?

Good morning. This is Rachel.

Jill Morrow-Gorton?

Good morning, everyone.

Kolynda Parker? Do we have Kolynda Parker here? Why don't we keep moving. Mihir Patel?

Good morning, Mihir Patel.

Lisa Patton?

Good morning, everyone. Hi there.

Sara Salek.

Good morning. Present.

Lisa Satterfield? Do we have Lisa Satterfield? Okay, we'll move on. Linette Scott?

Hello. Present.

Jennifer Tracey? Jennifer, you should be unmuted.

Good morning.

There you go.

Thanks, Margo.

Sure. Ann Zerr?

Good morning. It's Ann.

Bonnie Zima?

Good morning.

Okay, that's great. And, Karly Campbell, you still have your hand raised. Can you lower your hand? And let's see, we will come back to the folks that were missing, and we'll keep watching for them to join. All right, so with that, thank you Workgroup members for unmuting, raising your hand. We very much appreciate that. Okay, next slide.

We're also joined by federal liaisons who are non-voting members. 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 acknowledge 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 the measures. Next slide, please.

Our first topic today, as David and Kim referenced, is strategies for including digital measures in the Child and Adult Core Sets. I am going to provide a brief introduction, and then we'll hear from Workgroup members. We also will provide an opportunity for public comment. Next slide.

I wanted to start off with a bit of level setting about CMS's goals for digital measurements. Here, we provide a brief definition of digital quality measures. They're measures originating from sources of health information that are captured and can be transmitted electronically and via interoperable systems. This might be data from health information exchanges and information systems, or vital record systems. And as David mentioned, the use of digital measures in the Core Sets is part of a broader CMS digital strategy under Meaningful Measures 2.0.

Here, we have listed all of CMS's strategies that involve using FHIR-based standards to exchange clinical information, accelerating the transition to fully electronic measures, being able to identify quality problems before patients are harmed and intervene when appropriate, developing more APIs for quality measure data submission and interoperability, and also harmonizing measures across registries. Next slide.

As many of you know, HEDIS ECDS is a reporting standard developed by NCQA to provide health plans with a method to collect and report electronic clinical data for HEDIS. Eligible data sources include administrative claims, electronic health records, health information exchanges, clinical registries, and case management systems. ECDS is particularly salient for the Child and Adult Core Sets, as you will see on the next slide. Next slide, please.

So, on this slide, we first list the three measures in the 2022 Core Sets that are specified for ECDS reporting, and these measures are Follow-Up Care for Children Prescribed ADHD Medication, Breast Cancer Screening, and Colorectal Cancer Screening. These measures currently include administrative, hybrid, and/or EHR specifications, in addition to ECDS. But please note that ECDS specifications are not currently available for these measures for Core Set reporting.

Next, we list two measures previously recommended by the Workgroup for addition to the Core Sets that rely solely on the ECDS reporting method, and these are Prenatal Immunization

Status and Postpartum Depression Screening and Follow-Up. As noted on the slide, CMS deferred a decision on adding these measures to the Core Sets, pending further assessment of how the proprietary nature of the specifications impact the feasibility and viability of including these measures on the Core Sets.

And finally, we list the two ECDS-only measures under consideration at the 2023 Core Set Review that the Workgroup will be considering this afternoon, and these are Adult Immunization Status and Depression Screening and Follow-Up for Adolescents and Adults. Both of these measures were suggested as replacements for existing Core Set measures.

Before opening up Workgroup discussion, I wanted to share a few comments from CMS that will help frame our discussion now, and consideration of these two measures later. First, CMS requests that the Workgroup consider ECDS-only measures using the same criteria for addition that we outlined yesterday; that is, technical feasibility, actionability and strategic priority, and other considerations. And while CMS has not yet added any Workgroup-recommended ECDS measures to the Core Sets, this referral does not reflect the merits of the measures themselves. And, as we mentioned, CMS is continuing to determine how the proprietary nature of this information impacts the feasibility and viability of including these measures, as well as determining next steps around potential ECDS reporting method adoption. Next slide, please.

So, with that, we would like to turn to the Workgroup discussion around digital measures. Next slide. And here are some topics to guide the discussion today. First, we'd like to hear about opportunities for digital measurement, including ECDS, for state-level reporting in the Child and Adult Core Sets. Second, we'd like to learn about challenges of digital measurement for state-level reporting in the Child and Adult Core Sets. We'd also like to hear about any suggestions for technical assistance to build state capacity. And finally, any other considerations for the Workgroup discussion of the two ECDS measures suggested for addition to the Child and Adult Core Sets.

So, now we'll invite discussion from Workgroup members. You may unmute your line if you wish to speak. And please remember to say your full name before making your comment. So, who would like to go first?

Margo, this is Lindsay Cogan from New York.

Go ahead, Lindsay. Thank you.

Yeah, so I think that this is a great topic to start to really open up a little bit more on. I think your framing of the fact that we currently have Core Set measures specified for different reporting modalities. So, we have administrative-only measures. We have measures that are both administrative and hybrid, and we even do allow some electronic data sources now, although I wasn't clear, I believe that some of the measures we've labeled in the previous, in the coming slides is sort of EHR-based, I don't think that's entirely correct.

But what it would have helped, I think, to show is not just the number of states reporting these measures but the number of states that are reporting these measures, either administrative-only, the number of states that are reporting currently hybrid, and the number of states that are reporting using an electronic method. So, I think that's our best path forward here. So, adding a measure that's specified for ECDS would not preclude a state from doing an administrative reporting only.

So, I think there's a lot of confusion around some of these measures. But some states do administrative reporting for all of their measures. Some states choose to do hybrid for some and not others. And I see this as being our way of sort of adding this other reporting modality allowing states to choose which measures they would like to focus in on. We can't do them all. But I don't think it hampers us in a way that I've heard the discussion kind of being, we'll leave states behind or it will be an unfair advantage. By allowing us to collect these measures in different ways, it will continue to move us forward, and I don't believe it will hamper other states, because, of course, it's a decision that has to happen at the state level about where to focus resources.

But to continue to block this idea that we're going to not allow these electronic measures, it's really holding us back, I think. So, I do want us to think about this in a little bit of a different way. And I'll stop there and see if I'm resonating with others on that point.

Linette?

So, just to piggyback on Lindsay's comment some and ask a question, agree that one of the things that I think will be helpful is for CMS to be able to signal in the Medicaid measures that we're going to go to ECDS. I mean, there's, I think, been more use on the Medicare side, and so it's definitely being, so these measures are being used in the industry; right, as part of NCQA measures and such, and so we need to move in that direction from a Medicaid perspective and signal that.

So, actually, as I was looking at the measures that you were highlighting on slide 13, I think most of those measures are, well, not all of them, but many of them are in the Adult but not Behavioral Health category, which means they're not mandatory. So, from that perspective, those might be good measures to really push on, because, as Lindsay said, there are other options, but getting technical assistance and getting folks and states working on the ECDS measures would help move us in that direction. So, those Adult non-Behavioral Health measures might be a really good place to start to focus.

The other thing that's sort of a question/comment is, my understanding, as part of the NCQA accreditations, that there's a five-year timeline in terms of when the ECDS measures will be required as part of NCQA accreditation, and I don't know if somebody from NCQA can talk about that. But that might also be helpful context in terms of thinking about timing and alignment and how plans, both in Medicaid and elsewhere, are working on these measures. Thank you.

Thanks, Linette. Jill Morrow-Gorton?

I'd like to say I totally agree with Lindsay in terms of moving towards digital and sort of minimizing the amount of chart work and whatnot, which is really quite intensive to do.

I wonder about the opportunities to use other data sources, like the T-MSIS data that states are sending to CMS and HIEs. I know that, you know, HIEs sort of depending on where you are, there are multiple, or there's one so that it's kind of a mishmash. But I'm just wondering if any of those data sources might be available for this kind of opportunity.

Thanks, Jill. That's great. Katelyn Fitzsimmons?

Hi. Thank you. And I think this conversation is really relevant as we move to discuss the LTSS measures later on this afternoon, and I know we're not touching on all of NCQA's LTSS HEDIS measures. But these especially, coming out of case management systems and, potentially, EHRs. We're able to turn those almost into admin measures with the appropriate reporting technical assistance, but we would need to consider that some LTSS measures, as we move forward and add them slowly into the Core Set, are going to be required to be reported by community-based organizations that don't have that same level of administrative capacity and may only have the opportunity to use an EHR or case management system, so we definitely want to be mindful of the applicability of using ECDS, especially when NCQA LTSS accreditation requires so many of these measures.

Thanks. We'd love to hear from some other states who are maybe a little bit less managed-care oriented, if there are any, thinking about how this might work in your state. Tracy Johnson.

Yes, thanks for the opportunity to comment. Colorado is a partially fee-for-service state. We're mainly fee-for-service on the physical health side, and we are very interested in leaning into these kinds of measures. I don't want to minimize the lift. It is a lift. But if we're going to do meaningful value-based payment models, we really need to have meaningful measures of value.

And there's been so much federal investment in EHRs through Meaningful Use and other kinds of things, as well as HIEs. This kind of brings it all together. And, you know, as others have pointed out, there are alternative measures for states that aren't quite there yet. But one way to help get states there is requiring a few of these and, you know, focusing in on areas where the payoff is really going to be worth the investment, I think, is perhaps a lens to consider here. But it is a lift. We can't do this well yet, for the most part. But we think it's important because for certain measures the quality of the data is so much better than you would get from claims, or even the other sort of administrative approaches.

Thanks, Tracy. Curtis Cunningham. Curtis, are you able to unmute?

There we go. Someone just unmuted me. Yeah, I mean, I totally agree. The efficiency and the speed of the electronic measures, they are very beneficial. In this forum, I do want to just make the point that EHRs and Meaningful Use, many of our behavioral health providers and home and community-based service providers are left out of that conversation and that funding, so I think that's something to, as a national issue, to address and continue to expand out so we can really have member-centered EHRs.

And then I'd also, to the extent we can use things like T-MSIS, I agree that what we're already reporting would be beneficial. And then, finally, within the social determinants of health, I think just as a prep for that, starting to think about, not that we might have measures right now, but as we think about Z-codes and other diagnosis codes to associate, CMS looking at encouraging the use of those diagnosis codes, because I think those are important to have in accessing the Medicaid population.

Thank you. Kim Elliott?

Thank you, Margo. I really do think that this is a fantastic opportunity, because digital measures are really designed to understand or use health information technology to increase the efficiency of quality reporting, but I think it also provides incentive to states to help plans to really connect to other data sources that they wouldn't typically use for performance measure reporting. And I think somebody already mentioned some of those, such as case management systems, different registries, vital records, et cetera.

But I think what is also really important to keep in mind is, we already use different types of supplemental data for performance measure reporting, and all of the supplemental data sources, whether they're standard or non-standard, do go through different validation processes to be used in reporting to ensure the integrity/validity of the data. So, when you think about the digital measures, it's really very similar to the supplemental data, but it does have very standardized processes, electronic processes, which really help validate and ensure the integrity and validity of the data that's being used.

So, if you think about it from that perspective, it's not such a new source, but it really is a solid source of data, and probably more solid than the supplemental data, because you've got all of the electronic processes built out, where it pulls some specific fields in the different data sources and puts it directly into the reporting system or a warehouse to go into the reporting system. So, from that perspective, it really provides a lot of efficiency for use of data and really expands the types of data that can be used for reporting.

So, I think you're going to see more complete results when you're reporting the data over time, and managed care organizations have gotten really proficient at using supplemental data, and more and more of that you see heading towards the standardized, where it doesn't require as much validation and oversight from auditors. So, I just view this as a really good opportunity to really strengthen the quality of the reporting that we do and create a lot of efficiencies while we're doing it.

Kim, thank you for those comments. I think it complements what Lindsay said and kind of extends that, as Lindsay, you were saying there is an administrative component. I think from what Kim is saying and from my understanding, there is a lot more up-front work that has to be done to standardize the fields and the dataset to be able to read into the specifications. So, yes, it does accommodate the data sources that are currently being used, but there's a bit more work up front that goes into ingesting the data.

At the same time, there's less work to take a specification, a written specification such as that for the Core Set and for states that are doing their own programming or using other vendors to do the programming, there's some tradeoffs there. So, it's not straight going into administrative data but taking the administrative data and mapping it, essentially, to the more standardized specifications. So, as Kim said, more complete, and also more consistent perhaps across states. So, thank you, Kim, for those comments.

Rich Antonelli?

Thank you. I wanted to emphasize a couple of points to really do some framing here. So, we're about two-thirds of the way through a CMS-funded project at the National Quality Forum, looking at EHR-sourced care coordination and care communication performance measures. Importantly, in the first year of that project, we were successful in asking CMS to agree to allow us to talk about what would EHR-based functionality be in order to get care coordination and integrated care outcomes.

And so I know that our group is focused on the measures, but I do want to let people know that some really important work needs to be done around the functionality of EHRs in order to have truly meaningful measures for outcomes. This is especially important if we're thinking about equitable outcomes. So, there is actually a bit of a digital divide, not just for the people that are served by health care delivery systems, but by the systems themselves. In other words, some of the EHR vendors charge more for certain types of functionality. So, I want to make sure that, as this group is looking at measures that are dependent on EHRs, that, in fact, there is pretty global access and equitable access to that functionality. This was alluded to, but I absolutely want to emphasize this, especially since we're talking about LTSS later on today.

You know, the electronic clinical data systems; people think traditionally in that clinical, AKA, medical space, the case management systems allows us to think about this. But I really want to encourage us, we're really getting to integrated person-centered care. We're going to think about other partners, if you will, collaborators, that go beyond those traditional clinical settings that would require APIs and some degree of interoperability, behavioral health, developmental, housing, social services, et cetera, critically important.

And then finally, I want to call out a resource that we're increasingly talking about in that NQF project, and this is the ONC's oversight of the so-called USCDI and USCDI+. USCDI actually gives the opportunity to define what those standard data elements are that could then feed into systems to achieve FHIR-enabled interoperability. And then I just learned a couple weeks ago that ONC also has so-called USCDI+. The target audience for USCDI+ will actually be governmental agencies, so giving us a pathway whereby we can connect public health with the delivery system connectivity. So, I don't know whether anybody on this call is familiar with either USCDI or USCDI+. We should be thinking about those.

And so, to sum, thinking broadly to get the whole person integrated outcomes, looking across beyond just a traditional medical, and then I think that this needs to be a journey, and I appreciate the conversation today.

Thank you, Rich. David Kelley.

Thank you. A few comments, on slide 13, if you actually look at those measures, the current measures, you know, from my standpoint, quite honestly, the majority of them, there is no gain toward electronic measurement. It's almost all, all can be measured through claims. In fact, the ADHD measure, the Breast Cancer Screening measure, we actually make our plans do ECDS, and they were reporting it the traditional way. There was very little to no difference. So, don't really see the value add there.

Where I would see the value add-on is things like the electronic measurement of hemoglobin A1C instead of relying on CPT-2 codes, or blood pressure measurements for diabetics, or blood pressure measurements for individuals with high blood pressure. To me, I see the much bigger value add there. Those two measures, quite honestly, the ADHD measure and the Breast Cancer, there is no gain in, quote, unquote, ECDS. The old, standardized admin measure got us to where we want to be. So, I do have concerns about the Colorectal Cancer Screening measure going ECDS. Again, that is, traditionally has been claims based, but include a chart review, and I think that's going to move more to claims-based in ECDS. So, there may be some under-reporting there.

I think that we do require our plans to do, I believe, the Prenatal Immunization and the Adult Immunization Status, and I think there's a huge value add there, because it's something that we haven't been measuring. But quite honestly, between administrative data and our linkage with public health and our immunization registries, it's nice to add that to the list. But the heavier lift really are those measures that we cannot get out of administrative data, and we can't get out of immunization registries, and that's where I think we really need to hit. And I think with the FIHR standards, we need to think in terms of really enabling us to capture information, maybe not just at the EHR level. I would actually advocate many EHRs are connected to health information organizations and push various types of documents. That's the level that health information exchange level where I think we really should be looking to do measurement.

So, I know that one thing that I would advocate is that CMS think in terms of perhaps some, I'll call them quality grants, which CMS did, I don't know, probably a decade ago. But I would advocate for quality grants to help states move toward working with their health information exchange organizations to actually start to collect data. State Medicaid programs can work with their health information exchange organizations to collect data and measure quality at the statewide and regional level.

And I know in Pennsylvania, we have five HIOs, and several of them are already moving in this direction and are working in one of NCQA’s programs. But I think there's huge value in moving to that level and not staying at just the EHR and health system level, that we actually need to be able to work at that health information exchange level and to aggregate and to extract, and I think the technology is certainly there. But I think having some specific funding to do that would really drive the process along. It would speed it up. Thank you.

Thanks, David. Jim Crall.

Thanks, Margo. I just wanted to pick up on a couple of the previous comments, the first by Curtis, about many of the health centers et cetera being left out of the Meaningful Use initiative. The same applies to dental practices. I think largely because of the threshold that was set for the proportion of patients that needed to be covered by Medicaid really left out a lot of dental practices.

