2025 Child and Adult Core Set Annual Review:
Meeting to Review Measures for the 2025 Core Sets, Day 2 Transcript
April 26, 2023, 11:00 AM – 4:00 PM EST

Talia Parker:

Good morning, everyone. My name is Talia Parker, and I'm pleased to welcome you to the 2025 Child and Adult Core Sets Annual Review, Meeting to Review Measures for the 2025 Core Sets, Day 2. Before we get started today, we wanted to cover a few technical instructions. If you have any technical issues during today's meeting, please send a message to all panelists through the Q&A function located on the bottom right corner of your screen. If you are having issues speaking during Workgroup or public comments, please make sure that you are not also muted on your headset or phone. Connecting to audio using computer audio or the call me feature in WebEx are the most reliable options.

Please also note that call-in-only users cannot make comments. If you wish to make comments, please make sure that your audio is associated with your name in the platform. All attendees have entered the meeting muted. There will be opportunities during the meeting for Workgroup members and the public to make comments. To make a comment, please use the raise hand feature in the lower right corner of the participant panel. A hand icon will appear next to your name in the attendee list. You will be unmuted in the order in which your hand was raised. Please wait for your cue to speak, and remember to lower your hand when you have finished speaking by following the same process you used to raise your hand. Note that the chat is disabled for this meeting, so please use the Q&A feature if you need support. And finally, closed captioning is available in the WebEx platform. To enable closed captioning, click on the CC icon in the lower left corner of your screen. You can also click Control-Shift-A on your keyboard to enable closed captioning. And with that, I will hand it over to Margo to get us started.

Margo Rosenbach:

Thank you, Talia, and welcome back, everybody, to Day 2 of the Meeting to Review Measures for the 2025 Child and Adult Core Sets. I hope everyone had a nice evening. Just a brief recap, we had a very productive day yesterday. The Workgroup in the morning talked about stratification of Core Set measures, talked about the importance. There was broad consensus that it's very important. Also, a lot of challenges were raised, and also some constructive and productive ways of trying to improve stratification of Core Set measures. We also voted on three measures yesterday -- four measures, rather. The first, Oral Evaluation During Pregnancy, was recommended for addition. Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults was also recommended for addition. And the two Topical Fluoride for Children measures were discussed, and the Topical Fluoride for Children DQA measure was retained in the Child Core Set. In many ways, that was a fairly, I think, a big milestone. This is the fifth year that we have been convening the Child and Adult Core Sets Review Workgroup, and the first time that two adult dental measures have been suggested for addition. So, a very important milestone yesterday, I think. So today, we're looking forward to another day of discussions about the 2025 Child and Adult Core Sets. Before we begin, I'd like to turn to our two co-chairs, Kim Elliott and Rachel La Croix, for brief welcome remarks. Kim?

Kim Elliott:

I look forward to another productive day, discussing the potential value of either recommending additions to or removal of measures from the Core Sets related to chronic illness, behavioral health, and very importantly, the member experience with Medicaid care and services. As I was

thinking about the work we completed yesterday, I'm consistently delighted to hear everyone's deep perspectives, not only on the measures under consideration, but also the reason why each of us find value in the measures or don't think the measure will lead to improved quality, access, or timeliness of care and service delivery for Medicaid members. These open discussions add a lot of context to our work, and I believe will result in informed decisions when we vote on the measures. And I'm really looking forward to that same thoughtfulness and passion as we work through today's agenda. Rachel?

Rachel La Croix:

Good morning, everyone. I would just like to echo Kim's comments and Margo's comments. Yesterday's conversation was really robust, and I also think it's a great milestone to have added two adult dental measures in our recommendations, and I look forward to the conversation today related to acute and chronic conditions, as well as behavioral healthcare and the experience of care measures. So thank you.

Margo Rosenbach:

Thanks, Kim and Rachel. So now we'll conduct a roll call of Workgroup members. Next slide, please. We ask that Workgroup members raise their hand when their name is called. We'll unmute you, and you can say hello. After you're done, please mute yourself in the platform and lower your hand. This will allow you to unmute yourself when you would like to speak during the measure discussions. If you leave and reenter the platform or find you've been muted by the host due to background noise, please raise your hand and we'll unmute you. So next slide. On the next three slides, we've listed the Workgroup members in alphabetical order by their last name. When I call your name, please raise your hand. We'll unmute you, and you can indicate whether you are here. Remember to mute when you are done. Next slide, please. All right. So we've already heard from Kim and Rachel. Ben?

Ben Anderson:

Hi. Good morning. Ben Anderson, Families USA. Looking forward to the rest of today with you all.

Margo Rosenbach:

Thanks, Ben. Rich Antonelli?

Rich Antonelli:

Good morning. I'm present as well.

Margo Rosenbach:

Thank you. And also, Workgroup members, as you see your name coming up, please feel free to raise your hand and get in queue, and that will speed up our unmuting. Thank you, everyone. Stacey?

Stacey Bartell:

Hi. Stacey Bartell, American Academy of Family Physicians.

Margo Rosenbach:

Tricia? Tricia, you should be unmuted.

Tricia Brooks:

Yeah. I didn't hear something for a few minutes. It cut out on me. Tricia Brooks, Georgetown Center for Children and Families here. And I just want to reflect on yesterday. I was really happy with large consensus on all of the votes, but really delighted at the adult oral health measure. So thank you. Looking forward to today.

Margo Rosenbach:

Thanks, Tricia. Emily?

Emily Brown:

Emily Brown, Free From Market. I'm here and excited to engage in discussion today.

Margo Rosenbach:

Joy?

Joy Burkhard:

Hi, everyone. Joy Burkhard from the Policy Center for Maternal Mental Health. Really looking forward to another great day of conversation about these measures.

Margo Rosenbach:

Thanks. And Karly Campbell let us know that she might not be able to attend today. And it looks like she is not here. Stacey?

Stacey Carpenter:

Stacey Carpenter here from Zero to Three.

Margo Rosenbach:

Lindsay? Lindsay, are you here? Can you raise your hand? Derek, are you able to unmute Lindsay? Well, why don't we keep going? I see Lindsay, but I don't hear her. Jim Crall?

Jim Crall:

Jim Crall, UCLA School of Dentistry. And I'd like to add my thanks to everyone for all the work done yesterday on the dental and oral health measures.

Margo Rosenbach:

Thanks, Jim. Next slide, please. Curtis? Curtis, you should be unmuted now.

Curtis Cunningham:

Hi. Curtis Cunningham, Assistant Administrator for Benefits and Service Delivery within the Wisconsin Medicaid Program.

Margo Rosenbach:

Great. Thank you, Curtis. Erica?

Erica Park:

Well, good morning. Erica David Park from AmeriHealth. I'm here this morning, present, and looking forward to more discussion. Thank you.

Margo Rosenbach:

Amanda?

Amanda Dumas:

Hi, Amanda Dumas is present, Louisiana Medicaid.

Margo Rosenbach:

Anne? You should be unmuted. I think you cut out for a second. Okay. Clara? I don't see Clara. Is Clara Filice on the phone? Not seeing her. Let's keep going. Sara Hackbart?

Sara Hackbart:

Yes, good morning. Sara Hackbart with Elevance Health, looking forward to the discussion today. Thank you.

Margo Rosenbach:

Thank you. Sarah Johnson?

Sarah Johnson:

Good morning, this is Sarah Johnson from IPRO looking forward to the discussion today.

Margo Rosenbach:

David Kelley? David, you should be unmuted.

David Kelley:

Hi. Good morning. This is Dave Kelley, Chief Medical Officer, Pennsylvania Medicaid, looking forward to ongoing discussion. Thanks.

Margo Rosenbach:

Thank you. David Kroll? I'm not seeing David. David Kroll? All right. We'll keep going. Jakenna?

Jakenna Lebsock:

Good morning, everyone. Jakenna Lebsock, Arizona Medicaid.

Margo Rosenbach:

Okay. Great. I also think -- oh, David Kroll. I see you now. Derek, can you unmute David?

David Kroll:

Dave Kroll from Mass General Brigham Health Care, and I'm here. Thanks very much.

Margo Rosenbach:

Thank you. All right. And I think Lindsay Cogan is here, having audio issues. Lindsay, are you able to raise your hand and speak? Well, we'll come back to you. Lisa Patton? Derek, can you unmute Lisa?

Lisa Patton:

Lisa Patton, Vice President of Health Care Research at CVP. Happy to be here again today with you all. Thank you.

Margo Rosenbach:

Thank you. Laura? Laura, you should be unmuted. Laura, if you're speaking, we're not hearing you. Laura, can you raise your hand again? There you go.

Laura Pennington:

Yes. Can you hear me now?

Margo Rosenbach:

We can.

Laura Pennington:

Okay. Great. Sorry about that. Laura Pennington, Washington State Health Care Authority. Good morning, everyone.

Margo Rosenbach:

And we know that Grant Rich is unable to attend. Lisa Satterfield? I'm not seeing Lisa. Oh, there I do. Okay. Lisa?

Lisa Satterfield:

I'm Lisa Satterfield from the American College of Obstetricians and Gynecologists.

Margo Rosenbach:

Great. Linette?

Linette Scott:

[Inaudible] … California Department of Health Care Services

Margo Rosenbach:

Thanks, Linette. Kai? You should be unmuted now, Kai.

Kai Tao:

Good morning. Can you hear me?

Margo Rosenbach:

Yes.

Kai Tao:

Yes. Good morning. This is Kai Tao, a nurse midwife, and happy to be here. Thank you.

Margo Rosenbach:

Thank you. And we understand that Mitzi will be late today and not seeing her yet. Ann? Ann was calling in this morning. Ann, I'm not sure if you can speak or not. There you are. Okay.

Ann Zerr:

Ann Zerr from Indiana Medicaid. Thank you.

Margo Rosenbach:

Okay. Thank you. Bonnie, are you able to speak this morning? Are you? I don't see Bonnie yet. I know that she was having some issues this morning. But we'll be on the lookout for Bonnie. And then, finally, Sam, last but not least.

Sam Zwetchkenbaum:

I'm from Rhode Island Department of Health and Rhode Island Medicaid Program. Excited for more great conversations today.

Margo Rosenbach:

Great. Thank you, everyone. I know that we have some delays with the unmuting, it seems. So please be patient. And if you're not sure that you can be heard, please announce yourself and say, can you hear me? We very much want to hear from every Workgroup member today. All right. Next slide, please. So we are also joined by federal liaisons who are non-voting members. And we encourage federal liaisons, if you have questions or contributions during the Workgroup discussion, just raise your hand and we'll unmute you. Also like to acknowledge our colleagues in the Division of Quality in the Center for Medicaid and CHIP Services and also the measure stewards who are attending and available to answer questions about their measures. Next slide. So now let's get started. I'd like to turn it over to Chrissy who will lead the discussion of measures in the Care of Acute and Chronic Conditions domain. Chrissy?

Chrissy Fiorentini:

Thanks, Margo. Next slide. So first we'll start with the measures in the Care of Acute and Chronic Conditions domain in the 2023 Core Sets. There are three measures in this domain in the Child Core Set. Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Ages 3 Months to 17 Years, which was added to the 2023 Child Core Set. Asthma Medication Ratio: Ages 5 to 18, and Ambulatory Care: Emergency Department Visits. For the Adult Core Set there are 12 measures in this domain. They include Controlling High Blood Pressure, Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Age 18 and Older, which was new to the 2022 Adult Core Set and is the same measure that is now in the Child Core Set for the younger age group. And Hemoglobin A1c Control for Patients with Diabetes. Next slide.

Continuing with the Adult Core Set measures, there's PQI 01: Diabetes Short-Term Complications Admission Rate, PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate, PQI 08: Heart Failure Admission Rate, PQI 15: Asthma in Younger Adults Admission Rate, Plan All-Cause Readmissions, Asthma Medication Ratio: Ages 19 to 64, which is also in the Child Core Set for the younger age group, and HIV Viral Load Suppression. Next slide.

And the last two measures in the 2023 Adult Core Set are Use of Opioids at High Dosage in Persons Without Cancer and Concurrent Use of Opioids and Benzodiazepines. Both of these measures have been suggested for removal from the 2025 Core Set, so I will provide more information about them on the next few slides. Note also that both measures were previously included in the Behavioral Health Care domain. CMS moved them to the Care of Acute and Chronic Conditions domain as part of the 2023 Core Set updates. Next slide.

The first measure we will discuss today is the Use of Opioids at High Dosage in Persons Without Cancer or OHD-AD measure, which was suggested for removal from the Adult Core Set. The measure is defined as the percentage of beneficiaries age 18 and older who receive prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine milligram equivalents, or MME, over a period of 90 days or more. Beneficiaries with a cancer

diagnosis, sickle cell disease diagnosis, or in hospice or palliative care are excluded. The measure steward is the Pharmacy Quality Alliance (PQA), and it is NQF-endorsed. The data collection method is administrative. Next slide.

The measure was reported by 33 states for FFY 2020 Core Set reporting, with five of these states calculating the measure using other specifications, specifically the HEDIS specifications for Use of Opioids at High Dosage. And the measure is included on the Medicaid and CHIP Scorecard. The measure steward is considering this measure for retirement for 2025 due to the CDC's decision to discontinue updates to the Opioid NDC and Oral MME Conversion File, as this source file is necessary to calculate the measure. Several Workgroup members suggested this measure for removal, citing concerns about the measure's actionability and strategic priority.

One Workgroup member pointed out that states struggle with how to interpret the results of this measure and often question at what level the measure is actionable. Another Workgroup member noted that policy and practice changes following the 2016 CDC Guideline for Prescribing Opioids for Chronic Pain have reduced opioid prescriptions. The Workgroup member stated that the opioid epidemic is no longer driven by prescription opioids, but by heroin, illicitly manufactured fentanyl, and other drugs, and the AMA and others are calling for a shift in focus. The Workgroup member suggested that some of the actions providers may take to improve performance on the OHD measure may put patients at significant risk of harm or death. And a third workgroup member suggested this measure for removal to support implementation of CDC's 2022 Clinical Practice Guideline for Prescribing Opioids for Pain and to allow for maximum flexibility and care for the treatment of patients living with pain. Next slide.

The next measure suggested for removal is Concurrent Use of Opioids and Benzodiazepines, or COB-AD. This measure assesses the percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice or palliative care are excluded. The measure steward is PQA and it is NQF endorsed. The data collection method is administrative. Next slide.

