Child and Adult Core Set Stakeholder Workgroup: 2020 Annual Review
In-Person Meeting Day 1 Transcript
May 7, 2019

Hello, everyone, and thank you for attending today's event, "The Child and Adult Core Set 2020 Annual Review May In-Person Meeting, Day 1."

Before we begin, we wanted to cover a few housekeeping items:

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Now I'd like to introduce Margo Rosenbach from Mathematica.

Margo, you now have the floor.

Thank you, Brice.

My name is Margo Rosenbach. I'm a Vice President at Mathematica's Policy Research, and it's my pleasure to welcome you to the in-person meeting of the 2020 Core Set Annual Review Workgroup. It's wonderful to be joined in the room by our workgroup members, our federal colleagues, and members of the public; and welcome to those listening on the phone. We have a full agenda and important objectives to accomplish over the next two-and-a-half days.

Next slide...thanks, Dayna.

Our four meeting objectives are listed on this slide:

First, the Workgroup will review the 14 existing measures that were suggested for removal and the 42 measures suggested for addition to the 2020 Core Sets.

Second, the Workgroup will vote on the measures and make recommendations for measures to be removed or added to the 2020 Core Sets.

Third, we'll discuss gap areas and areas for future measure development. We encourage Workgroup members to make note of gaps over the next couple of days, and we'll discuss those gaps on Thursday.

Fourth, we'll provide opportunity for public comment to inform the Workgroup discussion about the measures.

I also want to mention what this meeting is *not* about...kind of the elephant in the room. This meeting is not about the scorecard, and it's not about mandatory reporting. As you review the measures for the 2020 Core Sets, the characteristics to be considered for the updated Core Sets are also key characteristics for the scorecard and for mandatory reporting; and we'll be talking a lot about this over the next couple of days, and we do also have a handout in your packets. So consider feasibility, appropriateness for state-level reporting, and use of the measures for quality improvement among other characteristics.

Next slide.

By now, this slide should look very familiar to you. It lays out the key milestones for the Core Set Annual Review process. Our journey began on February 14th and continued on April 23rd, with two webinars to get organized for the in-person meeting; and here we are today at the in-person meeting. We're grateful that you have taken the time to prepare for this meeting and to give two-and-a-half days to this important effort.

Next slide.

Now we will introduce the Workgroup members and any disclosures of interest.

Next slide.

To ensure the integrity of the review process, we asked all Workgroup members to submit a form that discloses any interests, relationships, or circumstances over the past four years that could give rise to a potential conflict of interest or the appearance of a conflict related to the current Child and Adult Core Sets or any new measures that are going to be reviewed by the Workgroup.

Members deemed to have an interest in a measure suggested for removal or addition will be recused from voting on that measure but not recused from talking about the measure...just from voting on the measure.

During introductions, members are asked to disclose any interests related to the existing or new measures that will be reviewed by the Workgroup. Rather than reading off all the names, we're going to ask you to go around the table and give your name and whether you have anything to disclose.

We're also going to do a little icebreaker as we go around the tables, so listen carefully. After you give your name and disclosure, please indicate what your superpower would be if you were a superhero. I'd like to start with our two Co-Chairs, David Kelley and Gretchen Hammer, and then go to Amy Mullins. In case you're wondering how you're seated, we've organized the Workgroup in alphabetical order by first name. I know that's a little confusing, but it's by first name.

I'll start off by telling you what *my* superpower would be to give you all a chance to think about it. If I had a superpower, it would be to have more than 24 hours in a day.

[Laughter]

David, starting with you...your name, disclosure, and superpower.

Thanks and good morning. I'm Dave Kelley; I'm the Chief Medical Officer for Pennsylvania Medicaid. My disclosures include the fact that I'm on the Committee for Performance Measurement for NCQA and currently on that Committee. And, also, I have been on the CSAC for NQF; I'm off of that Committee in December. My superpower, which is probably not a good thing for this meeting, is the gift of the blarney the gift of gab.

[Laughter]

Terrific...I'm Gretchen Hammer. I am the Founder of the Public Leadership Group...Public Leadership Consulting Firm. My disclosure is I was part of a project related to some perinatal depression screening follow-up measures that we'll be talking about, and my superpower would be that I could talk to animals.

I'm Amy Mullins, Medical Director of Quality Improvement at the American Academy of Family Physicians. I'm not sure if this is a disclosure I need to give, but I'm on the MAP Coordinating Committee. And my superpower would be to understand and be able to speak any foreign language that I wanted to whenever I wanted to.

[Laughter]

I'm Bonnie Zima; I'm a Child Psychiatrist Health Services Researcher, UCLA. I'm a standing member of the Behavioral Health Steering Committee for NQF, and my superpower would be the wisdom to know the difference.

Good morning. My name is Carolyn Langer. I'm the Chief Medical Officer for Fallon Health Regional Health Plan in Massachusetts. The only conflict or potential conflict is I received a grant two years ago from one of our regional Arcs to launch an Innovative Gap Year program for post-baccalaureate pre-health professional students to gain experience working with disabled populations. Oh, my superpower is definitely to be able to clone myself.

Thank you...I'm David Kroll. I'm a psychiatrist at Brigham Health in Boston. I don't think I have any disclosures that are relevant, but my superpower would be (audio break).

I am Diana Jolles. I'm a nurse/midwife from Tucson, Arizona; and I have no disclosures. If I had a superpower, I would cut the Core Set in half and require mandatory reporting in 48 hours.

[Laughter]

Good morning, I'm Fred Oraene with Oklahoma Medicaid. I'm the Director of our Office of Data Governance Analytics Group. I'm also here with the National Association of Medicaid Directors. I do not have any disclosures. If I had a superpower, it would probably be to be in multiple places at the same time.

Good morning. I'm Jim Crall. I'm Professor and Chair of Public Health and Community Dentistry at UCLA. I'm also Chair of the Measures Implementation Committee for the Dental Quality Alliance. I have a disclosure with regard to the two pediatric ED measures...that I've received support from the DQA to present those measures at the National Quality Forum for endorsement. My superpower would be the ability to read people's minds.

Good morning...Jami Snyder, Medicaid Director for the State of Arizona. I have no disclosures. My superpower would be the ability to predict the future.

My name is Jeff Schiff. I'm the Medicaid Medical Director for the State of Minnesota. I am co-chairing the Opioid Technical Expert Panel with NQF, which is a part of the SUPPORT Act, to look at the measures and measure gaps for the opioid crisis. My superpower would be not to be weighed down by gravity...philosophically or physically.

[Laughter]

Hi, my name is Jennifer Tracey. I'm the Senior Director of Growth and Sustainability for HealthySteps, which is a pediatric primary care program with ZERO TO THREE. I have no disclosure, and I think because I have three young kiddos my superpower would probably be being in multiple places at one time.

Hi, I'm Jill Arnold. I'm the Executive Director of the Maternal Safety Foundation in Rogers, Arkansas. I don't know I have anything relevant to disclose for this meeting, and I'd probably go with speedreading for my superpower.

I'm Jill Morrow. I'm a developmental behavioral pediatrician and the Medicaid Medical Director in Massachusetts and have no disclosures, and I would definitely do teleportation. I don't want to do planes flights and trains, et cetera.

Kim Elliott...I have no disclosures. I work for Health Services Advisory Group as an Executive Director. I think my superpower would be to find a way to keep children, elderly, and disabled safe and healthy.

Hi, I'm Laura Chaise. I lead Product Strategy at Centene for our Long Term Services and Support and our Dual Demonstration Program. My disclosure is just because I do work for a managed care company, to the extent that any of the Medicaid agencies put dollars attached to these measures, then my company would potentially have a financial impact to it. I would like to do some time travel, so I would take that one.

Hi, good morning. I'm Lauren Lemieux with the American College of Obstetricians and Gynecologists. My two disclosures are that ACOG is a participant on the National Contraceptive Board Group, which provides input on the three contraceptive measures; and I also was involved on the workgroup that developed the composite measure, the TDaP and influenza measure, for the quality performance National Vaccine Program Office. I'm with her...I would like to do teleportation.

Good morning. My name is Lindsay Cogan. I'm with the New York State Department of Health, and my disclosures relate to a few of the measures we're going to be discussing today. So the company agency that I work for has received grant funding from CMS to work on the contraceptive measure, as well as a subcontractor with the University of Michigan on the sickle cell measure. Oh, my superpower...to remember everything that anyone has ever said to me.

[Laughter]

Hi, I'm Linette Scott. I'm at the California Medicaid as the Chief Medical Information Officer and work on reporting these measures. Actually, our organization does have that contraceptive grant as well. In terms of superpower, I'm on the teleportation bandwagon.

Good morning. I'm Lisa Patton. I'm a clinical psychologist, and I've worked in quality measures from the federal side of HHS for several years. I worked on quality measure development and implementation from that perspective. I'm currently with IBM Watson Health, and so no disclosures at this point. In terms of superpower, I'm going with Laura on time travel.

Hi, my name is Lowell Arye. I'm the head of a small consulting firm, Aging and Disability Policy and Leadership Consulting. My disclosure is that I have been a member of and Board member of the National Association of States United for Aging and Disabilities, which actually has one of the core measurements that I've put forward and also moved it forward (audio break) actually worked with NASUAD on a number of them, none of them specific to (audio break). My superpower is to live every act as if it was the last act on earth.

Hi, I'm Marissa Schlaifer. I'm Vice President of Policy and Regulatory Affairs at OptumRx, a prescription benefit management company. As far as disclosures, I guess any measure related to drugs could impact my company in some indirect way. Also, I have served on the NQF on the MAP Coordinating Committee as well as a number of NQF Medicaid task groups, workgroups, et cetera. My superpower, not to repeat the more than 24 hours in a day, would be to go without sleep.

Good morning. I'm Rich Antonelli. I'm the Medical Director of Integrated Care at Boston Children's Hospital and the Medical Director at the National Center for Care Coordination Technical Assistance which is funded by the Maternal Child's Health Bureau. I don't have any disclosures. I guess I'd like to channel my superpower by saying when I come to meetings like this, I do try to keep in mind the patients

and families that I take care of every day. So that's the constituency that I represent, and I might once in a while throw in a quote from my grandchildren.

[Pause]

It was the channeling. I guess it was a very humble superpower.

[Laughter]

Good morning. I'm Sally Turbyville. I'm here representing the Children's Hospital Association. I'm a Senior Fellow in Quality Policy and Research. I have nothing to disclose. My superpower would be to be a quantum physics whiz...something like Charles Xavier. Perhaps then I could figure out time travel and some other things, but also to be able to make drinkable water out of air would be another power I would love to have.

Hi, good morning. My name is Shevaun Harris. I'm the Assistant Deputy Secretary for Medicaid Policy and Quality with Florida Medicaid. I don't have any disclosures. In terms of my superpower, my friends and family tell me I like to think I can defy time because I'm always running behind; so my superpower would be to *actually* be able to defy time.

Good morning. I'm Steve Groff. I'm the Medicaid Director in Delaware. I have no disclosures, and I like all the suggestions that everybody's said; but the more I thought about it, I don't think I really want a superpower. I'm fine just being me.

[Laughter]

I'm Tricia Brooks. I'm an Associate Research Professor at the Georgetown University Center for Children and Families. Since others have disclosed, I don't think it's a reportable thing; but I am on the Standards Committee at NCQA. My superpower would actually be to turn back the hands of time. It used to be flying; but now, time is more important.

[Laughter]

Good morning. My name is Tricia Elliott. I'm the Director of Quality Measurement at the Joint Commission. I do have a disclosure. We have two measures that we stewarded on the list today, so I'll be recusing myself from that. In terms of superpower...I think I'm last in line here, so I got to hear what everybody else said. I think I like the cloning. I want one of me at home to keep things in order and then one of me at work. Thank you.

Thanks, everybody. It was great to hear everybody's superpowers and to hear you introduce yourselves in your own words.

Next slide, please.

Next, I wanted to acknowledge our Federal colleagues in the room. Thank you for joining us. We appreciate your being here and being available as experts.

Next slide.

I also wanted to acknowledge the Mathematica Project Team. As they say, it takes a village; and it really does. It's been absolutely incredible getting ready for this meeting in terms of all the preparation and all of the logistics. Thanks to all the team members in the room and not in the room. Thanks also to Bailey Orshan, who is the Task Lead on this work and to our colleagues at Harbage who are helping to prepare the final report. I'm sure you'll be meeting them over the next two-and-a-half days. Thanks to everybody who's here.

Next slide.

Now I'd like to turn it over to Gretchen and David for their words of welcome and also to lay out some ground rules for us.

Thank you.

We've had the chance to all meet virtually on a number of conference calls, but David and I are thrilled to help shepherd our effort today; and in doing so, just wanted to sort of set some context. As you all introduced yourselves, you gave us a little bit of your background and your perspective; but I think one of the things we'd like to ask that we all do is to take Rich's approach perhaps...and that's that we're here in service of the Medicaid Program and the CHIP Program today. Each of you brings, obviously, a level of subject matter expertise that will be critical for our community as we form a community for the next two-and-a-half days; but when we come to the discussion and the voting, we really ask that you act more in the spirit of the whole and in the spirit of the program as opposed to advocating for just a particular perspective.

The disclosures were certainly important for all of us to know where people are, but even beyond just the notion of a disclosure to really do what is best for the Medicaid CHIP Program. It is such a vital program, and we really have an opportunity to be thoughtful about the kinds of quality measures that we could recommend for inclusion or removal.

The first ground rule is to ask you all to act on behalf of the whole and really to be a steward for the program, not just the individual perspective that you or your organization may hold.

The second ground rule we'd like to assert is that we will have robust discussion. When I was at Colorado Medicaid, we used to say, "Robust examination of ideas makes our program better." Right? So that is where we hope this conversation will go...that we have robust examination of people's perspectives, but that we remember that this about the measures and not the people talking about the measures. So let's separate, if we could, that robust discussion and have that both for the people asking questions and the people responding...to remember that this is about the measures themselves and about the program.

And then we are going to have to be concise. We're already five minutes ahead of schedule...good job, everyone. But I think Bailey did the calculations. It's something like 11-and-a-half minutes per measure that we have to discuss. Certainly, we're not going to do that; and some will go more quickly. We'll take the time we need to do this task correctly, but we are going to need to be concise.

As we discussed in our last conversation, the number of people who contribute to the dialog doesn't necessarily matter...just as the number of people who submitted the measure. Everyone will have the chance to vote. We're going to use these handy-dandy clickers, so your voice will be heard through the voting process and formally recorded. So if you don't have a unique perspective to add, we'd ask that you hold your comments; but we also want to have some robust discussion. So we're asking for some sort of professional guidance from you all about when to engage and when not to.

Lastly, because the task we have is large, we will be using the sort of formal structures of timekeeping. We're going to ask that people put their tents up, like this, if you want to participate in the dialogue after the presentation of the measures. Then you can put it down after we've given you your two minutes of time. So two minutes of time...we have a timekeeper, so we're going to try and be disciplined about that.

Then, we will be using a formal motion process; so be prepared to make a motion to vote on either removal or addition to the measures. We have the slides that will guide us in that, but we want to have a formal process so that nobody feels like we moved through the discussion too quickly or there wasn't ample time to participate. So we're going to use the sort of outline of Robert's Rules of Orders of a motion and a second and a formal vote...just to make sure that this process is as open and transparent as it can be.

Those are the guiding principles we'd like to use. I'll open it up in case there's anyone who has another guiding principle you've tended to use in these kinds of processes that are important for us to consider.

Yes, ma'am...Sally?

Thank you for setting up the guiding principles. I do have a question; and this might be for CMS, unless you already have the answer. When I look at the roster list, for my name it does say that I'm here nominated at the seat for CHA; not everyone has that. So is this an organizational representative to speak, or am I here as a subject matter expert?

I'll let Margo respond.

Okay.

We've had lots of conversations about that, Sally; so I'm glad you've brought that up. As Gretchen said, we want everybody to come here as individual subject matter experts...not a representative of an organization. We're here for the greater good of the Medicaid Program and the CHIP Program and the people that they serve, and want the Core Sets to do the best possible job of reflecting the quality of care and the potential to improve that quality of care and not be reflective of one organization's perspective or another.

You all bring incredible expertise to the table. It was wonderful to hear you all go around and meet you face-to-face, learn more about your backgrounds. You all bring the subject matter expertise that we're looking for over the next two-and-a-half days to really help improve the Core Sets and strengthen them.

Terrific...the only other thing I would just ask is we're going to probably build momentum over time. We may be a little clunky as we start with the dental measures. So if it feels a little clunky at times as we move through this, I'm confident that we will build momentum and sort of get a pace to ourselves; but I would ask that we all sort of contribute to our shared success as we begin and dive in after the formal presentation of the measures, and our first set of measures that we'll be looking at are the three dental measures. That felt like a good body of measures for us to start with, and so that's where we'll be headed next.

I'll turn it over to David to provide any additional perspectives, and then we can dive right in.

I'll be very brief so that we can stay on time. It's a great task at hand; thanks, everyone, for your patience. I think that we really need to think in terms of the number of measures we're going to be looking at. We also need to think in terms of the challenges that Medicaid agencies have in actually implementing these measures. So even if your pet measures don't make it onto the Core Sets, there will be other times; there will be other years. Hopefully, we'll be able to move things along and really work coherently. Really appreciate the wide range of expertise that's sitting around the table, it is quite a range.

All right, so now we'll move on to an overview of the current Core Sets; and this will be a level-setting conversation. I want to follow up on something that David said that we talk about a lot as part of this process.

The Core Set is just one of many vehicles that states have and that others have for measuring and improving quality of care in Medicaid and CHIP, so we shouldn't be looking at Core Sets as the be-all and end-all. There are lots of other opportunities both through Medicaid Managed Care oversight vehicles, other quality improvement initiatives that are underway. So keep that in mind also as you're looking at the measures.

We've got a lot of measures to review, and we already have a lot of measures in the Core Sets. So channeling what Diana said in terms of I don't know if cutting the measures in half is the right number; but whatever the number is, this is a great place to start with level-setting.

Next slide, please.

First, we wanted to review a question raised in the April 23rd webinar about whether there's a target number of measures for the Core Sets...so following up on the very point. Currently, the Child Core Set includes 26 measures, and the Adult Core Set includes 33 measures; that's the 2019 Core Sets.

As we discussed on April 23rd, CMCS does not have a target number of core set measures, either a minimum or a maximum; and we encourage the Workgroup to consider each measure on its own merits according to the criteria that Bailey will discuss later, and I'm sure you're going to be hearing these criteria a lot.

Next, we wanted to give you a sense of how frequently states report measures in the two core sets, as well as the reasons for not reporting the measures. This gives a sense of the feasibility of the current measures, which we think is really key. If a measure is going to occupy some real estate in the Core Set, we want it to be feasible, reportable, actionable by states.

For FFY 2017, which is the most recent cycle for which data are available, states reported a median of 18 out of 26 measures in the Child Core Set and 17 out of 30 measures in the Adult Core Set...so lots for us to talk about related to feasibility.

As you would expect, the most frequently reported measures are those that states can calculate accurately using claims and encounter data and those less frequently reported required other data sources and methods to produce accurate results...such as medical record extraction, electronic health records, or survey data collection. Perhaps not surprisingly, it often takes states a year or two to report new or revised measures since they need time to ramp up for reporting. So that's another consideration that the more the Core Set changes, the longer it takes for the measures to be adopted.

Next slide.

I also wanted to address the topic of Core Set domains. This slide lists the six current domains; and for the Workgroup review, we've designated two additional domains...long-term services and supports and other measures. We want you to keep in mind that CMCS assigns the domains when updating the Core Sets for 2020, and these will *not* be the focus of this meeting. We won't be focusing explicitly on domain assignment.

We also want to note that the Maternal and Perinatal Health measures cut across the Child and Adult Core Sets and that CMCS decides which Core Set to assign the measures to; so again, the domains are not the focus of this meeting.

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My final level-setting slide is about the evolving nature of quality measurement in health care. As you all know, measure stewards update various aspects of the measure technical specifications annually; and changes can affect a variety of factors such as new clinical guidance, coding updates, new data sources, and even technical corrections that may be identified by users. We're going to be hearing a lot about new data sources and methodologies during the next couple of days.

Many of the measures that are being reviewed are in the process of being updated or were recently updated. It's been a bit of a moving target, even over the last week or two, to capture the most accurate and up-to-date information for each measure under consideration. We've done our best to reflect the key attributes of each measure for the purposes of the Workgroup discussion, but it's very much an evolving process.

Next slide.

As we begin the review of the 2020 Core Sets, it's helpful to keep in mind the distribution of measures in the current Core Sets. More than half the measures in the Child Core Set are in two domains...primary care access and preventive care, and maternal and perinatal health.