You know, already the DQA, Dental Quality Alliance, did work with the Office of National Coordinator to develop an electronic measure that would essentially work for our sealant measure that we currently have in the Child Core Set. So, just make sure to keep in mind the variety of types of providers and clinical settings and operations, certainly as we move to more integrated type care delivery systems. And I know that some work is being done on the development of registries by various either states or other organizations, and I think that, and some software actually supports inclusion of both medical data and dental data, but there's a lot more that needs to be done to move towards more universal usage of electronic records.

The second point, and with that, and I think where that really gets to be important are things like, follow-up for ED care, where you have medical sector involvement on one hand, but the follow-up care, gets delivered by the dental care sector generally. So that's, I think, with respect to Curtis’, make sure that we're supporting infrastructure development that covers a broad range of services.

And then David's comments on the value of clinical information beyond just what we can obtain from utilization from claims is really also salient, because I think that the clinical information, really, one of the significant uses of that clinical information is helping to understand and adjust for population differences, patient population differences that is really important, I think, for value-based care, because we know that, depending on where clinical care is provided, which communities the health status of the individuals that are being covered, and that seek care in different places can vary. And so, for establishing just a baseline health status, as well as improvements in health status as a result of care, that's where I agree where the big bang for the buck from more robust clinical data is likely to come. Thank you.

Thanks, Jim. Michelle Schreiber. Derek, you can unmute Michelle.

Thank you all for the comments. I wanted to comment from a CMS point of view, and I recognize that I represent more on the Medicare side than the Medicaid side. But the transition to digital measures is really an important initiative across CMS for many reasons. We certainly learned during COVID that having access to data was essential, and we didn't always have it. And the story of digital measures is really the story of digital and interoperable data, and we're very supportive and have actually made the commitment that all of our measures will ultimately transition to digital measures.

So, I think the ECDS measures, even if they can be used in some fashion so that organizations can start getting used to working with digital measures may have a benefit there. With the digital measures there, clearly, you can get data more timely. You can share it with others. It could integrate with clinical decision support, leverage for advanced analytics, such as slicing and dicing, looking at populations, looking at subsets of populations. It gives you the ability to do that quickly.

Because there's the requirement now for systems to have FHIR, and to have FHIR APIs, we think that there's a good way of transmitting information. And I guess for the states and the state Medicaid agencies, I would stress, because we know that we are all moving in this direction, and that we need to, as part of, really, the digital transformation of health care writ large, that there's a lot of opportunities, as others have said, for states working with health information exchanges, now with TEFCA [Trusted Exchange Framework and Common Agreement] having been made public for ONC to develop those relationships, to ensure that we're connecting public health across the states and having all of the data that we need to have available.

I am the CMS representative to the USCDI Task Force, as well as USCDI+. I know somebody had comments and wanted to know about that. I think that that's going to be essential work as we define the standardized data elements that go into all of this, because if we start down the path of not having standardized data, we're going to run the risk of having chaos there. So, I would just really support the work of digital measures, of the states and state Medicaid agencies starting to use them in some form so that they can get used to it, recognizing that there are clearly gaps. There are gaps in places that were not touched by Meaningful Use and don't have the same EHR capabilities, but that everybody really needs to be building towards this, because that is an overarching goal of CMS, so thank you.

Thank you, Michelle. I'm curious to follow up also on David’s comment, whether there are any resources that your group, or others, that you're aware of, have to provide technical assistance to states to help them build the capacity, or to link into other existing capacities, such as HIEs or registries?

The quality improvement organizations have been doing some work when it comes to supporting digital, not just measures, but digital access in getting organizations and providers used to digital data. For example, they supported the providers in particular using digital data for the MIPS program. I don't know if there are other, I know David was talking about maybe having quality grants. I don’t know that those exist right now. But there has been quality improvement support, and I'll certainly take back the concept of quality grants, because I think it is true that something to kickstart this and help would be beneficial. But I do want to point out that this is where the industry is moving, and I think we have to take some steps in that direction.

Thanks, Michelle. I think that's part of the motivation for this special topic this morning because we want to make sure that Medicaid is represented here and that we've had a chance to talk about it publicly, so that's really helpful. Maybe we’ll get back in touch with you about USCDI and USCDI+.

Yep, I would be happy if there are people that want to talk about that at any time, just feel to reach out.

That's great. Thank you. Other comments from Workgroup members? Feel free to unmute and jump in. Curtis Cunningham.

I'll just add another area that EHRs are not implemented in is nursing homes and ICFs. That is another area of coordination that is lost, often papers being sent to hospitals from nursing homes, so just adding that to the list of various provider types that are not necessarily included in the full EHR conversation.

Thank you. I'm wondering if there are any other states that wanted to comment about their current capacity, needs for technical assistance, challenges that they anticipate, particularly when there's multiple different systems? I see Amanda Dumas.

Yes, hi. Thank you. I'm from Louisiana, and I can just speak to our experience there, which is that we do have an HIE pilot that's been launched in the New Orleans area, and so it's something that the state has wanted to move towards on the broader scale but just does not have the capacity right now. And we're talking about technical feasibility, that's just our limitation currently. Of course, this is where we all want to go, and it's the data that we want as well, but it's going to be an incredible lift to get the whole state integrated in a way that we can have meaningful information.

Thanks, Amanda. Rich Antonelli.

Thank you. So, Michelle, I'm so excited that you happen to be the USCDI person. Thank you, thank you. Margo, what I wanted to talk about is the opportunity to measure and include input from patients themselves. So, as we think about EHR-based information, I'm reminded that, you know, not too long ago, care coordination was, “Did Dr. Antonelli send Dr. Kelley a document?” And that was considered measurable care coordination. This may likely go into Day 3 when we go into prioritized gaps, but I feel it's really important to think about the impact that interoperability with the patient truly at the center, not just pediatrics but adult care as well, to be able to say, did that handoff actually occur, and did you get the outcome that you wanted. This will be incredibly important when we get around to the notion that Dan Tsai framed for us yesterday, that person-centered integrated plan of care. So, we should all be mindful about the opportunities for patient-reported outcomes in this space.

Thanks, Rich. Linette Scott.

Thank you. I just want to come back and echo some of the things that folks have talked about, I mean, T-MSIS, USCDI, the interoperability rule, NCQA accreditation activities. There's a lot going on in this space, and it would be, I think, really helpful if CMS or partners could think about, what does a timeline look like and how do we draw the connections between all these things. So, I know, as a chief data officer, I work with all of those things. We're implementing with interoperability rule. We're dealing with T-MSIS data quality issues. We're working on Core Set measures. So, we sit in that juncture. But it would be great to see kind of a coordinated plan that says sort of, like, over the next three to five years, here's how these things build on each other, support the process, and get us to where we're looking for.

I've been working with HITECH since day one, and so we're finally getting to that point where we have opportunities. There's enough of a base with electronic health records that we're going to be able to actually do this. But we still have pockets that have gaps, and folks have mentioned that. So skilled nursing facilities in particular, to echo on that. There's some of the different areas, like around behavioral health and dental that maybe didn't get as much attention under the HITECH programs in terms of advancing. And then I know, like, one of the things that's come up on some of the T-MSIS conversations, there's a variety of states, and California is one of them, where we still have some local code use that then makes looking at things nationally challenging, and some of that goes to systems that are probably a few years beyond when they should have been used, so they don't have the flexibility to incorporate some of the codes. So, there's a lot of pieces in play.

I think I’m also hearing folks say, we definitely need to move in this direction. Having some sort of mandate, guidance, direction, expectation will certainly help get us there. And so having that cohesive view of how these things come together would be I think, really, really helpful. And I appreciate all of the conversation around this. Thank you.

Thank you. Katelyn Fitzsimmons.

Thank you. One thing I haven't heard anyone speak to is electronic visit verification, and I know that’s a requirement moving forward for people, you know, getting home attendant services and personal care. And I think there's a lot of opportunity there to capture electronic data that is shared back with health plans and state partners, and I see a lot of the EVV agencies kind of shifting gears into providing additional or supplementary care coordination, so that's a large opportunity we could leverage as well.

Katelyn, can you say a little bit more about what types of information could be garnered from EVV systems?

So, any type of incident reporting that we may not be aware of, individual social drivers, social drivers of health may be caught in those types of discussions, brought between the caregiver as well as the member. There's opportunity for members’ caregivers to provide input into these EVV data health sets as well, and we have to also consider the implication of caregiving on our membership, because, of course, you know, if they are supported, it will prevent burnout and decrease institutionalization. But tons of metrics are being captured in EVV systems, especially as many of them pivot to become like adjunct care coordination teams. So, they're capturing measures and information about individuals that would be self-reported that may not be part of our standard assessment process.

Thank you. I just want to check, we have Tracy Johnson, you still have your hand raised. Do you have another comment? Or Jim Crall? Do we have any other Workgroup members that have comments? Michelle Schreiber.

Hi. I do have one comment, specifically to the Medicaid state agencies and the Medicaid plans. I think one of the challenges of all of this, you know, transitioning to digital, is to make sure that the digital divide doesn't become the new equity problem that we have. And to the extent possible, especially through Medicaid patients, making sure that they actually have access to internet, access to broadband, and I know there's work about expanding broadband, knowing how to use some of these technologies. Because when we talk about having patients have access to their records or patients being allowed to input into their record, or caregivers who can look at this, we need to make sure that patients actually have access and have knowledge around this, again, so that it's not the new equity divide. And I think any way that the Medicaid plans can encourage that would be really worthwhile.

Thank you. Other Workgroup comments before we move into public comments?

Hey, Margo, this is Dave Kelley. I re-raised my hand.

Good. Go for it.

Just a couple things; so, appreciate Michelle's comments on kind of the digital divide, and that’s one of the reasons why, at least in Pennsylvania, we're continuing to do telemedicine via telephone only because of some broadband issues and access issues, both in rural, but also urban areas.

To Rich's comment, I'd really like to think in terms of using electronic means to capture patient experience in, let's say, a more timely fashion. So, imagine if we actually had a home and community based CAHPS or regular CAHPS surveys being done electronically and we actually had results back, and they were actionable within a month or two, instead of, I don't know, the 18-months or 12-months lag that we currently have to deal with.

I also think that on the EVV question, that's really an interesting point to raise. I think that we've challenged our LTSS plans to think in terms of how to leverage that to identify, let's say, missed shifts, or if somebody has gone to the hospital and no one knew about it. So, there are various ways that an EVV might be able to be leveraged to reduce, let's say, missed shifts or to provide kind of indirect notification for hospitalization, or even discharge back to home.

One of the other things that we've done in Pennsylvania with our HITECH funding, which is now gone, is we've done onboarding grants over the years, including to our FQHCs to make sure they're linked into our key primary patient-centered medical homes. We also have onboarded nursing homes. And despite those efforts, I would say about a third of our nursing homes in Pennsylvania are linked. They have an EHR, but they are actually linked to do health information exchange.

So, I think, again, to put a plug in for, and I know ARRA HITECH is gone, but it would be really nice to be able to continue some type of funding streams to increase onboarding of provider types that have been left behind, because you can get an EHR. But if you have no way to exchange that meaningfully to a health information organization, it's just not as functional as it could or should be in gathering quality and other data elements. So, I'd really advocate ongoing funding for onboarding grants. We mentioned behavioral health providers have somewhat been left behind. Dentists were included in the initial, but, again, some of the requirements made it tough for them to take advantage of that funding opportunity.

And lastly, I think being able to, whatever we do with social determinants of health, if we can incorporate that into health information exchange, I think that's going to be valuable. We just actually released an RFA to do that with our health information organizations. So, I think we really need to move forward with our digital strategies. I'm hoping by the end of this decade that we actually get there, and I hope it's much sooner than that. But, you know, having dealt with, it took really a decade of ARRA HITECH super funding to get us to where we're at now. Hopefully it doesn't take that much funding or that much effort to continue to move the needle. But I think a focused effort around for both providers in Medicare and Medicaid would be very, very helpful.

Thanks, David. I just want to check, Katelyn, do you have one more comment?

Yes. Thank you. About the EVV reference regarding hospitalizations, that's a huge way that we are able to identify our non-aligned duals’ hospitalizations, because we are required to complete an assessment after discharge. But oftentimes, if they're not our aligned dual member and they belong to another health plan, we don't have information about that discharge, potentially ever, unless the member informs us. So, we have been using EVV to catch those hospitalizations, intervene early, participate in a discharge planning, and then we assess the members' needs post-discharge.

Great. Thank you. All right, next slide, please. So, now we'd like to provide an opportunity for public comment. We have about ten minutes allotted. If you'd like to make comments, please use the raise-hand feature in the bottom right of the participants' panel to join the queue, and then lower your hand when you're done. And we'll let you know when you've been unmuted. Do we have any public comment? Do we have anyone that would like to make a public comment before we turn to the break? One last call. All right. Well, it doesn't look like we have any members of the public that would like to make a comment.

This was an incredibly robust and informative conversation, and very wide ranging, so thank you to all the Workgroup members, and also, Michelle Schreiber, for your contributions this morning. With that, we'll take a ten-minute break and be back, actually, we'll give you even longer, because we did not have public comments. So, be back by 12:25, so a little bit longer than we had been planning.

But I want to first say, before we do break, to the Workgroup members, we ask that you sign onto the voting platform at this point during the break, and make sure you're on the waiting screen that says, “Welcome to the Core Set Review Voting Platform,” again, “Welcome to the Core Set Review Voting Platform.” If you have any problems, please get in touch with us via Q&A, and we can help you troubleshoot. That will make the afternoon go a whole lot more smoothly. So, thank you again for wonderful comments and discussion today. I think lots of action items for CMS and others, and with that, we will break for a little bit of time. Thank you.

BREAK

Welcome back everyone. I'm now going to turn it over to Chrissy to cover our first domain of the day, Primary Care Access and Preventive Care. Chrissy, it's all yours.

Thank you, Margo. Next slide. So, I'm going to go through the Primary Care Access and Preventive Care Domain. Next slide. This is a big domain, so let me give a quick overview of the current measures in the 2022 Child and Adult Core Sets. First, the measures in the Child Core Set include Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents, Chlamydia Screening in Women Ages 16 to 20, Childhood Immunization Status, Screening for Depression and Follow-Up Plan: Ages 12 To 17. This measure has been suggested for removal, so we'll go over it in more detail shortly.

Next, we have Well-Child Visits in the First 30 Months of Life, which is an updated version of an earlier measure that focuses on the first 15 months of life. The number of states reporting for FFY 2020 is for the previous version of the measure. Next slide.

Morgan, can you go to the next slide? Thank you. I think, did we skip a slide? Can we go back one? Sorry, everyone, just some technical difficulties with the slides here. Okay, here we go. So, the other Child Core Set measures in this domain are Immunizations for Adolescents, Developmental Screening in the First Three Years of Life, and Child and Adolescent Well-Care Visits. This third measure is a combination of two previous measures, namely Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life, and Adolescent Well-Care Visit measures. These are among the most frequently reported measures in the Child Core Set. Next slide.

Okay, so here are the measures in the Adult Core Set, including Cervical Cancer Screening, Chlamydia Screening in Women Ages 21 to 24, Colorectal Cancer Screening, which is new to the 2022 Core Set. Next, Flu Vaccinations for Adults Ages 18 to 64, which has been suggested for removal, Screening for Depression and Follow-Up Plan: Age 18 and Older, the same as the child measure, but with a different age range, and has also been suggested for removal, and, lastly, Breast Cancer Screening. And those are the existing Primary Care Access and Preventive Care measures in the Core Sets. With that framing in mind, let's turn to the measures suggested for addition or removal we'll be considering today. Next slide.

Okay, our first measure is Flu Vaccinations for Adults Ages 18 to 64, which was suggested for removal. The measure is derived from the CAHPS 5.1H Adult Medicaid Survey. The measure is defined as the percentage of beneficiaries ages 18 to 64 who received a flu vaccination between July 1st of the measurement year and the date when the CAHPS survey was completed. The measure steward is NCQA and it is no longer NQF endorsed. The Adult Immunization Status measure was suggested as a replacement for this measure, and I will present that measure shortly. Next slide.

Twenty-eight states reported this measure for FFY 2020, all using Core Set specifications. This measure was publicly reported for the first time for FFY 2020. State performance data are available in the measure information sheet that's available on our website. We also wanted to note that NCQA has proposed to retire the FVA measure for HEDIS measurement year 2023, which corresponds to the 2024 Core Set.

NCQA has indicated that the Adult Immunization Status measure will be publicly reported in measurement year 2022, which they noted presents an opportunity to streamline the adult immunization measures in HEDIS. They further noted that stakeholders have suggested retiring the three CAHPS immunization measures that rely on patient recall and focusing on Adult Immunization Status, which provides specific clinical information about vaccination.

This measure was suggested for removal for a few reasons. First, the Workgroup member who suggested this measure indicated a concern about the validity, reliability, and representativeness of the measure given low response rates on the CAHPS survey. The Workgroup member also noted that while states are making progress in reporting the measure, the data in the AHRQ CAHPS database are incomplete due to lack of submissions by states and plans. Finally, the Workgroup member suggested an alternate measure to assess flu vaccination rates, which we'll review shortly. Next slide.