The measure was reported by 28 states for FFY 2020 Core Set Reporting. This measure is not on the most recent Medicaid and CHIP Scorecard. A Workgroup member suggested this measure for removal, citing concerns about its actionability and strategic priority. The Workgroup member suggested that some of the actions that providers may take to improve performance on the COB-AD measure may put patients at significant risk of harm or death. In targeting chronic users, the Workgroup member indicated that the measure may motivate providers to discontinue or taper one of these two medications too abruptly, refuse to accept new patients on this combination, or dismiss patients from their practice. The Workgroup member argued that these actions can leave patients without necessary care and precipitate life-threatening withdrawal. The Workgroup member who suggested the measure for removal acknowledged that it was discussed by the Workgroup at last year's meeting. They suggested revisiting the measure because monitoring occurs under the Drug Utilization Review requirements, which are also focused on appropriate prescribing. Next slide.

And with that, I will turn it back to Margo to facilitate the Workgroup discussion around these two measures.

Margo Rosenbach:

Thanks, Chrissy. And I'm noticing that we still have some hands raised that I think are left over from the roll call. So if you do not have a comment to make, please lower your hand so we can have people queue up for this discussion. So first up, Bonnie, do you have a comment? Derek, can you unmute where the raised hand is? I think Bonnie signed in as one of our staff members. Derek, can you unmute Kate? The person logged in as Kate. Bonnie, is that you?

Bonnie Zima:

Yes, it is me.

Margo Rosenbach:

We'll get you straightened out, but for now. Thank you.

Bonnie Zima:

All right.

Margo Rosenbach:

Please go ahead and make your comment, if you have one.

Bonnie Zima:

I have no comment. I was taking attendance.

Margo Rosenbach:

Okay, great. Thank you. David? Derek, can you? There you go.

David Kroll:

Hi, everyone. Dave Kroll here. So I'm going to comment on both of these measures, if that's okay, but I think they're fairly well related. So the first one about the opioids in high dosage of patients with cancer, I'd love to hear a little bit more about the specifications and whether or not that we'll still be able to collect this measure based on the data set because that seems like the more compelling argument here. And obviously, if we're not going to be able to collect the data, we're not going to be able to collect the data. But I do want to point out that according to NIDA's most recent statistics, the death rate of opioid -- opioid-related death rate from prescription opioids has not really particularly gone down. There's a slight dip in it compared to two years ago, but certainly the death rates from opiates in general have not gone down, and the opioid epidemic has not gone away. So I remain concerned that this is still a very important measure and is still a very important marker of quality.

Now, with regards to the benzodiazepines and the opioid combinations, again, I continue to think this is a really important measure. It's one of the few areas where we can concretely say there's a big difference between high-quality and low-quality prescription care. The death rate is far higher for patients who are on combination regimens of benzos and opioids together. We

know it's a combination that is dangerous, and with very few indications, which I think are acknowledged fairly well in the exceptions of this. And so as a practicing psychiatrist, I come across this all the time. I take care of a lot of patients who arrive on this combination. But being able to point to this as here is a very well-recognized marker of quality, and it's very important that we follow through with this very well-recognized marker of quality and move towards dismantling these regimens and not starting these regimens is actually really important to have just from a treatment standpoint. So it's something that I think is really important because it sets a very important tone for practicing prescribers, but also because it's one of the I think rare measures that has a very, very clear association with the difference between high-quality and poor-quality care.

I really don't buy the arguments that this is something that puts patients at risk. Yes, it is true that certain prescribers may respond to certain regimens or patients in a certain way with the objective of trying to keep their quality measures up. I will say that in the Medicaid population especially, it's far less likely that Medicaid beneficiaries are walking into private practices who are cherry-picking their patients. Most of Medicaid beneficiaries are going to be going to large clinical systems who are very population-focused and recognize that we're going to be taking care of patients with a number of complex and sometimes high-risk needs. I will also say that the risk of dying from clinicians wanting to dismantle and taper their medication regimens is less of a concern to me than the risk of patients dying when these medications are prescribed together without any kind of check or discouragement.

Margo Rosenbach:

Thank you. Lisa Patton?

Lisa Patton:

Thanks, Margo. Yeah, I can be fairly brief because my comments are primarily going to reflect what David just expressed. I have a bit less angst around the removal of the first measure only because of some of the shifting challenges with the opioid epidemic, but I would like to see it stay on for now. In terms of the concurrent prescribing, another factor to consider is the older adult population, and there's a lot of concurrent benzo and opioid prescribing among that group in particular. With the potential for respiratory distress and just mortality and that kind of co-prescribing, I have concerns. We just have not done enough to address that in a lot of areas, and there are many initiatives that are focused on ensuring adequate pain management, but I just think with the potential for overdose and death with that co-prescribing going on, we still have a long way to go. As David so eloquently said, the opioid epidemic is still raging on, unfortunately, and I think we need to continue to focus awareness on those issues.

Margo Rosenbach:

Thanks, Lisa. Other Workgroup members? Mitzi? Mitzi, we are having a hard time hearing you. Mitzi, can you check your headset maybe? Mitzi, are you speaking?

Mitzi Wasik:

Yep. Is that better?

Margo Rosenbach:

So much better. Thank you.

Mitzi Wasik:

All right. Sorry. Technically challenged today. Just a few comments on this one. Putting a Medicare lens on it, this is a measure that's been a display measure for STARS for many years now. We actually thought we might see it come to fruition with a proposed rule, but there was so much feedback on the management of this that CMS did push that off, and they did not bring it forward as a STARS measure. Some of the issues that we see and concerns we have, especially probably a little bit different in a Medicaid population than Medicare, is that if the patient cannot get the medication from the pharmacy, from a physician, sometimes that will push them to a procurement on the street, which is more dangerous. And so, there's not a lot the pharmacist can necessarily do for it. If the patient is being managed, it's hard to get that historical data in to show that, yes, they are being managed by a physician, it's the same prescriber for both meds.

I know there's a little bit difference in the Medicare and Medicaid population, but it's a tough one that the patient is the one that ends up on the negative side of it if they just get blocked access from it, or if they are managed, they've been on it for a long time, then is there any withdrawal effects if it just all of a sudden goes away? And this also takes me back to early days of high-risk meds and the STARS measures where if patients couldn't get it through their insurance, especially the benzos, these are cheap enough, they potentially could just buy them cash. Not sure in a Medicaid population if that's about the same, but I did just take a peek at our baseline for Medicare, and national average last year was about 12 percent of this, and that was just really kind of ugly data because it doesn't take into account, were they the same prescriber, all the different factors that we could look into to really dig into those members that are the highest risk. So, I struggle with this one as well just because it's kind of the -- well first of all, the states that are reporting it, do we know what the averages are? Is this something that with the measure has brought it down significantly when reported out, or has it stayed the same? It's kind of that so what again, so this is one that unless there's a clear action plan that we can actually expect to happen that I tend to agree with the removal as well.

Margo Rosenbach:

Thanks Mitzi. Other Workgroup members? A lot of people queued up now. We have David Kelley, Erica, Linette, and then I will turn to Ben Shirley, the measure steward. David, you're first.

David Kelley:

Thanks, good morning. I would support continuing both of these measures on the Core Set. In Pennsylvania we have seen, I'll say, significant improvement in both measures and we continue to track this. In Pennsylvania we've had over 5,000 opioid-related deaths. We also have looked at hospitalizations independently. We have a health care cost containment council where we have gone from 3,500 hospitalizations down to 2,500 hospitalizations in 2021. The problem is 70 percent of those hospitalizations related to opioid overdose, and these are folks that actually get into the hospital and are admitted, that actually 70 percent of them are prescription related.

And again, I don't have a breakdown of how many of them are what I would consider the dangerous combination of benzos and opioids or just high MMEs. I will say that 54 percent of those hospitalizations are within Medicaid but what is constantly missed is 26 percent in our data here are individuals with Medicare. This is still an ongoing issue and intervention-wise, in fact we just got off of our DUR meeting, we are loosening some of our prior authorization guidelines because of some of the CDC's recent recommendations. However, I think that some of our prior authorization guidelines that we have put into place have helped us to appropriately reduce our performance -- or improve our performance on both of these measures, but you have to do that judiciously. And our DUR board, we have had a lot of discussion about making sure that there are safeguards in place that patients are not abandoned, that there is not just a hard and fast denial, that sometimes there is a safety period. So I think there clearly are interventions here that can be put into place, managed care plans can do utilization review and prior authorization, can also require -- again many states have their prescription drug monitoring programs that can help to reduce both high dose as well as concomitant use. I would support maintaining both of these measures on the Core Set. Thanks.

Margo Rosenbach:

Thanks, David. Erica?

Erica David Park:

Thank you. Good morning. Just a comment and a question actually too. First of all, I actually support also continuing these measures on the Core Set. Particularly, my focus really is on the concomitant use of opioids and benzos. You know, the impact that it can have on the elderly population, seeing that in clinical practice, that it can be some substantial adverse outcomes can occur there, but also in those with, you know, chronic respiratory conditions and so on. There can really be some major concerns. But I do have a question though. You know, we definitely hear anecdotally that, you know, there can be concerns about patient abandonment or patient avoidance and things along those lines, but I'm wondering if anyone's aware of any hard data supporting the argument that there are clinicians avoiding people who are on high dose opioids and opioid benzo combinations. Just wondering if anyone has any details on what that may look like.

Margo Rosenbach:

Great. Thanks, Erica, for the comment and the question. Turning now to Linette, who might have some of that hard data. Linette.

Linette Scott:

Good morning. I guess, I mean, a couple of thoughts in terms of the two measures. I mean, one aspect is when we think about the measures and whether they should be on the Core Set or not, part of it gets at -- and this is a conversation we've had in past years as well, is the Core Set the right place to monitor or is there other monitoring that we're doing? And is that complementary or is it redundant? Just given workload it takes to develop and report measures and recognizing that there's quite a few measures on the list. The fact that CMS moved these two measures to the Care of Acute and Chronic Conditions [domain] means they're not actually required. And given we only have, you know, a little over 30 states reporting at present, I think

that the fact that these are now still voluntary measures is significant. The drug utilization review boards, I really appreciated David talking about that some, are doing a lot of work in this space as well. And that is a requirement of all Medicaid agencies, both in the managed care and the fee-for-service space, to use those groups to help monitor prescribing specifically and prescribing patterns. So this is an area where we do have other monitoring and reporting that occurs.

So I guess that makes these measures a little different than some of our other measures where we don't have that additional monitoring that occurs in another part of the program. The other thing in particular for the first measure, the high dose, admittedly, as was noted, if there's a change from the measure steward perspective in terms of whether it will be supported or not, that certainly feeds into the feasibility conversation. So just some thoughts around thinking about how these measures fit into the spectrum, understanding how they are used and whether the Core Set is the right place or not. Given all of the other measures we have on the Core Set and recognizing that we do continue to generally grow the list as opposed to shrink the list, these two measures seem like measures that perhaps we could remove, given they do also have quite a bit of attention through the drug utilization review boards. So some thoughts for consideration. Thanks.

Margo Rosenbach:

Thanks, Linette. Next up, Ben Shirley. Derek, can you unmute Ben?

Ben Shirley:

Yeah. Hey, can you hear me all right?

Margo Rosenbach:

Yes. Very well.

Ben Shirley:

Yeah. Thanks, everyone. So my name's Ben Shirley, Senior Director of Performance Measurement for PQA, who is the measure steward, as always, just loving the great discussion here that we're having and appreciate all of your thoughts. So first of all, with respect to the high dose measure, I do think that we'd like to reiterate the context that was provided at the beginning of the call. So the source MME NDC Conversion File, which is the file that's used for population level MME conversions for specific drugs at the NDC level, that file is being discontinued by the CDC. And since the measure is sort of constructed on that foundation, given that it needs to establish MMEs to establish high dose, we are considering retirement and we do anticipate retiring that measure for 2025. So I believe -- I'm not intimately familiar with the Core Set procedures, but I believe that it would be removed, probably by default from the Core Set if it's no longer supported by the steward or if it's intentionally retired by the steward. So I, again, appreciate the discussion on that, but we'll sort of give you that context, which I think is important.

A few things on the COB measure, really appreciate the thoughtful discussion. And I know that we talked about this last year, so it seems like the focus this time is a little bit more on DUR. And

from that perspective, I think we do just want to emphasize sort of the differences between the Core Set and state DUR programs. I think it was a really thoughtful question from I think it was Linette, you know, is the Core Set the right place? We have these complementary programs. And I think that that's the right word. They are complementary, but they are not duplicative. Right. So the Core Set really exists to provide and publicly report data on high priority quality measures, it really helps us compare across states and identify where there might be opportunities for improvement and sort of hold states accountable to one another, ultimately to the patient, to the public, et cetera. You know, state DUR policies, they vary widely. They are certainly required in all states. But really the emphasis is on within state monitoring, whether that's proactive DUR or retrospective DUR. And the way that those results are publicly reported, if at all, is really not in a way that's conducive to making comparisons and doing what the Core Set does. Right. So instead of sort of siloing this information in 50 different states' DUR meeting minute publications, we do have these chart packs, right, where we can look at a map, I think someone mentioned, is there any data on what variation looks like? Yes, that is the crux for many folks of what the Core Set produces. It produces the map that shows us that we have an average of around 18, but we have some states at 30 percent concurrent prescribing. We have some at 10. And I think especially, you know, David was sort of talking about the quality signal. When you have some states at 10 percent and some states at 30, it's pretty clear that there is a quality signal in there. And I think that removing that resource that allows those comparisons is something that our team is definitely concerned about. And we talked to some DUR folks as well who sort of looked at that map and said, word for word, just sort of wow, you know, that variability we couldn't do with DUR alone. DUR is a state level resource. So I just wanted to give that context. I think that there was one other question around hard data with respect to, you know, discontinuation, tapers, cherry picking.

You know, we don't have hard data, nor are we aware of it. But I do just want to highlight, you know, we don't develop measures and sort of put them out and then never pay attention again. So we have open channels with both programs and measured entities and community groups. We take unintended consequences very serious and we're pretty vigilant in monitoring for that. To date, we haven't really received any sort of systematic or really not much, even individual single comments, about those sorts of unintended consequences associated with this measure. And given that this measure has been in Part D for some time, it's used in other state programs, it's used in the Core Set, it is pretty well-socialized at this point. So I think there's also an alignment perspective here, but I'm probably using more than, more time than I'm supposed to as a steward. So I'll be quiet, but happy to be a resource for any other questions.

Margo Rosenbach:

Thank you, Ben. That was very helpful. And just to clarify the point you raised about retirement of a measure, if the measure steward does not continue maintaining the measure or actually retires the measure, it would be retired from the Core Sets as well. So I think that's an important clarification. Thank you. All right. We have time for maybe one or two more comments from Workgroup members before we move on to the next measure. Any other comments? David Kelley.