For the Adult Core Set, two-thirds are related to care of acute and chronic conditions and behavioral health care. We look forward to the Workgroup discussions about the priorities for the 2020 Core Sets and remaining gaps for measure development.

Gretchen and David, I'd like to turn it back to you now.

Thank you, I don't have anything else to add...other than I think we're ready to get started.

Nothing else to add...let's keep moving.

Sure, this gives me great pleasure to introduce Lindsay Cogan for our state presentation. I think as most of you know, at these kinds of meetings it's really helpful to hear from a state, or more than one state, about their experiences using the Core Set measures; and we're very fortunate to have a lot of State folks around the table and former State folks as well. Lindsay will kick it off by talking about here experiences in New York; and then if there's time, we'll open it up to others.

Great, and I hope there is time today. I'm going to be brief.

Again, my name is Lindsay Cogan; I'm with the New York State Department of Health. I work in the Office of Quality and Patient Safety. In our state, our Medicaid agency falls under the realm of the Health Department; and I work as a sort of subsidiary to the Medicaid Program as kind of their quality consultant. Our group is in charge of collecting the information necessary to fulfill reporting requirements.

In thinking about what I wanted to talk to you all about today, there are a couple of key themes. In which measures to report...we report on almost all of the measures currently; how we collect data for the measures...I'll give you some examples; some challenges we've encountered and how we've addressed them and some new challenges which I'm sure have helped honestly move forward; and then how our approach to collecting and reporting has changed over time.

Just in speaking about how I think we are able to report so many of the measures is we do leverage our strong managed care in the state. So we do have a lot of reporting that sort of comes to us from managed care organizations, and we're able to then collate and put that information together. In our child population, almost all children are in managed care.

When we look at our adult population, we're able to leverage our managed care reporting; but we also do an enormous amount of work programming claims based in administrative measures internally. We were able to sort of kick off that initiative several years ago when CMS offered a grant looking at adult quality measures. So we were able to kind of leverage that grant, build some really strong infrastructure that helped kick off our ability to do a lot of the work that we're able to do.

I think of utmost importance these days is alignment with other programs. So when we are looking at what measures we're going to report, if you're going to hand us a one-off measure that is not used in another program, I'm going to tell you it's going to go pretty low down on my priority list because we are looking to drive and see that alignment come to fruition. It becomes very difficult when I'm challenged to bring to reporting status measures that cut across many programs, and then I'm sort of handed one that is unique in itself and doesn't cut across other programs; so that becomes difficult.

We also look to measures that support our existing initiatives, so our 1115 District Waiver was very focused on behavioral health and behavioral health integration; so we spent a great deal of time really digging deep into a lot of the behavioral health measures. We felt really good about reporting that information because we knew what it is that we were actually measuring, and we had been working with the measures for several years.

We also have a First 1,000 Days initiative in our state that looks at children, in particular the first early years of their life; and Medicaid covers many children in our state. So that initiative also drives our measure prioritization in looking at how we can bring measures like early developmental screenings up to being reportable.

The measures that are hard to report...since we are a managed care state, we do leverage HEDIS quite a bit. When it's a non-HEDIS measure, it becomes difficult for us to benchmark and get that good quality assurance because when we get the information from the plan, it is audited; it's checked. It comes to us and then we sort of use that to benchmark our own internal calculations and really get a good feel for the measure. So it does become a little bit difficult. It's not impossible when it is a non-HEDIS measure.

So for those that are putting forward measures understanding that states need benchmarks, they need to understand that the measures have been used somewhere and actually apply to the measurement setting. That's incredibly important for us to understand as we're looking to make decisions about which measures we are and are not going to report.

Provider-based measures are a little bit difficult when you're sitting at a state level, and your leverage may not be from State directly to provider; so that can become challenging.

Electronic data...we are excited, and I know I've spoken at several different forums about our state's desire to really push forward in this direction and really look at health IT-informed measurements. We are looking to integrate measure results from...we have a health information exchange authority. HIEs are really strong in our state. For the first time we've used that information to populate some of our district measures, in particular screening for clinical depression and follow up. So it was exciting; it was challenging.

You think you get so far, and then there's a lot to overcome; but we feel like that's an important direction to move. It's going to take several years for us to get in that sort of reportable form, but we are committed to ending medical record review. We've come as a state and said, "No more." There is no more cracking medical records and getting samples and paying hundreds of thousands of dollars for nurse reviewers. It's not sustainable, and it's just not going to get us where we want to be...which is population health management.

Resources...even though we have a lot of information coming in from a lot of different directions and we are generating a great amount of source code and running administrative claims measures internally, even administrative measures are costly on the state side. I think this is something that gets lost...just add a code, it's just administrative, it's claims data, no big deal. You have to realize we have seven full-time staff people who manage and intake all of this data coming from either a managed care organization or from the Federal Government or from our own internal systems or surveys...so having to manage that information.

What we do is we use a combination of data sources for reporting. We use our managed care plan supply data for certain administrative measures...like example, our Child Set. The children in our state not in managed care that may be covered by foster care...we don't have their information on the types of services they get, so we don't include that in our reporting because it's a bias when you include information or population but you don't have that claims data to actually tell something about what happened to them. So we exclude them from reporting.

When we have multiple data sources, we often will look at which provide the most accurate results. So we don't currently report developmental screening using administrative methods because we do not feel it's an accurate representation of the measure and what it's intended to do. So that's an example where we don't have another source; so right now, we haven't been reporting that measure.

I think I've talked a little bit about adding new measures, the prioritization exercise we go through.

Margo, you mentioned timing. It does take several years for us to get measures up to date. We're on an early fall cycle, so we kind of set our parameters for the upcoming year in September/October. If you don't put a measure out until November or December, just know that it's going to take us a full additional year to even get it on the list. Then for other measures, it may take even longer if there are these sort of new data sources and challenges to collecting that information.

Again, we have a huge team that goes into pulling together this information. We do three levels of review, and one to two FTEs doing manual data entry to get this information into MACPro. So this is not a light undertaking by any means, and I just want you to understand...am I out of time?

Okay, so I think it's just important for others to understand that we do take a great deal of time and effort and really do try to do our best to get you the information that you need!

I know Mathematica had asked...we did not do a risk adjustment methodology for our plan all-cause readmission this year. It was the first year it didn't make it into our work plan, and they had asked me if we could do the risk adjustment by May 20th. I kind of chuckled; and I thought, "No...no, there's no way we could do that by May 20th." We're happy to do it by next year, but that takes time. It has to go into the workflow. It has to be something that's planned and then, again, implemented and then goes through a process of review; and we need to ensure its accuracy. So again, these are not willy-nilly decisions that go into reporting.

Then this was the first year we actively chose not to report a measure...the use of opioids at high dosage. Because this measure included treatment for MAT in the numerator, we felt it was in direct conflict with the efforts in our state to increase treatment for Opioid Use Disorder. So I just want to throw that out there. It's like we made a decision as a state; we were not going to report that measure publicly. We didn't report it anywhere. We didn't report it in our managed care plans. We just felt strongly that...and the measure steward assured me at a previous meeting that they have since taken care of that in value set. So we're looking forward to seeing what happens in the new run of measures.

Always being additive and not removing measures is exhausting, so we really have to think through. If you're going to add a measure, you have to take something off the table. It's difficult to buy into another form of data collection when we are required to collect similar measures using a different method. I know there are new immunization measures that kind of parallel what we're doing with CAHPS, so I hope that we'll have an opportunity to discuss that later.

Then I don't think that people really fully understand the effort that goes into maintaining measures. It's not something that...I'm seeing other states, people who do measures are like ”ya” [nodding]. So it's not just adding new measures and not just removing measures, but the actual process of maintaining and updating these changes to measures is an undertaking in and of itself. We have a whole sort of separate workflow around just...so what changed?

If I know anything about quality measurement in the 15 years that I've worked in this space it's that it's always changing. Sometimes we underestimate exactly how much impact removal of a code or measure logic will actually have on the population being measured. So it's just something to think about. It's not, as I mentioned, that you've added yet to this Workgroup. But you might want to think about changes and, specifically, does that change still make this measure good in this space...so just something to throw out.

I think I'll stop there. If we have questions or....

Lindsay, if I could just follow up on that last point about changes to measures...in preparing for this meeting, I went back to look at our change summaries for 2019. We took away one measure; we did not add any measures; and the summary of changes was seven pages for one Core Set and four pages for another Core Set. Every year, I enter the process of the tech spec updates thinking, "We've got this. We've been doing this for so many years. This is going to be so easy this year." And every year, it's hard; and it takes a lot of time.

As I said, in terms of the evolving quality measurement landscape in thinking about preparing for this meeting, it felt like we were doing tech specs for 56 measures just in preparing. So I think it's a really important point to recognize that there is a landscape that is evolving, even with the current measures; and it's challenging for us too.

Perfect, and thank you. I think the state-based perspective is critical. There are a number of other medical directors and Medicaid directors in the room. Would anyone else like to offer a perspective?

Yes?

The other piece that doesn't get brought into this is that states have their own initiatives and things that they want to do. So it's not just a matter of the Core Set, but it's also a matter of measuring performance on other elements of the program. But that all goes to usually the same group of people to manage.

Thank you, Jill.

Maybe since there are people following us online...I know, this riveting conversation from the online perspective...but if we could try the best practice of saying who you are before you speak just to give people on the phone context.

Thank you, Jill, from Massachusetts. That is helpful context.

How about others from the state perspective?

Yes, Carolyn?

My name is Carolyn Langer, and up until a year ago I was the Medicaid Medical Director for Massachusetts...so Jill's current role. One question I had, maybe for Lindsay, is many states are moving forward with new value-based payment models, new delivery systems. I'm just wondering, Lindsay, to what extent that has shaped the direction in which you're going with your quality measure slate. As Jill said, Massachusetts has embarked on a very aggressive ACO initiative; and that has certainly shaped where Massachusetts is going with quality measurement.

Yeah...no, absolutely...that's important, and that goes back to that theme of alignment, right? We are also on a very aggressive path towards value-based payment...and not just in Medicaid, but in all payers. So again, it becomes that difficult situation where we want to have that parsimony of measures that go across not just our Medicaid population but across the entire state. So it does become something where we are trying to kind of narrow and focus and put our arms around a smaller core set of measures. So we are looking to refine; and while there is a lot of overlap between the Core Sets and what the measures are that we are driving that payment reform towards, we do understand that it's a starting place and that it continues to evolve over time.

Other state perspectives...yes?

Jeff Schiff from Minnesota...just a few quick things. One is that I agree with Jill that the State does a lot of things for quality improvement that are unrelated to this that are a level...I won't say "below," but are a level separate from this. The second is that I agree with Lindsay a lot. The staff who calculate these and keep them up to date are the real heroes, and any resource that we could have to bring these folks together to understand their work better across states would help with staff retention as well as morale and other things...so just to bring that up.

Then the last thing I think we really have...it's probably a separate conversation...but the whole idea of EMR review, electronic data extraction, creating a separate code for the results of a depression screen versus just doing a depression screen. Those kinds of technical issues are ones that are super important; and I think that we're sort of on this custom of saying we can't rely on the EMR extraction, but we have to rely on electronic data. I think one of the challenges of this set that we're going to talk about are some of those measures assume that we'll be able to do that, but I think we have to figure out how much we jump into that pool.

Thank you.

Jennifer, did you have something to add?

I did. It was a question actually for some of the State people.

Lindsay, that was a great presentation; and I jotted down a lot of wonderful notes. Thank you.

I noticed that in a lot of the comments that were submitted on the measures for potential addition, there were some that mentioned states had really high compliance rates or states were doing really well in certain measures. I would love to hear your thoughts, or other thoughts from the State perspective, on are those things that once a state does really well for a couple of years that as a state you think, wow, we really don't need to look at this anymore. How difficult is it to turn that off, not look at it; or are those things that states really want to track over a longitudinal period of time so that if there are tweaks in the measurement, you can kind of see how that may be impacted longer term?

Even if it's not in the Core Set, we still are looking at a larger and broader set of measures. We very rarely turn things off or take them completely away. You'll notice that some of these measures...the more mature states who have been looking at them for a while, they are relatively high. The rates could be in the high 90%s for some of them. So where we turn it off would be removing it maybe from our Payment Performance program when things are very high and we pay based on the differential of rates.

If we have all really high rates that are clustered very closely around, say, 95%, we don't feel like it's necessarily fair to say the difference between 95% and 94% should be financially rewarded or disincentivized. So that's one area where we may take it off of a list of measures that we would advise paying on; but we still keep it because, you're right. You never know...populations change, the Affordable Care Act and all these people kind of leapt into Medicaid with Medicaid Expansion; and we just wanted to keep a close eye on some of these even very high-performing measures.

Lindsay, I would add to that. In Colorado, I think we agreed that we may remove it from a value-based payment arrangement but still track it. But I think importantly...and I know David has done some work in Pennsylvania in this area...really understanding the experience of subpopulations. In Colorado, the rural / urban differentiation is critical; and since we can code – we had a lot more trouble in Colorado, although it was of great desire, to break our data down by race and ethnicity because our data just wasn't reliable as it related to individuals' race and ethnicity. But we could look at rural and urban; we could look at age breakouts, et cetera.

For example, our well-child visits...we incented in the three-to-seven range or three-to-nine, I can't remember the exact breakdown...because our very young children the data was pretty strong, but it dropped off in a way that made us uncomfortable in the older ages. So you can get at a subpopulation, and that's important.

David, I don't know if you have....

Again, we've looked at for many years race and ethnicity. We have a little bit more confidence (inaudible). But we've really used those breakdowns to really drive quality improvement with our managed care plans, focusing on particular regions or particular populations within those regions.

The other thing that we've focused on in our value-based arrangements, we're more focused on outcomes, not just can I get a hemoglobin A1C; but is my blood pressure up? So that's where we tend to want to focus more on the outcomes versus just pure process measures. We always love measure stability because our payments to our MCOs and to our providers, we're always looking at incremental improvements. So every time a measure changes, we actually have to double measure for a year or two so that we can keep our MCOs and providers whole.

So every time a measure even gets tweaked, that tweak sometimes creates a problem for us. We like to see stability because we like to focus on a set of measures that are very important to our program. I will say we definitely do look to a set where we're moving in the future (inaudible).

All right, are there other comments from any Workgroup members in this discussion? Yes, Lisa?

No, Linette.

Linette, sorry---t's really hard; my contacts aren't that good. Thank you, Linette.

Linette Scott, California Medicaid...I would echo the same thing that all my colleagues have said around the measurement process and such. A couple of other things just to highlight...sometimes it depends on how the measure is being used. One of the things Lindsay mentioned is things that are provider versus plan versus state type things.

When we look at a value-based payment, for example, we're trying to do that at the provider level; and so how we do that is going to be slightly different than what's in the core measure perhaps around the specification because you're doing it at the provider level. But we're trying to look at how we align that so that if we are incentivizing performance at the provider level, it's going to improve our Core Set measure performance.

So there are some subtleties in terms of the difference in terms of where you're measuring that and what the purpose is for that. That alignment, though, is something that I think we're all very in tune with because as you get to know the measures, there's a lot of subtlety to them. Some of them are straightforward; some aren't.

Then the other thing in terms of the eMeasures and electronic health records, I think we have a couple years' worth of transition here. So folks are starting to look at it; we have a few examples from a few states that they've managed to use a couple of those eMeasures. We know we're headed that way. The high-tech programs are transitioning. There's a lot of focus on interoperability. There's the notion of rulemaking related to interoperability that will help drive our ability to do these measures; but we're in transition. So we're probably not ready for it now; but certainly in two to four years, we need to be focused on it...so kind of setting the stage to know that we're headed there but recognizing what we have available today.

Then the other thing is just availability of data. There's tons of stuff we'd love to measure; but if it's cost prohibitive, it's survey-based, it's really hard. In California, we're really big; and surveys are just really tough. So in looking at what we can do with our administrative measures...while that's not always ideal, it does hit the practicality aspect and the resource aspect...so just to throw that out there.

Terrific...thank you.

Sally?

I have a question, if I may; and it comes to mind given the discussion that's come from the state representatives about high performance and a push to remove measures, which I'm all for. When we think about the consistent performance over time and across states and removing them from the Core Sets, I can't help but be aware that there are certain states that also consistently do not report on the Core Set and that at least some have different broadly-delivered systems for their Medicaid population and maybe even some important differences in the population itself. So I'm not really sure how to think about that unknown performance when thinking about removing measures. Any thoughts about how to think through that?

We can table that for further discussion, but that is one thing that I'm struggling with in how I would vote to recommend some of the measures that have been around a long time...consistently high-performing, but we still have no idea what that performance is in some populations.

Thank you, Sally. I really appreciate you adding that to our collective thinking, and I do think we probably want to tackle that as we go through each of the measures. I, in my preparation for the meeting, paused at some of the assertions that since everyone was high performing...I was like, ooh, I don't know that 84% is a high performance. So I think that we all had probably a different definition of high-performing that we'll have to sort through, but thank you for adding that.

Richard?

Thank you...and as always, Lindsay, thank you for being such a thought leader. I'm going to make an observation and then loop back to the point that you had raised before about the content that will go into the report from this. I was and continue to be very excited about the First 1,000 Days initiative. There are many things about that that are for me, as a child health person, I'm excited about taking a holistic approach and not just a medical approach to those measures; that's great.

To the degree, that there are measures in the Core Set, terrific; but there are things that aren't going to be in the Core Set and likely for the foreseeable future won't be in the Core Set. One example in multiple states now is the development and testing of a kindergarten-readiness measure. On its face, that sounds absolutely wonderful; however, it won't come up today. It likely won't come up a year from now or the year after that. That doesn't mean it's a bad measure.

So I want to make that observation because it comes down to that notion of states have initiatives. For those of us that are trying to think broadly...and so, Margo, this would be to you and the staff that will be compiling the report...if the report could state *very* explicitly that just because you didn't pass the beauty contest of landing in the core, nothing should be inferred about the value or the quality of that measure. It may be terrific, but it didn't meet the core. I just don't want people to think that this is the barn, and we're separating the chaff here; it isn't.

I'm going to argue that in some of those really high-quality, attractive measures looking across sectors and settings and disciplines, there's going to be a lot of upside value there for humans...not just kids but for humans; and I want to make sure the report captures that.

Terrific, thank you. I think for those of us who have worked in Medicaid for a long time, we value the State flexibility of the program and the ability to test and really have it be the laboratory of democracy in some ways...from a health care perspective. So thank you for adding that, and I think that's a shared value; and maybe, perhaps, we learn over time what states are able. I know Oregon is doing some exciting work as it relates to that kindergarten readiness. So we learn over time from those states and then make it, so I appreciate that perspective.

Jami, we'll go to you.

Thanks, Gretchen.

Jami Snyder, Arizona Medicaid...as we talk today, and Linette kind of alluded to this, the backdrop for me...I know, Gretchen, you asked a little bit about how this impacts state Medicaid programs...but the backdrop for me is always on how this has a downstream impact on providers. So it's just something I would ask that we keep in mind as we look at, in particular, the addition of measures. As we continue to kind of move the needle around value-based purchasing and tying reimbursement to value, as we add measures the level of complexity, or additional complexity, that that can add to those conversations.

We have tried in Arizona to really focus around kind of a smaller set of measures within that Core Set for our value-based purchasing work; but every time we have conversations about the addition of measures or changes to the specifications in measures, we have to open up that discussion again around what is this going to look like for providers as our managed care organizations develop value-based purchasing arrangements which would tie in some of those additional measures.

Terrific, thank you.

Yes, Amy...and then, yep, great...I was just going to say I think we're coming to the end of our state context setting. We seem to have all the shared theme...less is more, no dinking around and changing. That doesn't work for us, right? There are a couple of things that I think are coming up as thematic. We'll give everyone the chance who has any additional perspective to share, and then we'll go ahead and take our break. Then we'll come back and really dive in.

Amy, please go ahead first.

So I don't know if any of the states here...I don't think that I heard any of the states here that have not expanded Medicaid; but kind of piggybacking on what a couple of you have said, I don't know how that would affect some of the perspectives of the measures that we are looking to add, looking to remove, and how that is kind of a backdrop for the Core Set in general as those states that have chosen *not* to expand Medicaid. I'd like to hear...I mean, I don't know if any of the states here would have a comment on that or if you were in one of those states how that might change your perspective.

Sure, are there any states who'd like to respond?

[Pause for audience response]

Go ahead, Fred.