The next measure suggested for removal is Screening for Depression and Follow-Up Plan, which is in both the Child and Adult Core Sets with different age ranges. Note that while this measure is included in the Primary Care Access and Preventive Care domain, it is part of the Behavioral Health Core Set, which means it will become mandatory for states to report for both age ranges, starting with the 2024 Core Sets. The measure is defined as the percentage of beneficiaries age 12 and older screened for depression on the date of the encounter, or 14 days prior to the date of the encounter, using an age-appropriate standardized depression screening tool and if positive, a follow-up plan is documented on the date of the eligible encounter. The measure steward is CMS, and it is no longer NQF endorsed. The Depression Screening and Follow-Up for Adolescents and Adults measure was suggested as a replacement for this measure. And I will present that measure in a few slides.

Fourteen states reported the Child Core Set measure for FFY 2020, two of which indicated substantial deviations from Core Set specifications. And 15 states reported the Adult Core Set measure, three of which indicated substantial deviations from Core Set specifications. The deviations included using a hybrid methodology even though the measure is not specified for medical record review. A Workgroup member suggested the Child and Adult versions of the measure for removal because states report significant challenges in accessing an available data source that contains all the data elements necessary to calculate the measures, and because the specifications and data source do not allow for consistent calculations across states.

The Workgroup member noted that with states not consistently using the Core Set specifications, results are not comparable across states and reported results may not represent accurate information regarding the quality of care for Medicaid beneficiaries or state performance. The Workgroup member also indicated that all states might not be able to produce these measures by the FFY 2024 Core Set reporting cycle, or may not be able to include all Medicaid and CHIP populations. Next slide.

Okay, we're moving now to the measures suggested for addition. The first is Adult Immunization Status. This measures the percentage of adults 19 years and older who are up to date on recommended routine vaccines for influenza, tetanus, and diphtheria (Td), or tetanus, diphtheria, and acellular pertussis, or Tdap, zoster, and pneumococcal. Note that the Medicaid rate includes beneficiaries ages 19 to 65 and excludes pneumococcal vaccines. The measure steward is NCQA, and the measure is NQF endorsed. The data collection method is HEDIS Electronic Clinical Data Systems, or ECDS, and, as noted earlier, the measure has been proposed as a replacement for the FVA-AD measure. Next slide.

Here you can see the denominator and numerator definition for the measure. I won't read through all of these details but wanted to note that the measure includes three individual vaccine rates with different age ranges for the Medicaid population. Next slide.

We also wanted to highlight some proposed changes to the measure for HEDIS measurement year 2023, which corresponds to the 2024 Core Set. First, NCQA has proposed some updates to the population included in the Pneumococcal Indicator. Second, to address concerns that commercial and Medicaid plans to report the measure only for younger adults, and Medicare plans report only for older adults, NCQA has proposed that all three product lines report the measure for all adults. In addition, they have proposed adding age stratifications to assess measure performance among members ages 18 to 64, 65 and older, and all ages combined. The Workgroup member who suggested this measure noted that national surveillance data showed coverage for recommended adult vaccines is generally lower for adults with public health insurance than for privately insured adults.

The Workgroup member commented that inclusion of this measure in the Adult Core Set will not only help states to enhance monitoring of adult immunization coverage but could also reduce morbidity and mortality from vaccine-preventable diseases across the lifespan. The Workgroup member noted that the only immunization related measure currently in the Adult Core Set is the Flu Vaccination for Adults Ages 18 to 64. Addition of the Adult Immunization Status measure will close the gap in states’ ability to monitor uptake of all routinely recommended adult vaccination. Next slide.

The next measure suggested for addition is Depression Screening and Follow-Up for Adolescents and Adults. This measures the percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care. Two rates are reported. The depression screening rate is the percentage of members who are screened for clinical depression using a standardized instrument, and the follow-up on positive screen rate is the percentage of members who received follow-up care within 30 days of a positive depression finding. The measure steward is NCQA and the measure is not endorsed. The data collection method is HEDIS Electronic Clinical Data Systems, and the measure has been proposed as a replacement for the CDF-CH and the CDF-AD measures. Next slide.

An NCQA report showed that performance rates for this measure vary by data sources used for reporting during measurement year 2020. All Medicaid plans that use claims-only data to report on depression screening rates had performance rates of zero percent. The mean rate for Medicaid plans that use any non-claims data source was 5.7 percent, and the median rate was 0.6 percent. The measure steward commented that the low observed performance rates are likely due to health plans’ challenges accessing the clinical data needed to produce a valid rate.

The Workgroup member who suggested the measure for addition cited evidence for the effectiveness of conducting depression screenings in the primary care setting and providing early intervention for depression. According to the Workgroup member, depression rates have increased over the last three years in their state, and this measure can be used to ensure that populations are screened for depression at a higher rate than they are currently. The Workgroup member acknowledged that non-claims data, such as electronic health records, case management, or health information exchange (HIE) data, may not be available across states and that technical assistance may be required to help states connect to their HIEs. Next slide.

The next measure suggested for addition is Lead Screening in Children. This measures the percentage of children two years of age who had one or more capillary or venous lead blood test or lead poisoning by their second birthday. The measure steward is NCQA and the measure is not endorsed. The data collection method is administrative or hybrid. The measure steward noted that they are considering retiring this measure in the future since the U.S. Preventive Services Task Force has given universal lead screening of children age five and younger an “insufficient evidence” rating. NCQA has not yet determined the timeline for this potential retirement.

The Workgroup member who suggested this measure for addition noted that lead exposure remains a significant public health concern for some children and that there is no safe level of lead for children. Even at low levels, lead exposure has the potential to have long-term metabolic and neurologic consequences. According to the Workgroup member, ensuring that all at-risk children are tested for blood lead levels would facilitate connecting them to follow-up services. They noted that there is substantial room for improvement on lead screening rates and that state Medicaid and CHIP programs can directly influence improvement by working with state health departments to exchange data and enact policies that require reporting of lead screening metrics. Next slide.

The final measure suggested for addition in this domain is Adults’ Access to Preventive or Ambulatory Health Services. This measures the percentage of members 20 years and older who had an ambulatory or preventive care visit during the measurement year. The measure steward is NCQA and the measure is not endorsed. The data collection method is administrative.

The Workgroup member who suggested this measure for addition noted that it aligns with a CMS health care priority: Working with Communities to Promote Wide Use of Best Practices to Enable Healthy Living. According to the Workgroup member, wellness visits can subsequently reduce emergency room department visits. The Workgroup member also noted that there is room for improvement on the measure, and that states can influence improvement by using levers such as managed care organization contracts, and other initiatives. Next slide.

So, that wraps up our list of measures suggested for addition or removal in this domain. I will turn it back to Margo to facilitate the Workgroup discussion.

Wow, thank you, Chrissy. That was quite a lot to absorb. So, the way we're going to do this discussion is to go a couple measures at a time, and, first, talk about the Adult Immunization Status measure and Flu Vaccinations for Adults Ages 18 to 64. The Adult Immunization Status measure was suggested for addition, and Flu Vaccinations for Adults Ages 18 to 64 suggested for removal. So, we'd love to open it up at this point for our Workgroup members to talk about their reactions or perspectives on these two measures. And just a reminder to please raise your hand. Do we have any comments? Lindsay Cogan. Lindsay, are you able to unmute yourself?

Got it, uh-huh. Great. So, thank you. I think that the removal of the Flu Vaccination measure makes sense, right, because unlike the discussion around the Smoking Cessation, this measure is actually up for retirement, according to public comment from NCQA. So, I think this is the time. You have a measure steward no longer supporting it, so that would put a burden on states. If it were left in the Core Set, states would then have to figure out how to do this on their own. And, unlike the smoking measure, we now have a proposed replacement, so it would alleviate that concern that there would be a gap in the Preventive Care domain, as well as it allows the encompassing of additional adult immunization measures. I think this is a good example of where the retirement and replacement of a measure makes a lot of sense.

Thanks, Lindsay. Rachel LaCroix.

Okay, great. Thanks, Margo. I agree with the points that Lindsay just made. I would just like to also acknowledge, and this was part of the information given in the background for this measure as well, that not all states cover adult immunizations for their whole adult population. And I know for Florida Medicaid, we do not, and so that's one of the reasons we had not been reporting on the current survey-based measure. But I just feel like we should keep that in mind and have that be something that may be included as a caveat around publication or display of this metric. But I agree that switching over to the new HEDIS Adult Immunization Status measure makes sense for all the reasons that Lindsay mentioned.

Thanks, Rachel. Linette Scott.

So, I agree with Lindsay. And I know we talked about this measure several times in the past in terms of removing it and replacing it with the Adult Immunization measure, and just echoing Lindsay's comment that I think is now finally the right time to do this, so strongly support removing this one and looking at the replacement measure.

The other thing I would say is, is because of the COVID pandemic, there's been a lot of work on immunization registries and immunization reporting for all ages that maybe hadn't occurred previously, so there may be better ability to support some of that. But to the previous speaker's point, one of the things about adult immunizations is that there's not as much of a requirement around reporting those, and so it does vary state to state. But this measure, it looks like, would be in the Adult Core Set, which is not mandatory reporting. So, that maybe gives cover for states that don't require reporting related to the adult immunizations, and this may then be an opportunity to have that be rethought across the different states to think about that in terms of what that looks like. Thank you.

Jill Morrow-Gorton.

I'd like to ditto Linette and Lindsay. I think that now that we have a replacement for this measure, that it relies on recall, and done in a period of time that may not be conducive to that, is problematic. I think the other thing that we have to consider is that the CAHPS has had a significantly declining response rate over the last few years, and I worry about the error of non-response. So, who is it that is not responding to the CAHPS? And it becomes more and more difficult to get people to respond.

The other thing that, so this is putting my former practice hat on, we used to approach immunizations in children, and I'm a pediatrician, who had insurance that did not cover it, and this is years ago, by referring them to their local health department. So, I think that even if the state Medicaid program does not cover it, there are ways to potentially get it for people, and that practitioners should be thinking about that. And this, as a digital measure, may pull in all of the Health Department and other data, so that may be a way to capture it.

Thank you, Jill. Ann Zerr.

I am the biggest proponent of immunizations in adults. I'm an adult internist, and they're horribly underutilized, and there's always an outbreak of something in the adult population. I was really surprised to hear that Florida doesn't cover it for their adult folks. The way that health departments have traditionally been able to give vaccines is through the Vaccines for Children program, and so that's an unreliable source for adults, and at health departments, if you're uninsured, they still frequently charge an admin fee, so I think we have to be really, really sensitive to the out-of-pocket costs. That said, I think we need some measures, and I think that these are very important public health measures for adults. But relying on public health departments and a second stop for members who are already very difficult to serve, and perhaps quite vaccine hesitant, I think, is really going to be a huge challenge for those states.

Thanks, Ann. Other comments on the immunization measures? Rachel and Linette, it looks like you still have your hands raised. Do you have other comments? Erin Abramsohn.

Hi. This is Erin. So, regarding the Adult Immunization Status measure, I echo what others have said. Since this measure was last proposed, health plans have had additional years of experience reporting this to HEDIS, and there has also been substantial additional attention paid to tracking new measurement of adult vaccination rates due to the COVID-19 public health emergency, and the pandemic has emphasized the importance of all immunizations. So, this measure is more comprehensive, as others have said, and captures five adult vaccination measures versus simply adult influenza. So, also echoing if the Flu Vaccinations for Adults measure is dropped, then there would be no adult immunization measure on the Adult Core Set, so this may be the time, as others have said. So, thank you. Appreciate it.

Thank you, Erin. Do we have other comments on these two measures before we move on to the Depression Screening measures?

Hey, Margo, this is Dave Kelley. I just raised my hand. I have a question. This is an ECDS measure, and let's say we vote to remove the CAHPS question, and the ECDS measure remains in limbo. Is that a possibility? I'm just raising that as a question. Otherwise, I'm highly supportive of everything else that has been said. I don't want to be left high and dry without looking at especially influenza, but the other conditions that we're immunizing for.

Right. So, I think by virtue of your comment, what you were suggesting to CMS, and I don't mean to put words in your mouth, so tell me if I'm misrepresenting, that if we vote to remove the FVA measure from the Core Set and we vote to recommend addition of Adult Immunization Status, and CMS still has a deferral on ECDS measures, the recommendation you are suggesting is that CMS consider not removing flu vaccinations until it's been worked through. Is that kind of what you're saying?

I was posing it as question. I know we can't, I mean the structure of voting is, it's yes and no.

Right.

But it might be contingent, I mean, we can say yes, but in essence, if CMCS is not going to move forward with an ECDS measure, then that could be a problem.

Right. So, I think that what I recommend to the Workgroup is you vote on the merits of these individual measures, what your recommendation is, and then CMS will take that under advisement when they make their decision. So, I hear what you're saying is that there's a contingency here, but CMS is hearing this, and so they very much understand. And there are a lot of people who are very focused on adult immunization, and, particularly, influenza. So, I think what you're saying is that we'd like to vote the way we think about the merits of these measures, but then also recognize that there are other decisions that will need to get made. So, I think CMS is hearing what you're saying. But my recommendation is for the Workgroup to vote on the merits of those measures. Does that work for you, David?

Yes. Thanks, Margo. That definitely works. And, again, in the spirit of our previous discussion, I mean, to move to something that's administratively a lot easier than a CAHPS survey. For those states that don't do the CAHPS survey, obviously, hopefully, this would make it easier, so thanks.

Ann Zerr, do you have a comment?

I do. At Indiana Medicaid, we were just looking at the cost of these vaccines, and I think many of the Workgroup members and the folks for public comment understand the cost of these vaccines. So, if it's out of pocket for patients, the zoster vaccines are $150 to $250 per vaccine, and the new pneumococcal vaccine is $300 a dose, so that's just a thing that we have to remember with our members when they're not covered by their insurance plans, by their Medicaid agencies.

Thanks, Ann. And just also as a reminder, the order of voting is that we will vote on the measure to be added first, and then the measure to be removed, so that will be the order of operations here. Lindsay Cogan.

Just something to include in the public comment. So, I think that CMS can reserve the right to decide to require or report on certain indicators but not others. So, the example that comes to mind is childhood immunization, right? So, childhood immunization is a measure that is made up of multiple components. But in the Core Set, it’s the combo of three. So, just something to think about in relation to the last comment, you know, particularly if we're worried about a particular indicator, like pneumococcal or others, not to say that we are. But I do think that CMS should consider that or bring that back as a potential idea as well. When they add a measure, they don't necessarily have to require each component or report out on each component if they feel it's not representative.

Thanks, Lindsay. So, with that, I think we should move on to the next two measures, and those are the depression screening measures. As you’ll remember, there is the Depression Screening and Follow-Up for Adolescents and Adults for addition, and then the Screening for Depression and Follow-Up Plan for removal, we have two measures, ages 12 to 17 in the Child Core Set, and age 18 and older in the Adult Core Set, those are CDF-CH, CDF-AD, and these measures would be subject to mandatory reporting because they are in the Behavioral Health Core Set. So, who would like to speak about these measures? Rich, do you still have your hand raised?

Yeah, I do. I'll ask the question relevant to the prior measures. Do we have experience with race, ethnicity, language, or disability status for any of these measures yet, including the two that we’ve pivoted to? But, you know, if the Chairs will allow to have a minute of discussion about stratification on the prior two measures.

We do not have any experience with that.

For any of the measures now, the behavioral health, as well as the two immunizations?

Correct. We do not have experience with stratification of these measures.

Okay. Thank you.

Thank you. Jill Morrow-Gorton.

I was just going to say I believe that for both the Adult Immunization Status and the Depression Screening and Follow-Up for Adolescents and Adults, that the race, ethnicity, et cetera, stratification is proposed for 2023.

That's correct. Thank you, Jill, for that clarification. But in terms of experience for Core Set reporting, there is no current experience. Thank you. Curtis Cunningham.

For the race/ethnicity/language, I just want to put out there that one of the conversations we are having is what is the standard way to report, and where does that reporting occur within our Medicaid program. And so just some feedback for that, if there's going to be stratification that is across states, I don’t think there's any consistency or definitions in those data elements, so it's something to consider.

Right. It's a great question, Curtis. NCQA uses the OMB standard, as does CMS, so that would be the standard that I think would be expected. So, you've raised two questions. One is about the reporting side on how it would be measured. The other is how are the data collected. Two separate issues about how a state would collect that information, versus how it would get reported. But that is the plan, is that it would be using the OMB standard.

Other comments about the depression screening measures? Oh, my gosh, a lot of people just raised their hand. Why don't we hear from David Kroll next.

Hi. Thanks, Margo, and thanks everyone. So, you know, I guess I'm looking at this with sort of two questions here, because I think that it's not really a straight shot of, like, whether or not one of these depression measures is better than the other. But it's really also, I think, whether or not any depression screening and follow-up measure should be included, and so I'm trying to kind of separate those two questions out in my mind. And I don't have any sort of super strong ideas or opinions about which measure is better than the other, and I look forward to what other people have to say.

But I do think that it is important to note that what is really critical about these measures is not just that we are screening for depression, but that we are using a standardized screen. And it's becoming increasingly accepted, certainly within the field of psychiatry, and I believe other behavioral health specialties as well, that the standardized approach and using standardized methodology to screen for and then manage depression is essentially synonymous with higher-quality care. And so, I want to make sure that people consider these measures, that we recognize that the value of this is that the standardized screening, while on its own is not necessarily going to drive better outcomes, is really the lynch pin of high-performing clinical services, including collaborative care and measurement-based care services.