David Kelley:

I just have a question and I don't know if colleagues from the CDC are online, but I'm interested in why they're no longer maintaining the MME Conversion. Nationally we're still, I believe, in an

opioid crisis. And I'm just wondering why. I mean, that can't be that hard to do. There aren't that many new NDCs that come out each year. And so I'm just curious if any of our CDC colleagues could comment on that. So it sounds like that's why the measure may be retired.

Margo Rosenbach:

Yeah, that's a great question, David. I don't see our federal liaison, but is there anybody else from CDC? And if so, please raise your hand and we'll call on you. And Ben if you have any insights about that as well, please do share that. So I'm not seeing anybody from CDC. Ben Shirley, do you have any further information about that? Derek, can you unmute Ben? Thank you.

Ben Shirley:

Yeah. Unfortunately, no, I don't think it would be appropriate for us to see in this instance.

Margo Rosenbach:

Thanks, Ben. Kai. Derek, can you unmute?

Kai Tao:

I got it. Thank you. Yeah. Kind of similar to what David said, I don't really understand why there's some discontinuation when it is still very much a problem, a pandemic-level problem. You know, in the world of maternal and child health, a lot of state perinatal quality collaboratives, we are really working on mothers and newborns affected by opioids. When we look at maternal mortality, morbidity within one year postpartum, we still see substance use disorders as one of the top reasons, usually top three, depending on what state, where this is a big problem and not being knee deep in it, it just feels like -- it seems a little bit -- I'm not hearing enough of the reasons why we're taking our foot off the pedal to really make this a priority. So I just want to mention that. Thank you.

Margo Rosenbach:

Thanks. Thanks, Kai, and thanks, David and Ben, for those comments. What I would suggest to the Workgroup is if you would like to vote to recommend this measure to stay on the Core Set, in other words, not recommend it for removal, to send a signal of the desirability of the measure, that is the way to think about a vote not to recommend removal. And then if the measure is retired, then it would be removed just based on the status of the measure, with the measure steward and with the CDC measure set that is required. That is a minimum technical feasibility requirement. But this would also give an opportunity to learn a little bit more about why the code set might not be sustained in light of all of the conversations that we've been having here this morning. So that's one way to think about this vote. And that's frankly why we are bringing it to the Workgroup, because it has not yet been retired, even though it's being considered for retirement. It's important to have the Workgroup discuss it because it is not yet retired. Ben, I see your hand is raised.

Ben Anderson:

Yeah. Thank you for that, Margo. Just to sort of reiterate, I was having a similar thought in my mind. And so I thought I would come off of mute as a Workgroup member. You know, I think it's extremely hard in this scenario to support removal, even though the measure might be up for retirement. In particular, particularly in light that we don't have any information from CDC on this at this point. And so I think it just sounds premature for removal, even though it may be retired. And I think we ought to keep it on until we can get some more information from CDC. Thank you.

Margo Rosenbach:

Thank you. We have one more comment, time for comment from Linette and then we'll move on to the next measure. Linette.

Linette Scott:

Thank you. I guess this may actually feed into our conversation tomorrow as well. Just one of the other things, looking at the high dose measure, because that's the only one that's on the public data.Medicaid with two values. So I was just taking a look at that. And in terms of the states that have reported it, there are some ups and downs over the last reporting cycle. So not necessarily clear trends. And the other thing that people were talking about was mentioning, sorry, on the opioid benzo measure, particularly concerned about older adults. One of the issues we have in the Medicaid program is that many of our older adults are also duals. So we don't necessarily have as much information about those that are 65 and older who are getting their primary care from the Medicare side. And then where we're picking up funding in the Medicaid for places where Medicare falls short.

So again, if the concern is more about older adults, then it may be that it's a better Medicare measure than Medicaid measure just because of how the coverage works. So I just want to highlight that. The other aspect, just in terms of thinking about the fact that, you know, there's only 30 or so states that are reporting and that there's not necessarily -- reporting does not equal an improvement, right? So are there ways that this is being supported from technical assistance or those kinds of perspectives? And again, that probably goes into tomorrow's conversation. Thanks.

Margo Rosenbach:

Thanks, Linette. Thank you, everyone, who made comments. Now we'll move on to our next measure, and I'll pass it back to Chrissy to review the measure suggested for addition in this domain.

Chrissy Fiorentini:

Thanks, Margo. The measure suggested for addition is Statin Therapy for the Prevention and Treatment of Cardiovascular Disease. This measure is defined as the percentage of patients at high risk of cardiovascular events who were prescribed or were on statin therapy during the measurement year. The measure looks at three populations. Population one is all patients with an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD) or ever had an ASCVD procedure. Population two is patients age 20 years and older who have ever had a low-density lipoprotein cholesterol (LDL-C) level at or above 190 milligrams per deciliter, or were

previously diagnosed with or currently have an active diagnosis of familial hypercholesterolemia. Population three is patients aged 40 to 75 years with a diagnosis of diabetes. The measure has one performance rate that aggregates the three populations. CMS is the measure steward, and the measure is not NQF endorsed. The measure is specified for EHR or clinical registry reporting. Next slide.

The measure is specified at the provider level and is included in several quality reporting initiatives, including the National Million Hearts Initiative and MIPS. It is currently in use by the Texas Section 1115 demonstration for provider-level reporting. The measure steward has indicated that they plan to make a number of changes to the measure's technical specifications for the 2024 performance year. Specifically, they plan to change the population one criterion for the eCQM version of the measure to align with the MIPS CQM version, add an upper age bound to the population two criterion so that it includes patients aged 20 to 75 years, and they plan to add a fourth population to capture patients that are at high risk for ASCVD to align with the 2019 American College of Cardiology/American Heart Association Guideline on the Primary Prevention of Cardiovascular Disease.

The Workgroup member who suggested this measure for addition noted that heart disease and stroke are the first and fifth leading causes of death in the U.S., respectively, and that for people at high risk of having an ASCVD event, including heart attacks and strokes, taking a high- or moderate-intensity statin can greatly reduce the risk of having an event. The Workgroup member indicated that a recent analysis of National Health and Nutrition Examination Survey data showed that almost 28 million adults ages 40 to 64 who qualified for statin use per national guidelines were not taking a statin as recommended. And HRSA UDS data show that about 30 percent of their pertinent high-risk adult population is not currently taking a statin. The Workgroup member noted that statins are relatively inexpensive and readily available, making them a highly effective cardiovascular risk reduction strategy and intervention that states should be tracking. Next slide.

And with that, I will pass it back to Margo to facilitate the Workgroup discussion.

Margo Rosenbach:

Thanks, Chrissy. I'd like to open it up to Workgroup members. Does anybody have a comment about this measure? Curtis. Derek, can you unmute Curtis?

Curtis Cunningham:

Hi. I'm just curious. You mentioned Texas. Is there any other state supporting this measure, because whether establishing a registry or getting it from EHRs is a significantly burdensome thing to do. And I am worried with the absence of the CMS rule. The concern, I mean, we've talked about reprogramming the system for even claims data, but this would be a significant resource lift. And with, you know, again, with states, you require one thing, that means they're taking efforts off program oversight or integrity or other things. So I guess the question is, it was mentioned Texas is reporting this. Is any other state Medicaid program reporting it at this point in time? Thanks.

Margo Rosenbach:

Thanks, Curtis. That's a good question. We are only aware of Texas using it in its 1115 program, but I see we have Clara on the phone. I don't know if Massachusetts is using it or has any thoughts about that. So Clara, could you unmute and make your comment?

Clara Filice:

Thanks, everyone. Clara Filice from Massachusetts. I think the feasibility of this is our major concern with this measure. Obviously, from a clinical standpoint, couldn't possibly disagree with the intent of the measure and the goals it incentivizes. But from a practical implementation standpoint, we are concerned that by 2025 we wouldn't be able to feasibly report on it and might instead have to adopt the CQM version as an intermittent effort. So would support consideration for this to be a Core Set measure perhaps in 2026, especially given the FHIR compliance timelines as well.

Margo Rosenbach:

Thanks, Clara. That's helpful. Stacey?

Stacey Bartell:

Hi. Thank you. Hopefully you can hear me. Again, we in family medicine also agree with what was just said. We fully support the use of statins. However, understanding the number of patients out there who aren't on statins, there's a lot of exclusions to this measure that you can bill and code. And recently I even saw a document in their EMR. The prescription was written, but the patient is not taking. And to me, that implied that they wrote that in there so they met a quality measure, not so much that they actually, you know, cared that the patient was on a statin. It means they tried. So I worry about all the exclusions that are in this measure, and it's very hard to measure, especially as you pointed out, it's a cheap medication. Because it's also cheap, they can actually get it also through a pharmacy, cash pay it, and avoid the insurance and claims process altogether, which also makes it very hard for us to monitor in our EMR data.

Margo Rosenbach:

And, Stacey, when you say that, are you referring specifically to Medicaid in that case, that they would use cash in Medicaid?

Stacey Bartell:

Probably not as much in Medicaid, but we've also – like, again, I'm just looking at the full population when we look at our population health measures. And it's a very hard measure to stay on top of because of all the exclusions. If a patient doesn't tolerate a statin, if a patient has rhabdomyolysis in the history, it's one of those things you have to code every year. It's not one of those things, so every measurement year you would have to recode the exclusion. So just from a provider standpoint, it's a very hard measure to stay on top of.

Margo Rosenbach:

Great. Thank you. Laura?

Laura Pennington:

Hello, can you hear me?

Margo Rosenbach:

Yes.

Laura Pennington:

Thanks. So I agree. We're not currently using this measure in Washington State. We're actually using the NCQA HEDIS version that includes the statin adherence portion of it. I think the fact that that one relies on claims data and this one doesn't, we would be not in support of adding this measure. And so I'm just curious if the Workgroup member who proposed this one considered the NCQA statin therapy and adherence measure. Thank you.

Margo Rosenbach:

Thanks, Laura. That is a good question. We are still waiting for CDC to join, so they are pivotal to this question as well. So watching carefully to see when Erin joins and then we will pose that question to her. So thank you. Other Workgroup member comments? Ben Anderson.

Ben Anderson:

Yeah, hi. Thank you. So I think for this measure what strikes me is what looks like a potentially awfully large D, denominator, coming from what's called population two. Anyone who has ever had an LDL of 190. And I think when, you know, when dealing with these measures that advocate for a particular drug to be used and then to base quality upon whether or not the patient actually gets that drug, I think for all of the other reasons that I think we've heard from the states on, you know, how difficult this may be in terms of feasibility, but also just thinking about, you know, some of the many different reasons why consumers may be falling into some of those exceptions. I think we just, you know, when it comes to these kinds of measures, I think it's appropriate to be a little bit extra cautious, especially in light that, you know, there may be better measures out there, which I think was just mentioned. Thank you.

Margo Rosenbach:

Thank you. Kim Elliott.

Kim Elliott:

So when I'm thinking about adding new measures to the measure set, one thing that's really important from my perspective is to make sure that we have good, solid data sources and that we're really measuring something that is going to have the opportunity to have interventions that are going to be effective and work. And with this particular measure, there are other competing measures out there that I think do a little bit better job and have a little bit better data sources to be able to really make improvements for the Medicaid population. So for those reasons, I think I would probably not be in favor of adding this one. I would look for measures that have reliable,

solid data sources and are easier and not so labor-intensive or resource-intensive to be able to collect the data. Thank you.

Margo Rosenbach:

Thanks, Kim. Linette.

Linette Scott:

Thank you. I just wanted to echo the challenge of the measure because it is based on EHR data. So Medicaid programs are in the process of implementing interoperability rules that help establish data exchange standards, which was mentioned earlier. And, you know, just kind of echoing the aspect that getting the standards in place, getting the functionality in place is one aspect. Having data in the right places to collect it in the EHRs and making, you know, and helping to support that is another issue. And we're just not there yet. So even though we're talking about 2025, realistically, I don't think as state Medicaid agencies we're going to have that kind of connectivity to be able to do this kind of data collection. And then there's the aspects that folks have talked about just in terms of the challenges of having the longitudinal information and the exclusions. So this would be a very difficult measure. Thanks.

Margo Rosenbach:

Thank you. Clara, do you have another comment? Your hand is raised. Other comments from Workgroup members? All right. We are still watching for Erin Abramsohn and not seeing her. I think in order to stay on schedule, we should probably move to public comment at this point. And when Erin shows up, we can ask her a couple of questions before we move to voting. So with that, I wanted to ask if there are any -- can you turn to the next slide, please? If there are any public attendees who would like to make a comment about this measure. Actually, it's all three measures that we're going to be talking about. And please raise your hand and we will unmute you. And as a reminder, we're talking about Use of Opioids at High Dosage in Persons Without Cancer, Concurrent Use of Opioids and Benzodiazepines, and Statin Therapy for the Prevention and Treatment of Cardiovascular Disease. Do we have any public comments on these measures? Seema -- Derek, can you please unmute Seema? Please introduce yourself and where you are from.

Seema Ledan:
I'm calling from Kaiser Permanente. Can you hear me?

Margo Rosenbach:

Yes, very well.

Seema Ledan:

Okay, thank you. Yes, I just wanted to comment on the opioid and benzo and the opioid high dose. I do agree with many on the call that have stated that we should keep this measure as, you know, many health plans are continuing to review opioids. It continues to be a problem in many states, and we continue to see, you know, studies and evidence that shows that we

should be highlighting this combination of use and also highlighting the high dose. So I would recommend or comment or just provide commentary that we should keep these. Thank you.

Margo Rosenbach:

Thank you. And just to clarify, your comment refers to both measures. Is that correct, high dosage and concurrent use?

Seema Ledan:

Correct. Thank you.

Margo Rosenbach:

All right. Other public comments? Thank you, Seema. Do we have any other public comments? Well, we can wait a few more minutes for Erin to join the call. Are there any other Workgroup member comments? I think if there are no further Workgroup member comments and no further public comments, then we should proceed to voting. I know that it would have been helpful to have a member of CDC on the call. But I think the Workgroup member comments have been very robust. And I think to stay on schedule and move forward, allowing enough time this afternoon for the other domains that we should move forward with voting. So with that, I hope everybody remembers how to vote from yesterday. And now I will turn it over to Alli and Talia for voting.

Alli Steiner:

All right. Thanks, Margo. Our first vote for today is, should the Use of Opioids at High Dosage in Persons Without Cancer measure be removed from the Adult Core Set? The options are yes, I recommend removing this measure, or no, I do not recommend removing this measure. Voting is now open. And just a reminder, refresh your browser if you're not seeing the question. We're still waiting on a few more votes to roll in. Thanks for your patience, everybody. Still waiting on two more votes. We're just trying to determine who we're missing and keep moving. Thanks for your patience. We're just missing one vote. And we will let you know in one moment who we're missing. Thanks for your patience. All right. Looks like we might not have Linette's vote. Linette, can you try to submit your vote? And if that doesn't work, put it in the Q&A, please, and send it to all panelists. Thank you.