Fred Oraene with Oklahoma Medicaid...we haven't expanded yet. Now, there's a lot of discussion around the state around what expansion might look like...pros and cons...and basically it's the same type of discussion that other states have been having. I don't really see from an impact standpoint...I'm not sure that there's going to be very much difference as opposed to what my colleagues have already talked about. I didn't say anything earlier because I felt like you all were kind of echoing what I was thinking, so I didn't want to take up time. I didn't want to say anything.

But I think with regard to the measures that we have in front of us today, the ones that we're talking about adding and the ones we're talking about taking off, I think that for most of those I think the conversation for me would probably be from a measure-by-measure standpoint. So I think there are probably going to be some that, yeah, I can probably see how this might benefit or might help with the measure or something if we do in fact expand; and then there are probably going to be some others that I say, well, the same kind of constraints that we have today as to why we do not report those will probably still remain the same whether or not we expand or not.

Perfect, thank you.

Yes, David, please.

So within Pennsylvania, we did expand; and we added 700,000 adults...450,000 non-dual adults to 1.1 million. When we looked at it over time, the quality measures the first year of expansion of some of the access measures went down very, very slightly; but in subsequent years, we continue to see the access to care measures actually go up. Interestingly, the chronic care measures around diabetes and high blood pressure control, even with expansion and throwing 700,000 adults into the mix of quality measurement, we actually saw continued improvement.

So we certainly had concerns, especially obviously on the adult side, that we were more than doubling our population base with the measures; but interestingly, we didn't see a lot of wobbling and a lot of effect; but, again, every state may be different. Happily, we were able to really show that there was capacity, that providers or provider networks were able to see (inaudible) and get them into care. It is a challenge, though, when you expand and you get going. Your baseline measurements...there may be slight tweaks or there may be some differences in those measurements, especially in that first year.

This is Gretchen. The only thing I will add is I think that this is like Sally's comments...that as the measures are presented...so for example, the adult dental is an optional benefit; so not every state, whether you've expanded or not, may have an adult dental benefit. Then certainly any postpartum-related measures when a state hasn't expanded in eligibility ends at 60 days postpartum. There's just a difference in the populations that are important to account for. So my sense is that that's another piece of our dialogue as we get into each of the measures...is to reflect, is there any difference underlying in either the optional benefit structure of that particular area or the underlying population that may be being

evaluated in each state that would lead us to have concern about apples-to-apples comparison or apples-to-bananas or others?

So I think that's a great question and, again, one for our consideration as we move forward on each measure.

Are there any other final thoughts on this? Oh, Linette, yes, please.

Gretchen, I was basically going to raise what you did. The one other piece to add then is like, for example, behavioral health. There are a number of behavioral measures. I know this isn't about the required piece, but they are going to be required in 2024. So the benefit related to how we organize substance use delivery systems, what treatments are available from state to state. There's a lot of new development in that area; so whether it's expansion or dental or behavioral health or what have you, there are definitely differences state to state in terms of how those have implemented, and those will affect the measurement and the availability of data.

Thank you.

Yes, Jill?

This is a little off the topic, but I have a question about how we should be thinking about this given that 2024 is mandatory reporting; and it takes a fair amount of time to build up to being able to reliably report a measure, let alone reliably gather the data for it. Should we be considering that as part of our thoughts around measures, given that if we've got maybe four years...probably it's three?

Yeah, I'll certainly let the two experts to my right respond as well; but when we get to the actual discussion, there are those criteria of actionability alignment appropriateness for state-level reporting feasibility. Then I think to the point, strategic priority...so it is important. We are making a set of recommendations; as much as we'd like to be the people actually doing the Core Set work, we're not. We're here to recommend to our colleagues at CMS.

So I think that as we go through the discussion, it may not be ready...to use David's words...not ready for prime time in some of these cases. But signals of strategic priority around behavioral health or long-term services and supports or another gap area, I think that should be part of our conversation...but recognizing all of the initial conversations that everyone had around actionability, alignment with MIPS and some other places, and appropriateness, et cetera.

So I think it's a "both/and" in some ways; and given that this is a set of recommendations and we have time on Thursday to sort of explicitly...to Rich's point and to your point, Jill...talk about areas where as a collective body we would like to signal to CMS that this is a place where we want to continue to have focus even if we didn't make final recommendations around inclusion or removal.

Do you have anything to add to that, Margo or David?

I would just add that as I stated at the beginning, we're on a journey here toward 2024. This is not about mandatory reporting. But keep in mind the criteria what Gretchen just mentioned, with a particular emphasis on feasibility; and think about, and comment on, what's feasible tomorrow knowing that it does take time to ramp up and there are workflows, and we very much appreciate that.

Then also think a little bit towards the stretch measures. We don't want a Core Set that's just feasible tomorrow. We *do* want to be thinking about the kinds of changes that are underway. For example, as Lindsay mentioned...and I think, Jeff, you mentioned as well...the fact that there is more of a focus on electronic records. There's been a huge investment in that, and states are making progress in that direction; and that's how you really do drive toward outcomes that are clinically relevant to the measures.

So perhaps in the comments, think about what's feasible now and what's a little bit of a stretch but not unrealistic to think about over the next two to three years. And I think CMS will continue to think about feasibility and long-range planning as part of this process.

Terrific.

With that then, I'm going to ask that we conclude. We'll give ourselves an extra three minutes of a break. For those listening online, we'll be back at 10:30 a.m. Eastern Time. So if everyone could take a 15-minute break and be back and settled, we'll dive in after that.

[BREAK]

Okay, everyone, if you could please take your seats...we'd like to get started.

[Pause]

I'm going to suggest we all sit down and get started, please.

[Pause]

Okay, everyone, thank you so much and welcome back. I'm now going to spend a little time before we dig into the measures talking a little bit about the process that we're going to use, the criteria for reviewing the measures; we're going to do some practice voting; and I'll give a bit of a heads-up to what's coming on Thursday as well when we'll focus a little bit on the bigger picture.

Next slide, please.

I think, as you've heard from many of us, the Workgroup is going to discuss 56 measures over the next two days...which means we *really* have our work cut out for us or, I should say, *you* really have your work cut out for you. Just to note that the number has been updated from 55, which was discussed during the April 23rd meeting, to reflect that we have two measures that are very similar; and they'll be discussed together, but they'll be voted on separately.

As you've also heard, within these 56 we have 14 existing measures that have been suggested for removal; and then we have 42 new measures that have been suggested for addition.

There are also some slight differences from how the order of the measures were introduced on the April 23rd webinar, so just be prepared for that.

As you've also heard, this discussion is going to be centered around the measure domains; and with any measure domain, the Mathematica Core Set Team is going to present the existing...so the 2019 Core Set measures in both the Child Core Set and the Adult Core Set. Then we're going to talk about the measures that were suggested for removal, and we'll provide a brief opportunity then to ask any clarifying questions on the measure.

We will then talk about the measures that were suggested for addition, and that will also be followed by a chance for any clarifying questions on the measure specifications.

Then the Co-Chairs are going to lead the Workgroup, all of you, in a discussion about the measures. The discussion will be followed by an opportunity for public comment, and then the Workgroup will vote on each measure individually. I'm going to discuss a little bit more of the specifics on how you're going to vote and the voting process in a minute.

There are a few items I'd like to note to facilitate discussion. The first is that the discussion and the ultimate Workgroup recommendations should not focus on which core set the measure will be included in; this will be determined by CMS. Also, we ask during the discussion that you really focus on the measures in their specified form and do the same in voting.

Next slide, please.

We've mentioned these a lot. As you've heard us discuss, there are five characteristics for the Workgroup to consider when you're reviewing the measures for removal and for addition. You'll also see you have a folder in front of you; and these have been placed in there, so you can refer to them during the discussion. For those of you that are listening on the phone, the definitions are included in the slides, which are available in the Resources widget, as well as on the Core Set Review Page.

I've detailed the characteristics during the prior two meetings, so I'm just going to briefly touch on them right now. When reviewing the measures for removal, Workgroup members were asked to consider the following: actionability, clinical relevance, feasibility, whether there is a new or alternate measure proposed, and the previous state performance on the measure.

Next slide, please.

This slide details the characteristics to consider when reviewing the measures for addition to the Core Sets. The five characteristics are actionability, alignment, appropriateness for state-level reporting, feasibility, and whether the measure is a strategic priority. Again, these are in your folder; so you can refer to them at any time you would like.

Next slide, please.

This is just a little bit about the voting process. Like the discussion, voting will take place within the domains. For one domain, we will split it up just because there are a lot of measures. Workgroup members will use an iClicker, and I'll discuss exactly how we're going to use that in a few minutes. Notice that it's placed next to your folder, and each of yours has a name on it; so if you're confused or if you're not sure whose is whose, yours is labeled with your name on the back. We'll be using this over the next two days, but we'll practice using it in a second.

When you're voting, there will be a "Yes" and a "No" option only for each measure; and conditions for the measure will not be considered. For each measure for removal, Workgroup members will vote "Yes" or "No," where "Yes" equals "Yes, I recommend removing the measure from the Core Set" and "No" equals "I do not recommend removing the measure from the Core Set." Similarly, for measures for addition, a "Yes" vote equals "I recommend adding the measure to the Core Set," and a "No" vote means "I do not recommend adding the measure to the Core Set."

Each Workgroup member will vote unless you're excluded due to a conflict of interest, which has been discussed with you; and we ask that everyone does vote for every measure, regardless of what your specific interests or specialty or anything like that is...your one group.

A measure that receives two-thirds of the eligible Workgroup members voting "Yes" will be considered recommended for removal or considered recommended for addition. For example, if all 28 members are eligible to vote, that would mean that 19 votes are needed for that measure to be either considered for removal or considered for addition.

We ask that when voting at this point for the next two days, Workgroup members only consider a measure's individual merits on the characteristics that were detailed before. We recognize that this can be challenging with so many measures to consider, as well as some paired measures. But there will be an opportunity to talk about prioritization of the paired measures, the big picture, on Thursday; and that's when you can assess which measures you feel are the higher priority to recommend to CMS.

Next slide, please.

Just for a few more details about Thursday morning...on Thursday when you guys come in we will provide a list of measures that through these next two days of voting were either recommended for removal or recommended for addition. The Workgroup members will be prioritizing the measures that were

recommended for addition, and that is when you will have the opportunity to discuss the measures as a whole package as well as considering the parsimony of the measures with the current Core Set.

Next slide, please.

During this process, the Workgroup members will also have the opportunity to consider paired measures; and by paired, I mean cases where a measure recommended for addition was recommended to replace a measure that was recommended for removal. So you can kind of see the combination of measures that were being discussed.

Before we jump into some practicing, I want to turn it over to Gretchen and David to see if they have anything to add.

Nothing to add...lots of sort of structure to this process to ensure transparency and open voting, et cetera. So are there any questions or sort of things that you want Bailey to review a second time, given the information that she just shared?

[Pause for audience response]

Yes, please, go ahead, Shevaun.

I just have a quick question... Shevaun Harris from Florida. There are far more measures that are being proposed to be added than removed. So is the ultimate process that we make our recommendation, go back to CMS, and CMS is going to look at the larger landscape of measures and make some decisions about cutting back other measures? Let's say 10 of the ones that were proposed for addition get adopted or recommended. They'll see the benefits over the ones that are currently there?

Margo, do you want to respond?

As you note, there are a lot of measures under consideration. I think, again, the charge to the Workgroup is to consider each of the measures along the characteristics that have been identified. Then when we come back together on Thursday, there will be a prioritization process...not to kind of spoil the punchline here, but you'll all get 10 dots to be able to vote on your top 10 measures. You can put all your dots on one measure or spread them across multiple measures...so a very interactive process.

That gets to that second level of prioritization. So, yes, we recognize that there could be more measures recommended for addition; and CMS will have the ultimate decision. But we really want the Workgroup recommendations. And I think, as we mentioned earlier, I think it was Richard who said, "Let the record show; let the report show...." We want to be able to capture some of the flavor, the nuance of the conversation...not just there were 20 "Yes's" and 8 "No's." We want to be able to capture more of that nuance.

Hi, this is Dave Kroll from Brigham Health in Boston. I think what I heard you say is that when we vote on the measures, we will not be voting with respect to other measures being added. When we are discussing measures that do require or rely on the removal, how does that get factored in?

That's a good question. That is for Thursday, and that will be reflected in the recommendations to CMS of this measure was recommended for removal and this measure was recommended for addition; and that's what the Workgroup recommends. That's what we want to see. But it is possible that some measures might be recommended that don't have a pair, or maybe their pair wasn't recommended for addition; and that's okay as well. That's why we really want each measure to be considered individually; then on Thursday, the group will come together and be like, okay, now what does that look like for the bigger picture.

But for these next two days, as difficult as it's going to be...and we completely understand that...try to just look at that individual measure; but we will provide the information to you guys so you know if there was another measure recommended. So you can have that information, but we're asking you to vote specifically on the merits of that individual measure.

David, I think the only measures that are truly linked are the CAHPS measures...that if CAHPS were to be recommended for removal, the immunization and the smoking cessation measures from the CAHPS Health Survey would no longer be available. But I think those are the only two where there's a true interdependency.

Is there something else that you were thinking about?

That's the main one that I was thinking about. I think that conversation is going to be difficult to have without that understanding...but I get it.

Great.

Anything else before we do some practice votes?

[No response]

Okay, great...so has everyone located their iClicker device? It should be sitting right next to your things; again, it's labeled with your name. There are a bunch of buttons on here, but there are four buttons that will be used for voting purposes. The first is this orange button, which is how you'll turn on the iClicker. Then on the left when you're looking at it is a blue button; that's your refresh button. You'll press that between the votes, and I will cue you on that. Then, we're going to be using "A" for voting and "B" for voting; we're not going to be using "C," "D," or "E." It's just those four measures...Turn On, blue, "A" and "B." I will also prompt you on what "A" means and what "B" means before each vote; and it's also going to be on the slides.

You'll have about 30 seconds for each measure. Steve, who is sitting over there in the corner right there, will be cueing everything; so he'll be cueing you when the vote has started and when it stops when you're getting close. If at any point you feel like your clicker is not working, you accidentally voted a different way, you're confused; please just go ahead and raise your hand. We have a couple different staff members around the room that can come help you out. If your batteries die, if your clicker breaks, anything like that, just please raise your hand; and someone will come help you.

There's also a cheat sheet in your folders. In the red folders, there's a picture of the remote; and it talks through it a little bit. We're going to go through two practice questions that have nothing to do with the measures to ensure that you're familiar with this device for when we actually do get into the measure voting.

What I would ask everyone to do is please hit the orange button and power your iClicker on. It will take a second, but then it should say "Ready."

Next slide, please.

Our first question is, "Is this the first time using the iClicker remote?" "A" is going to be "Yes," and "B" is going to be "No."

Steve, can you please open the voting.

Note that you can see on your remote what you've selected. So if you selected "A," you can see "A"; if you selected "B," you can see "B." If that's not the vote that you had intended, you can change it right now. On the next one, we can practice changing votes if people want to.

[Pause]

So let's go ahead and see the results of who's used this device.

Great, so 57% of you have used the iClicker before; and 43% of you have not. I have to say, that's a much higher percentage than I was originally expecting; so I think this voting is going to go well.

Does anyone have any questions about this before we move on to the next practice vote, or did anyone have any issues with their remote?

[Pause for audience response]

[No response]

Wonderful...okay, if people want to see what happens if you vote after the question has closed, can everyone just go ahead and hit "A" or "B." You'll see your vote shows "Closed," so you will not be able to vote when the voting has closed.

Now we ask that everyone please hit the blue "Refresh" button so we can go ahead and do our second practice vote. This one is one near and dear to my heart. I would like to know how many of you have a dog; and if you have a dog, please press "A" to answer "Yes." If you do not have a dog, please press "B" to answer "No."

Steve, please open voting.

[Pause for audience response]

Let's see what the response is. Wow...so I have to say when we tested this yesterday, I was the only one with a dog; so this response makes me very happy. So 71%...just for the people on the phone...of our Workgroup has a dog, and 29% does not. I guess we're all dog people. Maybe we should have added cats.

Yes, Sally?

Quick question...is there any way when we're doing it live to make the presentation itself a little bigger?

Well, we can work on that; and I will be saying them verbally as well.

Does anyone have any other questions about the voting process or how your iClicker remote works before we jump right in and the votes actually matter?

[Pause for audience response]

[No response]

Okay, wonderful...so I'm now going to turn it over to Allison Steiner to discuss the Dental and Oral Health Services measure.

Alli?

Thanks, Bailey.

Next slide, please.

Now that we've had the chance to do some level setting and we've reviewed the logistics of the voting process, now we get to get to the real reason you're all here today when we get to review, discuss, and vote on the measures that have been suggested by the Workgroup for removal from or addition to the 2020 Child and Adult Core Sets.

We're going to start off with the Dental and Oral Health Service measures. Since this is the first domain that we'll discuss, I'm going to give a brief recap of the process that we'll use for each of the domains. First, we'll review the current measures in the 2019 Child and Adult Core Sets just to set the stage. Then we'll discuss any measures proposed for removal. In this case, there were no measures proposed for removal from the Dental and Oral Health domain.

Then we'll discuss the measures suggested by the Workgroup members for addition. We'll be giving an overview of each of these measures; but please be reminded that more information is available in the Measure Information sheets, which are on the Core Set Review website as well as the SharePoint site. Then after presenting the measures, we'll open it up for any clarifying questions and discussion, which will be facilitated by our Co-Chairs. Then we will open it up for public comment on the phone; and then, finally, the Workgroup will vote on the measure.

Before I get started assessing the Dental and Oral Health measures, I wanted to confirm that a representative from the Dental Quality Alliance, who is the measure steward for these three measures, is on the phone in case there are any questions that come up. Is there anyone? If you could please speak if you're on the phone?

[Pause for response]

[No response]

Well, if you have any trouble unmuting yourself, please message the Q&A Chat box; and we'll try again when we get to the discussion section.

First, you'll see here on the slide the two dental health measures that are currently included in the 2019 Core Set. Both of these measures are included in the Child Core Set. The first is the Dental Sealant measure, which assesses the percentage of children, ages six to nine, who are at elevated risk for dental caries that received a dental sealant on a permanent first molar tooth during the measurement year,

The second measure, which is reported as part of the Early and Periodic Screening, Diagnostic, and Treatment...or EPSDT...reporting, assesses the percentage of children ages 1 to 20 who received at least one preventive dental service during the reporting period. Neither of these measures have been recommended for removal, but we wanted to just set the stage with what was already included.

Next slide, please.

Now for the additions....

The first measure is the Ambulatory Care Sensitive Emergency Department visits for Dental Caries in Children. The measure steward is the Dental Quality Alliance, and it is NQF-endorsed. This is an outcome measure and has not been suggested to replace an existing measure. The measure can be calculated using administrative data. The measure denominator is the total member month for enrollees ages 0 to 20, and the numerator is the number of ED visits with a caries-related diagnosis code. The rates are stratified by age and whether or not the visit resulted in an inpatient admission.

The Workgroup member who suggested this measure noted that dental caries are largely preventable and can be reduced and managed in an outpatient setting. Caries-related ED visits represent potentially avoidable ambulatory care visits.

Next slide, please.

The next measure suggested for addition is the Follow Up after ED Visit for Dental Caries in Children measure. This measure is also stewarded by Dental Quality Alliance and is also NQF-endorsed. This measure assesses the process of care and is not recommended to replace any current measures. This measure can also be calculated using administrative data. The denominator is the number of caries-

related ED visits for children ages 0 to 20, and the numerator is the number of caries-related ED visits for which the member visited a dentist within 7 or 30 days of the visit.

The Workgroup member who suggested this measure noted that this process of care measure can be used to assess whether patients had timely follow-up with a dentist for more definitive care than can be provided in the ambulatory setting. It also allows programs to identify, monitor, and improve the percentage of children receiving timely care for caries-related dental problems.

Next slide, please.

The third measure suggested for addition in this domain is the Adult with Diabetes Oral Evaluation measure. The measure is also stewarded by DQA and is focused on the adult population. The measure is not currently NQF-endorsed but is currently undergoing testing. It is a process measure and can be calculated with administrative data. The denominator is the number of adults who have diabetes, and the numerator is the number of adults with diabetes who received a comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation.

The Workgroup member that suggested this measure noted that the current standards of medical care in diabetes call for initial care management to include referral to a dentist. The Workgroup member also noted that diabetes is associated with an increased prevalence in severity of periodontal disease and that oral evaluation represents an important entry into the dental care system.

Now I'll pass it over to the Co-Chairs, who will open the floor first for clarifying questions and then comments from subject matter experts.