There had been a comment about whether or not, particularly among the adolescents, the Depression Screening would be covered by another measure of a well-child visit. And I want to make a case that that's not really true, because while the well-child visits do screen for psychosocial issues, and of course any pediatrician can correct me on the details about this because I'm not a pediatrician, what's really unique about the Depression Screening measure is that it really does call attention to the standardized approach, which is so important for defining quality care.

Thanks, David. Anne Edwards.

Yeah, thanks, David. And maybe, as the pediatrician, I'll weigh in on your question around the well care first. Certainly, included in a well care would be a psychosocial evaluation, which we would encourage the use of a standardized screening. But I guess the uniqueness of this depression screen is that this can occur outside, and while we would all like high-performing systems to have high rates of adolescent well care, we know that the case may be adolescents may seek care for other conditions, and this measure actually would use those encounters to have this standardized screening.

You know, I think I concur that, I think as you consider both of these, there are needs for technical assistance in different ways, and I think listening to the conversation this morning, trying to work through where we might be going in the future for some of these measures, forward thinking, so that we can really understand performance and improve upon that, but I think core to us as pediatricians and thinking about adolescents, and I think I'll let others comment on the adults, and would think that it's probably similar. This is a high-focus area. There's a great need here to understand this and continue to do improvements, so would definitely favor that we continue to have a measure on depression screening in the set.

Thanks, Anne. Tricia Brooks

Yes, and Anne spoke more eloquently than I can. I think everyone knows that the AAP and the American Academy of Child and Adolescent Psychiatry and Children’s Hospitals have declared a national emergency in mental health for children that certainly has been accelerated by the pandemic. So, I too, believe strongly that we need a measure in here, and I'm really glad that I think it was maybe two years ago that we went to the method of, you know, considering removal and addition or substitution, in, you know, a single vote. I think that this is another place where that kind of process is really important. Thank you.

Amanda Dumas.

Hi. Thank you. I'm just wanting to speak to the fact that I also really think this is important. I'm a pediatrician. I do primarily adolescent health, so this is my bread and butter. I want to note, though, that the data collection for this measure really relies heavily on those electronic clinical data systems, of which a lot of states aren't really prepared. Right now, I don't know how you'd find any of the multiple screenings I do in a week unless you go to the EHR. So, it's not in claims. It's not reported separately. It's not reimbursed separately right now, so I think it could be really challenging to get meaningful data from this.

Thanks, Amanda. David Kelley.

Thanks. Yeah, this is, really, a challenging topic and, again, gets to the previous discussion around moving towards electronic digital measurement. And I think that is the wave of the future. In Pennsylvania, it's kind of back to the future. We are working with our patient-centered medical home learning network that has over a thousand providers in it to actually, there is an administrative way to actually capture this measure. And kind of one of our interim steps is that we're going to be educating that network of patient-centered medical homes on how to actually pay for, or not get paid for, but actually put it into claims according to and following the specifications that are currently out there. So, there is an administrative capability, and it's going to take an educational effort, but it might be a step along the way as we hopefully move towards digital capturing and measurement.

We know from chart reviews that we've done that PCPs are doing this. They are screening. And, actually, we did this in the sub-population of pregnant women. We know that a validated tool is actually being used. So, we know that a lot of this activity is being done by primary care, and others, without being paid extra. So, I would advocate, even though these are really a challenge, I would advocate keeping them on the Core Set. And I think I could be corrected, but these are not part of the, quote, unquote, Behavioral Health mandatory reporting, at least for adults. So, the pediatric one may be mandatory reporting at 2024. But for adults, I don't think it's mandatory reporting.

Actually, David, it is. It is considered part of the Behavioral Health Core Set.

Oh, it is?

Even though it's different domain, yes, it is considered part of the Behavioral Health Core Set.

Okay.

So, whichever measure, if a measure remains or a measure is added, it would be mandatory.

Thank you.

Sure. All right, I see a lot of hands raised and I'm not sure if they are leftover hands or new hands. So, Linette Scott.

Hi. Yes, in California, we've already been working towards adopting the replacement measure, so would support the removal, and then the addition related to the depression measure, and we are planning to use that with our managed care plans and have incorporated that into our accountability set that we're using with our managed care plans, so agree with the importance of depression screening and would very much support switching out the measures as proposed in terms of removal and addition. Thank you.

Lindsay Cogan.

There's a couple of differences between the two measures that I just want to highlight. In New York, we are also moving towards the new NCQA measure. But I do want to hear from our colleagues as far as Medicare. So, this is one measure that we put in here with the sight of alignment, because it's used in the HRSA set. It's used in Medicare. It's used in many different places. So, I just want to highlight, there is an alignment issue here that we want to be cognizant of.

But the difference between these two measures is that the current one requires a face-to-face medical visit, and in the new measure from NCQA, that is no longer the case, so you're doing a population-based denominator. So, there's just some nuances there, so I just want folks to be aware of that. And in some ways, that's a good thing, right? Because sometimes our screening may not happen in the context of a medical face-to-face visit. It may happen with a care manager or some sort of other provider that could be coordinating. It isn’t always a bad thing, but it is something that we picked up on, because we're using 0418 in a CMMI demonstration project. So just something that I want to alert people to. And there's a bit of a nuance there, so the measure will look a little different.

But, again, I don’t know that we are going to cover this. I don't think this is the right time to cover this, or if this should hold for Day 3, but we have not yet, as a state Medicaid program, we’ve been told these measures are going to be required reporting, but there’s been no indication of what would happen if we didn’t report it. So, I do think that’s important for CMS to be able to explain to states. We’re one of the states, I can tell you, that we report the 0418, but we were doing it using a different specified method, so we were not doing it according to the specifications. We clearly indicated that, as per the instructions. But in my mind, we met the reporting requirements. So, I do think that's an important thing to make sure that CMS is being incredibly clear as these stats become mandatorily reported, what that means to a state. So, apologies if this is not the right time for that or if we should hold that until Day 3, but I did want to just make sure that that was noted.

Thanks, Lindsay. I think it's a good thing to note for sure. We can't comment if this is part of rule-making and CMS has not released the draft rule. So, I think that will be the more appropriate venue and to certainly review it carefully and submit public comment during the rule-making process. So, I think it's a good thing to surface, and when we do talk tomorrow about preparing for mandatory reporting, you're welcome to raise that again. But I would encourage everyone, when the draft rule comes out, to look at it carefully in term of what it would mean for adherence to technical specifications, or deviations from technical specifications. Thank you. All right, so Bonnie Zima.

You know, just one other thing to remember, you know, when we talk about gaps, the issue of suicide screening always comes up. And even though this is not focused on this, what I like about this measure is that you can pass. If you have a positive PHQ-2 and you do a PHQ-9, number 9 is the suicide screener, and I think we need to be mindful of that, given that suicide is our second-leading cause of death among teens, and particularly the more recent literature showing increases in suicide rates, particularly among girls and teens post-COVID. So that's one comment. The other is really a question, and that is, in the follow-up, would follow-up in school-based mental health services get picked up?

Are you referring to the new HEDIS measure?

Yes, the new HEDIS, the addition.

So, that would be a question for the measure steward. Do we have anyone from NCQA available who could raise your hand? Emily Morden. Could you unmute, Emily? Derek? Oh, there you go, Emily. Thank you.

Thank you. This is Emily Morden from NCQA. So, yes, for the NCQA measure, we do count a number of different things for that follow-up, including visits that may happen in different settings that would address any behavioral health condition or address depression symptoms. So, we really try to be very broad, knowing that, you know, the follow-up could occur in those different settings, so we have a number of value sets that support that part of the measure.

Bonnie, does that answer your question?

Yes. But I still remain a little concerned about the data quality in our schools. I'll just leave it at that.

Okay. Tracy Johnson.

Hi. This is Tracy Johnson, Colorado Medicaid Director, and I just wanted to echo the comments of several others. I think trading out these two measures is worthy of consideration. I've talked to a few other State Medicaid Directors, and their support introduced Colorado to that concept. I do want to echo one of the concerns, I think it was David who spoke earlier, around really should have depression screening in the Core Set, and so if for some reason a replacement measure was not ultimately approved, then you know, I think we should not remove the other one. But if both were to happen, I think that's the direction I would lean. And this is a place where leaning into the newer measures that rely on EHR data more heavily or similar kinds of electronic data, I think would be a worthy investment because of all of the things others have stated about the prevalence of the disease and importance to the health of our population. So, thank you.

Going down, Anne Edwards, do you have another comment? Amanda Dumas?

Hi. Thank you. I just wanted to express concern about the Follow-Up measure for this. Again, nothing about the importance of this measure or the intent behind it, but the fact that this is going to be really hard to do, considering how many different ways a patient may then receive follow-up care, and how many of those methods are not documented or they aren’t communicated back to the original person who did the screening and how, on the ground, how difficult that is, and that's a real struggle in primary care.

I just want to, I guess, maybe others can help me understand then, what is the strength of our ability with these Core Set measures versus what is maybe a more appropriate thing to measure? And, again, I think the deeper we get into these clinical measures without HIEs being universal across the country, it's going to make these measures less and less meaningful. Again, I'm not saying we're not pushing for it, and that's not where we're going, but mandating this within a couple of years, knowing that this clinical information is not going to be available is going to make it a real struggle for some states, or the numbers just aren’t going to be very good. So, I just want to keep that kind of that thought in the back of our heads, because, again, as a clinician and as a Medicaid employee, I'm looking at this and realizing that it's going to be messy. That's all. Thanks.

Thanks, Amanda. It's a good comment, and one, again, as we talked about earlier, when the NPRM comes out, certainly having state public comment about that will be important, and also, I think when we talk about preparing for mandatory reporting, talking a little bit more about what kinds of technical assistance would be helpful to enable states to be ready, and also, the on-ramp time. I think that's something that CMS certainly is aware of is that there is an on-ramp time to new measures and particularly newer, harder measures.

Any other comments about the two depression screening measures before we move on to lead screening? All right, with that, let's open it up to talk about Lead Screening in Children. Rich Antonelli.

Thank you. I guess I want to strongly support including this. We know that it is a tremendous indicator of disparities in terms of safe housing and safe communities. For somebody that's been doing this clinical work for four decades, I'm sorry to have to be promoting ongoing lead screening, but I think it's become extremely important for us to track this and be mindful that it is quite an indicator of disparities related to, as I mentioned, housing, to community water supply, and has profound lifelong implications, and lead essentially has a zero threshold for being toxic, so I strongly support including the lead screening measure.

Thanks, Rich. Linette Scott.

Hello. Yes, I would support adding this measure to the Core Set. I would note that blood lead reporting is also done under the CMS-416, so in California, we've taken to reporting both the HEDIS and measures that we’ve, I guess, sort of developed that tied to the requirements that children in Medicaid need to have blood lead tests at age one and age two.

The challenge with the CMS-416 is that it doesn't follow more standard measure specifications, so it doesn't do, for example, a one-year measurement with 11 or 12 months of continuous eligibility. It only does the three-month continuous eligibility. So, it's a little bit different than our standard HEDIS measures. So, essentially what we did is we created a similar version that says plus or minus six months of the one-year birthday and the two-year birthday, to look at that. But given those are not standard measures that could be used, using the HEDIS measure is a measure that has a level of reporting. It does give more visibility to blood lead testing, and it is a really important issue, so would definitely support adding it to the Core Set measures. Thanks.

Thanks, Linette. Actually, one thing you said about the 416 that reminded me of an earlier conversation, talking about the availability of T-MSIS, and I think as many people on this call know, CMS has calculated, produced the 416 using T-MSIS data, and so that is one way that CMS is trying to reduce state burden and take advantage of other existing data. And so, I think to your point, there may not need to be duplicate efforts between the 416 and a new lead screening measure, because that would be calculated through T-MSIS.

Another thing I'll just mention, without having any firm commitment or information at this point, but I think one of the things we will look at with any new measures added to the Core Set, or recommended for addition to the Core Set, is the extent to which they could be calculated using T-MSIS data. So, if it's an administrative measure, the codes are complete and generally reliable within T-MSIS, we certainly would be looking towards that as a solution for reducing state burden. And lead screening may be one of those measures, that Lead Screening in Children measure from HEDIS, might be a measure that could be calculated through T-MSIS. So, I'll just throw that out there as a way that CMS is thinking about making advances in digital measurement using existing resources and reducing state burden. Tricia Brooks.

Thank you. I just want to echo what others have said about this being an important measure to add to the Core Set. 416 reporting has a lot of limitations. This is one of the few very specific reports on the 416, because it specifies, you know, a blood test, as opposed to screenings, which are sort of generic. And because of that, I think the 416 has had less visibility than the Core Set will have when it becomes mandatory reporting. So, I definitely, the fact that children are required to have these screens in Medicaid and CHIP, I think, it would be shortsighted for this not to be on the Core Set. Thank you.

Thanks, Tricia. Jill Morrow-Gorton.

I'd like to echo sort of the clinical importance of this and the long-term effects that lead poisoning has. I think this is a great opportunity for linking with public health, having been the doc for a public health lead screening program, the people are out canvassing neighborhoods, so it doesn't always come under the physician and the pediatric practice, so being able to link to those datasets and those sources of data is helpful.

I'm a little perplexed about the timeframe for this because it seems to me that two years, that they've had at least one by two years, when the recommendation for children in Medicaid from the CDC, and the AAP Advisory Panel on lead poisoning is testing at 12 months and 24 months. And it seems to me that to do it at two years kind of seems like it's late if you're going to be proactive and you're going to be, I mean, I know there are ways to kind of do sort of pre-looks at your data to see where you are in terms of how many people have had this screen or whatever, and then target people who have not. But it seems like you would want that to be earlier, and that's neither here nor there for this purpose. But for thinking about this measure or any measure where there's a recommended age range or recommended ages that we should think about, does the measure sort of accommodate the clinical recommendations? Do they match up or not?

Emily, do you have any comments on that, from NCQA, as the measure steward?

Sorry. No, I don't have any comments at this time. But it is something that we look at in terms of if there are new guidelines that come up, we would look to reevaluate the measure to ensure that it's still in line with current recommendations. And Sepheen Byron may have something to add here.

Sepheen.

Yeah, I think, you know, this measure was developed a while ago, and I think one of the challenges that we faced during development is that the U.S. Preventive Services Task Force does give this an insufficient evidence rating. And so, I understand that CDC and others do support this sort of screening, and I believe that, you know, really, what it came down to was, the compromise in a way was, to just look for at least one. It says "at least." You know, you can have more than one. But, you know, I think that's what speaks to sort of the difficulty with this measure, you know, because we hear sort of both sides here. On the one hand, no one is arguing with the importance of being able to do something about lead poisoning. But the issue is, is a quality measure really the way to go about it? Is it really more about things like housing stock? And that's one reason why when NCQA looks across the HEDIS measure set and really thinks about a long-term plan in terms of evolving the set and making sure it stays up to date, that's one reason why we would like to eventually retire this measure.

So, here are just some of the considerations to keep in mind. I don't think it's something that we will then go back and then make more stringent, because we are looking at it for retirement, so I would evaluate the measure sort of as it’s specified.

Thanks, Sepheen. Erin Abramsohn.

So, CDC would like to just voice support for the measure, the Lead Screening in Children measure. You know, from a public health angle, lead exposure is still a significant public health concern for some children, because of persistent lead hazards in the environment. You know, as it was said before, there is no safe level of lead for children, and even at low levels, lead exposure has the potential to have long-term metabolic and neurological consequences, so ensuring that all at-risk children are tested for blood lead levels would facilitate connecting them to follow-up services. Since the start of the COVID-19 pandemic, blood lead screening rates have declined sharply. In a 2021 CDC study, reports from 34 of our jurisdictions indicated that between January and May of 2020, 34 percent fewer children were screened for lead compared with the same period in 2019. So, we do believe that adding this measure would further prompt data exchange discussions to match lead screening data with Medicaid data and would increase screening. Thank you. I appreciate it.

Thanks, Erin. We have time for a few more comments. I see Amanda Dumas. Do you have another comment?

Yes. Thank you. I wanted to just speak in support of this measure as well. I think the clinical piece has been covered pretty well, but I've also noticed just some discrepancies between different data reports of this. In our own state, Office of Public Health often doesn't have a great way of measuring this and so, I appreciate that we might be able to do a better job to focus on Medicaid patients with a measure like this. Anecdotally, I also see some sloppiness on the clinical side sometimes in terms of adhering to the recommendations for screening and clinicians getting a little too subjective sometimes about when they're doing this and the timing of it.

And I guess my last statement in support of this is that I think we could argue with many of these measures that they're tied to social determinants of health in a way that we can't necessarily impact very strongly as clinicians, whether it's high lead levels being related to housing stock, or obesity and weight assessments, you know, being related to food insecurity and food swamps, et cetera. So, I think that this is something, though, that we can very concretely intervene on if we do find a problem, and so I support that we do measure its screening. Thank you.

Thanks, Amanda. Curtis Cunningham.

Hi. Yeah, I also want to endorse this measure, especially for Medicaid. This goes to the heart of inequities. When we geo-map our Medicaid enrollment over the housing stock, clearly, the historical inequities are apparent in that design, and so lead is something that disproportionately affects Medicaid.