Margo Rosenbach:

Linette, I see your hand raised. Can you unmute, Linette?

Linette Scott:

Apologies, because I did submit it, and it said it took. So I don't know why you're not seeing it.

Margo Rosenbach:

We'll take a close look for that.

Alli Steiner:

Linette, are you able to try again? I'm sorry. We're still not seeing your vote. If not, would you be able to send it to the panelists in the Q&A? All right. We reached the expected number of votes. Go ahead and move to the responses now. So we have 30 percent of Workgroup members voted to remove the measure. This does not meet the threshold needed for recommendation. So the Use of Opioids at High Dosage in Persons Without Cancer, OHD-AD measure, is not recommended by the Workgroup for removal from the 2025 Adult Core Set.

Moving on to the next vote, please. Okay. The next vote is, should the Concurrent Use of Opioids and Benzodiazepines (COB-AD) measure be removed from the Adult Core Set? The options are yes, I recommend removing this measure, or no, I do not recommend removing this measure. Voting is now open. Thanks, folks. We're waiting for just one more vote. Looks like we might be missing Tricia Brooks. Tricia, could you please try submitting your vote again? Okay. All right. It looks like we have all the votes we're expecting now. Thank you. Moving on to the results. Okay. So for the results, 20 percent of Workgroup members voted yes, and that does not meet the threshold for recommendation. The Concurrent Use of Opioids and Benzodiazepines (COB-AD) measure, is not recommended by the Workgroup for removal from the 2025 Core Set. And I think we're going to pause here. It looks like we do have CDC representation on the line, so I'm going to pass it back to Margo before we do the next vote.

Margo Rosenbach:

Thanks, Alli. And thanks, Workgroup members, for such a robust conversation about the OHD and COB measures, and also for your votes on these two measures. Erin, thank you for joining. You missed the conversation, but we did have a couple questions. And so before we vote on statin, I thought it would be helpful to debrief on a question or two on the COB and OHD measures, and particularly OHD. And then also we have a question on the statin measure. So I will do my best to capture that, and I think it's fine if we leave -- so here we go. We'll go back to this slide. So Erin, our first question about the OHD measure relates to the discontinuation of one of the files that would be required for calculating the measure, for maintaining, updating, keeping the measure active, and then to help states actually report the measure. So I'm curious if there's any update from CDC. Given the overwhelming vote by the Workgroup to retain the OHD measure, clearly people felt that this measure was very important, along with the COB measure. So I'd like to open it up to you, and you look like you are unmuted.

Erin Abramsohn:

Yeah. Hi, I'm Erin Abramsohn. Thank you so much for waiting for me, and I really apologize. We're pulled in a couple different directions over here, so I apologize for that. I was trying to connect on our side with our folks from our National Injury Center. I don't know that I have any better information or guidance for you. They're double-checking on our side. The only notes that I have on this one was that the two opioid measures that were in there no longer align with CDC guidance, but I don't know that that would make or break it for anybody else. So again, I'm trying to get some better information, but I don't know that it's going to be in time for your vote.

Margo Rosenbach:

Okay. Well, thank you. I think the Workgroup has spoken in terms of recommending not removing these measures, primarily from the standpoint of desirability, importance in the current context of measuring quality of care in Medicaid and CHIP. And I think as many of you know on the Workgroup and in the public, CMS does have a process where they coordinate with federal liaisons and other interested parties. And so I'm sure there will be follow-up between CMS and CDC about these measures. And so thank you for that. We also had a question leading into the statin therapy conversation, and I think you did suggest this measure for addition. A question came up, given the concerns about feasibility for states and availability of the data source for this measure, that there is an NCQA measure on statin therapy and whether you had considered that measure, and if not, why not?

Erin Abramsohn:

Here we go. Sorry, I could not get myself off mute there. That is a good question, and I do not know. I believe that they have looked at that measure, and I don't know why that wouldn't be considered, but I can take that back to our folks in our Division of Heart Disease and Stroke Prevention. Again, I don't know if that's in time for a vote here, and I apologize.

Margo Rosenbach:

Probably not, because we'll be voting right after this. I know we have some folks from NCQA on the line. I don't know whether anyone from NCQA has any insights about the statin therapy measure. While you're thinking about that and perhaps getting information, NCQA, I see Curtis is on, has a hand raised.

Curtis Cunningham:

I just wanted to take the opportunity. The individual that noted that it is above 190 milliliters, was there any discussion in the creation of that measure to be paired with other measures that look at, you know, changes that should be provided prior to statin, such as, you know, lifestyle things, exercise, diet, and other things? It does seem to me that that's a very absolute kind of measure with a standalone. So maybe a comment, but just also thinking about more of a holistic approach to management. Thanks.

Margo Rosenbach:

I see we have David Clayman, who is involved in maintaining the measure. David, do you have a comment?

David Clayman:

I am the measure lead for this measure. For this particular measure, we did follow the ACC AHA guidelines for blood cholesterol management. And so each population looks at each of their guidelines. So the first one looks at ASCVD. The second one looks at the cholesterol with 190 milliliters per deciliter. We were just following the guidelines for that. And in their guidelines, their recommendation is that the doctors should consider statin. We do have a denominator exception in there. So if you feel like statin is not needed, you could not order it and use the medical reason for that particular measure.

Margo Rosenbach:

Thanks, David. Any other comments before we proceed to voting on the statin measure? Or any other questions? Erin?

Erin Abramsohn:

I'm looking through our submission. And one of the things that they included -- if you can, could you repeat the first part of your question for the statin measure that was directed to CDC for me?

Margo Rosenbach:

Oh, the question was that one of the Workgroup members indicated that there is an NCQA measure that is based on administrative claims data that would be more feasible for states. And why this measure and not that measure?

Erin Abramsohn:

Yeah. And is that NQF 18, NQF-0018. Or you may not have it written down there. So one of the things that our program wrote down was that this measure that they were proposing is included in the Million Hearts Initiative as one of four nationally supported clinical quality measures -- the ABCs of cardiovascular health -- and that Million Hearts has worked with partners to have this measure, the CMS 347 included in a variety of quality reporting initiatives. You'll find it in the HRSA Uniform Data System, CMS Quality Payment Program and IHS Patient Management System and others. So another Million Hearts ABCs measure,NQF 0018 Controlling High Blood Pressure, is already included in the Medicaid Adult Core Set. That is a close proxy measure. I'm sorry. Another close proxy measure, NQF 0027, Medical Assistance with Smoking and Tobacco Use Cessation, is also included. So if this, if CMS 347 were also included in the Adult Core Set, improved performance on these three measures would be extremely effective at comprehensive cardiovascular disease prevention. So that was their reasoning.

Margo Rosenbach:

Thanks, Erin. I see we have a comment from Julia. You should be off of mute and able to speak. Please introduce yourself and where you're from.

Julia Skapik:

Hi, Julia Skapik, the CMIO at the National Association of Community Health Centers. And to piggyback on the previous comment, NACHC is one of the administrators of a large group of health centers that do the Million Hearts project. The data that we've looked at on statin therapy shows that there are significant disparities in these exact high-risk populations with 50 percent -- sorry, the African-American populations and female populations are half as likely to receive statins in these high risk categories in our Million Hearts data as men and as white patients. So we believe that this measure could potentially have a strong impact on health disparities and concur that it adheres to current guidelines. We have actually executed this measure in over a million patients in our Million Hearts project. We'd encourage CMS to go forward with this statin therapy measure.

Margo Rosenbach:

Thank you. And with that, let's proceed with the vote on statin therapy. Right back to Alli and Talia.

Alli Steiner:

All right. Thank you for that. So our third vote for this domain is should the Statin Therapy for Prevention and Treatment of Cardiovascular Disease measure be added to the Core Set? And the options are yes, I recommend adding this measure or no, I do not recommend adding this measure. And voting is now open. We're just waiting on a couple of more votes to come in. Thank you for your patience. Thanks for your patience. We're just waiting on one more vote. We did receive yours in the poll, Linette, so you're all set with this one. Thanks for your message. We are still waiting on one more, and we're just trying to determine who we're missing. Thanks for your patience. Okay. It looks like we might be missing Rich Antonelli. Rich, do you mind trying to resubmit your vote again in the platform? All right, Rich, we're still not seeing your vote. Are you able to submit it into the Q&A? Just make sure to select all panelists, please. Looks like we can close out the vote. Thank you. Okay, so now for the results. 31 percent of Workgroup members voted yes. That does not meet the threshold for recommendation. The Statin Therapy for Prevention and Treatment of Cardiovascular Disease measure is not recommended by the Workgroup for addition to the 2025 Core Set. Now I'll turn it back to Margo.

Margo Rosenbach:

Thank you, Alli, Talia, Workgroup members for voting. This was definitely a little bit nimble today in the way we handled the conversation. We had hoped to have some time to debrief on why the measure was not recommended, the statin therapy measure. I know that we are headed into a break now, a 20-minute break. I'm wondering if the Workgroup members who voted not to recommend the measure for addition could just throw some comments into the Q&A. We will see them. Others won't. It would help us to better understand what is behind the votes. I know this is something that Workgroup members have asked for in the past, is to have a bit of a greater understanding on why measures suggested for addition were not recommended. And that would be very helpful for us to have that understanding. So thank you. So the result for statin, again, was I believe it was 30 percent said yes and 70 percent said no or something close to that. Is that right?

Alli Steiner:

Yeah, 31 percent.

Margo Rosenbach:

Okay. So 31 percent. So that does not meet the threshold for addition. And so this measure was not recommended for addition. With that, why don't we take a break for 20 minutes and we will reconvene after the break to talk about Behavioral Health Care. Thank you.

BREAK

I wanted to recap a couple things from this morning. Thank you, everyone, for your careful consideration of the three measures. I wanted to debrief on the statin therapy measure. As I asked right before the break, if Workgroup members could share some reflections on why they voted not to recommend the measure, that we would be very interested in hearing a little bit more. And the most common reason was because of feasibility considerations. It is a very complicated measure that has multiple components and lots of exceptions, and it adds burden to providing patient care. So I think there were a lot of factors related to feasibility. Also concerns about whether it was ready to be used nationally. It's only being used, to our knowledge, in Texas in its 1115 demonstration, so concerns about its readiness for being used in the Core Set. And a final thing that I'll mention is that a state commented that they've been using the NCQA version of the statin measure for several years and use it in their value-based purchasing program and appreciate the adherence component of the NCQA statin therapy measure, and that if it were also required to report on this measure, it would pose an additional burden on the state and on their providers. That is a snapshot of the reasons, lots of concerns about feasibility and burden and readiness for national reporting.

So with that, I also want to ask anyone who is sending Q&A, please send it to all panelists. Some of the Q&A seems to be getting lost in the ether. So if you do have a question that you want to submit to the Q&A, please send it to all panelists. And with that, I will now turn it over to Kathleen to cover our next domain, Behavioral Health Care. Kathleen?

Kathleen Shea:

Thank you, Margo. Next slide. I will start with the current Core Set measures in this domain. There are seven Child Core Set measures and 11 Adult Core Set measures. Note that all of these measures are subject to mandatory reporting in 2024. I'm only going to read through the measure names, but these slides also show the data collection method and number of states reporting the measure for FFY 2020, the most recent year of public reporting. There are seven Child Core Set measures. They are: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication; Screening for Depression and Follow-Up Plan: Ages 12 to 17, which has been suggested for removal; Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17; Metabolic Monitoring for Children and Adolescents on Antipsychotics; and Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics. Next slide.

The last two behavioral health measures on the Child Core Set are Follow-Up After Emergency Department Visit for Substance Use: Ages 13 to 17 and Follow-Up After Emergency Department Visit for Mental Illness: Ages 6 to 17. Note that these last two measures were added to the 2022 Child Core Set.

And now we see the first few Adult Core Set measures. The first measure is Initiation and Engagement of Substance Use Disorder Treatment. The second is Medical Assistance with Smoking and Tobacco Use Cessation. The third is Antidepressant Medication Management. Next slide, please.

Next is Screening for Depression and Follow-Up Plan: Age 18 and Older, which has been suggested for removal; Follow-Up After Hospitalization for Mental Illness: Age 18 and Older; Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications; Diabetes Care for People with Serious Mental Illness: Hemoglobin

A1c Poor Control (>9.0%); Use of Pharmacotherapy for Opioid Use Disorder; Follow-Up After Emergency Department Visit for Substance Use: Age 18 and Older. Next slide.

And finally, the last two behavioral health measures on the Adult Core Set are Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older and Adherence to Antipsychotic Medications for Individuals with Schizophrenia. Next slide.

Our Workgroup member suggested the Screening for Depression and Follow-Up Plan or CDF measure for removal from the Child Core Set for children ages 12 to 17 and the same measure for removal from the Adult Core Set for adults age 18 and older. The Workgroup will discuss the CDF-CH and CDF-AD measures together and vote on them separately after we hear public comments. These measures are no longer NQF endorsed and are calculated using administrative data or electronic health records. The numerator for each measure includes beneficiaries screened for depression either 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 who, if positive, had a follow-up plan documented within two days of the encounter. For FFY 2020 Core Set reporting, 14 states reported the Child Core Set measure, 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.

When suggesting this measure for removal, the Workgroup member stated that there are challenges in collecting the data and producing reliable results for these measures. Some states are more advanced than others, and if a state cannot easily access electronic health record data, their administrative rates make performance on these measures appear to be worse than it actually is. The Workgroup member who suggested these measures for removal did not propose other measures for replacement. One thing we wanted to note is that this measure is included in the list of universal foundation measures that Jessica Lee referred to yesterday in her remarks. Next slide, please.

Now I'll pass it back to Margo to facilitate the work group discussion.

Margo Rosenbach:

Thanks, Kathleen. So now we'll invite comments from Workgroup members about the two CDF measures. Please raise your hand and we will unmute your line. Are there any Workgroup members with comments? Joy?

Joy Burkhard:

Yes, Joy Burkhard with the Policy Center for Maternal Mental Health. I feel obligated to make remarks both as a parent and also an advocate in the mental health space about the need to keep these measures, both of them, in the Core Set. I am very interested in hearing more about the struggles around data collection, but I also, having served 24 years at a health plan and as a director of quality at a plan, feel compelled to also share that I think there may be a problem not just with data collection but around intervention and supporting pediatricians and primary care providers in doing this critically important work. I would like the committee to consider whether they would like their name to be listed, for example, on a front page of the New York Times or L.A. Times or wherever you may be, as someone who voted in favor of no longer measuring these important measures at the height of our mental health crisis in the country. So I want to

pause there. Very interested in learning more about the challenges with data collection, but also feel very compelled on behalf of parents from across the U.S. that, you know, certainly this is not the time to remove these critical measures from the Core Set.