Terrific...so thank you, Allison, for doing the overview for the Workgroup members. Hopefully, you had a chance to review these measures in the pre-materials on the SharePoint site; but are there any technical questions about the measures as they've been presented that you need answered before you can begin the discussion of the quality or the content of the measures...Sally?

I was unable to ascertain whether or not those measures are ready for implementation for Medicaid. I didn't see, for example, any continuous enrollment criteria. I tried to find the specifications, so I'm just wondering from those maybe who have experience in using the measures how ready they are for state-level reporting as specified...not to get into the merits of the measure.

Okay, terrific...yes, please, thank you.

Yes, hello, thank you for the question. The two pediatric ED measures...currently in use in Michigan, Florida, and Texas Medicaid, as well as Covered, California. So those two are ready for use.

They're using the same – the specifications are not filling in the blanks anywhere. That's what I wasn't able to ……

Right. Yeah, the Adult Diabetes measure is not currently in use because it's just finished testing.

Perfect, are there any other technical questions?

Tricia, thank you.

Tricia Brooks with Georgetown...I'm just curious about the pediatric measures in the states where they are in use. What kind of prevalence are you seeing? I just want to get a sense of impact.

I'll comment because actually the testing was done in two state Medicaid programs and two state CHIP programs. The overall prevalence is in the order of around 13 per 100,000 member months. But if you look across stratification by age, particularly in younger children and then in late adolescence, the 18-19-20-year-old, in two of the state Medicaid programs, it substantially increases. In fact, the late adolescence are the highest levels. The preschool population and late adolescence is where we see the higher rates.

Carolyn?

On the 7-day and 30-day follow-up visits, I was just wondering if you could comment in those states that have implemented these measures...how they operationalize it where this measure really draws upon two different claims sets...so the medical for the ED visits and then the dental claims. I guess the second part of that question is do these states use a dental vendor, which creates a whole other issue around marrying these two claims sets together?

Yes, certainly...yes, you're absolutely right. For the ED follow-up measure, it does require linking the data from the medical side of the Medicaid database and the dental side. That was actually a very explicit sort of conscious decision on the part of the DQA to actually develop that measure. In the states where it's tested, that's exactly what they do; and those states do use managed care vendors, and the measures are specified to be used at both the program level and the plan level.

Any other technical questions before we begin the open discussion?

Yes, Jennifer.

Hi, this is Jennifer Tracey. I was just curious about the time frames in the ED follow-up in the 7 days and then 30 days. I was just curious; I know access to dental services in states is typically an issue, especially for Medicaid and CHIP. Are you finding that in the states that are collecting this it's possible to have follow-up in those two time frames?

Yes, and I'm not going to comment on the specifics in terms of states and the tech level of the follow-up. But again, that was a conscious decision; and it actually specified the two time periods. The idea would be obviously within 7 days, particularly because definitive care is usually not rendered in the ED for these conditions. They may give antibiotics; they may give pain medication, but not definitive treatment.

The 30 days was actually built in to allow for data capture, recognizing that if the individual didn't have a current source of dental care that even establishing that care was something that was going to take time. So that's why the 30-day (audio break) was included.

Perfect, thank you.

Yes, please, Lindsay.

I just have one more technical question. On the 7-day and 30-day follow-up, in areas where they've actually instituted dental treatment within the emergency department, do you count that; or does it have to be at least one day after the visit?

It has to be one day after.

Okay, then if someone received treatment from an emergency department from a dental provider, it would not count towards the numerator?

Actually, let me make sure I understand the question. So you're saying if it actually happened from a dental provider. I'm almost 100% certain that that *is* allowable; and in fact, from a structural standpoint, some of the programs have gone to actually creating dental clinics next to EDs because you just avoid that necessity of actually entering the ED in the first place. So that could be counted.

Yeah, I tried to click through to get the specs; but the link wasn't working on the measure worksheet.

The measure steward is on the phone with us, so if we could turn it over. Lindsay, you may want to repeat your question just to ensure that the measure steward has the question.

Sure, this has to do with the follow-up after ED for dental caries. So if you have a person entering the ED, if they're treated for those caries on the same day within the ED, would that count towards numerator compliance?

Can you hear me? This is Diptee Ojha from the DQA. Can you hear us?

Yes, you're a little light. If you could speak using your outside voice, that would be great.

Okay, thank you...can you hear me now?

Yes.

Okay, thank you for your question. We *did* test for 7 days, 14 days, 30 days, and 60 days out just to be able to capture all those populations...all those individuals who accessed the emergency department for any dental care if they were followed up in a dental visit. So those populations who accessed the care from the start of the date of service, it is captured into whether it is 14 days, 7 days, or 30 days. So that's how our testing is specified. Would that answer your question?

Lindsay, go ahead.

Yeah, so it has to do with when you start the clock. So is it inclusive of the day they showed up at the ED, or does it have to be at least one day after?

At least one day.

Okay, terrific, thank you very much for that clarification.

At this point, what I'm going to do is it seems like we're ready to maybe move...we can continue to mix technical and discussion; there's no hard and fast line there. But I know certainly, Jim, if you wanted, we have subject matter expert dentists with us as well as other pediatric and oral health experts. So we wanted to create first the opportunity for any perspective sharing by those who are closest to the work, if you will, and then general discussion. This will be the point in time where we do ask people to limit their commentary to two minutes. You guys are doing *great* so far; we're ahead of schedule. But we'd ask that we sort of keep on track.

Jim, did you want to offer some general comments before we open it up?

Yeah, maybe some perspective and context, thank you; and thank you for the opportunity to be here.

Really, Dental Quality Alliance has been in existence for a little less than 10 years. It represents all the specialties of dentistry but also includes payers, AHIP, National Association of Dental Plans. It includes the Joint Commission, PCPCI...so a fairly broad group. The initial impetus came at the request of CMS to develop a group with some expertise to be able to develop these measures; and the initial focus was on children for the reason you alluded to earlier.

EPSDT dental benefits are applied throughout the Medicaid programs in all the states, so that was our initial focus; and we developed what we called a starter set. It had that sort of marker of kids getting any dental care...getting preventative care, getting treatment-level services...so sort of a spectrum using primarily existing administrative data. And I want to say that historically, I think kudos to the states; and kudos to CMS for the attention because back when I started in this area, we had about 18% of kids in the country getting a dental service on Medicaid, and that's approaching 50% now for the country. And in some states, it's actual parity...not just in coverage or benefits but in actual utilization. So a lot of progress, but it's still uneven.

So with the ED measures, that was sort of a second wave of testing...an investment we made in developing measures with the notion of looking not just within the dental sector, if you will, but looking to

things that spilled over into the medical sector or hospital sector, et cetera, both in terms of ability to manage conditions as well as costs...significant costs.

So the ED measure looks basically just to not look at just any admission where there's something related to the mouth, but it gets more specific in looking at caries-related measures. We did a lot of testing to determine what those codes would be that would help us identify those conditions. Then the follow-up measure was developed essentially at the same time; again, because of the limitations in the care, this provided on-site.

For the adult measure, that is absolutely newer territory for the DQA. We recognized the comment made early on in this Workgroup...that we don't have any dental measures in the Core Set for adults. As we've shifted...not shifted away...we haven't shifted away from children; but we've just with resources allowed developing adult measures. Diabetes was chosen as one of the first measures simply because of the evidence that exists in terms of the oral health/systemic health connection as it relates to diabetes because, as you heard, Standards of Care calls for dental care to be initiated through a referral for individuals with diabetes and for that evidence.

So that's a newer measure in terms of maturation but is one we feel that really is important and in sort of the spirit that Rich was saying earlier. In terms of sending a signal, we clearly want to see some dental measures for adults included in the Medicaid population. Yes, you're right; it's an optional benefit still that folks are looking to address at a fundamental level. But the measure has been undergoing testing by researchers at UCSF and University of Iowa using data from Oregon and Iowa.

Terrific, thank you...thank you for that perspective.

What I will plan to do to just keep us on track is I'm going to put *my* tent card up when you are approaching time with your commentary. Again, we're not going to cut people off at exactly two minutes; but it will give you a signal. So if you see my tent card up, that will be the signal that it's time to start to wrap up your comments.

Jim, thank you...very important to have that perspective.

Are there other Workgroup members who'd like to comment?

Sally? Nope? Okay, no problem.

Carolyn.

I had maybe two follow-up questions for Jim or anybody else who'd like to comment.

Jim, by the way, in the spirit of full disclosure, two of my siblings are dentists; and two family members have worked as dental hygienists. So I appreciate the goal of what you're trying to accomplish.

I did have a couple of questions though with respect to the ED visit. My first question is do you see this as being somewhat redundant or overlapping with the existing preventive dental services, 1 to 20 measure that already exists if the goal is to get access to primary dental care?

Then the second question has to do with the specs. I noticed in some of the background material the goal was to prevent treatable tooth decay, and I noticed that many of the diagnosis codes that were listed are codes that would indicate that the child has already been under treatment. For example, there are codes there related to root canals and individuals who have undergone other types of treatment...whether it's root canals or restorative. So just wondering if you can comment on those two questions, please.

Sure, yeah, thanks for the questions; and must be some interesting holiday discussions.

[Laughter]

In terms of the overlap, we at least don't see it as overlap at all. We see it really as clearly we want an emphasis on prevention...children, adults, wherever, particularly in children. But we see it as the real test about whether or not the measures that we have for prevention actually go deeper than that and whether they're really having an impact. So we really did think with the ambulatory-sensitive condition notion that these are things that shouldn't be happening. They shouldn't be happening even if we have just basic dental treatment in place in the vast majority of cases, let alone if we have good prevention in place. So we don't see that as...we see them as complementary not overlapping.

Secondly, the question about...oh, yeah, the specifications...oh, yes, right, so the conditions that actually sort of help to determine whether or not the kids...the situation is actually a caries-related condition. And again, we did fairly extensive iterative testing over and over with a group of researchers at the University of Florida on this particular measure; and it really is to help to rule out those cases where a child shows up for something that is not caries related. It could be some swelling...clearly, it's not trauma. We've specified the measures so they don't include trauma, and they don't include some other general sort of swelling of the face that wouldn't be sort of more directly attributable to caries.

The fact that the kids have already evidence of maybe restorative care, root canal sort of treatment...we don't expect ED docs to be diagnosing down at the level of dentistry that a dentist would; but we do look to them to be able to recognize that, in fact, there's evidence of dental disease in the mouth.

Yes?

(inaudible question)

I guess we looked at it in a bigger picture sort of way in terms of if states saw a variation or plan...they saw a variation among the plans who were administering their benefits, saw unusually high rates in particular age groups or overall in this that that would then lead to the next level of understanding why those children weren't being seen for routine dental care in a timely manner and lead to changes/improvements in the program geared toward trying to improve basic access in use of services before they got to be as severe as they would lead someone to get to an emergency department.

Perfect...Shevaun? You still...nope...you put it up or down?

I just wanted to offer some perspective as a state who did adopt the three measures. In Florida, we are placing a very heavy emphasis and focus on reducing ED visits; and in our data, we identified a concern for dental-related visits and felt like this was an opportunity to really focus on going one step deeper. I will say this brought out a couple of challenges, and we have just recently bifurcated our medical from our dental in our managed care plans. So we will have to collect data from two separate entities and merge. So I do think that will pose a bit of a challenge.

However, we're still moving forward. We've put enough safeguards in place, and so this is something that states will have to think about. We have a process in Florida where we can notify the subscribers of any ED visits. So our dental plan then we'll be able to sign up for that service to be able to do the follow-ups after an ED visit. We also have a partnership between our (audio break) medical plans. So, again, I think you will have to put a lot of things around on these to make them work when you have a bifurcated system.

Rich?

Speaking as a pediatrician...this is Rich Antonelli...I'm thrilled to see that there's a proposed measure for adults to the Core Set; and I welcome the conversation about that to move that forward.

I'm still not sure that I feel I have an understanding of some of the issues that Carolyn had raised. So I think about the ED measure as they're utilization measures. Are they a reflection of the ineffectiveness of doing primary and secondary prevention...and I've got a follow-up question to that...or is it related more to dental access? I'm struggling with this being a true primary outcome. I think it's indicative of something. In the testing that's been done so far, Jim and/or the steward on the phone, I'm just curious; have you

looked at the correlation, if any, between the performance on the primary preventive measures that are already there with the ED utilization measure?

Yeah, you're raising a really good point, Rich, because clearly there's literature that goes beyond dental as to usage of EDs for things that could be provided through primary care providers, right? What I'm aware of, there's some analysis that's been done by the ADA Health Policy Institute looking at the ways of classifying the acuity and sort of a triage system for those conditions that come in, whereby a good proportion of them...at least probably half, many more in some cases...actually have been attributed to something that could have been diverted. It didn't need to be seen in an ED at all.

Your underlying question was...is that simply a reflection that there wasn't a dentist available for the individual to actually see?

I don't know, and I'll ask Diptee if she's still on the phone, whether or not we actually looked into that into the testing. I remember a lot of testing using different sorts of inclusion criteria/exclusion criteria. I'm not aware of that. Obviously, some of the other analyses that have been done have found that the situation tends to be more acute, if you will, in the more remote areas...more rural areas outside of large urban settings. In larger urban settings, generally that's not an issue. I can tell you having lived in both New York City and in Los Angeles, typically that's where you have the good supply of providers...some might say, even oversupply of providers.

Diptee, are you understanding the question about did we actually look at a correlation between general access and the rate for the ED measures? I believe that's Rich's question.

And also correlation with existing measures, like the PDENT and the Sealant measures. I'm just trying to figure out does this measure add something new other than utilization in a high cost environment; and if there is a correlation, I would argue that I don't know that it's offering anything new other than that utilization. So that's actually the heart of my question.

This is Diptee from DQA. We have our methodology expert also on the line, and she can address that better to address this question. But I do want to bring up the point that NQF did review this measure as an outcome measure; so because dental caries happens to be largely a preventable condition and because it can be reduced and managed through our patient care processes, this represents an outcome of a system failure in getting a patient to an outpatient setting and having the patient...that the condition exacerbated to a point that they had to seek care in an ED setting.

Jill, are you on the line; and are you able to speak more to Richard's question?

[No response]

Might she be muted?

[Pause]

Hi, this is Jill...can you hear me?

Yes.

Okay, wonderful...good morning, everyone. So we did observe inverse associations between the ED measure and the prevention measure, which the NQF Committee actually viewed as validating the ED measure. It's really viewed as being similar to the HRQ quality indicators of prevention with potentially preventable admission. So they did view it as an outcome measure. They had kind of a similar discussion around access versus outcomes; and it is classified, and that endorsement is an outcome measure. So it's similar to what Dr. Crall mentioned earlier...that it's a complementary measure to prevention.

Also, as Shevaun talked about, which is what we've heard from other states, there does seem to be a lot of interest by states in looking at these dental-related ED visits because they are, by and large, ones that

really can be either prevented or managed in outpatient settings and really signify the exacerbations of outcomes that can be more effectively addressed elsewhere because you aren't getting the definitive care.

Thank you, Jill.

So they are kind of high-impact health state measures.

Terrific, thank you for that additional clarification.

We've got a number of Workgroup members. We'll go from Jill to Linette to Lindsay to Sally, in that order. So we'll continue. Just from a timekeeping perspective, we are ahead of schedule. The Workgroup conversation was scheduled to begin at 11:35 a.m. So while we're going to spend a little extra time here, we're going to also have to remember that when we get to measures that have multiple things in them, we're going to have to move.

I'd also like to make...at some point us to move to the discussion of the Adult measure in addition to these Pediatric measure we've been discussing.

Jill, please go ahead.

Great, I'll hold my comment for the Adult measures then.

Wonderful.

I actually really like the concept of looking at this as an ambulatory care sensitive or technically preventable ED visit concept, and I see it as being very different from the preventative care. It seems to me that just because a child has had previous dental work doesn't mean they have a usual form of dentistry. It doesn't mean they have ongoing care, and it doesn't mean they can get an appointment in a (audio break) center.

The measure on the medical side is looking at ambulatory care-sensitive conditions or preventable conditions doesn't really say why. So it doesn't say that the issue is access, the issue is timeliness, the issue is whatever. That's for the state, the provider, the MCO to figure out. So I really like this measure. I think that it gives you the other side of what dental care looks like. It gives you sort of the underbelly of dental care. And I like the concept of the follow-up to it as well because that gives you a sense of whether or not people are able to access it.

But I agree with you, Lindsay, around the timing because we have a number of initiatives where they're doing dental triage, and that dental triage gets the person into dental care *that* day...not the day after or the week after or the month after. So I think that needs to sort be considered.

Terrific, thank you, Linette.

In terms of the ED visit for those caries, again, that's preventable, so to speak. Just highlighting the contrast...I mean, I think this would be great; we are using it to our dental (inaudible) efforts in California. But like the preventive screen measure that currently came from the CMS 416, we have this mismatch...three months eligibility, one-year lookback. Nobody suggested we're moving it this year, but to have an alternative measure that looks at dental treatment that has a better match of eligibility to treatment eligibility is something that I think would be a very good thing to add and give us another alternative to that mismatch that we currently have on the preventive services from the CMS 416.

In terms of the follow-up, on a lot of our programs in California we're very focused as well on how do we get integration. So the fact that that follow-up doesn't count unless it's one day later is actually a negative against all of our efforts towards integration...so just to throw those out there.

Terrific...Lindsay?

In the spirit of kind of what, Jami, you brought up is when we think about these measures at the state health system or managed care organization and then provider level. So I just wonder how do the dentists feel...because ultimately, we're going to hold the dental providers accountable for not being able to get in to see a dentist. We've come up against this quite a bit. We use some of these measures in our pay for performance, and what I hear is that they won't take Medicaid.

So I'm looking for alternatives...like what do we do when we get to that point...like how do we act? I can't make money come out of air; I can't make people take my money.

Lindsay, I appreciate that. Help me how that would help inform your vote of "Yes" or "No." That feels to me like an implementation question, so does that help bridge why that would matter for the voter..."Yes" or "No" on the measure.

Yeah, so I guess it might be outside of scope a little bit from the discussion, but it just is something that we've encountered as we look to bring in more dental measures. I don't think anybody is objecting that dental health is important.

Right, so I think that's important. We asked the earlier question about what's the underlying premise of the Medicaid program, so it is important to add; but I think some of those implementation challenges are then what gives the states a directive to go figure out how to solve the problem. And then you've got to figure out how to go solve the problem. So I think that's an important question.

Do you want to respond, Jim?

Just quickly...I get the point. I mean, I've sat in rooms and heard Medicaid directors say, "It doesn't matter how much we pay those dentists; they won't see Medicaid clients." I am *happy* to point to data that's been accumulated between the 1990s to the early 2000s to now that show great movement in many states in terms of improving their utilization. So it is not an intractable or an unsolvable problem. It's not a simple problem to throw money at it either; but clearly, we have models out there and examples where it's happened.

Terrific.

Sally?

My question...I think it's been answered but not directly, so I just want to make sure I get it right. I'm not a clinician; so in looking at the preventive dental seals measure, my assumption is you can get dental seals on time "as prescribed" as the guidelines say and still have an avoidable ED dental caries. Is my non-clinical assumption...can it be confirmed clinically as true?

Yeah, it's possible because obviously we have hopefully lots of teeth in our mouth; and the sealants are actually only generally applied to certain teeth. The permanent molars are the primary targets, and then obviously other permanent teeth that have those pits and grooves and fissures; but it's possible to have decay beyond the biting surfaces of the tooth, so that's one aspect to address.

The other thing to bring in is that there are things like school-based sealant programs. Oftentimes, the data doesn't even actually get into the system; but there could be sealants going on. So we have no immunizations for caries. We have no immunizations on the horizon for caries, so a sealant is not an immunization for caries; but it helps on a selective basis.

Great....Jeff and then Lisa.

Jeff Schiff from Minnesota. I'm a pediatric ER doc, so I have to say that this measure...the first one, especially...is near and dear to my heart because it's very frustrating to see kids in the ER and have to give people a set of phone numbers to go call dentists in the morning and some pain medicine...maybe some ibuprofen, antibiotics maybe...not opioids usually.

I think that the other thing that's really helpful about this, especially the first measure, it's a measure of how the state is implementing an oral health program potentially. So fluoride varnish, sealants, hygienists, school-based sealant programs...all of those things are sort of outside the realm of did your patient get a dental visit. And in states that haven't had a whole lot of dentists stepping up to the plate, this is a state-level measure of oral health. So I think there's something to be said about that as well. That's all...thanks.

Perfect...Lisa, and then I'm going to ask that we turn the discussion to the adult measure since we haven't delved as deeply into that one. Lisa?