I guess the other issue I'd like to bring up is that there is this differential between the CDC and this measure, you know. So, if we use this measure to require HMOs to report on, then, you know, we have the CDC measures. It would be nice to, in the future, have some conversation to bring this together on what is the true measure that people want to come together around on lead between public health and Medicaid programs.

Thanks, Curtis. All right. So, with that, let's move on to the last measure in this domain, and that is the Adults' Access to Preventive and Ambulatory Health Services. Who would like to speak? Rich Antonelli, do you have your hand up for that one?

No, actually, I don't.

Did you want to speak to the lead measure before we move on? You have your hand up.

Yes. I was excited to hear that we have the measure steward, and I just wanted to find out, we know what the public health data is around equity, which is why I made the comment that I did. But does the measure steward have any experience with R, E, L, or D stratification with the implementation of this measure?

You're talking about race, ethnicity, and language stratification for lead screening?

Yes.

And disability status.

No, we have not stratified this measure, and we're actually adding race/ethnicity stratification across HEDIS sort of in a prioritized fashion, and this measure is not on our list.

And the reason it's not on the list?

So, the reason I described earlier, which is that we would like to retire this measure. You know, I'm not arguing with the public health importance, but it's really an issue whether a quality measure is the right approach here, or if it's really about other issues. And as we move towards evolving HEDIS and trying to think through whether measures should be revised or digitalized or removed, we have deprioritized this measure. It has an insufficient evidence rating from the US Preventive Services Task Force, and so that's why.

Thank you.

Thank you, Emily and Sepheen, for your comments. So, let's now move on to Adults' Access to Ambulatory Health Services, and any comments on this one? Lindsay Cogan.

I would not be in favor of adding this measure, and I know it's probably going to make me very unpopular. But it's a very broad swath. It does not get at narrowing the focus into where I think we want it more primary and preventive care. We find it to be very, very broad. So, it is a measure of any access to care, but is it a quality measure? We struggle with these more access and utilization-based measures. We think, obviously, it's important to have equitable access, but this is not a measure we can compare across payers. There's different specifications for commercially insured versus Medicaid, so it becomes an issue where, if we wanted to look across payers to ensure we have equitable access among our Medicaid members, we're not able to do that using this measure. So, I would say with the real estate as it is on the Core Set, we're really looking for those high-quality benchmark measures, the ones we're really striving towards, and this is a pretty low bar. So, that's just my initial, I would not recommend adding this to the Core Sets.

Thanks, Lindsay. Jill Morrow-Gorton.

Lindsay, I will be unpopular, with you. I agree. I think that, so the literature is really mixed. Clearly with people who tend to use the ED for minor health conditions or for chronic conditions, primary care is absolutely valuable. There's sort of questionable value of sort of routine visits for younger people or people without chronic conditions in terms of health and that sort of thing.

And I think that there are potentially other innovative ways to approach health, health literacy, prevention of chronic conditions for that population, that if we put the emphasis on a practitioner visit, would not be able to happen, because you know, I think those things can happen in lots of different ways. But if we're only going to measure it this way, what tends to happen when you measure things is you encourage this, as opposed to thinking about are there other ways to engage people who are well in preventive care and healthy lifestyles and that sort of thing. And I think this doesn't get us there, in addition to being very broad and could capture things that we would call preventive care that aren't really preventive care.

Thanks, Jill. Any other comments, especially from people who want to speak in favor of the measure? Any other comments on this measure? It’s the last call before we vote. Lindsay, do you have another comment? Your hand is still raised. Any other comments on the measures in this domain that we've talked about before we turn to voting? Well, with that, let's, well actually, we're going to turn to public comment, I am mistaken. Before we vote, we’ll have public comment.

Margo, this is Dave Kelley. I raised my hand there towards the end.

David, sure.

Just a quick question, going back to the depression measures, and Lindsay had a comment about the denominators being different, and if New York measured both of those, it would be interesting to know, was there a big difference and were there concerns of one over the other if they, indeed, were measuring both. And then my other question on that same measure, does CMS use their measure in the Medicare program?

Why don’t we take the two questions separately, David? So, the first question being for Lindsay, about the two different denominators. Lindsay, do you have a comment about that?

I can't yet speak to the differences. We haven't fully operationalized the second measure. But when we were working with a provider group, they were very concerned about not having that visit included. So, it was just something that we hadn't initially picked up on. Again, I don't have a strong feeling either way, but I, too, am interested to hear from particularly Medicare, which direction they think they're going to go now that, if they're going to move from their measure to this new measure.

Michelle Schreiber, are you on, and is this something you could speak to, or do we have someone, Alaya or Anita who could speak to the CDF measure in Medicare? I'm not sure we have anybody on that can speak to it, but I agree, it is a question that has come up in terms of alignment across programs. It's something that we are aware that there could be some misalignments, potentially, between Core Set and other, but, again, I think that what I would encourage the Workgroup to be thinking about is what is best for Medicaid and CHIP in this regard, given some of the differences in the programs, the way that the data are captured, that it’s state level and not as much provider level, and the aggregation of the data from providers to plans to states, how that works. Oh, Michelle Schreiber, I see your hand. Would you like to speak?

I'm unmuted, but I didn't catch the question. So, what's the question because I'm happy to speak to alignment of measures. Can you guys repeat the question for me?

Yes. So, it’s related to the Screening for Depression and Follow-Up Plan, what we call the CDF measure, ages 12 to 17 and age 18 and older, and it's if that measure were to be removed in favor of Depression Screening and Follow-Up for Adolescents and Adults, which is an ECDS measure, a digital measure, does it create any potential issues of alignment?

Well, this is a measure that we use and we like. We use it certainly in the MIPS program. It's less used on the inpatient side, so it does create some misalignment with the MIPS program, but MIPS measures are also voluntary measures. And so, to that degree, the answer is yes, a little bit. But across CMS, we actually have a Measures Alignment Workgroup that meets and looks at measures, and we recognize that there are differences in where you want to use certain measures and what are the best populations to use for certain measures, and so recognize that there may be somewhat different needs in Medicaid. And getting back to what you were saying, I would encourage people to vote by what they think is important to Medicaid. But I would add that we think mental health in particular is very important. There's a cross-HHS committee on mental health and maintaining measures for screening and depression and follow-up actually is important.

Thanks, Michelle. I think going back to what David said about the CPT-2 codes and the fact that the screening is happening, it's just not being captured in the administrative data, the CDF measure in some states is being measured through hybrid, but the measure is not specified for hybrid. So, there's a little bit maybe of a disconnect here of how it's being used in Medicaid relative to how it's specified and how Medicaid claims are, I guess, how providers file claims, not the use of CPT-2 codes.

David, did you want to say anything else about that, because I know this is something that you're spending a lot of time thinking about how to promote this measure and use of CPT-2 codes?

Yeah. And, actually, I think just regular CPT codes for this metric. There may be some CPT-2 codes as well, but we've kind of gone down this pathway using the current CMS specification, but I think that I want to look at all the details. But I think the NCQA spec does allow for administrative capture, probably in a similar way. So, I think either way, you know, we're working with our providers to educate them on the appropriate use of CPT codes to code this up administratively, because we know it's happening. So, that's really where we're headed, even though my longer-term goal over the next two or three years is to really measure this electronically, because that's the way we definitely need to head. And I just wanted to make sure that there wasn't going to be, like, total misalignment or a major problem if we moved in one direction or the other.

Thanks, David, and, again, I think the instructions to the Workgroup are to vote on the merits of the measure as you see it within Medicaid and CHIP, so thank you for that. All right, now it's time for public comment, so next slide, please.

If you would like to make a comment, please use the raise-hand feature in the bottom right of the participant panel, and we'll let you know when you're unmuted. Lisa Foster. Derek, can you unmute Lisa? And please state your full name and affiliation.

Good afternoon. My name is Lisa Foster, and I'm a manager for the Adult Vaccine Access Coalition. Appreciate the opportunity this afternoon to offer our coalition's support for the addition of the Adult Immunization Status measure that's being considered today. Immunizations are a highly cost-effective form of preventive medicine that helps save lives by protecting the health and wellbeing of individuals and communities nationwide.

Over the last decade, advancements in technology, policy, infrastructure have strengthened the immunization landscape, and many of the panelists today have highlighted some of these advancements.

Vaccines have always been one of the greatest public health achievements, but especially in the midst of the COVID pandemic there's been overlap between populations that are vulnerable to the COVID-19 virus, as well as other vaccine-preventable illnesses. We appreciate that there is a new focus on the importance of vaccines as a preventive health measure, and appreciate the discussion that's happened over the course of this afternoon amongst this group. We believe that improved federal benchmarks and quality measures are key and are also key priorities for our coalition, and we believe that the ECDS measure for adult immunization will help encourage better reporting of adult immunization status that will result in increased adult immunization coverage rates, as well as identify gaps in different communities where immunization may not be happening.

Quality measures for adult vaccines play an important role in preventing illness and death, reducing caregiving demand, and avoiding unnecessary health care spending, and setting the foundation for healthy aging. We support moving forward with the Adult Immunization measure. We believe that now is the time to do so, for many of the reasons similarly outlined by the panelists this afternoon. In addition, AVAC believe that the adult measure complements much of the work that's happened through the National Vaccine Advisory Committee around standard immunization practice, which provide guidance to health care providers who care for adults and take steps to assess, share, and document adult vaccination with each visit. We believe that the measure satisfies many of the objectives that have been outlined in CMS's Meaningful Measures framework and really appreciate the opportunity today to express our support for the measure. Thank you.

Thank you, Lisa. Are there other public comments? Please raise your hand. Do we have any other public comments on the measures in this section?

Well, I think at this point, we will turn it over to Alli and Dayna for voting. Thank you, Workgroup members and measure stewards, and others for a wonderful conversation today. I think we all learned a lot, and we are now ready for voting.

Thanks, Margo. So, we will switch over to the voting platform, if everyone on the Workgroup can get ready to vote, and we'll move on to the first vote of the day. All right, great. So, for the first vote today, the question is, should the Adult Immunization Status measure be added to the Core Set? And the options are, yes, I recommend adding this measure to the Core Set, and, no, I do not recommend adding this measure to the Core Set. You can see that the votes are already starting to come in, so thanks so much, everybody. We'll give it another minute or two.

We're expecting a couple of more votes, so we'll pause and try to figure out who we're missing. Thanks for your patience.

All right, looks like we got the expected number of votes in. Thanks, everybody. Okay, so for the results, we have 89 percent of Workgroup members voted yes, and so that does meet the threshold for recommendation. Somebody might need to mute themselves. So, let's see, the Immunization measure is recommended by the Workgroup for addition to the 2023 Core Sets. Next slide.

Okay, so for our second vote, should the Flu Vaccinations for Adults Ages 18 to 64 measure be removed from the Core Set? And voting is open. All right, looks like we reached the expected number of votes. Okay, now for the results, 96 percent of Workgroup members voted yes. That does meet the threshold for recommendation. The Flu Vaccinations for Adults Ages 18 to 64 measure is recommended by the Workgroup for removal from the 2023 Core Sets. Next slide, please.

So, now we'll be voting, should the Depression Screening and Follow-Up for Adolescents and Adults measure be added to the Core Set? Voting is now open. Okay, thanks everybody. Moving along to the results. Okay, 93 percent of Workgroup members voted yes. That does meet the threshold for recommendation. The Depression Screening and Follow-Up for Adolescents and Adults measure is recommended by the Workgroup for addition to the 2023 Core Sets. Next slide.

Okay, now we'll vote on the two removals next. So, the next vote is, should the Screening for Depression and Follow-Up Plan: Ages 12 to 17 measure be removed from the Child Core Set? And voting is now open. Okay. Thanks everybody for your vote. So, 81 percent of Workgroup members voted yes, and that does meet the threshold for recommendation. The Screening for Depression and Follow-Up Plan: Ages 12 to 17 measure is recommended by the Workgroup for removal from the 2023 Core Sets. Next slide, please.

Okay, now we'll vote on the adult version of the measure, so the question is, should the Screening for Depression and Follow-Up Plan: Age 18 and Older measure be removed from the Adult Core Set? And voting is now open. Okay, now moving along to the results. For the results, 89 percent of Workgroup members voted yes, and that does meet the threshold for recommendation. The Screening for Depression and Follow-Up Plan: Age 18 and Older measure is recommended by the Workgroup for removal from the 2023 Core Sets.

Moving right along to the next vote. The next vote is, should the Lead Screening in Children measure be added to the Core Set? And voting is open. We've reached the number of expected votes. Okay, and so for the results, 81 percent of Workgroup members voted yes. That does meet the threshold for recommendation. The Lead Screening in Children measure is recommended by the Workgroup for addition to the 2023 Core Sets.

And now moving on to the last vote of this section. The question is, should the Adults' Access to Preventive/Ambulatory Health Services measure be added to the Core Set? And voting is open. We've reached the expected number of votes. Okay, and so for the results, 30 percent of Workgroup members voted yes, and so that does not meet the threshold for recommendation. The Adults' Access to Preventive/Ambulatory Health Services measure is not recommended by the Workgroup for addition to the 2023 Core Sets.

Thanks so much, everybody, for getting your votes in. And I'll turn it now back to Margo to facilitate discussion of gaps in the Primary Care Access and Preventive Care Domain.

Thanks, Alli and Dayna, and everyone else behind the scenes working together. And thanks, Workgroup members for very efficient voting. So, here we are at the point to talk about gaps in the Primary Care Access and Preventive Care Domain. So, we wanted to know what suggestions the Workgroup has for further strengthening the Core Sets in this domain. What types of measures or measure concepts are missing in the Core Sets? Are there existing measures to fill the gap? Are there new measures to be developed? So, remember to state your name before making your comment. Raise your hand and let us hear your comments about that. Tricia Brooks.

This will overlap with the e-mail I sent you, thinking I would miss an opportunity on gaps. First of all, I want to talk about the need to develop a measure for continuity of coverage. We know that we don't get a complete picture of the quality of care without having continuity, because so many people who are in and out of the program, whatever their experience is, doesn’t get swept into the quality measures. And we can certainly see from the continuous coverage protection in the public health emergency how impactful continuous coverage has been.

Recently, Mathematica did an analysis of churn using T-MSIS data from 2018 that shows that state policies make a huge difference in the continuity of coverage and how much churn there is in the programs, things like whether they've adopted 12-month continuous eligibility, if they do periodic income checks, et cetera. So, you know, without really knowing where states stand on continuity of coverage, we just have a really incomplete picture, and we're not able to really fully compare across states. So that, I think, has always been very, very high on my list.

I also want to lift up the fact, and this has been noted in prior meetings, the importance of being able to assess and address trauma and ACEs in children. I think we should also keep our eye on some of the school readiness measures that are being tested in a few states in Medicaid, and then yesterday, of course, we talked about drivers of health, so I still think that is important to lift up here as well. So, I think that's it. Thank you.

Tricia, before you sign off, I do have a question for you on continuity of coverage and whether you think this could be a T-MSIS-based measure similar to the churn analysis you mentioned. I know there’s work going on for MACPAC and others using T-MSIS data, for example. Is that the kind of thing you had in mind, or are you thinking of something different?

No. I think the T-MSIS can be used for this. I think it was really enlightening to see the MACPAC churn report. I had talked with folks at Mathematica prior to that about using T-MSIS. We know that we're not getting a full picture yet, because of not all states are reporting everything that needs to be in the data set, and certainly, there are issues associated with REL breakdowns in continuity. But I think T-MSIS would be an option for the development of this kind of a measure.

Thank you so much. Other comments on gaps? Curtis Cunningham.

Hi, this is Curtis Cunningham. I guess I did mention the discrepancy between public health and the measure we just voted on. I also just want to continue to make sure to reiterate, I know CMS is aware of, you know, as we talk about moving out into other things, making sure Medicaid does what they should do well, and that is make sure there is access to health care. Due to the financial arrangements of Medicaid not being the best payer in many ways, there is a concern that there is access issues and, you know, that it exacerbates inequities within our health care system. I'd also like to see how we can better assess potentially preventable events. And I don't know if that's been a conversation in the past, but I really think that’s some of the outcome measures that we want to get to, and also looking at the health of the Medicaid population. Some thoughts. Thank you.

Thanks, Curtis. Just a quick question on your first comment about access. Were you thinking of network adequacy? Is that the idea that you were trying to convey, variations in network adequacy?

Yeah. I mean, the idea that, right now, you look at an HMO and you look at their contracting, and it's not necessarily looking at, is the person getting the care they need when they need it, you know, at the right time, at the right place, right cost, you know. So, what is real access in the Medicaid program from a member’s perspective?

Okay. Thank you. Rich Antonelli.

Yeah, thank you. I'm going to make this observation. I've made it in prior years as well, but I'll bring it forward in the context of gaps, and, specifically, I'm going to wear my pediatrician hat for the comment I'm about to make. Children, youth, and young adults, and even, for that matter, adults with childhood onset of complex and chronic conditions often have a variable relationship with traditional primary care providers. In fact, increasingly, the literature is demonstrating that the care that these patients and families and caregivers receive is actually quite fragmented.