Margo Rosenbach:

Thanks, Joy. We have a lot of people in the queue here, so next is Anne, then Kai, then Lisa. Anne?

Anne Edwards:

Thank you. Can you hear me?

Margo Rosenbach:

Yes.

Anne Edwards:

Okay, great. Hi, everyone. This is Anne Edwards, and I'm going to echo some of what has just been said. I think we are at critical crisis levels around mental health issues for children and adolescents. This actually started prior to the pandemic but certainly has been exacerbated, and I think we could all look at the worsening trends in statistics that are recognized among adolescents themselves. So I think this would send a message, were we to remove this, that might not be what we would want to send. I always appreciate feasibility issues, and I think that this is a measure that for a long time has had those questions. I think it is an interesting point that was raised about interventions, and I will lift up that while mental health issues are really across all children and adolescents, there certainly are systemic and structural barriers for certain communities related to access creating worsening disparities. So I also think that this is a measure that we need to look at how it could really strive for quality improvement and access and addressing some of those equity issues. So maybe I'll pause there and allow others to speak too.

Margo Rosenbach:

Thank you so much. Kai?

Kai Tao:

Yeah, I also am in favor of keeping this with what already has been said about the continuing increase of mental health issues, depression, suicides. I feel like it's important to think about when we use a screening question, it really helps to de-silo and de-stigmatize, and I work from an FQHC framework of primary care. And if we can routinely be screening and talking about how normal it is to feel sad, et cetera, then that's how we can have more people come up and talk about it and admit that they need help. I feel like some of these other measures we're seeing are a little bit downstream, right, post-hospitalization, release from a hospital inpatient stay. Important factors, obviously, but it feels a little downstream if we can do more work structurally to de-stigmatize and normalize the discussion of behavioral health and primary care services. So I would vote we continue to keep this. Thank you.

Margo Rosenbach:

Thanks, Kai. And I want to remind people that this is the time for Workgroup member discussion. We will have an opportunity for public comment after that. So if you are a public attendee, I'd appreciate it if you would lower your hand and raise your hand later when we get to public comment. Thank you. Tricia?

Tricia Brooks:

Yes, I want to echo a lot of Anne's comments. We do have a mental health crisis among the youth, and without an alternative measure that would, you know, help us move, you know, our awareness of the issue and how prevalent it is upstream, I just would not be able to vote to discontinue this. So I'm with the other commenters that I think we should keep this on the Core Set. Thank you.

Margo Rosenbach:

Thank you, Tricia. Jakenna?

Jakenna Lebsock:

So I agree that the importance of mental health and the focus is absolutely critical, and especially for our youth. I think we can't understate that enough. However, I also come from a state where we won't publicly report this measure because we don't think it's reflective. We don't have good access to the EHR data. Our administrative rates do not tell us anything meaningful because we know it's grossly underreported. And so we really struggle because it's super important, but the measure itself in no way serves us, and we can't use it to drive change because it's not reflective of what we do. And so from a technical perspective, it doesn't work for us as a state, but from an area of focus, it's critically important. And so, you know, in my mind, there's a little bit of a misalignment there because it's not doing anything, and our health plans are monitoring it, we're monitoring it. We have conversations about this all the time, but everyone agrees that it doesn't reflect what's happening. It does not reflect the need nor the focus that goes into it and how our individuals receive services. And so it's hard to be in that place, especially when we're being critically evaluated for how we perform on these measures.

Margo Rosenbach:

Thanks, Jakenna. I would like to remind everyone on the Workgroup that these measures would be subject to mandatory reporting in 2024, or will be. They are in the Child Core Set and the behavioral health measures in the Adult Core Set. So coming 2024, they will be mandatory. I know we have some other people who are in the queue. I'd also like to see if David Kelley would be willing to be in the queue because I'm pretty sure I remember in another Workgroup meeting maybe last year you talked about how you were working with your health plans and providers on reporting this measure. So if I recall correctly, it would be great if you would be able to speak up to that as well. Rich Antonelli.

Rich Antonelli:

Yeah, thank you. Specifically, I guess I'd like to start by complimenting the MPR staff; the measure information sheets are so helpful in general, but in particular this one. And so for this vote is about removing this measure. But for the new folks, we've debated this in the past. In fact, this group made a recommendation to remove this one and replace it with the depression screen and follow up, as opposed to the follow up plan. Again, I want to be very respectful of what this particular proposal is. But in the prior year, our group did move that forward. The reason I want to call this out is twofold. One is I'm not just speaking to the child measure, but to the adult measure. And if anything, because of the pandemic, things are worse now than they ever have been with respect to behavioral health needs. And so we're sort of being asked to defend a measure that in the past we were willing to say, change it out. I feel strongly for both the child and the adult measure that removal without putting a gap filling measure back in would be a devastating message for the country. Could a depression screening measure be better and more actionable? Yes. And I recommend take a look at the discussion that we've had in the past. But we have to defend this little bit of real estate for effective care, again, for both the Child and the Adult Set. Thank you.

Margo Rosenbach:

Thanks, Rich. And that's actually a really good point. I will also mention one of the reasons why CMS did not remove this measure was for alignment with other federal programs. And you heard Jessica Lee talk yesterday about the Universal Foundation. And so this measure is being used in other programs. And the idea also being that there's multi-level alignment, alignment across federal programs. So at this point, that is one of the reasons why CMS did not remove the measure, among others. So I just want to call that out as well.

Rich Antonelli:

Thank you.

Margo Rosenbach:

Sure. Lisa Patton.

Lisa Patton:

Yeah, thanks. And thank you, Rich, because I was going to offer that historical perspective as well. We've discussed this one many times and found it unsatisfactory in many ways. But I strongly vote for retention of both these measures today. It's so critical. And one of the previous speakers noted just the importance of having these conversations, particularly now in this post-pandemic world and with the increasing rates of suicidality, depression, and so forth. And, you know, part of the reason that in our -- you know, several years ago when we first got this measure on, that was a real driving force behind it, was to have the opportunity to have those conversations, raise this issue, and openly discuss it. And so I think it's imperative that we continue to support this.

Margo Rosenbach:

Thanks, Lisa. Bonnie? Derek, can you unmute Bonnie? Bonnie, you should be unmuted. Bonnie, if you're speaking, we can't hear you.

Bonnie Zima:

Can you hear me now?

Margo Rosenbach:

Yes.

Bonnie Zima:

Okay, great. Thank you for letting me know. I really appreciate it. We've had this sort of creative tension, not just on this measure but others about importance versus feasibility. And I really appreciated the comments in our earlier discussion that was really quite a nuanced approach to use our vote against removal to send a signal. And I also concur with many of the comments of the other Workgroup members. Just to add some unique comments and some data, if we focus on U.S. teens, according to the National Survey on Drug Use and Health, 16 percent of U.S. teens report symptoms of depression. This has been up 7.7 percent over the last 10 years. Among high school students, 20 percent report serious thoughts of suicide. The other big issue is disparities, and disparities are worsening. And I think it's really quite disheartening to realize suicide rates in Black males, 10 to 19 years, has increased 60 percent. Early adolescent Black youth are twice as likely to die by suicide compared to their White peers.

Also, there was an earlier mention about COVID. And I just want to remind again with data, among children, among 44 U.S. children's hospitals, hospitalizations for suicide attempt or self-injury following COVID-19 school closures rose 42 percent. The other unique comment I want to make is that removal of this measure is a little confusing at this time because it's sort of juxtaposed to the National Institute of Mental Health. NIMH RFA-MH-23-265 has just earmarked $1.5 million to actually invest in the development and validity of these type of quality measures that actually requires use of standardized measures for clinical status. And so I want to pause there, but I appreciate the opportunity to put this on the record.

Margo Rosenbach:

Thank you, Bonnie, and thank you for sharing so much data with the Workgroup. I think one of the things that would be very helpful to hear from the Workgroup, if there is information on any efforts being made to try and improve the feasibility -- use of the G-codes, that's really where the problem is, is that the two codes that are included in the measure are not commonly used. And because they're not paid for, they're not commonly used. So if there are any efforts underway in learning collaboratives or any other work, we'd love to hear about that, perhaps if not today, then tomorrow. So next up is Emily.

Emily Brown:

Hi. I just want to say, as a new member to the Workgroup, I really appreciate the historical context and framework around this measure. And I am voicing my support for keeping the measures on because this is such an important issue and understand the challenges with reporting. But just as a parent, this is such a critical issue.

Margo Rosenbach:

Thanks, Emily. David Kelley, you're up next.

David Kelley:

Sure, thanks. I agree with what's been said about how important these two measures are for both kids and adults. I think one of the challenges is certainly feasibility. And so, for instance, I'm looking at from our HEDIS reporting, and again, the measure might be slightly different than what we're talking about. We have seen in the 12 to 17 age range screening between 2 and 10 percent. I've got to tell you, I think our pediatricians and family medicine colleagues are really doing much better than that. And the follow-up really was around 60 percent with a range by MCO between 32 and 87 percent, and that's the follow-up. So I think there is still a feasibility issue here that we really do need to work on. Likewise, we were looking specifically at, within our state, looking at postpartum and prenatal screening and follow-up as well, which I think now may have made it onto the HEDIS specs.

And I'll tell you, those results there are fairly low. We have actually done chart audits and have publicly reported on chart audits that our rates are very significantly higher than that, that we're actually screening somewhere around 80 to 85 percent of women, both prenatally and postpartum, and a very high percentage of them actually get appropriate follow-up. When we look at administrative data, though, those numbers fall off significantly, so there's a significant gap. So there is a feasibility issue, and that's why we are working with, we have a patient-centered medical home learning network that includes probably over 1,000 practices and probably close to a little bit under two million participants that are covered within those practices. And we have been working diligently to educate those practices on using the administrative codes. So I don't have any results. We'll see what 2022 shows us. Those results we won't have until later this year. But that was one of the efforts that we took with our learning network. There were multiple technical sessions that were provided on that learning network. We typically meet both regionally and statewide. Because of the pandemic, they were all done virtually, so probably things aren't as good as we'd like compared to face-to-face. But that's one of the efforts that we've undertaken. Unfortunately, I don't have any results of that to report on and probably won't until later this year. But we figured this was going to be queued up for both adults and kids in the Core Sets. So we really wanted to get proactive with our provider network to really improve the feasibility of this measure.

Margo Rosenbach:

Thank you, David. Clara?

Clara Filice:

Hi, thanks for the opportunity to weigh in on this one. It's been a great discussion so far and really interesting to hear folks' perspectives. I'll just offer a little bit about our experience with this measure in Massachusetts. First, I want to say that we, you know, strongly agree with the importance of this measure as a pediatrician myself and also in recognition of our population and the level of need, both in child, children and adolescents as well as adults, we think this is critically important. So I would offer that removal without replacement should not be considered. We've also had a little bit of a different experience on application of this measure in

Massachusetts. We've used it in our ACO program for the past five years and have observed a lot of validity in our measurements. We've taken it to audit and every ACO has passed. We've compared to external data sources and really feel confident that our results reflect true improvement and accurate performance.

I would also offer that this measure is preferable in our view relative to the NCQA version as it currently stands in that it offers more flexibility for organizations to choose their approach to screening, decide upon follow-up, et cetera. For our program where there's always new guidance on behavioral health screening instruments, on codes to use, settings in which they can be billed for versus not, this has been -- you know, this version has been more conducive for us than the NCQA measure, which is much more stringent in screening selection, and in some cases we found has actually been inconsistent with our benefit. This measure also is clinically up to date and the exclusions are fairly reasonable. And as has been mentioned, technically it can include perinatal populations as well and there are, you know, recommendations for how to approach that, which is really programmatically important for MassHealth. Despite all that, however, we have also, like many, found it challenging to operationalize, which we've been able to overcome through an adaptation to our implementation to use chart review to supplement the administrative data. So moving forward, you know, we would make a strong push for, if possible, asking NCQA and CMS to try to align their measures with regards to guidance on instruments, allowing for the flexibilities necessary for Medicaid programs to use it, and also to revisit this in the future, probably not ready yet, but as an eCQM-specified measure. The specifications as they are now still indicate that it's administrative, I believe, or EHR-collected, which, as I mentioned, we've had to adapt. So that I think will facilitate more widespread collection and reporting on the measure in the longer term. Thanks.

Margo Rosenbach:

Thank you so much. David Kroll.

David Kroll:

I'll keep this brief because I think a lot of people have already shared a lot of the thoughts that I would have shared and agree with support of keeping this measure in. The only thing that I would add, and, again, I apologize if someone said this earlier as I was briefly kicked out of the WebEx at the very beginning of the discussion, is that I actually would conceptualize this less as a behavioral health measure and really more of a preventative care measure, because it really is focused on processes that take place at the primary care level and really goes a long way to reinforce the use of collaborative care. The use of collaborative care, again, just to remind people, is to use a systematic approach to depression screening and management within primary care clinics, and it's very closely linked to high-quality care, meaning that the evidence that working in a systematic way to screen for and document the screening of depression is very closely linked through more than 100 studies of better outcomes with lower costs, and keeping in mind, too, that the stakes are very high here. Depression is the leading cause of disability in the world, and it's an area where there's a lot of opportunity to measure quality, and this measure is very closely aligned with it despite its faults in terms of being feasible for everyone. Thanks.

Margo Rosenbach:

Thanks, David. Linette? Linette, if you're speaking, we can't hear you. Why don't we move on to Jakenna?

Linette Scott:

It took a minute to have that come through. I guess one of the questions I have about some of the logistic aspects, so previously in 2020 there were 14 states that reported, 14, 15 states. I know you all are still analyzing all the data that we submitted for '21 and '22. Do we know if the reporting by states came up in that? And, again, I guess this is something that would probably end up back into the conversation tomorrow some, but, I mean, I think a lot of the conversation I've heard so far today is absolute support for the need to have a measure that looks at depression screening and absolutely agree on that. The question is the feasibility and what does the data tell us, recognizing that, as was said, the CDF measure is dependent on codes being submitted that are not being paid for, and so understanding what that means and what that tells us and how we interpret the information as it is shared. But kind of the immediate question was just wondering if there was increased reporting in '21 and '22, even though those results aren't out yet.

Margo Rosenbach:

Well, that's a great question. And I can say that more states are reporting the measure, the measures, so that we're on track to have more states reporting for this year. All right. So thank you, Linette. And next, Laura Pennington, then Ben Anderson and David Kelley.

Laura Pennington:

Can you hear me, Margo?

Margo Rosenbach:

Yes.