Lisa Patton...I was just going to offer up sort of a larger framing comment that a lot of this is saying there are many similarities in terms of utilization, reimbursement, provider capacity, safety net, in the behavioral health arena. So we've been addressing a lot of those issues from the behavioral health perspective for a while. There may be some kind of efficiencies that are lessons to be learned from that work.

Thank you.

Dr. Kelley has a perspective and a quick question.

Quick comment, question...there are two measures that are fairly similar. You mentioned, I think before, that it's about 13 per 100,000 members. That and that's like kind of at a population level, you can look at what's happening. That's sensitive enough that ones that you actually can prove...especially in states that, say, may have – like we have 1.1 million kids; but that's a case for Wyoming where there are fewer kids. But then the other question is do we need to have both? If they seem to be similar in length...and personally, I like the follow up one because that really gets me to the nature of the issue. The denominator also kind of gets you back into the process.

Yeah, I'll comment on the testing that was done, again, with two state Medicaid programs and two CHIP programs. We actually did see some good variation across those in what we would expect, given the socioeconomic characteristics of the populations covered by those different programs and certainly did see differences across the age groups, as I mentioned earlier.

The adolescents in one state, if memory serves me correctly, we saw almost ten times that overall rate in those years. So you'll see multiples of 13 up into the hundreds in at least the State Medicaid Program with the older kids.

And then the linking question...it was on my mind too, so I appreciate you asking.

Yeah, definitely you're absolutely right. It does require this issue depending on how you're structured to administer your plan to being able to pull data from two sources and link it together. It is, I believe, the ultimate measure because if you're really concerned about an outcome...about if somebody gets their infection, their pain, or whatever it is at least addressed, it's something that's likely to have a longer-term impact other than pain meds or antibiotics, then absolutely. It's more burden from the data standpoint; but in terms of telling you overall how many kids actually are getting seen as your denominator and then whether or not you're actually getting the follow through so that they're out of pain and out of infection, et cetera, I think that they're linked.

And there were two options...sort of one to tell you a part of the story with a certain level of burden, if you will, of data acquisition and then one that would actually go farther but tells you definitely more of the story.

Jeff or Sally, are the pediatric--?

I'm confused with the fact how I vote on here. Is the follow-up measure following up for avoidable ED, or is the follow-up measure for any reason in which they hit the ED for a dental caries? It's my read on the follow-up measure it would include those that maybe weren't avoidable. It's about if you hit the ED for a dental caries reason, that must get a follow-up visit which is different than the way I'm sorting through it than the avoidable measure, which is system failure and not getting them to hit the ED in the first place.

So I just want to know if the denominator of the follow-up and numerator are avoidable; or are they treated differently?

They're very tightly linked, as you said. Basically, the follow-up is for the condition that got you classified as having a caries-related ED visit. I think I understand your next level of distinction, which is by some level of acuity, you might say that needed to be treated in an emergency department or not and could have been seen somewhere else. The way we framed the measure, the way we looked at the measure, it was a system failure. So the fact that they were *there* was avoidable.

I understand that, I guess. I'm trying to understand the follow-up measure...if that denominator includes more children, more visits than would be in the avoidable. So often an avoidable measure will narrow who is included, and a follow-up visit may be broader because it doesn't matter if it was avoidable or not. But perhaps in this case, by diagnoses of what is being looked at, they're actually quite closely linked.

Yes, you're absolutely right on.

Okay, terrific...moving then to the conversation about the adults with diabetes oral evaluation, it's been acknowledged that not every state's Medicaid program has an adult oral health benefit. That's just a piece of context for our conversation. Are there subject matter experts...either clinicians or experts as it relates to diabetic care or oral health...that want to weigh in or general Workgroup discussion?

A general comment...it was noted that this measure was actually being reported in, I believe, the Oregon Health Authority Incentive Reporting program. So it has been used by Oregon and as part of their incentive program. So I guess that's feasibility.

Carolyn?

Thank you, so this question relates to both the adult measure as well as the one we were just discussing on follow-up care for ED visits. This is a question related to the technical specifications again. I'm sorry to keep getting in the weeds on technical specifications, but I just want to make sure that we can operationalize these things.

And I apologize if this is a sensitive question, Jim; but this is really an important issue for Medicaid programs. Under the technical specifications for these two measures, I couldn't tell if the dental care could be received by, delivered by a licensed dental therapist or advanced dental therapist. This is a new licensure in a number of states, and these professionals provide access particularly for those in rural areas who otherwise wouldn't have access. So just wondering if you or your colleagues on the phone can clarify if the dental services could be delivered by a licensed dental therapist in those states where they have that licensure.

Well, I'm going to call on Diptee, who is probably closer to that issue than I am. I will say that it's tied to comprehensive examination, evaluation, periodic evaluation, or a periodontal evaluation. So in any state that allowed that within the scope of a dental therapist, then that would be technically what was measured. That would be what the procedure that the claim came through on that would identify it in the dataset.

Diptee, do you know for the different states?

This is Diptee. Thank you, Dr. Crall. Any dental visit that was rendered by any eligible provider will be captured into this numerator. It does not distinguish between dentists or a health provider. We do not use any NACC codes to distinguish between a dentist versus dental hygienist or a dental therapist or a health provider. It captures all oral evaluation that was conducted for that patient.

Terrific...thank you for that clarification. Are there others who have comments? Yes, Linette?

Linette from California...this is sort of a crossover comment on just the practical data availability aspect. In California, we have a separate contract that does our claims processing for dental as opposed to our fee

for service as opposed to our managed care encounters. So we bring all of that data into our data warehouse, and we combine that. That also then includes our specialty mental health and our substance use disorders. So when we run these measures and we look at these measures, we put all of the data from the different places...even though the transactional claims processing is happening in different ways across each of those different areas or delivery systems, we bring it together in a central warehouse where we do our measure calculations.

So, yes, there is a linkage aspect; but to the extent that they're Medi-Cal members and they're using their Medi-Cal CIN, client index number, then that's the linkage between those in terms of putting that together. I also highlight that because all of us that are intricately involved in sending data to CMS for the Transformed Medicaid Statistical Information System, T-MSIS, we have requirements around that; and so to the extent that we're sending that data on, also these administrative measures could be run using T-MSIS's data.

So depending on how a state is organized around how they're doing their T-MSIS and their data warehousing, we bring our data into our data warehouse; and from there, we send it to T-MSIS so we have that consistency. But just from a logistics perspective for both the adult and child measures, that's something that again as long as it's administrative, we have that potential to do it. It doesn't require a chart review.

In terms of the adult measure, I don't know if this is kind of a combination question/comment. I know we're looking at the dental piece specifically; but one of the conversations we had on our site is...is the focus more on the dental or more on the diabetes. So it's specifically an oral exam for those that have diabetes; and so while there is a gap around dental oral health for adults, there are a number of diabetes measures for adults. So we were thinking of it in terms of the context of diabetes as opposed to specifically oral health. So just interested if there are any comments along this line.

I'll respond, and then Diptee again. I was intimately involved in the testing of the pediatric measures but moved to a different committee, and so I haven't been on the adult side...other than informational work that comes out of the workgroup that looks at that.

My sense is, Dr. Scott, that you're right; it's on the diabetes, it's not broadly. It's got a particular dental focus about whether or not they're actually accessing dental care as standards and guidelines sort of recommend. But it's not on a broad spectrum; it's about a specific subset of the population.

And then just to check...this would be a technical question...are the specifications for identifying diabetics the same specifications we use for the other core set measures that identify diabetics?

Margo is nodding her head; you can't see her. She's out of your line of sight.

Okay, I am sensing we're about to transition to our first public comment and then vote. I'm sensing that we've got about 20 minutes left, and I want to have sufficient time to make sure we get it all right and everybody feels comfortable with the process. So I'm going to ask for...this is what I think we're going to do over the next 20 minutes. We'll have a little bit more discussion, and then we will open it up for public comment. After that, I will ask for a motion for the recommendation.

Committee conversation can continue after the motion. That's what the motion is; the motion is that we're going to take action. There can be final discussion about that. Then we will go through and vote. We can take a motion on all three together to just say let's move to vote on these. And then we'll do the votes, though, independently. We just don't want to have to have three motions for each one to try to be a little efficient here.

So that's, I think, what we're going to do in the next 20 minutes. So first, any final comments and discussion; then we'll do public comments; then I'll be asking someone for a motion, some brave soul out there, for a motion; and then we can continue any discussion as needed, and then we'll vote.

Sally, go ahead.

I have a question about how to think through this measure still being in testing, and it will apply to measures later on as well. So it's currently in testing, yet I did note that it has been implemented. I don't know if that's part of the testing or if the testing is going to potentially change what has been implemented. So there are some questions specific to this measure, but more broadly; also will we just measure by measure if, say, our state is still being in testing...make a decision based on the merits of that measure of the testing. Is that how you want to handle it?

Yes, and we'll be voting on the measure as it is presented today. So if there were any changes based on the testing, that would be then a different measure.

My question though is, is the testing being implemented...part of the testing, or is there sufficient testing complete that shows the measure as valid and reliable? Where is the measure in its implementation pipeline?

Margo?

Do we know?

Diptee, could you respond to that?

Yes, Margo, and thank you.

So the two pediatric measures...the ED measures...are validated. They've been completed testing and given endorsement. The oral evaluation for diabetics is currently under testing, which means we have completed the testing. Our process entails that it goes through our full voting process with the full DQA, and they do not meet until June. So we are just waiting for that formal voting process to get that approval, but the testing is completed.

And the specifications that you have in front of you or whatever link that has been provided to you is the specification that has been finalized as of right now by our committee.

Great...Shevaun?

I just have one follow-up question. At that June meeting, is it possible that the committee decides to make specification changes? Would that likely happen?

I'll go; and then, Diptee, you feel free to add.

No, the specifications don't get changed by the vote of the full committee itself. They could send it back for additional testing if the Executive Committee and then the full DQA felt that there was something in the testing that was lacking. But, no, the measures are not amended on the vote as part of the vote process.

Thank you, Dr. Crall.

Back to the diabetes question...just want to make sure...the measures as specified now are the same specifications that the Oregon Incentive Program has been using. Is that correct?

Yes, correct.

Yes, I thought it was.

Terrific.

Just to add to Dr. Crall's comment about...so our process entails that during our testing we have released an interim report so any changes that are made or suggested happen at that time. And during June when the full body of the DQA meets to vote on these measures, those amendments are made at that time. So if there are changes, it happens beforehand.

Terrific, thank you very much.

At this point in time, I'm going to ask that we move to public comment. For those who are interested in public comments...Margo, they let Brice know? How does one do this? Thank you.

So we'll go ahead and start in the room. If you are a member of the public in the room with us today and you have a public comment, please raise your hand; and we will come to you with the microphone. And then we will go to any public comments on the phone.

Thank you. So if you have a public comment on one of these three measures, please raise your hand if you're in the room.

[Pause for audience response]

[No response]

Okay, and now, Brice, we will move it to the phones. So if you have any public comments on the phone, you will press "5 star" to open your line; and your line will be unmuted.

Brice, do we have any public comments?

We don't have any public comments at this time. As Bailey mentioned, you'll need to press "5 star" once you've joined the teleconference. Instructions for joining the teleconference are mentioned on your event console. You'll see those instructions written there.

[Pause for responses]

Brice, just confirming...any comments at this time?

Still no comments at this time.

I think we'll call that a sufficient amount of time, unless anybody thinks we should wait longer.

I think that concludes our public comment period, just to give everyone a sense of where we are. That concludes the public comment period on these three dental and oral health services measures.

The next thing we'd like to do is ask for a motion to vote, for a recommendation to add these measures to the Core Set. So the motion is to add the measures, and then we will vote "Yes" or "No" on this on each of the measures. Is there a motion to add these three measures to the core set?

This is Jill Morrow from Massachusetts. I move that we vote to add these three measures to the Core Set.

Terrific...is there a second to that motion?

Second...terrific...multiple...we appreciate that.

Thank you, Jill, for going first on our first motion. You are deeply appreciated from the team.

At this point...yes, Bailey, help me?

Diptee, if you're still on the phone, I want to confirm something. I think it may change how people vote. If I understand, you contacted one of our team members that the measure actually *does* include the same day. Diptee, I was hoping you could confirm that because I think that might change some people's perspective. Are you still there?

I am, and I actually have Dr. Jill Herndon, who led the testing. She can probably clarify it better because she is more – she is clear on the specifications on testing.

Jill, we do capture same-day visits for the follow-up measure, correct...just to confirm?

Are you able to hear me?

Yes.

Oh, great...so, yes, a determination was made to include same-day visits; and there was actually a lot of discussion around that. The consensus was that the majority of cases would involve the ER visit preceding the outpatient dental visit, and there was a very big concern that excluding same-day visits could potentially create a disincentive for same-day follow-up...which would be in direct contrast to the intent of the measure. So it does include.

Great...thank you, Jill, that is important.

And thank you, Bailey, for stopping us to make sure we all had that information because I do think that that is an important distinction, given some people's comments that it could be a disincentive as you just described...so thank you.

We still are in the forum. Now that we have a motion on the table to consider these three for addition to the Core Set, is there any final discussion before everybody finds their clicker, confirms it has their name on it, and also reminds themselves if they have an interest in this that they will put their clicker down and not vote on it; but are there final areas of discussion?

Yes, Jim?

I just have a point of order. Is this two-thirds or over two-thirds to get accepted on the Core Set because if we have our recusal, we'll be—

So it is two-thirds; you round up, whole people. So when there are 27 people that are eligible to vote, it will be 18 members. If it's the full 28, it's 19 members. I don't believe we go below 27 for our processes today.

So what we're going to go ahead and do –

I just have one more question. When we're voting on the measures, we are not to take into consideration... the domains are already – that's going to be handled on Thursday with prioritization?

Yes...and the slide maybe...can we put the first vote slide up to give us all comfort of what we're doing? I'm sorry if my head is in the way of the bottom of that. We should maybe move that up more.

The actual vote is...should the ambulatory care sensitive emergency department visits for dental caries in children measure be added to the core set? The "A" button is, "Yes, I recommend adding the measure to the Core Set; and "B," "I do not recommend." You're going to do each of these separately. You're voting on the merit of the measure, as we have discussed. And then, yes, Lindsay, we're going to come back together. We're going to disaggregate, and then we're going to reaggregate on Thursday to put them into some semblance of recommendation and prioritization and relation to one another at that point in time.

Are we ready?

Everyone, please turn on the clicker using the orange button. Make sure it says "Ready." Everyone good?

Great, okay...also, we are going to open voting.

Steve, please open voting.

Please go ahead and vote. You will see the letter on your clicker. "A" again is "Yes, I recommend adding the measure to the Core Set." And "B" is "I do *not* recommend adding the measure to the Core Set."

[Pause for voting]

Voting is now closed. Thank you.

Let's see where we are. Okay, so our results for the phone are...and we tried to make this a little bit bigger, but I'll read it for the room as well. So 59% of the Workgroup members...this is the eligible Workgroup members...so 16 voted to recommend adding the measure to the Core Set; 41% voted to not recommend adding the measure to the Core Set. This measure is *not* recommended for addition to the Core Set because it did not meet our two-thirds threshold.

Now we're going to go ahead and move to the second vote on the measure. Again, everyone please hit the blue button on your remote. So you're going to refresh it; it should be clear. The second measure that we're voting on today is Follow-Up After Emergency Department Visits for Dental Caries in Children measure. Again, you will select "A" if you recommend adding the measure to the Core Set. You will select "B" if you do *not* recommend adding the measure to the Core Set.

Everyone's remotes good?

Okay, Steve, please open voting.

[Pause for voting]

Voting is closed, thank you. We'll go ahead and see our results. For this measure, again, we had 59% of the Workgroup that voted to recommend adding the measure to the Core Set; and we had 41% that voted to not recommend adding the measure to the Core Set. This measure also was *not* recommended for addition to the Core Set.

We'll move to the last measure within this domain. The measure that we're voting on now is the Adults with Diabetes Oral Evaluation measure. Again, select "A" if you recommend adding this measure to the Core Set; and "B" if you do not. Before we vote, please press the blue Refresh button.

Steve, please open voting.

[Pause for voting]

Voting is now closed. For this measure, which is the Adults with Diabetes Oral Evaluation measure, we had 18% of the Workgroup that voted to recommend adding this measure to the Core Set; and we had 82% that voted to not recommend adding this measure to the Core Set. So this measure was *not* recommended for addition to the Core Set.

I want to thank you all; that went very smoothly, and everyone did great.

[Applause]

Let's give ourselves a hand

Terrific...you guys that was great...good job. Over the course of the afternoon, we're going to get into a couple of other sets, but now we are going to break for lunch. For those listening on the phone, we're going to break for lunch. I believe lunch is outside, Margo? Lunch is outside for Workgroup members.

Yep, so Workgroup members, right where there was coffee and stuff, there will be lunch available for you. If you requested a special meal, we'll have that for you as well. If you have any questions, please find us. Thank you.

[LUNCH BREAK]

Hi, everyone...that was really loud, sorry! Can everyone please make their way to their seats? We'll get started momentarily. Thanks.

[Pause]

Okay, if I could ask for people in the room to find their seats. The phone line is being reactivated as we speak. You all are *very* quick to get quiet...thank you.

So great work with the dental measures...we have for the next two-and-a-half hours...is that right...so 3:10 p.m., to work our way through the next domain. Again, we organized these by domain for purposes of our discussion; they don't relate to the final domain that something could be in, in the Core Set. But with 56 measures, we need to have some sort of organizing mechanism.

We're going to start with the Primary Care Access and Preventive Care. We'll go through the same exercise of having a Mathematica staff person walk us through the current Core Set measures. Then we will tackle the discussion of the immunization measures, so that will be our first time of looking at both a removal and addition framework for the measures.

We're not scheduled to take a break, but we may have to take a mental break after the immunizations and stand up and do the hokey-pokey or something to just give ourselves a little bit of energy to then come back and tackle the other discussion of the Primary Care Access and Preventive Care measures.

We will create the opportunity for public comment on both those buckets and also complete the vote on the immunization measures before we can move on to the Primary Care Access and Preventive Care measures.

We recognize there are a number of measure stewards. We really appreciate you all being available for technical support. We would ask that you keep your comments concise; again, we're trying to use the two-minute framework...so to the extent that you can do that. Obviously when we're in a question and answer period, we're not going to follow two minutes exactly because people are trying to get information that will inform their process of voting. But you guys did a great job with dental. We're going to just have to be disciplined as we move into the afternoon.

We will take a formal break at 3:10 p.m. to 3:30 p.m., and then finish out our day on Experience of Care, the Patient Reported Outcomes. So we will have a little bit of a wrap-up at the end of the day to reflect on how it went, if there's anything we'd like to change as we move into tomorrow. Then for the Workgroup members, there's a reception at the hotel, the Hilton Garden Inn, with a cash bar and some snacks.

So that's the game plan for the rest of the day. Of course as needed, please take the breaks that you need.

With that, Bailey, is there anything else?

That's perfect. Thank you, Gretchen.

As she said, we gave you a little bit of a slow pitch softball to start the morning; and now we're going to fast-pitch baseball. This is a big domain, the Primary Care Access and Preventive Care domain; and as Gretchen said, we're going to split it into two sections. We're going to start with the immunization measures, and then we're going to move on to the other measures. I first want to check just to make sure we have time.

Measure stewards, I'm going to go through you quickly...there are a lot of you...just to see if you're on the line. If you are not on the line, please refer back to the instructions...or if you're having trouble unmuting yourself, I should say, please refer back to the instructions on how to do that. If you're still having trouble, please use the Q&A box; and our staff will help you.

Is there a representative from NCQA on the line?

[Pause for response]

[No response]

In the room?

Here.

Oh, perfect...hi, Sarah.

Is there a representative from PCPI Foundation in the room or on the line?

[Pause for response]

[No response]

Okay, a reminder to use the Q&A function if you're having trouble unmuting yourself. Is there a representative from CMS on the line or in the room?

[Pause for response]

[No response]

Is there a representative from PMCoE in the room or on the line?

[Pause for response]

[No response]

Okay, and is Laura back; and are any other staff members that were going to help Laura Seef contribute to a measure discussion on the line?

[Pause for response]

[No response]

It is, yeah...just give people time to unmute themselves.

Okay, so I'm going to jump in; and, as Gretchen said, I'm going to discuss the current Core Set measures. Then we'll go on to discuss the measures for removal and addition. I'm going to go quickly because we have a lot to get through, and there's further information in your folder. You're also welcome to ask questions when we get into the clarifying questions, but I'm going to go pretty quickly.