A significant amount of their care often is done within a subspecialty environment and not always in a coordinated way. And so, I want to revisit this issue, with the goal of thinking about that whole-person-centered integration, and encourage the Workgroup and folks listening in to our deliberations today to be really thinking about, you know, what do we mean by primary care access and preventive care access? Is it really with the PCP or is it with an entity that is the locus of integration?

We continue to struggle, if you look at the Core Sets, for a variety of reasons, at least to get on the pediatric side, measures that are relevant. The children with complex needs, including neurodevelopmental disabilities, autism for example, there really isn't any indication of looking at the needs of these persons across the age spectrum. ADHD is about as complicated as we get. Granted, that's related to prevalence and things like that.

But, again, I feel that for the amount of resources that Medicaid pays to provide services for these children and their young adult counterparts, that we're not getting a good view of the true value or equity in that space. So, I just want to bring that forward, Margo. And that could potentially be a conceptual segue, talking about LTSS for example. But I wouldn't want it to be limited to LTSS. Thank you.

Thank you. Russell Kohl.

Great. Thank you. I just would follow on with the previous speaker’s thought process around patient-centered measures that matter, looking at the things that we're measuring as to how they affect the patients. I've been somewhat surprised since this is my first year with the group, but the approach of humans as a collection of pathophysiological processes and measuring those pathophysiological processes, or the responses to them, as the definition of quality, and certainly that's not the way that I was trained to look more holistically at patients. And one of the things that I would say that we do have a large gap as we look at the Primary Care Access and Preventive Care domain is, how does the patient look at this? What does the patient view as having appropriate access to care? What does the patient view as appropriate access to prevention and the care that they're receiving?

Well, certainly there is a point for the scientific aspect of it. I think that we do have a significant gap in recognizing what our patients actually value and find important. I think that's something if we could better deal with that, this would actually, ultimately, look like a higher quality, because quality is somewhat in the eye of the beholder, and the beholders are ultimately the patients.

Thank you. Anne Edwards.

Thank you. And maybe to build on the last several comments, and even going back to what Tricia mentioned earlier, you know, I think that there's a theme throughout our conversations the past couple of days around understanding, whether it be whole person or this more holistic, and that includes social drivers, so getting into some measures that think about that. But I also want to lift up when we get to that concept, it's also thinking about this from a strength-based approach, and that hasn't maybe come out quite as clearly. But as I look at some of this, you know, what does this look like if we look at healthy mental development, healthy development across the readiness for school measures might be of interest, but also some others. We know a lot about how development occurs and how that impacts future health. So, looking at that as a gap and an opportunity to maybe bring some of those that might be more aspirational but develop some of those measures in that space to build on those strengths.

Thanks, Anne. David Kelley.

So, I'll start out by saying that I think there are some significant gaps that currently are in the Core Set. One of them is actually in adult dental. We have nothing that really measures adults' access to care, and we measure it in Pennsylvania, in both our LTSS product, as well as our HealthChoices product. It’s something that’s very, very important, and it has kind of fallen by the wayside, and it’s just a very basic access to care measure that’s extremely important. We’ve spent a lot of time and energy thinking in terms of that for kids, which I think is vitally important. But we provide coverage for adults, and we are an expansion state, so we provide coverage for 1.2 or 1.3 million adults. So that's certainly a gap. So, perhaps there are ways to think in terms of further development of a measure there.

From Rich's comment, one of the things that I think is really important, in Pennsylvania, we're trying to do this but, is access to care for special-needs children. And one of the things that we're doing in Pennsylvania is we're looking at especially kids that get shift-care nursing. These are usually very complex kids, and developing a specific patient-centered medical home and learning network, but also looking at care plans and looking at, similar to kind of the home and community-based gaps or LTSS measures around, is there an annual care plan? Or an update whenever there has been a significant change? I mean, we do this in the LTSS space, but we don't do it in the pediatric space with these really, really complex children. So, I think there's really a need to be able to look at that.

In Pennsylvania, we actually do look at dental for those children with special needs. So, again, I think we really need to think in terms of developing measures in those areas for kids with special needs. They may not be a huge number, but they are a huge budget driver, and their quality of care is really very, very important, especially as they transition into becoming adults. The other comment I would make is, you know, we have several questions on the CAHPS survey about access to I think PCP care or your regular doctor care. Those are CAHPS questions that have been around forever. Same thing, with, I believe, dental, at least for kids, is the perception of, do you have good access to timely care? Those are survey questions. I know that's difficult. But that really actually gets to the patient's experience instead of us just measuring a claim of I went and had a primary care visit. This is actually getting to the individual's perception of, are they getting good care. Do they have timely access? So, food for thought there in the future years. Those are current validated questions on the CAHPS survey.

And then, lastly, one thing that we've seen in part of a multi-state initiative with AcademyHealth with Medicaid programs with our state health partners. And one thing that we've looked at recently is we looked at individuals with OUD, but even more broadly, with SUD, and we looked at screening rates for HIV, Hep-B, and Hep-C. And I'll just say they were pretty abysmal. And there's a huge opportunity just to do some very basic screening. And what I will say is it’s a very high-risk population for those viral conditions. And I know that from a public health standpoint, we certainly have, there is a focus on elimination or reduction of Hep-C and HIV. So, that might be another opportunity. And I would probably lump that into primary care access and preventive care because that's really where this care should be done while you're seeing your primary care provider, where you should be screened so that we could see if you need further treatment. So, those are my thoughts. Thanks.

Yeah, thank you so much, David. A couple of reactions; one, I just want to remind everyone that we have gaps conversations at the end of every domain, and we'll have an opportunity to talk about that, and oral health services tomorrow, so I fully expect adult dental will come up at that time. We also will have experience of care, so we’d love to hear more about that tomorrow as well.

But one of the things that did occur to me as Russell was talking about patient-centered measures that matter and patient view of appropriate access is the extent to which CAHPS might serve that purpose, kind of tying together what you just said, David. And I'm hoping that we can have that conversation tomorrow as well when we talk about experience of care measures and individual perceptions of that. Not just patients but people. So, with that, we have about one minute left before we're ready to take a break. Any last comments? All right. So, why don't we take a break? Thank you, everyone, for such a thoughtful conversation. Great voting. Lots of thoughtful remarks and we'll be back at 2:30 from this break.

BREAK

Hi, everyone. Welcome back from the break. My name is Tricia Rowan, and I'm a member of the Mathematica team. I want to acknowledge that Margo Rosenbach has been called away for a family emergency, so I will be helping to facilitate the rest of today's meeting. At this point, we're going to turn it over to my colleague, Kathleen, to provide an overview of the Long-Term Services and Supports Domain. Kathleen.

Thank you, Tricia. We'll now discuss the Long-Term Services and Supports, or LTSS Domain. There is one LTSS measure in the current Core Set, and three measures have been suggested for addition, which we'll discuss. Next slide.

The LTSS measure in the 2022 Adult Core Set is the National Core Indicators Survey or NCI. The NCI measure was added to the Core Set for federal fiscal year 2020. Next slide.

The first LTSS measure that has been suggested for addition to the 2023 Core Set is the LTSS: Shared Care Plan with Primary Care Physician. This measure assesses the percentage of LTSS organization members with a care plan that was transmitted to their primary care practitioner or other documented medical care practitioner identified by the plan member within 30 days of its development.

This is an NCQA measure that is not NQF endorsed. The measure is calculated using case management records. As noted on this slide, the measure is based on a review of records drawn from the systematic sample with a minimum sample size of 96 beneficiaries. When suggesting this measure for addition, the Workgroup member indicated that since approximately 30 percent of Medicaid spending is for LTSS, tracking compliance with assessments and care planning goals will improve the national quality of health care.

The Workgroup member also noted that monitoring the elements of the care plan and sharing the plan with an individual’s provider supports continuity of care. Next slide.

The next LTSS measure that has been suggested for addition to the 2023 Core Set is the LTSS: Successful Transition After Long-Term Institutional Stay. This measure calculates the proportion of long-term institutional facility stays, defined as stays of 101 days or more, among Medicaid MLTSS plan members aged 18 and older, which result in successful transitions to the community, defined as community residents for 60 or more days. This measure is reported as an observed rate and a risk-adjusted rate. This is a CMS measure that is not NQF endorsed. The measure is calculated using administrative claims. Next slide.

CMS is currently respecifying the existing measure for Medicaid fee-for-service LTSS participants. The updates to the managed care version of this measure and the testing and development of the fee-for-service version of this measure are in process and scheduled for completion in 2022.

Changes to the specifications currently under review include expanding the definition of institutional facility to include psychiatric facilities and specialty hospitals, including any payers in the count of discharges, removing the medical benefit requirement from the benefit-eligible population, and adding stratification by dual-eligible participants and Medicaid-only participants.

In suggesting this measure, the Workgroup member noted that individuals receiving HCBS are less likely to have emergency department visits, injuries, and instances of abuse and neglect when given appropriate community supports. The Workgroup member also noted that this measure can be trended over time, and performance can be compared across health plans and states. Payers and providers can directly influence improvement on this measure by collaborating on transition incentive programs and alternative payment arrangements. Next slide.

The final measure that has been suggested for addition to the 2023 Core Set is the National Core Indicators for Aging and Disabilities Adult Consumer Survey, or NCI-AD. NCI-AD is a voluntary effort by state Medicaid, Aging, and Disability agencies to measure and track the performance of LTSS programs. Indicators address 18 different areas, listed on this slide. This measure is stewarded by ADvancing States and Human Services Research Institute. The data source is an in-person survey and is not currently endorsed by NQF. The sampling frame for the survey includes older adults age 65 and over, or adults age 18 and older with a physical disability who receive LTSS at least two to three times a week. Next slide.

Thank you. Twenty-nine states have used NCI-AD in the past, are currently using it, or plan to use it starting in 2022. Sixteen states collected data using this tool in 2018-2019. Ten states had state-specific results for 2019-2020, because data collection was unexpectedly abbreviated due to COVID. And seven states participated in a remote survey pilot in 2020-2021.

When suggesting this measure, the Workgroup member indicated that the NCI-AD would close the gap in the Core Set, given the lack of Core Set measures for older adults and people with disabilities. This measure can be used by states to measure quality of care nationally and across states for a population that is responsible for 23 percent of Medicaid expenditures. The Workgroup member also noted that this instrument provides states with specific information as it pertains to LTSS outcomes, beneficiary experience, and quality of life measures that span beyond service provision. The responses can be, and are, trended nationally and at the state level, and states use their indicators to compare performance across programs. Next slide.

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

Great. Thank you, Kathleen. So, we will now invite discussion about these three LTSS measures from Workgroup members. You may unmute your line if you wish to speak, and please remember to say your name when making your comment. Let's begin our discussion with the LTSS: Shared Care Plan with Primary Care Physician measure. Are there Workgroup members with comments on this measure? Please raise your hand. I see Katelyn Fitzsimmons. Go ahead.

Yes, thank you. This measure plays a really important part in continuity of care for individuals with LTSS. I saw and noted that it was mentioned that it was a case management record review. I think that was more so about the actual care plan development. This measure can be executed via many ways, and it can be done electronically, so most care management systems have the opportunity to push out information and correspondence to providers via way of a provider portal, so it doesn't really need to have that actual paper burden that individuals would need to do a lot of extra work to do that.

Essentially, LTSS members have care plans that outline their community-based needs, social drivers of health, et cetera, and it really does not so much focus on that medical aspect, and I think that there is a large gap between physicians understanding the additional needs that their patients have, and that there would be a lot of value to providing this information to physicians to see if there are ways to integrate the care better, and provide opportunities and referrals to community resources that might align with the members' goals.

Physicians may make recommendations that are important for the individuals, but these plans highlight what's important to the individuals, and we really need to marry that in order to ensure that members have whole-person, person-centered whole care, really, essentially. So, in order to provide that comprehensive care, we need to make sure that the physician is aware of the member’s comprehensive care plan and receives it every time that there is an update. Also, what’s notable about this measure, it is not necessarily the PCP of record, but it can be any other specialist or physician that the member indicates they wish to share the care plan with.

Thanks for those clarifications. We appreciate that.

One more comment, actually. This measure is part of four measures that are now part of NCQA's LTSS HEDIS set. They also support NCQA's LTSS Distinction, which is an accreditation program that highlights superior execution of LTS services across health plans. They now, as contracts renew for MLTSS programs, they are requiring, in many instances, the attainment of this LTSS Distinction's accreditation, and essentially that file review process that is currently part of that accreditation is working toward shifting towards only these LTSS HEDIS measures. So, you know, to make this part of the Core Set will help plans start that process, as it will be required essentially if they need to maintain accreditation.

Okay. Thank you. Rich Antonelli, you're next.

Thank you. In fact, I'm excited to be able to talk about this. But I'd like to get into the details a little bit about this care plan. Can we talk a little bit about the process of that? I've seen care plans be very prescriptive. These are the resources available to you choose, versus having the patient/family offer their priorities for what they would like to get done, so you know, how that gets captured.

The second piece is this notion of the dynamic nature of this over time. So, transmitting a care plan to the PCP for example, or other provider on the care team is important, but that's potentially just a unidirectional transmission, which really, in my mind, is not even a proxy for a patient-reported outcome of integration. So, I don't know whether the measure developer or measure steward could comment on those aspects.

Thanks, Rich.

I can certainly comment on the care-planning process and how it is not supposed to be one that is set up by the individual's legal representative. But I know you had some questions about that unidirectional facilitation of it, so I know NCQA has some folks on the phone. Maybe they'd like to speak to that.

Yeah, we do have Lindsay Roth from NCQA on the phone. Derek, can you unmute Lindsay. Lindsay, your line should be unmuted now.

Thank you. So, I can answer the first question, which I believe was asking about whether the care plan should be requiring certain things for all adults with LTSS versus considering patient-driven goals for care planning as well.

So, in the care planning, LTSS care planning measure in HEDIS, there are actually two rates that are reported. The first rate, the core element rate, looks at those care planning elements that we believe should be performed for all LTSS members, and there's a second rate, that looks at whether supplemental elements, at least, I believe, four of eight supplemental elements were documented for care planning, and so that rate can get more at those individualized patient preferences and goals.

So, I also wanted to mention that NCQA also is exploring development of additional patient-driven outcome measures, as well that I think can get to more of those aspects of care that were mentioned as well. I just wanted to bring those measures up as potential future measures that we're considering.

Thanks, Lindsay.

If I could add to that, actually. In the specifications for the NCQA's Distinction accreditation, not only do you need to hit certain core and supplemental elements within the care plan, but then you need to draw a conclusion as to what you will do with this information and how to support the member. Ideally, the PCP or other physician specialist should be part of that IDT team that participates in that care planning process so that it doesn't happen in a vacuum.

Essentially what we are moving towards as a nation, is this person-centered thinking that puts what's important to the person in the forefront, while also maintaining what's important for; so what's important for would be things like DME, PT, OT, maybe I have medical needs that need to be addressed. But, really, we want to drive this process with the member at the forefront, and they want to have their physicians involved. We're also seeing an increasing amount of health home clinic models for folks with IDD and LTSS, which is kind of intertwined in this measure, and that really allows physicians to be involved with the entire whole-person care process.

Thanks. Rich, did Lindsay answer your questions?

All except the other part about the updates because I'm sort of looking at the specifications and seeing the transmission by a certain period of time, and I like the timeliness of that. But recognizing that these patients are sufficiently complex, that a change could potentially necessitate a retransmission, and then I'm, again, sort of seeing this firehose phenomenon of just sending amendment after amendment after amendment. So, if you could give me a brief description of that. And just to be clear, I am a zealot about documentation and person-centered care with a care plan as a tool. But I just want to make sure we're distinguishing the difference between data transmission and information receipt. So, tell me a little bit about what happens each time a change occurs.

Oh, yes. So, I can clarify that currently the measure just looks at whether the care plan was shared within 30 days of either the development of the plan for a new member or any at least an annual, within 30 days of an annual update to the care plan.

So, it wouldn't be a constant barrage of updates if the member changes, say, their personal intended care agency? It's just within 30 days of the annual care plan development.

Correct. Yes.

Okay. Thank you.

Jill Morrow-Gorton, you were next.

I feel a bit of a traitor. I'm very, again, like Rich, very much promote communication, back and forth communication. This measure to me, and again, I apologize to all of my MLTSS colleagues, this measure to me is sort of care coordination by what Rich talked about at the beginning, which is Dr. Antonelli sends Dr. Kelley a record or a letter or whatever, and that's what happens. At this point, you get credit for putting it on a portal. It doesn't mean the doctor reads it. It doesn't mean it's meaningful to the doc if they try to read it. And I read these all the time. I know this is a start and I know that people went back and forth about whether or not it should be signed by the doc as evidence that they at least acknowledged it or whatnot. I feel like this is so rudimentary that it's maybe not ready for being part of a Core Set, and that we need to figure out how we make meaningful communication between the LTSS system and the physical health, and the behavioral health system.

Thanks for that comment, Jill. Kim Elliott, you were next. I think we may have lost Kim’s audio connection. While we wait for her to rejoin, I'll go to Curtis Cunningham.

Thank you. Yeah, just in response to the care plan, the care plans under 1915(c) are pretty prescriptive on what you need to have in there. And there are already requirements under that plan to share that care plan with any provider within the, providing HCBS services. I agree, it's a rudimentary measure, and it’s definitely a start. If we had Meaningful Use across long-term care, behavioral health, and hospital physicians, we wouldn’t be having this conversation. We would be saying, is there an EHR to utilize. But we're not there yet.