Laura Pennington:

Great. Thank you. So I would say this topic or this area is a priority in Washington State, especially within our primary care initiative work. Our primary care providers feel that this is a very important topic, but they also acknowledge the difficulty of reporting the follow-up piece. So with that said, we've started prioritizing the depression screening and follow-up and also the depression remission and response, the two NCQA versions in our contracts, including tied to value-based purchasing. However, we also have been in conversations, not with our Medicaid providers yet, but our commercial carriers, about how we can support providers by giving them TA to be able to report those codes. Just what you mentioned, Margo, about the difficulty for some of this is at the provider level about better understanding of how to report those codes. So we agree in Washington State this is a very important topic. But I still feel like we're a little bit kind of in the early stages of partnering with our providers and our health plans to figure out how we can do this and do this successfully. So with that said, we do agree we should consider retaining it, however, until we have a replacement or we skip this one - but, however, I would acknowledge this is one of a very few numbers of core measures that we're currently not able to report due to the feasibility. So if we do leave it in and it's required reporting for next year, I'm

not really sure what that is going to mean for us. I just know we have to try to figure that out. I don't know if we'll be able to do that in time for next year's reporting. But we're working on it is what I'm trying to say. Do I have an opinion either way about leaving it in or not? I'm kind of neutral in this, again, agreeing that it's important, but also acknowledging the feasibility is really a barrier for us in Washington State. Thank you.

Margo Rosenbach:

Thank you. I also want to ask if people are finished talking, if you could please lower your hand. And also, if you are a member of the public, please lower your hand. We'll get to public comment shortly. We still have a lot of people in the queue. Next, Ben Anderson.

Ben Anderson:

Hi. Thank you. So as a maternal child health person, that is the area where I spend most of my day. I just wanted to make sure that I came off and was on the record as noting, of course, that we're in an adolescent mental health crisis as well as a maternal health crisis. And so the idea of removing these without a sufficient replacement or any replacement, I don't think is something I'd be able to recommend at this time. And I think, you know, as I think for consumers, you know, I think on the issue of feasibility, seeing that, you know, there are a number of states, more than a dozen, and that number is growing. It makes it look as if reporting on this measure is, in fact, feasible. But perhaps in some states, you know, the states have not taken the necessary steps, or in this case it sounds like providers have not taken the necessary steps to get reporting around this. And so, you know, to me, that doesn't sound like it's not feasible. It sounds like it is and just, you know, a little bit more effort is needed there. And I think, you know, everything that I'm hearing from the providers and from some of the states who are trying to work towards improvement on this issue, that's really heartening to hear as well. But I am, you know, sympathetic to, you know, what I'm hearing around the challenges and difficulties around this. And I think, you know, if there is a better measure for this particular issue, I'd certainly be the first to line up and support that as well. Thanks.

Margo Rosenbach:

Thanks, Ben. Next, Lindsay Cogan.

Lindsay Cogan:

Yes, thank you, Margo. And a lot of my comments, I think, have already been mentioned. But I just want to also mention from a state perspective, we have sort of committed resources to this particular area because we feel like if we can figure out how to capture information on screening for something and follow-up, that's going to open up a wider door and pathway towards other measures. So just another thing to think about in the quality measurement world. Yes, condition-specific measures are important. Processes of care are important. Obviously, we're looking towards, you know, moving in the direction of outcomes-based measures. But sometimes we will apply strategic priorities and strategies and resources towards trying to figure out how to measure something that would open up the door to other conditions like screening for the social determinants of health. Right. It's those kind of pathways. And so in the quality measurement world, sometimes we may use this opportunity to help scaffold to other areas. So just another unique perspective that I haven't heard mentioned so far in thinking about this particular

measure on the Core Set, and especially in light of the comments regarding the Antidepressant Medication Management potential removal, if that is retired. You got to think in looking across the Core Set, looking at that balance of sort of care processes, measures and thinking more strategically. So just something to think about.

Margo Rosenbach:

Thanks, Lindsay. Amanda.

Amanda Dumas:

Hi, thank you. I just wanted to, I guess, reflect back some of the things I'm hearing overall. And for context, I'm in Louisiana Medicaid, and I certainly relate a lot to the sentiments around feasibility. I'm also a pediatrician and primarily an adolescent provider. So this is very close to my heart. And I kind of take issue with the thought that I have to even say that to justify that there's problems with this measure. But I feel like I have to because we seem to be coming to a point where we're saying that maybe what's more important here when we think about the three things we're going for, feasibility, desirability and viability of a measure, that what's more important here is really our messaging to the public around our commitment to addressing adolescent depression. And that commitment and that messaging is really more important than our ability to actually get good information from the implementation of this measure. And so I just want to make sure that we're able to keep those different things and hold them at the same time without -- I guess without making people feel basically guilted into accepting a measure that their state just simply can't perform right now.

I think the other thought that comes to mind when I'm hearing this, though, is that if this measure is approved and we move forward with it, that what we're going to end up doing is probably pushing states to reimbursing it. So that might be -- I think that's the desired effect, honestly, I think that we need to support providers, not with TA, but with actual cold, hard cash because we know our primary care providers are really suffering. So I think that might be a great outcome. But I think that we're going to be doing that at the cost of getting some pretty sloppy data at the beginning. And I just want to acknowledge that those two things can exist at the same time.

Margo Rosenbach:

Thank you. That's a great comment. Bonnie, do you have another comment? Are there any other Workgroup members that have comments before we move to public comment? All right. Well, at this point, next slide, please. We will move to public comment. So if you are interested in making a public comment, please raise your hand and I will call on you. And please also remember to introduce yourself. Okay, so public comment from -- I'm sorry if I mispronounce your name. Raymonde.

Raymonde Uy:

Yes, thank you very much. This is Raymonde Uy from the National Association of Community Health Centers. So I'm a physician informaticist by training and I'm not going to repeat what everybody has said in favor of not removing this measure. And I'm hearing what everybody else is saying, where code and reporting are a difficulty. I think that one of the issues that I wanted to

bring up is -- I think people have said it, removal of this measure is counterproductive or inappropriate, because this enforces or encourages the mental health workflow. Many patients who don't necessarily get the positive screen will not say that they have a mood problem or anything like that. And I'm sure a lot of physicians here in this call have experienced this as well. And I just want to comment on the informatics piece where I know there's these two HCPCS codes on the measure and there's difficulty in reporting it and there's no replacement.

And there are a lot of surrogate codes that can be used to represent these. There are specific CPT codes in the 335 XX hierarchy that is for depression screening. And we all know the CPT Code 96127, which are using and documenting behavioral-emotional or behavioral assessments using a depression inventory, or 99420, which is administration or interpretation of health risk assessment instruments such as again PHQ-2 or PHQ-9 depression screening. Lastly, there's also LOINC codes that are specific for standardized measurement or standardized depression screening was conducted. For example, 57242-0 as a LOINC code represents standardized depression screening was conducted. And there's also specific LOINC codes for adolescent depression screening assessment 73831-0 and adult depression screening assessment LOINC code 73832-8.

Last but not the least, EHR vendors are supposed to be supporting SNOMED CT. Right. And there's a lot of codes there to represent the concept of social or mental health interventions. There's a plethora of SNOMED CT codes that show referral to psychologists, referral to psychiatry services, referral to mental health team or mental health counselors. There's also SNOMED CT codes specific for depression screening, negative depression screening, positive depression screening using PHQ-9. I believe that there is a public health informatics issue in the workforce that it's difficult to find folks who can query EHR databases to do this kind of reporting. And then there's a lot of third-party vendors and cost issues that they have to pay these vendors to do this kind of reporting. So that's kind of my informatics piece. Again, CPT, LOINC codes, and SNOMED CT codes as a way to represent this. We shouldn't remove this if there is no replacement. Thank you so much.

Margo Rosenbach:

Thank you so much. And thank you for your detailed information about coding. We do have folks listening who are involved in a lot of the work on maintaining the measure. And so they are listening carefully about your feedback on the coding. Thank you. All right, Julia, you're up. Julia, if you're speaking, we can't hear you.

Julia Skapik:

Sorry about that. I took down my hand instead of unmuting myself. Julia Skapik, CMIO of the National Association of Community Health Centers. I think some of this is more of a workflow problem than a coding problem. And I can say on the reverse end of benefiting from the workflow changes we've made to support this measure, that I have diagnosed a significant number of patients, I can't even tell you how many, as a result of the medical assistant doing the screening and putting that information in the EHR where I can see it. I have seen that information and then asked the patient, tell me about your mood. And usually the patient breaks down at that point. Otherwise, I would not have talked to the patient about this. So it's really critical if we're going to respond to this need in the community that we build that into the workflow. I don't think the technical part is so difficult, although I strongly encourage CMS to

provide maps in the way that Raymonde discussed and to work directly with the vendors to ensure that they support at least some form and manner of this workflow in a way that is accommodated in a typical primary care visit. But to echo everyone's comments, I think removing these measures without replacing them at this time would be inappropriate and probably harmful to our country's mental health.

Margo Rosenbach:

Thank you so much. Are there any other public comments before we move to voting on removal of these two measures? Last call for public comment. Okay. Well, with that, I will turn it over to Alli and Talia to help us with the voting.

Alli Steiner:

Thank you, Margo. So first we'll be voting on the measure with the child age group. So the question is, should the Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH) measure be removed from the Child Core Set? The options are yes, I recommend removing this measure from the Child Core Set, or no, I do not recommend removing this measure from the Child Core Set. Voting is open. Just a reminder to refresh your screen if you're not seeing the question. We're just waiting on one more vote. Thanks for your patience. It looks like we may be missing a vote from Joy. Joy, I see that you have your hand raised. Okay. And we have received your vote in the Q&A now, Joy. Thank you for sending that. All right. We have reached the expected number of votes.

Okay. So for the results, 10 percent of Workgroup members voted yes. That does not meet the threshold for recommendation. The Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH) measure, is not recommended by the Workgroup for removal from the 2025 Child Core Set.

Moving on to the next vote. So now we'll be voting on the measure in the Adult Core Set. The question is, should the Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD) measure be removed from the Adult Core Set? The options are yes, I recommend removing this measure from the Adult Core Set, or no, I do not recommend removing this measure. Voting is now open. Okay. We've received the expected number of votes. Moving to the results. All right. Again, we have 10 percent of the Workgroup members voted yes. That does not meet the threshold for recommendation. The Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD) measure is not recommended by the Workgroup for removal from the 2025 Adult Core Set. Next slide, please.

And so that concludes our voting on the Behavioral Health Care domain. I'll now turn it back to Margo.

Margo Rosenbach:

Thanks, everyone. This was a really helpful conversation. I would like to encourage everyone to be thinking more about how to work toward building state capacity for reporting these measures. We do know that the rates are very, very low. I found the conversations about learning collaboratives, workflows, coding to be very helpful, and I think tomorrow when we have an opportunity to talk about building state capacity for reporting Core Set measures, we'd love to

hear more and be thinking constructively, specifically about improving capacity for these measures, given how important they are. So with that, we will take a break. We'll resume at 2:10, so that's around 25 minutes right now, and then we will move on to the two Experience of Care measures. So I hope everyone enjoys the break.

BREAK

Hello, everyone, and welcome back from the break. We are now turning to our final domain of the day, which is Experience of Care. Next slide, please.

The Experience of Care domain contains two measures, which you see here. The measure in the Child Core Set is Consumer Assessment of Healthcare Providers and Systems, or CAHPS®, Health Plan Survey 5.1H - Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items. The measure in the Adult Core Set is CAHPS Health Plan Survey 5.1H, Adult Version for Medicaid. Both the child and adult measures were suggested by a Workgroup member for removal from the 2025 Core Sets. Next slide, please.

The child version, known as CPC-CH, measure provides information on parents' experiences with their child's health care. Results summarize children's experiences through ratings, composites, and individual question summary rates. The Children with Chronic Conditions or CCC supplemental items provide information on parents' experience with their child's health care for children with chronic conditions. The CPA-AD, or the adult measure, provides information on the experiences of adult beneficiaries with their health care and gives a general indication of how well the health care meets the beneficiaries' expectations. Results summarize beneficiaries' experiences through ratings, composites, and question summary rates. AHRQ is the measure steward for the survey instrument in the Child and Adult Core Sets, and NCQA is the developer of the survey administration protocol. The measure is NQF-endorsed, and the data collection method is survey. The denominators include a sample of beneficiaries who are continuously enrolled the last six months of the measurement year and who were currently enrolled in Medicaid or CHIP at the time of the survey. The goal is 411 completed surveys and at least 100 valid responses for each question. Next slide, please.

This slide shows the four global rating questions and four composite scores. A single question reflects experience with coordination of care. Item-specific results are reported for select questions. The Child Core Set measure also includes supplemental items on the experience of Children with Chronic Conditions, as you can see here. Next slide, please.

The Workgroup member did not suggest a measure for replacement but mentioned that a partial replacement could be achieved through the Mental Health Statistics Improvement Program survey or analysis of access, frequency, and timing of services via claims data. For FFY 2020, 39 states reported the Child Core Set measure and 36 states reported the Adult Core Set measure. The measure is not included in the Medicaid and CHIP Scorecard, but it is included in the Universal Foundation as an indicator of person-centered care.

A few other points to note about the CAHPS measures. CHIP programs are required to conduct the CAHPS survey under Section 2108(e) of the Social Security Act, as implemented through the Children's Health Insurance Program Reauthorization Act of 2009 or CHIPRA. And we've included some language from the statute on the slide and in the measure information sheet. As a result, CHIP programs would still be required by statute to collect the child CAHPS measure,

even if the Workgroup recommended it for removal from the Child Core Set. The Adult Core Set includes two measures derived from the CAHPS 5.1H adult survey. Flu Vaccinations for Adults Ages 18 to 64, or the FVA-AD measure, is being retired for HEDIS Measurement Year 2023, which is the 2024 Core Set, and will also be retired from the 2024 Adult Core Set. NCQA has also proposed to retire the Medical Assistance with Smoking and Tobacco Use Cessation, or MSC-AD, measure for HEDIS Measurement Year 2024, which is the 2025 Core Set. The proposed retirement of MSC-AD is pending NCQA's review of public comments. As we've talked about in the past, CMCS has been conducting a pilot and providing technical assistance to utilize submissions to the CAHPS database to support state reporting of the CAHPS measures.

And turning now to the Workgroup member's reasons for suggesting both CAHPS measures for removal from the Core Sets. The Workgroup member indicated concerns about the reliability and validity of the survey instrument and whether it was appropriate for comparative analyses by demographics. The Workgroup member also expressed uncertainty about whether self-reported data are reliable and valid enough to use to assess state progress as compared with claims data. Finally, the Workgroup member questioned the financial viability of the CAHPS surveys, noting that the surveys require time, expense, staff expertise, and a contractor to collect data according to the technical specifications.