The first current measure, there are two in the Child Core Set Immunization measures and one Adult Core Set immunization measure. The Child Immunization Status measure looks at the recommended measures as shown on the slide. I'm not going to go through them all because...oh, it's not on the slide, I'm sorry...as shown in the materials in your folder. I'm not going to go through each of them because there are a lot of them; but one thing to note is there is a rate calculated for each vaccine, as well as nine separate combos for this measure; and there is one combo that is publicly reported.

The next is Immunization for Adolescents measure. This is the percentage of adolescents age 13 who had one dose of meningococcal vaccine, one tetanus, one diphtheria toxoids, and one acellular pertussis vaccine...and I apologize for my pronunciation...and have also completed the HPV vaccine series by their 13th birthday. This measure also calculates the rate for each vaccine, and then it calculates two combo rates.

Finally, for the Adult Core Set, we have the Immunization measure, which Is Flu Vaccinations for Adults Ages 18 to 64. This measure is recommended for removal. Note that there's a typo on slide 46. It should

say "Adult Medicaid," not "Medicare." This measure is the percentage of beneficiaries ages 18 to 64 who received a flu vaccination between July 1st of the measurement year and the date when the consumer assessment of healthcare providers and systems, or CAHPS, 5.0H Adult Survey was completed. This measure, as I said, was proposed for removal. I'll provide some more details about the measure.

Next slide, please.

This measure is NQF-endorsed. The measure steward is the National Committee for Quality Assurance, or NCQA; and I'll use the abbreviation "NCQA" as I move on through the domain. Its rate is the number of eligible beneficiaries who have responded "Yes" to having a flu shot or flu spray in the nose since July 1st of a specified year, and that depends on what measurement year is being used. The denominator is any beneficiary who responded "Yes" or "No" to the question about having a flu shot or a flu spray in the nose during the same time period.

Two new measures were actually suggested to replace this measure in the Core Set, the Adult Immunization Status measure and the Influenza Immunization measure. We'll discuss both of those in a few minutes. This measure was reported by 19 states in FFY 2015, 18 in FFY 2016, and then 20 in FFY 2017. Just as a reminder, FFY 2017 is the year of data that are most recently available for reporting for the Core Set. This measure is not included in the Medicaid and CHIP scorecard.

Workgroup members suggested this measure for removal for a few reasons. First, states reported challenges with conducting the CAHPS 5.0H Survey annually, as well as just reporting the measure. The measure does not provide actionable results for State Medicaid or CHIP agencies. Finally, the measure only covers flu vaccinations for beneficiaries age of 18 to 64, while other measures include additional immunizations as well as wider age ranges.

Some reasons that states reported for not reporting this measure in FFY 2017 include that data were not available due to budget and or staff constraints, the data source was not easily accessible, and the information was not collected by the State and/or the health plans within the state.

Before I move on, does anyone have any clarifying questions about the specifications for this measure? As a reminder, this is the flu measure for ages 18 to 64.

[Pause for audience response]

[No response]

Great, so moving on to additions, the first measure I will discuss for addition is the Flu Vaccinations for Adults Ages 65 and Older measure. Just as a reminder, I'll go through all the measures for addition; and then we'll open up for discussion on that.

This measure is the same one as the 2019 Adult Core Set measure that I just discussed, which was suggested for removal but would add the 65 and older age span. It will allow the assessment of influenza immunizations in an age bracket that is more likely to die from influenza than the younger age bracket, and the rate of influenza vaccination for dual eligibles is not known. The immunization reduces hospitalizations by 71%. Those were the reasons that it was recommended for addition...so the wider age bracket, and it's important to know what the level of immunization is for dual eligibles for 65 and older.

Next slide, please.

This next immunization measure proposed for addition to the Core Set is the Influenza Immunization measure. The measure steward for this measure is the Physician Consortium for Performance Improvement or PCPI Foundation. Again, I'll use the acronym going forward. This measure is NQF-endorsed, and it's also a process measure.

The measure is recommended to replace the Flu Vaccinations for Adults Ages 18 to 64 measure, and the measure can be collected using the administrative or EHR methods. Its rate is the percentage of patients

six months and older who were seen for a visit between October 1st and March 31st and who received an influenza immunization or reported previous receipt of an influenza immunization. "Previous receipt" is defined as receipt of the current season's influenza immunization from another provider or from the same provider during a prior visit.

Workgroup members suggested this measure for addition because they noted it was superior to the existing measure, which is collected by CAHPS, and has a low response rate, is high cost, and is not comparable for diverse populations. Additionally, they noted that CDC estimates that influenza has resulted in between 9.3 million and 49 million illnesses and between 140,000 and 960 hospitalizations, as well as a number of deaths since 2010. The first and most important step in preventing flu is for all persons ages six months and above to get a flu vaccine every year.

Next slide, please.

Our next measure that was suggested for addition is the Adult Immunization Status measure. The measure steward for this measure is NCQA. The measure is *not* NQF-endorsed, and it is also a process measure. It is the other measure that was recommended to replace the Flu Vaccinations for Adults Ages 18 to 64 measure, and its data collection method is the HEDIS electronic clinical data systems, or ECDS, method. This includes data from administrative claims, electronic health records, case management systems, and health information exchanges and clinical registries.

Next slide, please.

This measure has four rates and one combo rate, and the numerators and denominators vary a bit for each of these rates. I'm not going to spend too much time going into each of them, but they are presented on the slide. The denominator for the influenza and Td/Tdap rates are beneficiaries that are age 19 or older, while the denominator for the zoster rate is beneficiaries 50 and older, and then for pneumococcal is 66 an older. These denominators are added together for the composite rate.

Next slide, please.

The numerator for this measure also varies based on immunization type. For example, for the Td/Tdap rate, a vaccination can be received in the nine years prior to the measurement period; whereas for the influenza vaccine it's over a year period. I'm not going to go through the specific numerator requirements, but they are detailed on this slide and the next one, which is included in your information.

Next slide, please.

One note about this measure is that it’s a first-year measure in HEDIS 2019, so 2019 was the first year that it was included in HEDIS. The reason that this measure was suggested for addition by Workgroup members is because it includes more vaccinations than just the flu vaccine. The Advisory Committee on Immunization Practices also recommend tetanus, diphtheria, and acellular pertussis and/or tetanus and diphtheria vaccines, the herpes zoster vaccine, the 13 valent-pneumococcal conjugate vaccine and the 23-valent pneumococcal polysaccharide vaccine at various ages for routine adult immunization.

The measure overall would help states in enhancing monitoring of adult immunization coverage and reduce morbidity and mortality from vaccine-preventable diseases.

Next slide, please.

The final immunization measure suggested for addition is the Prenatal Immunization Status measure. NCQA is also the measure steward for this measure. This measure is also not NQF-endorsed and is also a process measure. It also has the data collection method of ECDS, and it has three separate rates. It has the percentage of deliveries in the measurement period in which the women received an influenza vaccine, the percentage of deliveries in the measurement period in which the women received the Tdap vaccine, and then a combination of those...so the percentage of deliveries in the measurement period in which the women received both of those vaccines.

Note that the denominator is the same for each rate and is deliveries during the measurement period with exclusions.

Next slide, please.

A few additional pieces of information about this measure. It is also a first-year measure in HEDIS 2019, and Workgroup members suggested it for addition because maternal and perinatal health have been identified by prior reviews as an area to strengthen the Core Sets. There are not any measures of vaccination for that population in either of the 2019 Core Sets, and this measure can serve as an important indicator of receipt of recommended preventative services for maternal and perinatal health.

Additionally, there are significant performance statistics and disparities in prenatal immunization levels which this measure would support efforts towards illuminating...or eliminating...and also illuminating.

[Laughter]

Prenatal immunizations reduce the chance of hospitalization as well as protect infants from disease such as pertussis.

Those are our suite of measures to discuss. We're going to, as Gretchen said, go through the ones on immunization and then move on. I'll turn it over to Gretchen and David to lead the discussion.

Terrific...thank you, Bailey.

Like we did the last time, let's start with just basic clarifying technical questions that either the measure stewards can help us or Bailey and Margo and others. Are there any questions from a technical perspective? Yes, Marissa?

This is probably due to my lack of knowledge and familiarity; but on the Adult Immunization Status, one of the questions I had when reading it is especially having been in conversations with people lately about trying to figure out when they had their measles shot and trying to find...if your parents aren't around anymore, who do you ask.

On things like Tdap that are 10 years, or the zoster that once you've gotten it you've gotten it, for patients that are in and out of Medicaid and managed care plans, is that information going to be available? And this is just my lack of knowledge.

Hi, this is Lindsey Roth from NCQA, one of the measure developers. Are you able to hear me?

You'll need to speak up, please.

Okay, is this better?

Yes.

I can help clarify this. This measure is reported using our electronic clinical data system's reporting method, and that allows several different sources of data to be able to be used to report the measures. It includes things like electronic health records; and for vaccines that do have this longer lookback period, EHR records could be used...for instance, if the patient reports that they had received the vaccine...and then that is documented in the EHR. That's one method that could be used to collect that data.

Another data source that could be really helpful for these vaccines with a longer lookback period are immunization registries. We know that states, although it does vary across states as to how robust those registries are, this is another data collection source that can be used to get more of these vaccination histories.

Terrific...thank you.

Does that help, Marissa?

Yes.

Okay, Rich.

Rich Antonelli...just a procedural question. The proposed addition for vaccines for adults above 65...why is that in scope for this body of work or for this committee?

Because of the dually-eligible...so there are Medicare and Medicaid beneficiaries. So this would give us insight into the folks over the age of 65 who are also enrolled in the Medicaid program.

Okay, but this measure would only apply to the dual-eligible patients that are 65 and above...not pre-65?

There's already an existing measure for those that are under 65.

Yes.

Many states actually spend more money on their LTSS services than their other traditional Medicaid program.

Yes.

So we're really not measuring immunization rates for these usually very complex individuals. They're older, so they're more complex; medically they have other chronic conditions; and they're susceptible to having bad outcomes when they get into influenza. So that's one of the reasons why; it's a population that is very expensive. Medicaid is paying maybe not the primary dime on the medical costs, but we're paying a lot for LTSS waiver-related—

So in the context of the work of this committee, David, is there a complementary measure for dual eligibles pre age 65?

Yes.

There is.

The answer is, "Yes."

Okay, so this proposal for addition is basically to say can we extend it for those duals?

Yes.

Okay, that's helpful.

The same status as the existing core measure that's already on the Core Sets.

But it is also the one that is proposed for removal, so that's where it gets a little complicated.

I was trying to get my brain around that...thank you.

We're going to put a puzzle together here along this.

Laura?

I guess a related question then for the Adult Immunization Status measure and the Influenza Immunization measure, what are...within the specifications...do we believe that there will be accurate reporting for dually eligible beneficiaries within both of those measures given the data sources that are available from the Medicaid side?

As I read it...and, Bailey, if this is what you'd prefer to do, please tell me...the addition we were looking at on slide 44 is presented as adults 19 years older, as defined. So it would include dually eligible beneficiaries over the age of 65. Was that your question, Laura?

Currently in Pennsylvania, we look at this in our under 65 population. The self-reported rate is 40% across that population across our managed care population. We publicly report that. I'm going to say that that is probably fairly close to reality when we look at some of our Department of Health statistics. So it just gives you an idea that it's not perfect; it is self-reported, and there are barriers in the CAHPS survey.

My question is for the ones that are *not* CAHPS-based, the ones that are administrative- or EHR-based, do we believe that the Medicare claims information or there is some type of data source for dually-eligibles to be able to include them in the measure? I understand the CAHPS piece; CAHPS has its own issues, right? But that would overcome that by allowing for the self-report, but I'm not sure on the other two measures.

I want to ask our NCQA colleagues to clarify.

This is Lindsey from NCQA. One of the things that we do for our HEDIS ECDS measures is we actually require plans to report data by data source categories. So they actually report the number of members who meet the numerator by using administrative claims versus EHR versus case management, et cetera. I think one of the things that we would recommend is potentially stratifying the data by data source category as well, just because right now there is potential variation across states and plans with their access to the different data sources.

I hope that helps, Laura.

Jill?

I think my question was actually the same...can you get comparable data related to the...kind of can you do flu and then can you...is this a duplicative measure in that you can get it for 19 to however old people are versus looking at it 65 and above, 18 to 64? That was sort of my question, so I think we got the answer to it.

Okay, terrific...we'll come down the line here and then go down this side.

Jennifer?

David, I think you may have answered one of my questions; it was around the flu immunization and self-reporting and how reliable that is because I have a feeling when your PCP asks if you've gotten the flu shot, some people may say "Yes" even though they really haven't. I would be curious to see if there's any research out there that sort of supports that one way or another. That's my first question.

Then my second question is around the prenatal immunization and if there's any kind of research that shows where women are getting these immunizations. I'm assuming it's from their PCPs, but are they allowed to get these immunizations from their OB GYNs as well?

Yes.

Okay, that's helpful.

Then the last one that I had was around the Adult Immunization Status. It sounds like obviously that's not a combo vaccine because you've got influenza. There are several that we'd be looking at. So I was just curious about the feasibility and burden since it's not a combo measure. Is that going to be difficult for providers in state health plans to report on all of those different combinations of immunizations for adults? It seemed like a lot upon first reading it.

David, do you want to respond to the CAHPS versus EHR?

I'll refer to whomever is the measure steward for the CAHPS because I personally haven't done any research to answer your question. I feel that it's an important piece of information in our program...the fact that only 40% even reported that they got a flu shot. That tells me we may be overreporting that, and there's a gap there. We have not done any research though that's a match-up to that with some validity. We do look at some of our Department of Health immunization (inaudible). I don't have a better picture of reality. But it's helpful for us, as a Medicaid program, to look at where we're at; and that is self-reported.

Does the measure steward have any perspective on the reliability of data collected through the self-reported CAHPS versus through electronic health records...or any quality expert? There are a gazillion in the room.

[Laughter]

Lindsey?

This is Lindsey from NCQA.

Go ahead, Lindsey.

Lindsey from NCQA.

I'll just make a quick comment that I think overall we think that the Adult Immunization Status measure is a better path forward than using the CAHPS measure. Then I did also just want to clarify about the rates within the Adult Immunization Status measure. There is an overall composite rate that looks at the overall number of vaccines recommended for the population and then the percentage of those where the member actually received the vaccine. We heard stakeholders really do want that kind of bird's eye view approach of quality across all the different recommended vaccines. Then there are separate rates for each different type of vaccine so that you can zero in and look to see where performance is high or low based on vaccine type...so just wanted to clarify that about that measure.

Lindsey, may I ask a technical follow-up question? For states that don't have managed care plans that deploy the delivery system in their Medicaid program, how does the state of Wyoming...to use them as an example...how does the state of Wyoming collect this information if it's HEDIS-based EHR?

Yes, that is a good question, yeah.

I think this is something that we're starting to think through internally at NCQA. We started out focusing more on the managed care plan level but recognizing that this is something that I think we do want to tackle.

This is Sarah Scholle from NCQA. Also, just think about the measure's data sources that would be available to the states. The states have supplied measures from HEDIS when they don't have managed care. In other cases here, the question is...what data sources do they have available? Will they be able to see these immunizations in their claims data, in their registry system and their case management system, or in other kinds of electronic data that they request from providers? So the issue is less about how to apply it than the availability of the electronic data from those different (inaudible).

Terrific...thank you.

Lindsay from New York, do you want to add?

We've done nothing formal, but have sort of benchmarked our CAHPS results with CDC reported results from the U.S. in New York State, and we're relatively close with our CAHPS results. We could even be a little bit higher; we're at about 40% of the 18 and older. If I look at my commercial, it's about 50%; if I look at my Medicaid, it's 42%. So it's hard to kind of relate the two directly.

Moving over to a new data source, you're going to have a wide variety of scores that come in across states. Some may be really good at collecting this, and others maybe have data lock. So we could certainly learn from each other. I would say we're years away from accurately saying definitively this isn't a data issue; this is a quality-of-care issue. It's going to be a journey.

In our state, our immunization registry is not mandated for adults. We've looked into this data source pretty closely for other reasons, and that was kind of disappointing. We're rock stars with our kids. We can use our registries. We have two registries in the state. We use them reliably for the child measures; they're excellent. But with the adults, there's not mandated reporting; so it's completely unreliable at this point.

Terrific...yes?

Rich...and you asked one part of the question about non-MCO states. I just wanted to ask...and maybe it gets to what Lindsay was saying...do most states use the ECDS for their child immunizations because you have the HEDIS child; or is there a different source for the children?

This is Linette from California. We currently are doing our immunization reporting for children using what managed care plans report, and they are using a combination of their chart reviews and immunization registry in the state. We're looking to move to using the immunization registry like New York, but we're in the process of doing that transition. We would have the option of using the immunization registry for adults as well.

One of my program areas is the EHR Incentive program, so I can tell you it breaks my heart that we use a telephone survey for flu vaccine as opposed to registries. But as we move forward, that might be something to think about, how we transition from telephone surveys to registries. We've done a lot of investment in EHR incentive programs, mainly program interoperability, et cetera. But inherently if a state doesn't require the reporting, it's going to be challenging.

David?

Thank you, I have a similar question to Gretchen and Jeff's; but I would also add Medicaid is also a situation where a number of patients move in and out over time. So with quality measures that look at 5- and 10-year frames, not knowing a lot about these registries, to what extent would these efforts be contiguous between plans if patients were to shift in or out of Medicaid? I happen to be looking at you because you were speaking, but really for the NCQA people more than anything.

Hi, this is Lindsey. Our proposed Adult Immunization Status measure does require continuous enrollment throughout the measurement year. That does not exactly align with some of these lookback periods; but because we're allowing these other data sources, this is just a case where the continuous enrollment does not exactly line up with the lookback period for some of these vaccines.

Do you mean to say then that for some of these measures that do rely on a 5- or 10-year time frame would you expect to be eligible for the measure that says patients or the clients would need to be continuously enrolled in Medicaid for the 5- to 10-year frame as well?

No.

So currently they would only have to be enrolled in the proposed measure for the measurement period.

Part of the logic here would be you're responsible for checking on their immunization status. You might not give it, but you would know what it is. The data could come from the electronic health records or a registry that shows what was done in a (audio break). It's actually better than using administrative data that would just be from the time period you're enrolled. The question is if it's better than a survey where you ask somebody about what you've had and the bias from people responding or "I don't remember."

Perfect...Amy?

And that sounds great. This is Amy Mullins. That sounds great, but this is kind of a direct follow-up to that. I think I heard Lindsay say earlier that New York State isn't going to do any EHR extraction to get their measures?

We're moving in that direction.

So I think that these things are going to come to a head, where that's not actually going to be feasible; and you are going to have to have the actual claims data in the lookback on these measures. And there's going to be a gap there to not rely on the EHR extraction, and that goes back to provider burden to actually get that data somewhere as well when it's not in claims. So you need to be cognizant of that.

The other thing I'm going to say while I've got the mic on is flu shots, flu shots, flu shots...they are so hard to track. How many people actually got your flu shot in your PCP office? How many people got the flu shot in the airport, CVS, Walgreens, or somewhere else? So, point made.

For those on the phone, many hands went up to the second question, only a few to the first question; and so that's important. We'll go to Carolyn; and then we'll come back to this side of the table, which has been so patient.

I think my comment kind of echoes what many others have said. I just wanted to clarify one point because, Sarah, I think your criticism of the CAHPS was it relied on patient recall; but then I think I heard Lindsey say that for the physician who does not have documentation...and again, I am concerned about the churn having worked in Medicaid for a number of years...but I thought I heard somebody say if the clinician does not have documentation because the patient might be new to that practice, they would also be relying on patient recall, so I wasn't clear what the difference was.

I guess the second part of that question would be has this been piloted somewhere using this prescribed methodology here?

I'm going to let Lindsey respond.

Yes, so we do in our HEDIS guidelines have guidelines around how patient-reported information can be captured. It can't be just something like the patient says, "I got the flu shot." They need to know, I think, the exact date that it was received or at least month and year. So we do have some specific guidelines in there so that we're making sure that the data is valid. Does that help answer your question?

It sounded like you were just saying, if I heard you correctly, that you rely on more than just the patient recollection. I'm still not quite clear on what that clinician would be relying upon if they couldn't get the old medical records because the patient may be coming to them from a totally different health system where they may not have access to that EMR system. So apart from asking the patient, I'm not clear how else that clinician would base their decision.

Yeah, so I think, for example, some of the things that we require is that any member-reported data could be something like providing their medical record or a response to a standardized assessment...so something that's delivered in a standardized fashion and structured data that would be accessible. So it's a little bit more than just the patient saying, "I got this vaccine."

Thank you.

Sally?