I do think that the uniqueness of people utilizing home and community-based services is a very fragmented environment. Many state Medicaid agencies are operating their HCBS waivers in different operating agencies than within their medical and acute primary areas. Many of them are running totally separate programs, and then you also have the complication that many of the people, if not most, depending on the state, are dual eligibles. And they're bringing in Medicare, Medicare Advantage plans.

So, while I think this is a rudimentary step, I think this coordination is a start of putting the toe in the water. And I do think we need to continue to think about how to combine the social model HCBS with the medical model, because there's many interactions there that are important to the overall person-centered care. But I do understand some of the other comments.

Sure. Thanks, Curtis. Kim Elliott, it looks like you might have your audio back.

I do. Thank you so much. Yeah, I think that this shared care plan is probably one of the more important measures. We haven't had, over the years, many really good measures for the long-term care population and programs. And in an ideal world, of course, the providers are all involved in the care planning and that they have a copy of the shared care plan. But, in reality, that just isn't always case. And it's so important for all of the people involved in planning long-term services and supports, health care, behavioral health care, all of the different components of the individual's care to be involved, so measuring this puts a little bit more emphasis on it, and I think it's just really a valuable measure to consider for the Core Set.

Thanks, Kim. Linette, you were next.

Hi. So Linette Scott from California Medicaid. And I guess I'm concerned about this measure, just because it is a case management record review, and so that means it's going to be more time intensive and resource intensive to be able to collect, so I'd be really concerned about adding it at this point in time.

The other thing that I think that becomes a consideration when we think about a measure like this is that, if I read it right, and I'd be happy to have folks correct me if need be, then, essentially, we're taking that sample of 96 members across California, and that would meet this requirement. I'm not sure that that is really representative when we have a program that has 13 million people in it, 14 million people in it. So then becomes a question, do we do it by plan? How do we do the sampling across a large program? So, I'm really concerned with the feasibility of what it would take to do this at this point in time, given that it is a case management record review. Thank you.

Thanks, Linette. Katelyn, it looks like you have your hand up again.

Yes. Thank you. To clarify, when this measure was submitted, it was also submitted with the Comprehensive Care Plan and Update measure, which, that is a case management record review process. However, that has been automated; at least, many health plans now have been able to map that using that ECDS process, and this process means there is already an existing care plan within the case management system that needs to be transmitted. So, this is not a case management record review measure. I think that was a little lost in the communication there. And the way it was initially set up, when CMS set this measure, CMS also was a measure steward here, but the sample size was 411 members. NCQA initially took this as a 411-member sample size and reduced it to 96, and then that would be per health plan in order to align with NCQA's distinction, which would only sample a record of 40 members for a file review.

Thanks, Katelyn. Are there any other comments from Workgroup members on this measure before we move on to the next one? David Kelley, go ahead.

Yeah, thanks. I think it's an interesting measure. I don't know if NCQA could comment on, the question I always ask is, what's the current performance, and is there opportunity to improve? And I think the answer is there's a huge opportunity to improve, even in this very rudimentary sharing of the care plan with the PCP or others. So, I don't know if NCQA could speak to that, and also maybe speak to whether or not they intend to, at some point, move beyond the denominator of 96. I think initially there was a lot of, I'll say, difficulty when I think the initial number was higher. It was 400 and something by health plan. So, I'm wondering if NCQA could comment on the current performance, where we're at with measurement, and then whether or not there might be a move towards a slightly higher denominator.

Lindsay, are you still on the line?

This is Lindsay Roth from NCQA. So I can first comment on the performance for this measure, and also, two, personally I can share some aggregate data for the Comprehensive Care Plan measure. From measurement year 2020, we did see average performance at 82 percent for the core element rate, and then 81 percent for the supplemental element rate. And then for the Shared Care Plan measure, we saw average performance of 60 percent, so obviously, we are seeing some room for improvement on both of those measures. And then to the question about the sample size, you are correct. So, we have been planning to revisit that sample size issue again, and potentially consider raising that back up to 411, but, at this time, I can't say exactly what measurement year that would be, but that is in our immediate plans to look at again.

Okay. Thank you.

Okay. Thanks, Lindsay. Any other comments on the Shared Plan with Primary Care Physician measure before we move on. Rich.

Thank you, and I think the Mathematica team, this question won't surprise you since I’ve been sort of knocking on this door. I’m just wondering, what is the experience looking at race, ethnicity, and language stratification with use of this measure?

All of this information about the care plan lives within our comprehensive case management system. If you were able to identify a member by, say, internal subscriber IDs, there would be no difficulty to stratify it in that way.

Okay. Thank you.

All right. Now let's pivot to discuss the LTSS: Successful Transition After Long-Term Institutional Stay measure. Any Workgroup members have a comment on this measure? Please raise your hand. And please remember, if you had your hand raised for the previous discussion, to lower it, unless you have another comment. Katelyn, go ahead.

Yes, thank you. I think this measure is vitally important, not only because of the huge budget burden that this population has on Medicaid spending overall, because the individual should be able to live in the least restrictive setting of their choice, and this is aligned with the Olmstead Act. Not to mention that as an individual transitions from an institution into the community, they're able to use community-based supports instead of or in advance of leveraging Medicaid state plan benefits or waiver benefits. So not only is the individual exercising their own choice in control if they want to move from a restrictive to least restrictive or community-based setting, it's saving the agency a ton of money while allowing the individual to be fully integrated in the community.

Thank you. Jill, go ahead.

I have to say I agree. I think this is a really important measure. I think it, rebalancing is such a big part of MLTSS and sort of moving people out of nursing facilities and ICFs into home and community-based services. I think 24 states were using it when 24 states had MLTSS. I would suspect there are more states now that have MLTSS than when that happened.

I think the other thing that this does is it may make people think about preventing long-term stays to start with. If you're paying attention to who is in a nursing facility and how long they've been there, I mean, sometimes it's like inertia, people go in for a short-term stay and they end up never coming out. And so, I think this really embodies the values of rebalancing, and I really like this measure.

Thanks, Jill. Other Workgroup comments? Curtis, go ahead.

I'm curious; this is limited to MLTSS plans, have nursing homes incorporated into their portfolio? I'm just struggling with, if the goal of Core Sets is to try and go across all programs and, you know, all various different state models, is this really only speaking to MLTSS in a certain way that their MLTSS system is developed? It's more of a question than a comment.

Mary, I see you have your hand up. Mary, go ahead.

Hi, it's Mary Botticelli from CMS, the MLTSS lead for the HCBS quality measures. You're correct, we're talking about the MLTSS measure, which we call MLTSS-8. CMS is currently in process of respecifying this measure, actually, for fee-for-service delivery systems in Medicaid states, and so the testing and the development of the specifications will be completed this year. And we agree that although, you know, when this measure was first developed, it was developed for MLTSS plans. We agree though, that, of course, it needs to expand to all populations under a Medicaid state, including fee-for-service.

Thanks, Mary. Other Workgroup comments or questions on the LTSS: Successful Transition After Long-Term Institutional Stay measure? Okay. I'm not seeing any more hands for this measure, so now we'll turn to the National Core Indicators for Aging and Disabilities Adult Consumer Survey, also known as NCI-AD. And I do want to clarify before we get into the discussion, we got a clarification from the measure steward that the NCI-AD survey can be deployed in person, by phone, or by video, starting in 2022. So, now we'll open it up for Workgroup discussion. Katelyn, go ahead.

Thank you. I'd say at this time that there is no mechanism to assess member experience of care at the state level, which is exactly what this survey is intended to do. I know CMS is either just finalized, or in the process of finalizing some HCBS measures that we can use that also support this population. But I think most of them had been process-oriented and we're not quite at the point where we're able to assess experience of care in an administrative way, of course, because it is subjective. So, this is so valuable, not only because it's not intended to be used as comparison among states to see who is performing better necessarily, but it's been designed to allow states to see their overall program and to make adjustments or program improvements to better experience, to better cater to their members and increase their satisfaction with their experience.

Thanks, Katelyn. Other comments on the NCI-AD measure? Tracy Johnson.

Yes, hi. Thank you. In our state and several other states we're aware of, this survey is completed every other year. Is this measure intended to be reported annually?

Camille Dobson or others from the measure steward, are you on the line and able to answer Tracy's question? I see Rosa has her hand raised. Derek, can we unmute Rosa.

Hi. This is Rosa Plasencia from ADvancing States. The states determine the frequency in which they provide the survey. Most do every year, but there are a few that provide, that alternate between NCI-IDD and NCI-AD. Does that answer your question?

Thank you very much.

Sure.

So, I guess the implication is, if it's part of the Core Set, and it's annual reporting, for those states that do IDD, sorry, there's some background noise here, for those states that do the IDD survey in the off years, there's going to be some tradeoffs there that we just might want to consider. So, it would be helpful for me to know if this measure, from a Core Set perspective, wouldn't be required every year, or is it if you're in the Core Set, it's just automatically annual?

Yeah, thanks for that question, Tracy. Curtis Cunningham. Actually, I see, yeah, Camille, do you have your hand raised? Were you going to respond to Tracy's question? Derek, we need to unmute her.

Yes, thank you. I was going to respond to Tracy. The National Core Indicators Survey for IDD is already in the Core Set. It was approved a couple of years ago. And in those cases states do the survey every other year, and only the states that do the survey are ones who report for that particular Core Set year.

That's very helpful. Thank you.

Okay. Curtis, go ahead.

Thank you. Yeah, I mean, I do think also, in our state we sometimes survey down to various levels, whether it's our MCOs or by programs. But what I also would like to point out too, by combining the IDD and the AD survey, you're really getting the larger holistic picture of your home and community-based services programs altogether. Different states have different, some have DD agencies; some have aging agencies. In Wisconsin, we have all of our HCBS target populations combined, and so this allows us to get a good view of the entire HCBS program and how it's running. So, you know, one, I think 25 states is quite a bit, and I think it will grow to the size of the IDD. But what is interesting to me is to really think of your HCBS population holistically across all the different types of members and participants, and so this would round out being able to see that whole picture. I'm very in favor of it. And I would say this is a strong outcome-based tool similar to the DD measure.

Thank you, Curtis. Other Workgroup comments on this measure? Tracy, I see you have your hand up. Is that just from before? Okay, thanks. Any other comments on NCI-AD before we move to public comment? Okay.

Before we move on to public comment, I do just want to quickly circle back to Tracy's question about whether annual reporting would be required. The NCI measure currently in the Core Set does have the threshold for public reporting, is whether 25 states are doing it in any given year, and so that would also apply for the NCI-AD measure if the Workgroup were to suggest adding it to the Core Set. I hope that helps. Next slide.

All right, now we'd like to provide an opportunity for public comment. If you would like to make a comment, please use the raise-your-hand feature in the bottom right of the participant panel to join the queue, and please remember to lower your hand when you're done making your comment. We'll let you know that you have been unmuted, and if you would please kickoff your comment with your name and organizational affiliation, that would be appreciated. So, are there any public comments on any of the three LTSS measures that have been discussed? I see Lowell in the queue. Derek, can we please unmute Lowell. Lowell, your line has been unmuted, if you could introduce yourself and provide your affiliation.

Yes, my name is Lowell Arye. I am President of the Aging and Disability Policy and Leadership Consulting. I was a member of this committee for three years. I just wanted to remind everyone that the NCI-AD was recommended three years ago when the NCI was put forward as well, and CMS did agree to put in the NCI. But for some reason, which still, to this day, is unclear, did not put in NCI-AD. I think it is an outcome-based program. It travels across all HCBS programs, as well as PACE programs, Older American's Act, et cetera, and it is person-centered. It deals with every single gap that has been discussed over the last several years in LTSS by this review group. So, I certainly would hope that it would be recommended. Thank you.

Thank you, Lowell. Stephanie Giordano, you're next. Derek, can you please unmute Stephanie. Stephanie, your line is unmuted. Please introduce yourself.

Thank you, this is Steph Giordano with Human Services Research Institute. I am a co-director of National Core Indicators. I just wanted to thank you all for inviting us to the conversation today.

We are really excited to see the direction to include some of these really important measures of quality and service delivery, especially as it relates to NCI-AD for older adults and people with disabilities who represent, really, the largest number of LTSS users.

Understanding the outcomes of services directly from the perspective of people who are receiving those services, it's really the underpinning of NCI-AD. In addition, we strive to take part in national conversations and, importantly, to support our states to structure samples and use our data in a way to really understand disparity as it relates to race, ethnicity, disability types, gender, and several other characteristics that we know can impact the experience of service users. We know that NCI-AD is not a small undertaking for any of our states, but we really do believe that the measures we collect are really critical to understanding the quality of services and several domains of people's lives. Thank you.

Thank you, Steph. Next, we have Rosa Plasencia. Derek, can we unmute Rosa?

Hi, my name is Rosa Plasencia. I'm also a co-director of the NCI-AD program, and I work with ADvancing States. In the current survey cycle, I wanted to note that we have seen an increase in the participating states to 19 fully participating states in this cycle. And as Camille noted earlier, we have pivoted to offer this survey in the three different modalities rather than just the face-to-face, which was noted before.

And as members of the Core Set Workgroup may be aware, over 30 percent of all Medicaid expenditures are spent on LTSS, and of that 30 percent, older adults in physical disability programs utilize 60 percent of the total cost of LTSS. It is important for states, consumers, and the larger health and human services system to know and really understand the outcomes of these services, given that the LTSS costs are expected to increase as the aging population continues to grow and more people utilize the services. But the cost of LTSS aside, which are significant, the efforts to collect the quality of life in outcomes data that honor the dignity and the worth of older adults and people with disabilities is a core tenet of the survey, and we really appreciate the opportunity for inclusion and consideration.

Thank you, Rosa. April Young, do you have a comment?

Hi, this is April Young at ADvancing States. I was just curious where the requirement for at least 25 participating states comes from, if there is reasoning behind that number?

You mean the threshold for public reporting of Core Set measures?

Yes, correct.

Sure. Is there anyone from CMS that wants to answer that question, or we can go ahead and do that? Well, I can just comment, actually, Gigi Raney is in the queue. Go ahead, Gigi.

Thank you. And thank you for this question. CMS, in conversation with Mathematica, established a 25-state threshold for public reporting of the Core Set measures, because when we're looking at the Core Set measures, we're really not just looking at any state’s rate they're providing us, but also trying to look at the national median for the entire country. And so, 25 states is about 50 percent, if we're not including D.C. and the territories of the states. So, any numbers smaller than 25, we really didn't feel would be an adequate number for us to be able to look at the data as a national sample of information across the states.

Got it. Thank you so much for that clarification.

Thanks, Gigi. Just as a reminder, if you've already made your comment, if you wouldn't mind lowering your hand in the platform, that would be appreciated. Thank you. Camille Dobson, you're next.

I just wanted to thank Gigi for her feedback and share our curiosity. I think that there are so many measures in the Core Set that have less than 25 states reporting. So, is it that initially you had to have 25 states commit to report the measure, and that's why you continue to have measures in the Core Set that have many fewer than 25 states reporting? We're still confused about that inconsistency. Thank you.

This is Gigi again. Thank you. There actually are not that many measures on the Core Set that are not reported by at least 25 states, and then we see increases in reporting every year, and which we think is fantastic and a testament to all of the hard work that our states and partners have been doing to report the voluntary Core Sets over time. The majority of the measures that still do not have 25 states reporting are measures that actually have been on the Core Sets since its inception or the things that we've been working with other agencies to grow.

The HIV Viral Load measure, for example, is one that does not have 25 states yet, but through collaboration with HRSA and other federal agencies, we've been working really hard with states to be able to increase the number of states that are reporting that. So, over time, that number of measures that’s not reported by 25 states has decreased significantly, but also our understanding of what it takes for states to report measures, the complexity, and the feasibility of measures, has grown as our program has advanced. So, as you guys have probably noticed, especially our Workgroup members, the criteria for measures that are submitted for consideration by the Workgroups is now very detailed. I would say four or five years ago, that was not necessarily the case. We didn't have as much information about the measures that we are considering making decisions about. So, as we learn more, we are trying to do better and make our own positive improvements, so trying to make sure that the measures that are added to the Core Set are feasible for our state partners to report, especially as we’ve been moving towards mandatory reporting which starts in 2024. That’s really been a very big consideration.

Thanks, Gigi. Are there any other comments? Any other Workgroup member comments on these LTSS measures before we move into voting? All right, seeing none, now we thank everyone for their comments in this discussion, and let's move onto the next slide. And I will turn it over to Alli and Dayna for voting on these three measures.

Great. Thank you, Tricia, and thank you to everyone who commented. Let's move on to the first vote in this area. All right, so for our first vote, should the Long-Term Services and Supports: Shared Care Plan with Primary Care Physician measure be added to the Core Set? And the options are, yes, I recommend adding this measure to the Core Set, and, no, I do not recommend adding this measure to the Core Set. Voting is open. I see the results are starting to come through.

It looks like we might be missing Anne's vote. Anne, are you able to submit your vote? We're also missing Kolynda. Kolynda, if you're there, could you please submit your vote? All right, it looks like we got in all the votes. Thanks, everybody.