Just want to point out that another Workgroup member suggested retaining the CAHPS surveys in the 2025 Child and Adult Core Sets but changing the frequency. They indicated that they would like to see the surveys conducted less frequently, such as every other year, due to growing concerns around survey fatigue and unwillingness of members to engage in survey efforts. The Workgroup member noted the increasing difficulty to gather sufficient responses for statistically valid results and indicated that it is increasingly challenging to use the results to drive improvement due to low response rates.

Please keep in mind that the question the Workgroup will vote on today is whether to recommend removal of the CAHPS measures from the 2025 Child and Adult Core Sets. If the measures are retained in the Core Sets, the frequency with which they are collected will be determined by CMCS. Next slide.

So at this point, we will now invite Workgroup members to discuss the CAHPS measures in both the Child and Adult Core Sets. If you wish to make a comment, please raise your hand. Lindsay?

Lindsay Cogan:

So I understand the comments made about decreasing response rates. So that is definitely something our state sees continuing to drop every year. So it is something that we are keeping a close eye on. I will say that in New York State, we do do less frequent surveys. So we will do an adult survey one year and then a child survey the next year. And we'll do them, you know, on off years. And that does help a little bit, but we still see dwindling response rates. So I do think that there is a need overall to think about different ways to capture enrollee experience. And I'm putting that out there more for the folks that are listening in on this meeting, is that this is a definite need, the modality in which we interact with members and get information back on their experience with care. I think it needs to be rethought a little bit. So I would definitely, you know, I understand that this is an important arm of understanding experience of care. Thinking about

different ways to capture this, we would be supportive of removing or keeping with a less frequent cadence. I think either or any of those options are completely viable.

Margo Rosenbach:

Lindsay, can you clarify your last comment, exactly what you're supportive of, of removing altogether or keeping with less frequent? Just want to make sure that I heard that correctly.

Lindsay Cogan:

That is correct. That is correct. We could go either way. I see the benefits of sort of removing and focusing in and looking for different ways, but would also be supportive of a decrease in cadence. I think that is a good suggestion put forward by a Workgroup member.

Margo Rosenbach:

Okay. Thank you very much. Other comments? Erica?

Erica David Park:

Hi, good afternoon. Can you hear me?

Margo Rosenbach:

Yes, very well.

Erica David Park:

Great. Thank you. All right. So my thoughts are, I think, you know, there's definitely benefit to the data that's obtained through the CAHPS survey. And, you know, although a lot of good information can be obtained from claims data and other sources, currently the best way that we currently have to obtain information, like a wide scale on member experience is really has to be based on self-report. You know, self-report. We can't get opinions based on claims data. However, I do agree that we should at least think about alternative methods that we can use to try to capture those member experiences. So I definitely would love to, you know, another time have more discussion about how we can do that and how we can put something like that together. But my thought is that until we have something like that set up, it wouldn't make sense to remove the CAHPS surveys at this point. I am also, however, in support of the idea of decreasing the frequency at which it needs to be done. So you know, maybe not really like every other year or something along those lines. But I know we're voting only on the measure itself. So that is my thought. Thank you so much for the time.

Margo Rosenbach:

Thank you. Kim Elliott.

Kim Elliott:

I think it's really important to voice member experience in the core measure set. So for that reason, I really think it's important to keep these measures. I don't disagree about the potential change in frequency, but I'm not sure that that's really an option up for discussion, but may be good for information for CMS going forward. Until we come up with some other way to really collect and include the measure voice, the member's voice, I think this is an important one to keep.

Margo Rosenbach:

Thanks, Kim. Jakenna.

Jakenna Lebsock:

Very similar comments to what's already been stated. I really appreciate the viewpoint that comes with the CAHPS survey. I think it's really important to understand how individuals feel about the care and services that they're receiving, and that perspective really is an important aspect of how we push forward quality. However, as others shared, the frequency, I think, is where the concern comes from this, is if it's mandatory to be annual with all of the concerns around survey fatigue and things like that. That's really where I think the biggest opportunity is until such time that we can find another way to get that member voice. But I appreciate the measure and what it offers. It's just the frequency is really where the concern lies, at least from an Arizona perspective.

Margo Rosenbach:

Thanks, Jakenna. Rachel?

Rachel La Croix:

I echo a lot of the concerns and the support for the measure. It is something that we as a state may still require our plans to do annually, even if the reporting did become every other year, but I think we would be open to considering less frequent, particularly if that did somehow contribute to higher response rates. We know response rates have been an issue for everybody across different types of surveys. I don't know to the extent that CMS and NCQA and AHRQ, I don't know if there's some additional work being done to try to figure out what some alternative modalities might be to survey administration and other things, whether it's increasing sample size or other things, to try to get more representative response rates. I think if more effort could be put into that to help these results be more meaningful, I think that could help all of us, because the patient experience really is important to include as we're looking at all of these different measures of care.

Margo Rosenbach:

Thanks, Rachel. David Kelley?

David Kelley:

Thanks. From our standpoint in Pennsylvania, we use this annually, and I think there's some value to looking at plans annually. When you go through a re-procurement, some plans change.

Plans may be different within each region. Senior leadership within health plans can change, and there may be new utilization management policies and whatnot that are put into place. So from a consumer standpoint, I think if I'm making a plan selection, I don't know if I really want stale two-year-old data to help me to decide what plan I'm going to choose. I want something that is fairly current, that participants from that previous year actually weighed in on what they thought was going on within their health plan. So I think it's really valuable to have this participant input.

Certainly there are the challenges. I think Lindsay had mentioned that it's increasingly the response rate's not where we want it to be. Are there other means of gathering this electronically or more efficiently or using social media? That would, you know, I think would really be helpful. But I think the consumer's voice is really vital. We use it in our report cards. We also have used it in the past in our RFP process and have, you know, given it considerable weight along with a lot of other quality measures. And I don't know if NCQA or others' question is -- I think there was a comment earlier about the validity of patient self-reported data, and I don't know if anybody from any stewards want to weigh in on that validity on certain questions. I'm sure that's been studied. But I'm supportive of maintaining these measures for both kids and adults, and I would probably advocate that we continue to keep the frequency on an annual basis. Thanks.

Margo Rosenbach:

Thanks, David. Rich Antonelli, you're next.

Rich Antonelli:

Yeah, thank you. I want to speak out very strongly in favor of retaining both measures. Experience measures is a critical aspect of what systems need to hear and payers need to hear. That is the voice of the customer. And just to be clear, I always try to differentiate satisfaction from experience. Satisfaction implies you know what to expect. So the whole idea of what is the patient experience has significant implications around equity of access and equity of outcomes. I think this is really, really important. And, Margo, MPR team, one of my favorite slides that you've reprised now several years is that multi-level of what are we measuring at what level. So I just wanted to call out for our colleagues on the Workgroup the opportunity to implement additional measures at levels for certain subpopulations. So think about the Health Home group for patients with particularly complex needs. Some of the work that HRSA, Maternal and Child Health Bureau, are supporting with respect to children with medical complexity and their families, including those patients transitioning, those patients with complex needs transitioning from pediatrics to adult care.

This experience measure is a common thread. We all need to hope for increasing response rates. But I also want to call out the fact that we need to get more work in this area and assure that patients and families are telling us what's important to them and then looking at what those outcomes are. And then finally, the ability to continue to stratify, to look at the differences between those subgroups, whether by disability status or other. So I'll close by saying I strongly recommend that we keep both the Child and the Adult experience measures in the Core Set. Thank you.

Margo Rosenbach:

Thanks, Rich. Emily Brown?

Emily Brown:

Yes, I echo Rich's sentiments and kind of everything that's been said before. You know, I'm really on this call as a former Medicaid recipient, and I can't stress how important it is to elevate the voice of the patient and the member and their experiences as they navigate the systems for care. There can be challenges and there are great opportunities for improvement, but sometimes we may not be able to identify them if we're not engaging the end user. In this case, that's the patients and families themselves who are receiving care through Medicaid. So I am strongly in favor of keeping these measures because they are extremely important. And when it comes to response rates, I just echo again my comments from yesterday in that, you know, engaging members in the best ways to collect this data I think is really important. Because it's true, there is survey fatigue because oftentimes members are having to use their data as currency as they navigate within not only the health care system, but the other many systems that support our social safety net. So reaching out to them, engaging them in that process to make it better, to improve those response rates is critical.

Margo Rosenbach:

Thank you. Ben Anderson.

Ben Anderson:

Hi. Thank you. You know, coming from, you know, Families USA, where, of course, our focus is on the experience of the consumer, it's been really heartening to hear plans and states and providers speak to the importance of this measure. And what we know and what we hear across the country through various components of our work is that consumers, you know, would like to see more measures in the area of Experience of Care. And right now, this is our only measure in the Core Set that evaluates consumer experience. So we think it's important to keep it here for those reasons. You know, thinking back also to the conversation that we had yesterday around how to improve processes where it may be difficult to capture information from consumers. The other thing that we would encourage those who are involved in the collecting of the data to support this measure is to really make sure that not only are you listening to the communities that you're serving in terms of how you're collecting the information, but also look at, you know, hiring practices. You know, do you employ people within your organizations that come from the community? And having those individuals on staff who are expert in speaking to their neighbors can also help a lot in terms of the implementation of this measure. So again, we support retaining this measure for all the reasons that I think you're hearing in the discussion today. Thank you.

Margo Rosenbach:

Thank you so much. Before we move on to other Workgroup members, I thought I would call on either Dale Scaller, Naomi Yount, someone else who's involved with the CAHPS survey who might be able to speak to the question earlier about validity and reliability. And if you are available and able to speak, could you please raise your hand? Naomi. Derek, can you unmute Naomi? Thank you. Naomi, can you introduce yourself?

Naomi Yount:

Can you hear me okay?

Margo Rosenbach:

Yes, I can.

Naomi Yount:

Okay. Thank you for giving me the opportunity to talk. I can just say overall the measures are reliable and valid, and there is evidence of this, ample evidence that we can share with the Workgroup after this meeting. I don't think I can share it via talking about it, but there is evidence for it, and we're happy to share that.

Margo Rosenbach:

Thank you. I guess something that came up yesterday related to NQF endorsement, although I know that's not a strong consideration here, but just the fact that it is NQF endorsed means that it has gone through that testing. You have provided the evidence. Does that sound right? That the evidence was provided as part of NQF endorsement. All right. With that, anything else from the measure steward from AHRQ or Westat? All right. Naomi, is there something else you wanted to say? Derek, can you unmute, Naomi?

Naomi Yount:

I had muted myself. Yes, I would agree with you. It has been NQF endorsed, and so there is evidence for that. So I just wanted to follow up and say that I agree with you, and, again, we can provide that evidence.

Margo Rosenbach:

Thank you. All right. Laura Pennington.

Laura Pennington:

Hi. On behalf of Washington State, we just wanted to say we support retaining this measure. If it is removed, we'll still continue to collect it and report it and require our managed care plans to do that. So we do, although, acknowledge that some of the difficulties with the CAHPS measure, specifically between the time of the visit and the receipt of the survey. So just wanted to have folks think about going forward, is there a better way to collect more real-time feedback from patients? Because we do think that's very valuable, and we do agree that patient experience is something that we should prioritize. So just wanted to say that we're okay with keeping it for now. Thank you.

Margo Rosenbach:

Thank you. I see, Jakenna, you have your hand raised. Do you have another comment?

Jakenna Lebsock:

No, sorry. I just keep forgetting to take my hand down.

Margo Rosenbach:
No problem. And if any other Workgroup members have comments, please get in the queue. And remember that Q&A is not a vehicle for providing comments. I see Kai. Kai, can you unmute?

Kai Tao:

Mine was just more of a question, not being intimately familiar with the CAHPS. Does it specifically address respectful care and implicit bias? It's a lot of the work we do in maternity settings and reproductive health equity settings. Does anyone know?

Margo Rosenbach:

Yeah, so can you go back to the slides that shows the composites and ratings? Kate, or whoever is driving the slides, can you go back to that? Yeah, well, okay, there you go. So you can see there is a composite score related to how well doctors communicate. So these are the composite scores that include other elements, getting care quickly, getting needed care, how well doctors communicate, and customer service. And so within the how well doctors communicate does have information that I think addresses your question. For others on the Workgroup, if you have other comments about that, we'd love to have you all weigh in as well. Rachel, do you have another comment, or just your hand is still raised? All right, Joy Burkhard, you're next.

Joy Burkhard:

I'm just going to address the last speaker's question or comment about respectful maternity care. There's a new measure, a new CAHPS survey that's being developed, or at least AHRQ is seeking feedback as of today on what that might look like in terms of respectful maternity care or a CAHPS survey around maternity care more broadly. Just wanted to share that.

Margo Rosenbach:

Great, thank you. And I see Kamila from AHRQ. Did you want to speak to that? You are unmuted.

Kamila Mistry:

Am I unmuted? Yes. Okay. Yes. I just wanted to confirm that AHRQ right now has an RFI out, which is a request for information around the work that we're doing around developing --

Margo Rosenbach:

You're breaking up. Could it be an issue with your headset or your speakers?

Kamila Mistry:

Can you hear me, Margo?

Margo Rosenbach:

Now I can, but you were coming in and out.

Kamila Mistry:

Okay, sorry. Just to confirm that AHRQ is working on a CAHPS focused, or a maternity-focused CAHPS survey, and there's currently an RFI, which is a request for information that's out. So if folks want to look at that and provide some feedback to us, that would be great. And that will focus on respectful maternity care and other aspects that we want to include in terms of measurement for experience.

Margo Rosenbach:

Thanks so much. David Kelley.

David Kelley:

Yes, thanks. I was looking at the CAHPS questions and there are several questions that actually ask about respect from both the provider but I think also the health plan. So those are some very specific things that are asked about courtesy and respect from both the health plan, but I think also from your personal doctor and/or specialists. So it looks like that is in multiple places within the questions. And I know that, you know, we're just looking at the overall domains, but it seems like that's incorporated in many of the questions asking if the doctor showed respect for what you had to say. So for both the doctor and the health plan. So that is something that is incorporated in the spirit of the survey.

Margo Rosenbach:

Thanks, David. And Sarah, do you have a comment as a measure steward? Other comments from other Workgroup members? Do we have other Workgroup members who would like to speak before we move to public comment? Give it another couple of minutes. Jim Crall.