First, I think ECDS maybe provides a lot of opportunity with many different options in which to collect the data and populate measures. What I don't understand...and I think it goes to some of the questions that I've heard so far today...is how much this has been tested for feasibility at the state level for Medicaid. I'm interested in whether or not NCQA had an opportunity to test the measure's feasibility at the state level.

Then also, especially around immunizations but this applies to all ECDS measures; but I think with the immunization (audio break) of the registries, case management (audio break) and data sources.

The other is also related to the first-year positioning of the measures, which is fantastic. They've been implemented broadly; but it means that NCQA still has some decisions to make in terms of them going. So I'm just wondering what the implications of that is in terms of putting them on the recommendations for Core Set this year versus next year when they would have had the opportunity to go through final NCQA measure developer thinking and (inaudible). But first starting with ECDS testing at the state program level.

Lindsey, do you want to respond?

Yes, for the immunization measure specifically, we did not test at the state level. We looked at managed care Medicaid plans only and commercial plans.

And how did it go? Were they consistently able to submit the immunization measures through ECDS; or we just see opportunity that this will, as they improve in collecting that data, it will be an alternative to the existing measurement approach?

Yes, so we did see some variabilities in our field tests; however, I will say I think the prevailing wisdom right now is now only integrated plans will be able to do this. But we did actually find that not just integrated plans were able to feasibly report the data; however, that being said, we did see some variation. That is one of the reasons why we think right now it is important to stratify the data by the different data source categories so that we're comparing plans based on what data they do have access to.

We are currently doing several different initiatives to help provide technical assistance to plans to be able to report these measures. We have several different learning collaboratives currently ongoing, as well as some case studies of plans that have been able to do this successfully. So I think, overall, we know that it's slowing gaining some traction. There is currently limited uptake of the measures; but some plans are able to do it, and I think we want to just keep moving forward. We also think that having these measures in the Core Set will also give states and plans and providers more incentive to continue working on these areas as well.

Thank you.

If I could ask for the PCPI measure steward to answer the same question that Sally asked, which is can you speak to how the influenza immunization measure that we're considering was tested at the state level, if at all?

[Pause]

Okay, never mind...it doesn't appear that PCPI is on the phone. Does anyone in the room have a perspective on that question?

I did note it’s specified at the provider level. That was one of my questions as well. I wasn't sure what else has been done with the (inaudible) existing measure.

Perfect...Shevaun?

I have a technical question. Have states had any difficulty acquiring Medicare CAHPS results for the flu vaccine?

When you say "difficulty"....

[Laughter]

I have kind of a question...does CMS administer a Medicare CAHPS currently?

Yes.

Okay.

The data exists somewhere, so it wouldn't require states to actually administer a Medicare CAHPS. This is an existing data source that could be pulled in from existing places.

It's a great question, Lindsay. I think we have to look into whether it's disaggregated according to dual eligibles. I don't know the answer to that.

Given the differences in our states, probably the majority of folks (audio break). That's why our LTSS product, where we have dual eligibles, I would really like to know what is the (audio break). We could go into it; we get some of the (inaudible) claims (inaudible). There are other ways we can (audio break). Again, many states have less secure (audio break).

It sounded like a state did have actual experience, so was it challenging getting access to the results?

Getting access to the data wasn't so challenging. I think what was more challenging is a measure for seniors that relies on recollection.

[Laughter]

So what you will find is virtually every Medicare Advantage plan has strategies...sending out reminder postcards to their members to ensure first of all they are compliant with their vaccinations, which is a good thing, but then also reminding them maybe that they had them. It's recollection, and you're dealing with a specific population.

All right, so I'm going to keep us on track. I've got Tricia and then Jill and Kim, and then we'll start to conclude our dialog. We'll still have opportunity for public comment, and then we'll move to the voting and further discussion as needed.

Tricia?

By the way, I got my flu shot at Rite Aid; and my primary care provider knew when I went in for my annual that I had gotten it. So I was impressed with that.

Okay, so this might be a moot point because if we vote to eliminate the current immunization for adults, we probably wouldn't add the other one for older adults. So as a child advocate, I'll show my naiveté and ask if this was a Medicaid measure and Medicare is responsible for primary care of our dual eligibles and measures are supposed to be actionable to show improvement, what are the Medicaid agencies supposed to do with the data on the dual eligibles who are not immunized when they don't even contract with those providers necessarily for that care?

I'll respond to that. In our state, we have LTSS managed care. We have what's called a MIPPA contract with our aligned or not aligned (inaudible). We actually hold them accountable. So if I know that Mrs. Smith hasn't gotten her immunization and her husband has the primary responsibility, actually in our contract, we expect our LTSS managed care plans to coordinate care by legal contract with these MIPA plans or other Medicare Advantage plans. But we hold our plans accountable because even though they're not the primary payer for that particular service, they are supposed to be sharing data with – they're supposed to be coordinating care with – those D-SNP programs. That's one of the problems with...well, Medicare sometimes if they have a MIPPA contract that CMS requires makes our plans interact and coordinate care with those Medicare (inaudible).

Would that be common among states though?

I suspect CMS requires anyone who is doing LTSS—

[inaudible]

Okay, great, thanks.

Tricia, Jill, and then Kim. Oh, and if people could speak directly into the microphone, the people on the phone are having a little trouble hearing us. No, I got that before you spoke, Lowell. That was my little note that Bailey passed me.

Go ahead.

I just wanted to come back to the issue of the immunization registries. Those are not Medicaid registries. They're usually public health. They're all anybody, all insurers. So moving from Medicaid to CHIP to commercial insurance and back, your data should be in there if your practitioner is using that database. So it's not the kind of thing that would be in there only if you were in Medicaid and then if your family is seasonally employed or whatever, so you have time that you're on and time that you're off. It should still all be reflected in that immunization registry.

Now, there are always issues with getting data back and forth and that sort of thing; but that's the purpose of the registry.

Terrific, thank you.

Kim?

I agree with a lot that has been said. What I would say though is for both of these, the Adult and Prenatal, are really focused on the outcomes of why we're measuring these types of things and the different racial disparities that still occur in both the prenatal and the adult immunization. I think data sources are improving; and with that, I think we need to kind of grow and evolve with that so that we're able to accept these new data sources, whether it's electronic health records or another source.

I'm really looking at from the prenatal side of what that immunization really means and if we measure it, how we're protecting all of the infants that don't have that protection when they're born. And with all of the increases in these diseases coming back into the United States, it's very important that Medicaid really put an emphasis on measuring the status of prenatal and adult immunizations.

Terrific, thank you.

Are there any comments? We've got a couple of tent cards up, but I think they're historic.

Sally, is yours up again? Do you have another comment? Okay, please go ahead.

No, we've moved into the just general discussion. We're not very good at distinguishing the two, so we're going to mix them together. Thank you.

This is Sally Turbyville. I did want to add on to what Kim said. It's been a long time since I've seen a measure...and I'm talking about the Prenatal Immunization measure in particular, that's tied to such huge differentials in outcomes where they've found that getting a flu shot at the right time while pregnant reduces the woman's risk of hospitalization by 40%, that young infants are at great risk of pertussis which we know, and that immunizing mothers in their third trimester protects 9 in 10 babies from pertussis. I mean, it's been a long time since I've seen an intervention as simple as an immunization technically, politically not so simple for many reasons.

I think where I sit right now is I really struggle with what to do in terms of making a recommendation for the Core Set for *this* year, given questions about [inaudible] I do think there's a lot of opportunity. I'm excited that NCQA is looking at ways to pool information from a varied amount of electronic sources. But

I'm wondering, and maybe the states could weigh in... if you show first your status, it's also not only a first-year status measure, but it's using very new data collection methods. Even if an improvement is new, is it ready for Core Set 2020; or do we encourage, or at least I would, if I voted "No" it would be because I wanted to come back next year and find out how it went and working more with states, et cetera. If I were to vote it down, that would be the only reason.

Yes, I haven't seen a measure tied to outcomes like this in a really long time.

I appreciate that perspective. I will just share from a state that does not have Colorado physical health managed care, I have significant concern that this is framed as only a managed care frame. I get that people use HEDIS that are outside the managed care system. But there are a lot of rural states in the West that don't have the population nor the interest...the state of Connecticut purposely is not a managed care state...so that also gives me significant pause, despite the clinical excitement that we could really improve lives. So I think there are a bunch of considerations on there for sure.

Shevaun, did you have some additional comments? Okay.

Anyone down there...Linette, go ahead. Lindsay first and then Linette.

I have one kind of similar to that theme. So just operationally and just going forward, when you put out a first-year measure for the Core Set and don't give us pilot test data, I'm feeling like I don't have enough information to really make a decision. So I would recommend that going forward when you have measures in test status, when you have a first-year measure, those could almost be triaged. It might be good to have a discussion, but I don't think that us voting on a first-year measure that no state has any experience with at this point is a good idea. So I'd like that recorded in the report.

Yeah, we appreciate that. Just to give everyone comfort, there was a base review done by Mathematica staff that it met sort of general minimum quals for lack of a better word; but your point is still well taken.

Let's begin to move toward public comment. Linette, we'll have you be the last. Then again, we'll have a chance for group discussion after a motion is made; but we want to keep our train moving forward here.

Go ahead, Linette.

Echoing some of what's been said, but...gosh, I'm sorry, I had this thought and then....

[Laughter].

Sally had one more thing to add, so we'll go to Sally and then come back to you.

Thank you so much.

Yeah, no problem.

Just quickly, there is state experience with the prenatal immunization measure. California is a huge advocate for this measure. In Medi-Cal, they've already noted differences; and it may be worthwhile for NCQA to explain what "first-year measure" means. It's NCQA terminology; it doesn't mean the measure hasn't been tested. But anyway, I just want to put that correction out there.

Sure, thank you.

I remembered, thank you.

It worked.

It did work. One of the things is I just wanted to respond to the comment about whether it's HEDIS and whether there's managed care or not. When we've been running the measures in California, we take the

Core Set measure and we run it for the state. So again, we're running against the data warehouse. So if a managed care plan is reporting the measure in California, then we take a look at our administrative data; we identify the denominator based on the eligibility requirements; we pull those folks out; and then we run that measure against everybody else that's left, so to speak...so fee-for-service, sometimes one managed care plan, sometimes another. And then we combine it and make it a statewide number.

So HEDIS isn't just managed care. We're running HEDIS for the state. We're treating our Medicaid plan as a plan and running the HEDIS measure for the plan. So I would just caution against the idea that HEDIS is only a managed care. We using that as a way to do apples-to-apples comparison, whether it's fee-for-service or managed care; and what we're using for the continuous eligibility is the time in Medi-Cal as opposed to the time in a plan.

Yes, and I appreciate that perspective. I'm not sure every state does it that way; I appreciate your perspective though.

Right, but I think that's one of the things that as we're shifting as we look at administrative data, and if you want to actually cover the whole state not just those folks in managed care. I mean, we have a few states that are 100% managed care; but for the most part, we're 80% to 90% managed care. But that still means we have a couple million people in fee-for-service. Anyhow, I think it's important that we look at it that way.

And we've appreciated having specifications in the Core Set measures because they're in the public domain. So we point to them; we use them for definitions. We use the value sets to help create consistency. It's more than just the measure that we get value out of in that respect as well.

Terrific, thank you.

All right, I'm going to ask that the Workgroup pause; and we're going to create the opportunity for public comment. Again, first here in the room, you have two minutes to submit your public comment to us including our federal liaison partners. If you are on the phone, be prepared; you'll have the opportunity, if you so choose, to also submit your public comments.

This is Laura, CCDC. I think I'm a federal liaison, and I think I'm a member of the public here. I'm going to share some of my two minutes with my colleague from the National Vaccine Program.

I want to reinforce a couple of the fabulous points you made in the beginning in response to a few things I heard. It bears emphasizing, first of all, that the flu 65-plus and the adult immunization have some duplication. So the flu is obviously 65-plus just flu; the adult immunization is 19-plus, and it's influenza, tetanus, diphtheria, pertussis, zoster, and pneumococcal. That combined measure is recommended by ACIP. CDC puts forward. The National Vaccine Program is aligned with.

It addresses two important gaps. First, we know that vaccination among adults are low; and we know that receipt of vaccination by adults on public insurance is lower than others. So we feel that those are important gaps. And other areas that the adult measure is aligned with is Medicare Shared Savings Program; so we see nice alignment with the use of the adult measure.

I want to turn to you to add some technical...I don't know if you get your own few minutes.

Yes.

Thank you. This is Alice Tsai. I represent the National Vaccination Program Office. Thank you for the opportunity and for us to help serve as a federal liaison. I just wanted to share with you that given my understanding of the charge, the Workgroup is to look at the measures as a set...so to potentially support the strengthening of the Medicaid program and our beneficiaries.

So when you look at the set, right now with 49 patient preventive services, there are already childhood immunization status as well as immunization for adolescents. And by way of the inclusion of the adult

status as well as prenatal, essentially you're covering the entire vaccine with immunization quality measures across a lifespan with the ultimate goal of...I mean, I think earlier we asked about the superpower. I wish I got asked because my superpower would be to eliminate all infectious diseases. Thank you for the time and comments.

Sure, thank you.

Others in the room for public comment...no?

Brice, is there anyone who has identified an interest in commenting from the phone line?

We don't have anybody at this time. As a reminder to our callers and our webcast audience, you can raise your hand to make a public comment by pressing "5*" once you have joined the teleconference line. Again, instructions on doing that are listed on your Web console.

[Pause for audience response]

We actually do have a comment now, so I'm going to unmute the caller.

You'll hear a brief message come through your line. Once you hear that, you can state your name and affiliation and make your comment at this time.

Hi, good afternoon, everybody. This is Abby Bownas. I'm with the Adult Vaccine Access Coalition. We are a diverse coalition that represents patients, public health, provider groups, innovators, registry experts. We just wanted to voice our strong support for adoption of the Adult Immunization Status measure. We believe that the HHS National Vaccine Program Office and the Centers for Disease Control have worked in strong collaboration with the National Adult Immunization and Influenza Immunization Summit to develop and test this composite for adult immunization. Having flu, Tdap, shingles, and pneumonia as part of this has been a success and has been tested out in the Indian Health Service Program.

So we're very excited that it's currently being rolled out as part of HEDIS 2019. I would just note that similar composites have also been developed for the maternal immunization. We've also seen them in end-stage renal disease patients. Having an immunization composite would provide a single focal point to promote adherence to adult immunization clinical standards of care, which is really about finding out what the patient has had, what vaccines are recommended...either vaccinating or referring out to the pharmacy for vaccines...and then capturing that data.

We believe that having the composite in Medicaid would put vaccine coverage rates into the larger context, and it would encourage a more consistent approach for all vaccines. It would be complementary to similar composite objectives that are currently included for both childhood and adolescent immunization status. It would also provide a robust means to monitor immunization coverage among at-risk populations at the national level.

So overall I just, again, wanted to thank you for considering this. We believe that it will provide meaningful national picture to access; and we are looking forward to further conversation on adoption of the composite. So again, thank you very much.

Thank you very much, Abby. We appreciate your concise, within-two-minute comments and the background that you provided to the Workgroup.

Brice, is there anyone else who has identified themselves as being interested in commenting?

No one at this time. So again, a reminder..."5*" once you've joined the teleconference to raise your hand.

[Pause for audience response]

Thank you, Brice. I think we're going to conclude the public comment period. We appreciate the federal liaisons sharing their perspective, as well as those who have joined by phone...again, trying to make this open and transparent.

We are going to move now. This is a little awkward because the motion is going to be to recommend removal or addition to the Core Set, since we're going to vote. Or we could take a first motion around a recommendation to remove, have the vote on the removal, and then a group of additions. Is there a preference among the body...lump them all together, separate them out? Lumping...we don't do technical versus content; we're going to just lump.

[Laughter]

So we need a motion to recommend removal or addition to the Core Set for the immunization measures.

Move to lump.

[Laughter]

Second.

And we have a second to the move to lump, excellent. Again, what we will do is while we are going to consider these each individually, I want to just rely on the committee. There is some interaction between a couple of them. I know people have a lot of passion around this issue. As Margo had said, the report will contain the body of our dialog not just these final votes; so there will be some context to the final voting as we move through this.

I don't believe...are there any disclosures of not able to vote on this one?

No.

All right, so the number that we're aiming for is 28 for completion.

Bailey?

Okay, so we're going to do our first measure vote for the immunizations. This is Measure Vote No. 4. This is a removal vote, and this is the Flu Vaccinations for Adults Ages 18 to 64 measure. You will be pressing "A" if you recommend removing this measure from the Core Set; and you will be pressing "B" if you do *not* recommend removing this measure from the Core Set.

Can I first ask everyone to please power their remote back on using that orange button? It will say "Ready." Is everyone's remote ready? Excellent...okay, we are now going to open voting.

Steve, please open voting.

[Pause for voting]

All right, the voting is closed at 28 votes; and we'll see the results.

Okay, so there were 61% of the Workgroup that voted to remove this measure from the Core Set; and there was 39% that voted to *not* remove this Measure from the Core Set. This measure was not recommended for removal from the Core Set because it did not meet the two-thirds threshold.

Now we'll move on to the next measure vote. This is measure Vote No. 5. This is going to go for an addition. This is for the Flu Vaccines for Adults Age 65 and Older measure. As a reminder, again, this is for the addition. So you would press "A" if you want to recommend adding this measure to the Core Set, and you press "B" if you do *not* want to recommend adding this measure to the Core Set. But before we do that, can everyone please press the blue button on your remote to refresh it.

Steve, please open voting.

[Pause for voting]

Great, voting is closed and we'll see the results.

[Pause]

For the Flu Vaccinations for Adults Age 65 and older measure, 29% vote to recommend to add it to the Core Set; and 71% voted to *not* recommend adding it to the Core Set. So this measure did *not* pass for recommend of addition to the Core Set.

Moving on to Measure Vote No. 6, this is the Influenza Immunization measure; and this is an addition again. If everyone could please press that blue button to refresh your remote. Again, "A" is "Yes," you recommend adding the measure; and "B" is "No," you do *not* recommend adding the measure.

Steve, please open voting.

[Pause for voting]

Is there a problem? We can revote.

Okay, let's go ahead and see the results. This is the Influenza Immunization measure. We can go ahead and show the results, yes. So 21% of the Workgroup recommended to add this measure; 79% recommended *not* to add this measure. This measure did *not* pass recommendation for addition to the Core Set.

Moving on to Vote No. 7 for addition...this is the Adult Immunization Status measure for addition to the Core Set. If it's helpful, just as a reminder, this is the NCQA measure. Again, you will be voting "A", yes, I recommend adding this measure to the Core Set; "B", no, I do *not* recommend adding this measure to the Core Set. Before we start, please press your blue button on your remote, if you have not already, to refresh it.

Steve, please open voting.

[Pause for voting]

Just check your remote and make sure it has a letter on it.

[Pause]

Everyone see "A" or "B" on their remote?

[Pause]

Yes, maybe everyone just click your choice again and see if that catches us up with the last one. Excellent, we learned something.

[Laughter]

Okay, so we'll move on to the results. For the Adult Immunization Status measure, we had 54% of the Workgroup vote "Yes, I want to recommend adding this measure to the Core Set" and 46% vote "No, I do *not* recommend adding this measure to the Core Set." This measure is *not* recommended for addition to the 2020 Core Set.

Moving on to the final vote for the immunization measures, this is the Prenatal Immunization Status measure. If everyone could press that blue button again. Just as a reminder, "A," is "Yes, I recommend adding the measure," and "B" is "No, I do *not* recommend adding the measure to the Core Set."

Steve, please open voting.

[Pause for voting]

Great, we'll see the results. This is the Prenatal Immunization Status measure result; 61% voted to recommend adding the measure to the Core Set, and 39% voted to recommend *not* adding the measure to the Core Set. This measure did *not* pass for addition.

So great job, again. We went through the first softball. We, I think, played baseball pretty well, which is excellent. Is everyone needing like a five-minute stretch break before we move on? Mentally I think it would be good for us, so let's take a quick break if we could. Stand up, stretch, use the restroom if you need to; and then we'll come back and come into the next set of measures.

[BREAK]

All right, I'd like to ask folks to take their seats, please.

So really appreciate having had the chance to take a little bit of a break. During the break, a couple of people I think wanted to raise the question of sort of how all of these votes are so close. After having such a nice, robust conversation, we actually haven't made a single change yet to the Core Set...just going to say it out loud. To some extent, that may be okay because one of the things we talked about early on from the State context perspective is less change is sometimes easier.

But I do think that a couple of people are questioning the two-thirds threshold. What will we be prioritizing with our 10 stickers on Thursday if there are only six measures or something? So I guess what I wanted to do is just want to acknowledge that tension because I think a lot of people felt it at the break and to also say that we can figure this out. We haven't had a chance to discuss it here, but there certainly is the opportunity for us on Thursday to go back and look at close votes.