Okay, now for the results. So, 59 percent of Workgroup members voted yes. That does not mean the threshold for recommendation. The Long-Term Services and Supports: Shared Care Plan with Primary Care Physician measure is not recommended by the Workgroup for addition to the 2023 Core Sets. Next measure, please.

Our next vote is, should the Long-Term Services and Supports: Successful Transition After Long-Term Institutional Stay measure be added to the Core Set? And voting is now open. It looks like we got the expected number of votes. That was a close one; so, for the results, 63 percent of Workgroup members voted, yes. That does not meet the threshold for recommendation. The Long-Term Services and Supports: Successful Transition After Long-Term Institutional Stay measure is not recommended by the Workgroup for addition to the 2023 Core Sets.

Moving on to the last vote of the day. The final vote is, should the National Core Indicators for Aging and Disabilities, NCI-AD Adult Consumer Survey measure be added to the Core Set? And voting is now open. We've reached the number of expected votes. Okay, and the results: 56 percent of Workgroup members voted yes. That does not meet the threshold for recommendation. The National Core Indicators for Aging and Disabilities Adult Consumer Survey is not recommended by the Workgroup for addition to the 2023 Core Sets. Now I will turn it back to Tricia to facilitate a discussion of gaps in the Long-Term Services and Supports Domain.

Thanks, Alli. All right, so now we would like to hear from Workgroup members about possible gaps in the Long-Term Services and Supports Domain. What suggestions does the Workgroup have for further strengthening the Core Sets? What types of measures or measure concepts are missing in the Core Set, and are there existing measures to fill the gaps, or would a new measure need to be developed? Please remember to say your name before making your comment, and Workgroup members, please raise your hand to make a comment. Katelyn, go ahead and kick us off.

Thank you. I know, previously, the Comprehensive Care Plan and Update measure was submitted, but I believe the decision was deferred or something in that capacity. Would someone be able to expand on that and why it was deferred?

Sure.

This is Margo. I can answer that. It was deferred because, as you probably know, CMS has been in the middle of its process of developing its HCBS measure set. And so, for purposes of alignment, CMS was waiting to decide on that measure for addition to the Core Set based on the finalization of the HCBS measure set. So, it's still under consideration, still deferred, but no decision has been made.

Thank you. That was helpful. Jill Morrow-Gorton, you are next.

So, I think there are a lot of gaps in terms of LTSS. It's a relatively new concept in terms of measurement. There are some sort of standard health things like pressure ulcers and falls and those kinds of things that are more likely to occur in people with disabilities than not. And we don't have any of those measures. I think the other big gap is measuring care coordination. And I mean measuring it in a meaningful way, not just, you know, do you have everybody signing the plan, or do you have, but do you actually have real sort of conversations and communications?

Are people getting useful information back and forth, and are you able to coordinate between all of the aspects of health, including the social determinants for people? I don't know that there's a measure to do that at this point. But I think that's really kind of the crux of LTSS, and so I think that is a gap.

Thanks, Jill. Curtis Cunningham, you are next.

Yeah, I mean, clearly, I think with the voting, it's hard to find a path forward on MLTSS Core Sets, or actually HCBS. And I just I think we need to start somewhere, and I think it needs to evolve. When I look at acute and primary services and the infrastructure around quality and development, and then I look at our HCBS, you know, that's still developing. But Medicaid is one of the key, is the HCBS system in our nation, and so it will be interesting to see where CMS goes. But we do need to start measuring it.

There is the medical coordination and stuff like that, but this is really about community integration, the ability to live the life you want to live, and so I do think the perspective of how we measure successful HCBS systems, you know, I'll go back to NCI-AD and the IDD measures, is really about the quality of life and the customer experience. And I think that’s just something we need to continue to focus on. So, I hope that we'll continue the dialogue to get some measures in this Core Set, because right now, it's a huge part of Medicaid programs, and the Core Sets are woefully underreporting in this important area.

Thanks, Curtis. Linette Scott, you are next.

So, I know we've talked a lot about the challenges of having appropriate measures in this space, and folks have already said that. But one of the things I wonder, in terms of how to address, is if there is an opportunity to think about the population that receives LTSS, long-term support services, and then we think about that as a population in the same way we would with those with severe mental illness, for example. So, we take the standard measures that we already have in the Core Set, and then we stratify it by this population. And that would be a way at getting at some of the care coordination, right?

So, if somebody has diabetes and they're getting long-term services and supports, if they have an adequate care plan that coordinates their care for their diabetes and their hypertension and their long-term supports, then their rates of hemoglobin A1c that's controlled should be similar to others, right? So, just maybe throwing out the idea of thinking about Core Set measures that we're already doing, and is there a way that we can stratify those to get at some of the issues folks have raised around care coordination, around outcomes to take a look at that? And along those lines, there's some of the measures that we've had in the past, like ED utilization, emergency department utilization, that we've removed from the Core Set, but is it something, as a process measure, related to this particular population that we could look at to see if we're getting adequate support services, does that reduce other kinds of utilization? Because I think we all agree there are gaps, but the challenges, especially given the data environment for these services and some of the integration aspects, it's just harder from a data perspective to have something we can measure consistently across the states. Thanks.

Thanks, Linette. Rich Antonelli, go ahead.

Thank you. I was actually going to make that point second, Linette, but I'm always actually quite inspired by your observations, so I'll sort of call out what we led off yesterday with was race, ethnicity, language, disability status. And from my perspective, the sooner that we can adopt, nationally, an approach to stratification, the better, because that would be really, really important.

My other point, though, to sort of take a deep breath, when I think about how much money is spent for persons eligible for LTSS and the gaping hole we have in the Core Set to really look at equity and look at value, I'm speaking not just as a health advocate but even as a taxpayer, I'm actually disheartened. But I, obviously, don't have access to the head counts, but my quick scan of the percentages that came across the screen is, I think one or two of those votes possibly was one, maybe two people. And so, I'm sort of reacting to that notion of, gee, do we need new measures? And we always need to ask that question.

But I'm wondering, you know, how productive would the discussion be to really find out, you know, what's missing. And we heard some commentary back and forth, but nothing that really jumped out at me that said, yep, definitely not ready for prime time. I want to thank Gigi for weighing in and giving us that historical perspective about, you know, where does 25 come from. And when you looked at the prep for these measures, you could see that the numbers were not, you know, all set in stone; that 25-plus states. It's a little bit of a moving target over the course of the last few years. So, I'm making an argument to not throw the proverbial baby out with the bath water but to find out what it is that we need to close the gap for that, because it's just so hard for me year after year after year not to have something meaningful in the LTSS space.

This also loops back to the commentary I made an hour ago about the gaps for children with special health care needs. So, for those of you on the group that are not pediatric focused, there are children that are LTSS-eligible as well. So those are my comments. But I urge the group, let's think about why one or two votes went in the negative direction and see if we can make progress going forward. Thank you.

Thank you, Rich. Kim Elliott, I see your hand is up.

Yes. One of the things that always seems to be a gap for the LTSS measures is how they are included or not included in some of the other measure areas, such as the chronic illness, the preventive health. And when I think about that, I think about some of the exclusions in some of those measures, such as frailty and not exclusions but not inclusion because of other types of coverage, maybe commercial, Medicare, and whether we're really getting to the preventive health, to the access to care and chronic illness management for the long-term care population to keep them in the healthiest place that they can be, and really deliver that quality of care. So, I don't know that that's necessarily a gap in a measure but may be across all of the measures and how we're really looking at that as a measurement criteria for the LTSS members, the people that are served in that domain.

Thanks, Kim. Next, we have Lisa Patton.

Yeah, thanks, Margo. I really just wanted to second what Rich said. I know that this panel, for several years now, we've really sought to address this key gap. And, you know, I really kind of had hoped we were going to turn a corner and hope a couple of votes would have gotten us there, and so, you know, as the previous speaker said as well, I'm really trying to understand where, as a body, you know, we would really like to see the measures go, or how we're addressing this, because I just think, you know, we really need to sort this through because of the longstanding conversations we've had on this. I just wonder if we could hear some more from people who felt torn; a bit more about their decision or what exactly was missing to get us there.

Thanks, Lisa. David Kelley, I see you have your hand up.

Sure. Thanks. A couple of comments. You know, one of the challenges of many of the individuals that are duals in these LTSS products is the lack of being able to actually do some of the, quote, unquote, regular quality metrics. And it's challenging because of, some folks may be fee-for-service, they may be Medicare Advantage. States may or may not have MCOs, LTSS MCOs may not be aligned and may not have access to those claims, and if they're NCQA measures, if they're not responsible for those services, for paying for those services, they're excluded. So, food for thought, CMS, you have all the data, I'm told, both Part D, Medicare Advantage and fee-for-service, and maybe even some PACE data to actually do some of the routine, bump that up against your home and community-based by state who those members are that are home and community-based and actually do some of the very basic measures, the quality measures, I'll call them the non-LTSS, but other basic quality measures like access to care, or emergency room visits, we had 30-day readmissions, et cetera. So, food for thought there. I know that some states have it and we're trying to put all those databases together, but CMS could certainly do that, because I think you're sitting on that data.

From a care management standpoint, I like the comments about, you know, we really need to have, I'll say, more meaningful care management. I like the idea of sharing plan with the PCP, but that's kind of step one, and there is room for opportunity. But there has to be more robust ways of looking at care management. And I know in Pennsylvania, we require our non-aligned D-SNP plans to submit data to our LTSS plans around admissions and readmissions, and we recently asked them both to identify whether or not they or our LTSS plan had done care management. And these are people that were readmitted at least twice within 30 days. And I'll tell you, the percent that actually had care management was abysmally low.

So, those are the types of things that we can leverage, some basic claims data, but then also look at whether or not they're really being care managed, and that information could be pulled out of care management software. So, just food for thought, at least on some basic rudimentary things.

And then I think one of the challenges with all the various surveys, I mean, we had the NCI-DD and the AD and some states, we're one of those states, we also do the home and community-based CAHPS. And it's like, well, we can't do them all. So, are there a few questions that are at the essence of what we want to get at the consumer experience? And at least in our state, we pulled one question out of the home and community-based CAHPS survey, does the care plan meet your needs? To us, we felt that was the essence of what LTSS should be doing. So, maybe we need to think in terms of adding entire surveys, are there particular questions that we could hone in on and focus in on? I know the validity of asking those questions in isolation of an entire survey gets tricky. So, those are my thoughts. We'll keep plugging away, and again, maybe the LTSS, maybe there needs to be a separate LTSS quality Core Set.

Thanks, David. I appreciate your reflections. Linette Scott, you have your hand up. Maybe that was from before. Curtis.

It was from before.

Okay. Thanks. Curtis Cunningham, you have your hand up as well.

I just wanted to follow up on David's comments, because one of the things I was thinking of as I was looking at the measures between NCI-IDD, AD, and others, is could we, and maybe this is just a recommendation for those survey groups to come together and find some of the common data elements, because many of the questions are similar, and I think if you looked at some of these surveys, you could potentially get some sort of composite across those. Obviously, we'd need to test it and everything. But I think some of the questions are similar because they are focused on HCBS. So, I would encourage a conversation or a dialogue amongst the surveyors to see if there could be some way that even though the surveys are for different populations, they are looking at very similar things and could we draw from multiple surveys to create some sort of composite measure, giving states flexibility. So, it's something I'm going to follow up on. But I think that might be a good idea to help look at bridging the gaps here.

Thanks, Curtis. Jill, I see you have your hand up again. Go ahead.

Yeah, I just wanted to sort of bring out a thought about surveys in general. I think people are kind of surveyed to death. And you can create a really good survey, but when you have a response rate of less than 30 percent, is that a meaningful piece of information? And I think, you know, if you look at the survey response rates, they just keep dropping. And part of it is survey overload; right? There's the CAHPS, the HCBS CAHPS. You go to the grocery store; you get a survey. You go to the pharmacy; you get a survey. And I'm just wondering if we don't maybe need to think about another way to get that information. It's valuable information. It is so helpful.

We use the NCI-ID data. I mean, we poured over it and we pulled out things and we made changes. But I do think that the response rates are alarming to begin to try and make sense of using that data and have it reflect the whole population. So, I'd like to, again, I don't know exactly what that is, but to maybe be able to get the same information in a way that people would be willing to participate.

Thanks, Jill. Katelyn, I see you have your hand up.

Yes. Just adding on to what everybody is saying here about the surveys, and 30 percent is a generous response rate from what I've seen, at least for HCBS CAHPS. But one of the things also that I think is detrimental with the survey approach is we survey, say, you know, and internally Anthem, we do member experience surveys. We also do an HCBS CAHPS, but we make sure the same folks don't get it. But each year, we're not surveying the same members, so how can you really drive meaningful improvement if, you know, each year you're getting a separate set of opinions. So, if we're not able to sample the entire population that we're supporting, you know, it's kind of hard to measure improvement in a valid way. Just another obstacle.

Thanks, Katelyn. Are there any other Workgroup comments on gaps in the LTSS Domain? All right. Seeing none, we'll move on. I want to thank everyone for your thoughtful input in this discussion. Next slide.

So, we are in the home stretch on Day 2 of the Meeting to Review Measures for the 2023 Child and Adult Core Sets. I want to thank everyone for a robust discussion today and for powering through all of the measures and voting. We appreciate all of your contributions today, from the Workgroup members, federal liaisons, members of the public, and measure stewards.

Let me quickly summarize the votes for today. The Workgroup discussed and voted on 10 measures in two domains. We began by discussing the Primary Care Access and Preventive Care Domain, where we discussed seven measures. The Workgroup recommended three measures for addition to the 2023 Core Sets. These measures were Adult Immunization Status, Depression Screening and Follow-Up for Adolescents and Adults, and Lead Screening in Children measures.

The Workgroup also recommended three measures for removal, and these were the Flu Vaccinations for Adults Ages 18 to 64 and the Screening for Depression and Follow-Up Plan measures, both the version for ages 12 to 17 in the Child Core Set, and the version for age 18 and older in the Adult Core Set. The Workgroup also voted on three measures in the Long-Term Services and Supports Domain, and none met the threshold for recommendation for addition to the 2023 Core Set.

So, now I would like to briefly preview the agenda for tomorrow. Next slide. Tomorrow, we will discuss measures for removal and addition in one remaining domain, which is the Care of Acute and Chronic Conditions Domain. There is one measure suggested for removal and five measures suggested for addition in this domain. We'll also spend some time providing a recap of the meeting and discussing future directions, including further discussions of gaps and areas for measure development. We'll also discuss next steps in the stakeholder review process and provide an opportunity for public comment. Before we adjourn for today, I'd like to give our co-chairs, Kim and David, an opportunity to provide any closing reflections they have on today's discussion. Kim, would you mind going first?

Sure. Thank you, Patricia. I think we had a very productive day again today, and I do want to thank all of the Workgroup members for the continued active participation during Day 2. And I'd also like to thank Mathematica, the measure stewards, CMS, and other partners for all the preparation, organization, the dialogue, and particularly all of the information that was shared throughout the meeting, because I think it did have a meaningful impact on some of the discussion that we had, as well some of the voting that occurred during the call today.

And similar to the social determinants of health, health disparities, and health equity discussion during Day 1, the digital measure discussion today was very informative, and the discussion indicated a strong desire, but also a real need for the Core Set to advance and include digital measures to relieve burden from everyone involved in reporting performance measures or quality measures. It also highlighted that it is the direction that CMS is preparing to go in and is already heading in that direction for the Medicare program. And it also provided a strong indicator to measure stewards that this is a direction that CMS and members of this particular Workgroup intend to go in from a consideration of new measures for the Core Set, or different measures for the Core Set, and I'm confident that this discussion will be strongly considered going forward by all of us that participate in these discussions and in these Workgroup meetings.

And I think today also really highlighted that there is certainly a continued passion around primary care, preventive care, and long-term services and support measures, and even though not a lot of the measures made it through to a recommendation to add to the Core Set, the discussion and dialogue continues to advance our thought process and what we may do in future Workgroup meetings. And the discussions did focus heavily on the populations that are served by Medicaid, the feasibility, the desirability, the viability, and the importance, really, of the different topic areas for the Medicaid program, and those that are served by the Medicaid program. So, I'm looking forward to Day 3, and we'll certainly have an equally active discussion on measures recommended for removal and for addition to the Core Sets related to care of acute and chronic conditions. David, I'll turn it over to you.

Thanks so much. And I just want to thank the Workgroup for all of the, again, due diligence, the great questions, the great conversation. Also, I want to thank CMS for their responses to the questions and their listening in to the conversation, as well as our other federal partners. I also found very interesting today some of the public comment, I thought, was very well helpful as well. So, it's been a very productive day, really look forward to tomorrow, and hopefully we'll be able to wade through the last day and finish our mission here in making recommendations. So, I'll turn it back over to the Mathematica team. Thanks.

Thank you, David and Kim. All right, well, we will begin again tomorrow, promptly at 11:00 a.m. Eastern Time, and we ask Workgroup members to sign in about ten minutes early just in case we have any technical difficulties. We hope everyone has a great rest of your day, and we look forward to seeing you tomorrow. With that, we will conclude Day 2 of the Meeting to Review Measures for the 2023 Core Sets. This meeting is now adjourned. Thanks, everyone.