Jim Crall:

Thanks, Margo. Yeah, I just, you know, certainly appreciate the importance of the consumer input. But having, you know, sat in this group for several years, I think the issue of the declining response rate grows more troubling to me every year. And, you know, I see recommendations that response rates, 40 percent for Medicaid population are recommended, 50 percent for commercial. And then I see state reports on the Internet of response rates of seven and 12 percent. And it's just troubling, I guess, to me. And I know, you know, that perhaps process and there are a lot of really smart people that worked on CAHPS for years and years and years. And, you know, the potential is there. But you know, I am troubled and have questions about how useful, you know, when you get response rates of seven to 12 percent are for a state program.

Margo Rosenbach:

Thanks, Jim. Kai?

Kai Tao:

Yeah, I have to say I'm in the same vein. I mean, having been a provider for 20 years and work in the safety net clinics, you know, these CAHPS surveys are always there. We hear about them in different reviews and processes. Because of the low response rate, because of the change in how consumers are providing feedback, right, for everything from Target to getting your doughnuts, it seems like there's got to be better ways to do this where we are actually hearing from people. I mean, that survey in itself is long. I know it's trying to be comprehensive, but I mean, that might be contributing to the low feedback. But also, I don't know if anything's being done when we get feedback like this. I rarely see true, you know, kind of process quality improvement work because we'll say it's aberration or it's a one-off. This patient had a bad experience. But overall, the other eight were fine. I mean, just these really low numbers. So I'm just not convinced the CAHPS survey and how it originated is consistent with our times today and how everything's sort of on demand, quick, short text, et cetera. I think it's important, don't get me wrong, but I'm not sure this is the mechanism. So time and resources.

Margo Rosenbach:

Sorry, a couple of thoughts. One is I would certainly encourage the Workgroup tomorrow when we talk about gaps and prioritization of gaps and identifying measures for development, refinement, testing, to definitely think about that tomorrow. But then also as voting today, recognizing that the voting to remove the measure for 2025 would remove any measures from the Experience of Care domain. So I think that's the framing of whether to remove the measures for 2025 or be working through the gaps prioritization for identifying additional work in this area. I think these are all really good comments and definitely be thinking about that trade off or that tension when the vote would come to remove these measures from the Child and Adult Core Sets. Other comments? Are there any states that want to speak to how you use the data to drive improvement? I think, David, you already mentioned that you use it in Pennsylvania to select plans that have evidence of higher quality, higher ratings of member experience. Other comments about how the data are used from the standpoint of improving beneficiary experience? David?

David Kelley:

Thanks. It took me a while to get unmuted there. So we publicly report some of the results on our website. We use it. And also I believe there's a question or two in our consumer report cards. And in our LTSS program, we also use it in one of our managed care paid performance programs, looking at overall satisfaction for the health plan. And then, as I previously mentioned, it was part of one of our RFP procurements, re-procurements for our managed care program. So those are multiple ways in which we use it. Every year we look at results. We do some supplemental questions as well. And we look at results and then we ask our plans to work with us to work on ways to improve certain aspects that may not hit certain thresholds.

Margo Rosenbach:

Thanks, David. Jakenna?

Jakenna Lebsock:

So in Arizona, we definitely use it with our health plans. And for comparative purposes, just so they can see how member satisfaction is between their plan and others and how they're performing, we do post it publicly on our website under our scorecards so that the general public can see the perception or the member-based perception of the plans and how they're doing. We require corrective action plans or sometimes PIPs in order to address some of the findings. And so it could be MCO specific where we have particular concerns about performance, or it could be system general where we see performance that we aren't satisfied with across the board. And so then our health plans have to work collectively on how to address and improve that aspect of care. So we actually use it in a number of ways. It's very informative to, again, making sure that the concerns we're hearing from members are really being taken seriously and that the health plans are being responsive to those perceptions.

Margo Rosenbach:

Thank you. Rachel?

Rachel La Croix:

Yes, in Florida we use the survey results very similarly to what David mentioned for Pennsylvania. We do use it to help with scoring for competitive procurement. We also publicly put the Child and Adult survey results on our website, on the Florida Health Finder website, so that members can look at those results and use that information when choosing a plan. And we do also require our plans to use their survey results to identify areas for improvement as well.

Margo Rosenbach:

Thanks, Rachel. Amanda?

Amanda Dumas:

Hi. In Louisiana we do something similar. We have both a quality dashboard where anyone from the public can go onto that site and see the results of actually all of our different quality measures, including these. And you can see both how it's broken down by plan as well as how those ratings by plan have been changing year to year. And then we also have a health plan report card where some of these measures are included in the star rating. Thank you.

Margo Rosenbach:

Thank you. I'm wondering, Kim Elliott or Sarah Johnson, you are both with EQROs, External Quality Review Organizations. Do you have any insights about the use of the CAHPS surveys to drive improvement? Kim?

Kim Elliott:

This is Kim. Across the states that we work with, they use it for multiple different purposes, including a lot of the things that have already been mentioned. One of the big things that I see them using it for is pay for performance. They're tying it into RFPs. They are tying it into their public reporting, so putting it on their website, so that members have a better opportunity to make selections and plans based on some of the feedback and responses. So there's a lot of consistency in the states that we work with, but there's also some unique differences across the states.

Margo Rosenbach:

Thanks, Kim. We have time for a few more comments. If you have a comment, please raise your hand. And if you've made a comment and are done, please lower your hand. Tricia Brooks.

Tricia Brooks:

Thank you. You know, I'm definitely in the camp that we need to keep something in the Experience of Care domain. But I also think that there is a lack of transparency around the CAHPS reports, and it's not, even though it's required on the Core Set, it's not reported as part of all of the analysis work that you do, Mathematica, and fabulously do in terms of the chart packs. And, you know, I think this is really more a comment to our friends at CMS who are listening, that I hope that they are thinking about better ways since HHS will be required to publicly report Core Set measures. The Secretary may have a little more latitude as to when they report, but it seems to me that we need to do more to make these data available to stakeholders who may want to advocate for improvements along the way.

Margo Rosenbach:

Thanks, Tricia. That's great. And as we mentioned earlier, we have been working collaboratively, AHRQ, CMS, Westat, and Mathematica, to encourage states and their health plans to submit to the CAHPS Database and making some good progress there. For those who are listening, I'll just say that reporting submissions to the CAHPS Database are open June 5th to June 30th, and so that's really what we're working toward, is having as many submissions as possible to the CAHPS Database and using the data, hopefully soon, to be able to report based on those submissions. So that is the goal. I think we talked about that a couple times in the past, but we're inching closer to that, and so I will just put in a plug on behalf of AHRQ, CMS, Westat, and Mathematica for states and plans to submit to the CAHPS Database between June 5th and June 30th. I see Sarah Johnson has her hand raised.

Sarah Johnson:

Hi, apologies. I was trying to unmute myself before in response to your prompt about EQROs. I just wanted to mention that I think we've seen a lot of states incorporating these measures into their performance improvement projects in particular, but also struggling with a lot of the limitations that have been discussed already. So I'm going to just echo what a lot of others have said more eloquently, and just that I think we would support keeping the measures for right now in the absence of a sufficient alternative, but do recognize that there are a lot of limitations that have to be considered and, you know, really hope that moving forward we can come up with some better solutions that allow for the voice of the consumer to be represented.

Margo Rosenbach:

Thanks, Sarah. Naomi, do you have another comment?

Naomi Yount:

Yeah, I wanted to go back to the comments made about response rates and survey fatigue, and just add that you don't need to sample everybody. I know the survey fatigue is a real thing, but hopefully not everybody is being surveyed every year, and that there is studies going on to improve response rates, and part of that is how you're administering the survey. So a lot of that may be mail/phone, but there's new evidence showing the benefits of web and phone, and so just wanted to point out that you can increase response rates by the mode of administration, as well as some of the Workgroup comments of engaging your members to complete the survey.

Margo Rosenbach:

Thanks, Naomi. Other comments from Workgroup members? It's been a great conversation. Any other Workgroup members before we move to public comment? All right. With that, next slide, please. Let's go to public comment. Sara Toomey. Derek, can you unmute Sara?

Sara Toomey:

I'm the Chief Safety and Quality Officer and Chief Experience Officer at Boston Children's, also the co-lead developer of Child HCAHPS, which I know is not being discussed today, but just to give some context to the committee. And I just wanted to speak just for a minute and give my very, very strong support for keeping this measure in the core measure set. You know, just to go back to the fundamental principles that I have learned about patient experience measurements is that, you know, the reason we do it is because not only do we always make a point of making sure what we're covering is important to patients and families, and that they can uniformly report on it, admittedly, when they do complete the survey. But also, most importantly, and I think we really need to remember this, we are asking questions for which they are the best source of information.

So a great example for that is when we ask, you know, for instance, clinicians how well they think they're communicating, explaining things to their patients and families, they often will say, we do a great job. And then when you actually ask patients and families how well they're being listened to, how well they understand what's being explained to them, they actually report a very different story. And if we aren't allowing our patients and families to express themselves, we really are doing a disservice. In addition to that, just to state it, we do see disparities in patient experience. And this, too, in particular, in the Medicaid core measure set, I think, is really important to not lose the voice of what are already, in particular in pediatrics, a vulnerable population. And so in sum, just wanted to say strong support, agree that we do need to be making changes, and looking forward to having this committee potentially help shape what some of those changes might be or where we need to go in terms of improving what we do. But I think to remove this would really be removing the voice of a vulnerable population of patients. And so I would strongly support keeping it in. Thank you.

Margo Rosenbach:

Thank you, Sara. Other public comments? Are there people from other states or other organizations who would like to make a comment? Last call for public comment before we move to the vote. All right. With that, I will turn it over to Alli and Talia. And I'll just say that this vote is based on whether to remove the measures from the Core Sets. It's not about the frequency. It is about whether to remove or not.

Alli Steiner:

All right. Thank you, Margo. So for our first vote, the question is, should the CAHPS Health Plan Survey 5.1H Child Version (CPC-CH) measure be removed from the Child Core Set? The options are yes, I recommend removing this measure from the Child Core Set, or no, I do not recommend removing this measure from the Child Core Set. And voting is now open. We're just waiting for a couple more votes. Looks like we may be missing Lisa S. Lisa, if you are able to submit your vote, please do so. Thank you for your patience. We're just doing a bit of troubleshooting. All right, everyone. We're just waiting for one more vote to be submitted. Thank you for your patience. Hi, everyone. We're just troubleshooting one last vote. Thank you for waiting. We have extra suspense on this question. Thanks again for your patience. All right. There we go. We can close out the vote.

Okay. So we have 21 percent of Workgroup members that recommend removing this measure from the Core Set, and so that does not meet the threshold for recommendation. The CAHPS Health Plan Survey 5.1H Child Version (CPC-CH) measure is not recommended by the Workgroup for removal from the 2025 Child Core Set. And now moving on to the next vote, please. So now we'll vote on the adult measure. Should the CAHPS Health Plan Survey 5.1H Adult Version (CPA-AD) measure be removed from the Adult Core Set? The options are yes, I recommend removing this measure from the Adult Core Set, or no, I do not recommend removing this measure from the Adult Core Set. The voting is now open. All right. Looks like we got all the expected votes. Okay. We have 21 percent of Workgroup members that voted yes, that does not meet the threshold for recommendation. The CAHPS Health Plan Survey 5.1H Adult Version (CPA-AD) measure is not recommended by the Workgroup for removal from the 2025 Adult Core Set. That concludes voting for today. I'll now turn it back to Margo.

Margo Rosenbach:

Well, that was a little bit of suspense. Next slide, please

So we're in the homestretch on day two of the meeting to review measures for the 2025 Core Sets. Thank you, everyone, for a robust discussion today. And thank you for powering through all the measures and the voting. We appreciate everyone's contributions today. Can you move to the next slide?

I'll just keep going. So I'll preview the agenda for tomorrow. We should be on slide 52. So tomorrow the Workgroup will vote on three ECDS measures that were previously recommended for addition to the Core Sets and deferred by CMCS. We'll then hear from a few Workgroup members about their use of Core Set measures to drive quality improvement for their Medicaid and CHIP populations. And this will segue to a discussion of gaps in the Child and Adult Core Sets.

We'll ask the Workgroup to help prioritize current gaps in the Core Sets, identify priorities for future measure development, testing, and refinement. I think a lot of the conversation today will feed very nicely into that discussion. We'll provide a recap of the meeting and discuss future directions. We also will discuss next steps in the Core Sets Annual Review process and have a final opportunity for public comment. We will begin promptly at 11 a.m. Eastern again tomorrow, and we ask Workgroup members to sign in about ten minutes early. So before we close, I just want to turn to Kim and Rachel, our two co-chairs, to see if they have any final thoughts for the day.

Kim Elliott:

Thank you, Margo. I do want to thank everyone for their work today, as always. It was a very productive day, and again, there was very informative, thoughtful, and informed discussions and real active Workgroup member participation in each of the measure discussions. The general themes I heard today were overall satisfaction with the topic of the measures that we were discussing. However, I also heard concerns with feasibility, the resource burden, and also a strong desire to improve measures of data collection, use of access to other data sources, and use of other code sets, including the Category 2 codes. There also appeared to be a relatively strong desire to move towards measures that are more outcome-focused, including whether care and services were delivered versus there being a plan in place for follow-up care. And I think that's kind of consistent in what we've talked about over the last several years with measures.

So overall, there also appeared to be a strong desire from the Workgroup participants to maintain the members' voice in the Core Sets, and it's a critical component to measuring the quality of care experienced by those served by Medicaid. And these themes are also consistent with what we have heard in prior years. There seems to be a strong desire for additional effort to identify other ways, perhaps less resource-intensive and maybe financially burdensome, to include the members' voice in the Core Sets. So I'm also looking forward to tomorrow's discussion on the ECDS measures and how we are going to use Core Set measures to continue to drive quality improvement. And, of course, I'm always interested in the gap discussion to see where we might go next. Rachel?

Rachel La Croix:

Thanks, Kim. And I echo a lot of what Margo and Kim have already said, so I will not go over those exact same things. But I do really feel like our conversations today, in addition to yesterday's, really have already started getting into a number of the areas we'll be focusing on tomorrow related to gaps, things that we would really like to see in measures and may not be seeing yet, and continuing to focus on areas that we all agree are important, but that we aren't sure we're quite where we want to be in terms of measuring them yet. So I'm definitely looking forward to our Workgroup reflections and talking about future directions we want to go with measures and addressing gaps and other ways that we can measure some of the outcomes and the areas of care that we feel aren't quite where we want them to be yet. So again, thank you to everybody for the robust conversations today, and I'm looking forward to tomorrow.

Margo Rosenbach:

Thank you, Kim and Rachel. So with that, we'll end about 15 minutes early, give you a few minutes back in your day. We wish everyone a nice rest of the day. This concludes Day 2 of the Meting to Review Measures for the 2025 Core Sets. The meeting is adjourned. Thank you. Bye.