What I would ask if we do that is that there isn't active lobbying of Workgroup members between here and there. That can happen, and that's not what the pause is about. The pause is about us making sure we're doing our task, which is to be stewards of the Core Set. So if there is tension, let's acknowledge it and then agree that we can find a path through it...create some sort of structure that if it was above 50%, let's revisit it; if it was less than 50%, we think that maybe that was the consensus of the group...or whatever the metric, I don't know what that is on the fly here. But I didn't want us to move into the last big set of the day without acknowledging the sort of twitter that was at the break.

Does anybody else want to add to that dialog...yeah, Sally?

I agree, and I think that's great that we can revisit after going through this because there can be fatigue throughout where we get easier and easier and make sure that those measures first up weren't hit the hardest.

Sure, I think that's great. So let's do that.

Yes, Laura?

(inaudible) the feasibility criteria.

And again, that needs to happen whether something makes the Core Set or not because I think a lot of what we just got done discussing, whether it makes the Core Set or not, needs to move forward. We need to move forward with electronic measurement and data collection and to be focused on preventative things like immunizations. So once again, just because something didn't get the thumbs up here doesn't

take it off the priority table. Everything we've talked about here for me, as a Medicaid program, is a priority. Just because it didn't make it or our recommendation to CMS isn't that this should go into the Core Set still, as states, we're going to take these back. I'm going to go back and look at those dental measures, I can guarantee you.

I want to advocate again that the immunization measures, especially the electronic measurement, it is the way of the future. For us to think that we're going to continue using administrative data runs is silly after we've invested in all of the electronic health records that are being used for productivity. Again, I'm actually very positive even though we didn't give anything with a thumbs up. I think on Thursday we are going to come back to maybe some of this discussion. I think it's important. I think CMS is in the room taking notes. They are hearing the discussion. Even though there's a thumbs down vote. I'm sure they're noting the discussion and the close vote. So, everybody, don't get discouraged. We need to (inaudible).

Yes, thank you for everybody committing to that; and those comments are super helpful, David.

What we are going to do in our next endeavor is dive into the Other Primary Care Access and Preventive Care measures. Bailey is going to walk us through them. There are a number. We're going to ask Bailey not to go a gazillion miles an hour. I have a sister in (inaudible) with her. So, please, we'll take the time we need; but this is our next big task. We will keep the process consistent, acknowledging though the conversation that we just had.

Bailey?

Perfect, thanks, Gretchen.

First, I want to just do a quick check on the measure stewards. I know we have NCQA in the room and on the phone. I was curious if we have a representative for the Preventive of Care and Screening Body Mass Index Screening and Follow-up Plan measure.

I believe that's a representative from CMS that should be on the phone. Are you there?

[No response]

It might also be a contractor. Just a reminder...if you're a measure steward and you're trying to speak, we sent specific instructions in e-mail; or you can use the Q&A Chat, and someone else will assist you.

Do we have anyone representing the Pediatric Measurement Center of Excellence?

[No response]

Quality Insights is on for the BMI measurement.

Great.

Anyone for Patient Family After Developmental Screening?

[Pause for audience response]

We'll work on that as we go through.

As Gretchen noted, this is a big group of measures; and these are the other measures in the Primary Care Access and Preventative Care domain, so the non-immunization measures. I'm going to first talk about the ones that are in the 2019 Child or Adult Core Set. There are eight measures in the Child Core Sets currently and five measures in the Adult Core Set that fit within this domain.

The first is the Body Mass Index Assessment for Children and Adolescents measure. And this is one of the measures that is suggested for removal, so I'll dig in a little bit in a few minutes about this measure.

And it is a measure that looks at the percentage of children ages 3 to 17 who had an outpatient visit with a primary care practitioner or an OBGYN practitioner and who had evidence of body mass index percentile documentation during the measurement year.

The next measure in the Child Core Set is the Chlamydia Screening for women ages 16 to 20. And this one is the percentage of women who were identified as sexually active and who had at least one test for Chlamydia during the measurement year.

The next measure in the Child Core Set is the Screening for Depression and Follow-Up Plan Ages 12 to 17. This one looks at the percentage of beneficiaries in those ages who were screened for depression on the date of the encounter using an age-appropriate standardized depression screen tool; and, if positive, a follow-up plan is documented on the date of the positive screen.

The next Child Core Set measure is the Well Child Visits in the First 15 Months of Life. This one measures the percentage of children who turn 15 months during the measurement year and who had the following number of well child visits with a primary care practitioner during their first 15 months of life. So it's basically one through six well child visits.

The next measure is the developmental screening in the first three years of life measure. This one is the percentage of children screened for risk of developmental, behavioral, and social delays; and it is using a standardized screening tool. This needs to happen before their third birthday.

The next measure is the Well Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life. This one is the percentage of children ages three to six who had one or more visits with a primary care practitioner during the measurement year.

The next measure is the Adolescent and Well Child Care Visit measure. This one is the percentage of adolescents who had one comprehensive well care visit with a primary care practitioner or an OB GYN practitioner during the measurement year.

Next slide, please.

For the final child Core Set measure that's in this domain, this is the Child and Adolescents Access to Primary Care Practitioners measure. This one looks at the percentage of children and adolescents who had a visit with a primary care practitioner, and there are four separate percentages for this. I'll dig into this measure a little bit more when we discuss it because it is one of the measures that was recommended for removal...I should say suggested for removal.

Now I'll go into the Adult Core Set measures.

The first is the Cervical Cancer Screening measure. This measure is the percentage of women who are ages 21 to 64 who were screened for cervical cancer using a couple different criteria, depending on the age of the woman. Again, within your folder there's the specifics if you're interested.

The next measure is the CHL-AD Screening Measure for Women ages 21 to 24. This is the same measure that's in the Child Core Set; it just uses a different age group.

Same for the Screening and Depression Follow-Up measure...again, same measure that's in the Child Core Set with a different age group and then the Age-Specific Screening Tool.

The next measure is the Breast Cancer Screening measure, and this is the percentage of women who are ages 50 to 74 who had a mammogram to screen for breast cancer.

Then the final measure, this measure is also recommended for removal; so I'll dig into it shortly. This is the Adult Body Mass Index Assessment measure. It looks at the percentage of beneficiaries who are ages 18 to 74 who had an outpatient visit and whose body mass index is documented during the

measurement year or the year prior to the measurement year. So that one's a little bit different than the child one.

Next slide, please.

I'm now going to dig into the specific measures that were recommended for removal within this domain. The first one is the Child and Adolescents' Access to Primary Care Practitioners. As I mentioned, this is looking for children age 12 months to 19 years who had a visit with a primary care practitioner. Depending on the age of the children, the rate is looking at a little bit of different things.

For children ages 25 months to 6 years, it's looking for one visit. For children ages 7 to 11, it's looking for a visit within the measurement year or the year prior. So that's a little bit different for that age group. The measure steward is NCQA. The measure is *not* endorsed; it's an administrative measure.

Next slide, please.

This one does have measures suggested for substitution; but instead of a new measure being added, the member that suggested this measure for addition noted that the three current well child visits that are already in the core set are substitutes for this measure. Then the reporting for this measure...in FFY 2015, there were 45 states that reported it; in 2016, there were 47; and in 2017, there were 48. As a reminder, 2017 is the most recently available data that we have for reporting from the states.

The Workgroup member that suggested this measure for removal is because the measure does not provide actionable results for Medicaid and CHIP agencies. It defines primary care visits broadly, and that functions more as a utilization measure rather than a quality measure. There are other measures in the Core Set that are captured in the measure concept.

Next slide, please.

The next measure for removal that I'll discuss is the Body Mass Index Assessment for Children and Adolescents...we'll get to adults in a second. This, again, looks at children ages 13 to 17 who had an outpatient visit with a couple of different types of providers and then who had evidence of a BMI percentile documentation during the measurement year. It is again the measure steward of NCQA. This measure is endorsed; and it can be collected using the administrative, EHR, or hybrid methods. There has not been another measure proposed for substitution.

Reporting...in FFY 2015, it was reported by 33 states; FFY 2016, 39 states; and then FFY 2017, 37 states. One thing that's important to note: this measure has been proposed for changes, and this is for the ICD 10 Coding Guidelines have changed; and so there are implications for the data collection method for administrative. Starting in 2020, this measure will only look at people for the administrative specifications that were diagnosed with obesity; and so that's a change for 2020 which would affect this measure and have applications for the admin data collection method.

Workgroup members suggested this measure for removal because the measure is a documentation measure and does not reflect the evidence-based practice for quality of care provided for children with or at risk for obesity. Additionally, calculating the measure can require substantial resources when the hybrid measure is used.

Next slide, please.

The final measure for removal that I will be discussing within this domain is Adult Body Mass Index Assessment measure. This one looks at beneficiaries age 18 to 74 who had an outpatient visit and whose body mass index was documented in the medical record during the measurement year or the year prior to the measurement year. The measure steward is also NCQA. This measure is *not* endorsed. It can be collected using either the admin method or the hybrid method.

There is a measure that was proposed for substitution for this measure in the Adult Core Set, and that is a 2017 MIPs measure; it's Measure No. 128. We'll discuss it when we talk about additions, and it's the Preventative Care and Screening: Body Mass Index Screening and Follow-Up measure. This measure was reported by 29 states in FFY 2015; was reported by 33 states in FFY 2016; and was reported by 32 states in FFY 2017. This measure is not included in the Medicaid and CHIPS scorecard; and like the WCC measure that was on the Child Core Set, due to the ICD 10 Coding Guidelines that have changed, the same impact will happen to this measure for the administrative method where it will then only be able to capture people with a diagnosis of obesity. So that will have an impact on the administrative method.

I am going to stop there, and we're going to try again for clarifying questions for the removal since we do have quite a few additions to discuss. Were there any clarifying questions on the three removals that Bailey just went through? We're going to try...discipline...to technical questions.

Lindsay from New York.

So I just don't know how the WCC measure doesn't adhere to guidelines. I guess...and I think I'm struggling probably with the BMI versus the Counseling for Nutrition and Counseling for Physical Activity. So I'm just not clear how that doesn't...I know that BMI is kind of processey, kind of checkbox the way BMI is documented. But the other two, how do those not relate back to clinical guidelines? I don't know...that's a clarifying question more on the rationale for removal.

Looking to the pediatricians in the room....

Lindsay, can you clarify the question because we only have the BMI percentile documentation in the medical record component, not the counseling measures in the Core Set.

Oh, you only have the BMI.

We only have the BMI.

I'm sorry, the question is withdrawn.

The pediatricians are off the hook by Margo.

Terrific, that was an excellent question; and now we're clarified that it is part of that; it's the BMI part that's only currently in the Core Set and up for removal. Thank you.

Other technical clarifying questions?

Sally, yes, thank you.

Quick question...for the Child and Adolescents Access to Primary Care Practitioners, which NCQA is proposing to retire in 2020 as the measure steward, if we don't recommend removal, will there be someone...whether it's NCQA or otherwise...to maintain the measure for states if it remains on the Core Set? Maybe we don't know, but...

Do you know, Margo?

It's a great question. I can tell you what's happened in the past when a measure steward has retired a measure. It has been challenging to get updates to the measure. So I think it's a very, very good question.

Other technical questions on these three removals? Rich?

Are you distinguishing questions from comments?

I...no, go ahead.

[Laughter]

Yes, we're going to go with the lumping.

Okay, good.

The goal is to lump.

Otherwise I was going to say never mind, but I shan't. So a technical comment...I'll limit my remarks to the Child BMI measure. There is no evidence that my checking and recording of BMI and then advising a parent, a child, that they need to exercise and eat more wisely makes a difference. There is evidence that using a model that's more integrated with services in the community, a referral to a place where the child can exercise safely...on a playground, in a school, et cetera...so there are existing models with existing evidence as a more better way of impacting the obesity epidemic.

I'm just pushing back on the real estate issue for this. The number of states that are currently reporting on that I view as important. They should be paying attention to obesity, but I'm really concerned that people will get comfortable reporting a measure for which there is no evidence to advance it. So that's my technical comment.

Terrific, thank you for that. We appreciate it.

Others? Yes, go ahead, Jennifer.

So this actually is sort of in line with what you just mentioned. My question is if we take off some of these BMI measures, does it almost disincent physicians from conducting a BMI assessment? Does it do anything to the Standards of Practice, and is there research to show that? Everybody is shaking your head "No," but I'd love to hear.

From the EHR incentive perspective, it's required under Meaningful Use...like recording it and such. Again, simply recording it in the record is already part of other environments.

I concur as a frontline clinician. This is baked into that data stream that we be able to move the measure into the arena of something that's more evidence-based.

Okay, terrific.

I think we're going to then move to the additions. In particular, there is one toggle between one of the additions. Yes? I was actually going to ask (inaudible) to comment on the Primary Care Access to Care measure and what happens when an SA measure is retired.

Hi, this is Christine Holland from NCQA. Can you hear me?

Yes.

Okay, this is Christine from NCQA. I heard a question about retirement. So ideally when things are retired from programs, we try to work with all the different folks to make sure that we are trying to stay in alignment. So when we remove something from HEDIS, I think usually it's for reasons where a measure no longer demonstrates the same relevance or scientific soundness and feasibility; or perhaps there's no more opportunity for improvement.

We do try to work really hard to coordinate with all the folks who are using the measures outside of HEDIS, and I think that it's really kind of a case-by-case basis in terms of how those measures are being used. We had earlier proposed retirement of the Child and Adolescents Access to Care measure; however, because it was being used in the Core Set and other programs, we did end up keeping it. So I think it's an example of really working together with all the different users of measures to make sure that we try as hard as we can to stay aligned...recognizing that there are probably different reasons for keeping or dropping measures from specific programs.

I know that's not really a direct answer. We do try to work to keep the measures updated, and we're always happy to offer some technical assistance. But at a certain point, we want to make sure that if the measures are retired from the HEDIS that unless there's a really compelling reason to keep it in another program, we try to work together so that we are all on the same page about measures that are useful.

Terrific, thank you so much for that clarification.

One other additional comment on that particular measure and well child visits, there's actually a huge gap when you look at the age span between the Access to Care measure and well child visits. Well child visits do not equal access to care. There are a lot of comprehensive visits. So as a program there is, I'll say, some utility even though it's not a perfect measure in looking at did that child get in. Usually, it's a PCP; but it could also be a specialist.

So there is a difference; and there is, I think, a separate value of this measure compared to just the three age spans of the well child visits. I think other states probably see that same experience in their reporting of these measures.

Thank you.

We're going to move to the additions within this domain...to Bailey.

There are six measures proposed, or I should say suggested, for addition within this domain. The first one is the Colorectal Cancer Screening measure. This measure looks at the patients 50 to 75 years of age that had an appropriate screening for colorectal cancer. The measure steward is NCQA. It is NQF-endorsed, and it is a process measure.

The data collection methods are either administrative or hybrid, and there are a number of different requirements to meet the numerator for the colorectal cancer measure. You can see them on this screen here. NCQA has tested and improved this measure for Medicare and commercial health plan reporting.

The Workgroup members that suggested this measure for addition, it is because colorectal cancer is the second most cause of cancer death among cancers that affect both men and women and the second leading cause of cancer mortality in the U.S. Recent studies have noted an increase in incidence of colorectal cancer among adults ages 45 to 49, which prompted the American Cancer Society to recommend that average risk adults initiate screening at age 45.

There is strong evidence that the screening for colorectal cancer reduces the incidence of death from the disease; and despite strong evidence for its use, only 67% of age-eligible adults are up to date with colorectal cancer screening. They noted that adding this measure to the Core Sets would increase screening among a population that faces disparities in colorectal cancer incidence, mortality, and screening.

Next slide, please.

The next measure for addition that I'll present is the Preventive Care and Screening: Body Mass Index Screening and Follow-Up Plan measure. Note that this measure was suggested to replace the Adult Body Mass Index measure. This looks at the percentage of patients that are 18 years and older that had a BMI documented during the current encounter or during the previous 12 months; and when there was a BMI outside of the normal parameters, a follow-up plan is documented during the encounter or also during the previous 12 months.

This measure has the measure steward of CMS. It is NQF-endorsed. It's a process measure, and it has a data collection method of admin or EHR. One notice that this measure has an update from 2017 to 2018...the frequency of BMI documentation was revised from 6 months to 12 months, so we're presenting the revised specifications here.

Then this measure was suggested for addition by a Workgroup member, and the reason for that was that it is to replace the Adult Body Mass Assessment measure because screening for obesity is not enough to achieve better quality of care for the use of evidence-based follow-up.

Next slide, please.

The next measure that was proposed for addition is the Follow-Up with Patient Family After Developmental Screening. This one looks at patients that are age 6 months to 36 months whose family received a follow-up discussion of developmental screening results on the same day as the screening visit. It has the measure steward of the Agency for Healthcare Research and Quality, or AHRQ; and that's the Pediatric Measurement Center of Excellence. This measure is *not* endorsed; it's a process measure. It was not recommended to replace any measures within the current Core Set. Its data collection method can be EHR or medical record review.

The reason that a Workgroup member suggested it for addition is because an estimated 1 in 7 children have some sort of developmental delay, but only half of these receive treatment before they enter school. Diagnosis and treating delays as early as possible is important to help children be ready for school.

Can you hear me?

Yes.

We will get to you during the measure steward comment period.

This is Donna Woods. I've been trying to get in. So you can hear me now?

Yes.

Hello?

Hi, yes, we can hear you.

Okay.

We will be getting to comments from measure stewards or the public in a few minutes.

Brice, can you please mute the phones?

Okay, I just wanted to make sure I was in.

Yep, you're in. Thank you, we'll be muting public and measure stewards.

The next measure for addition is the HIV Screening measure. This measure looks at the percentage of patients ages 15 to 65 years of age who have been tested for HIV. It has the measure steward of the Centers for Disease Control and Prevention or CDC. It is not endorsed. It is a process measure, and its data collection method is EHR or electronic health records.

The reason that it was suggested for addition is that an estimate 1.1 million people in the United States are living with HIV, including one in seven who are unaware of their status. Approximately 40% of new HIV infections are people living with undiagnosed HIV. The current Core Set does not include a measure to track HIV screening. This measure would track screening, which is central to HIV prevention efforts. It would also allow Medicaid and CHIP to track progress towards ending the HIV epidemic by 2030, an initiative that was launched in February 2019.

Then the final measure that was suggested for addition within this domain is the Lead Screening in Children measure. This is the percentage of children two years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday. The measure steward is NCQA. The

measure is *not* endorsed; it's a process measure. It was *not* recommended to replace any current measures in the current Core Sets. The data collection methods can either be the administrative method or the hybrid method.

The reason that it was suggested for addition by a Workgroup member is because undetected elevated levels of lead in the blood have long-term and metabolic and neurologic consequences; and this measure would focus attention on the issue and increased screening. One state that focused on this topic for many years raised its 2018 statewide average to 80.3 compared to the 2017 Medicaid national average of 68.9.

That ends the presentation of the measures within this domain. I'm going to turn it back to Gretchen and David to facilitate conversation.

Terrific...we'll try again. We did a good job last set. Are there technical sort of specifications or questions that either Bailey and Margo can provide context to the measure stewards? These all seem fairly straightforward.

Yes, Rich?

Rich Antonelli...the lead screening, are there dataflows already that go either state departments of public health and/or to the CDC?

I might be able to answer that. This is Lindsay Cogan from New York State. Our state public health department does track lead screening. Right now, we are engaged in an effort to match their lead registry with our Medicaid data because they have no way right now of parsing out among the children who are tested for lead and have high blood levels who are in Medicaid. So I don't know that there's an existing data source to kind of pull...I think you were thinking along the lines that there might be a reporting mechanism or a way to kind of take an already existing dataflow and then kind of push it into our report.

I don't know other states' experience, but ours is that there's no way currently for them to identify Medicaid children in the public health reporting of lead.

In Pennsylvania, we actually have a data exchange mechanism in place after many years of discussion about a Memorandum of Understanding. But our state gets *all* kids their lead screening results that screen positive. So we actually now have a mechanism in place where we are able to identify those Medicaid kids, and then we usually push that data to our health plans and have them follow up and find out both medically and then whether or not there's some type of home assessment.

But I don't think there's a unified report of states that are all different. I don't think there's anything. The states may report up to CDC, but I'm not even sure about that...if it's done in a uniform fashion.

Our CDC colleagues are saying, "No, it's voluntary."

Just for those on the phone, not a consistent Lead Program at the CDC and not a consistent reporting mechanism.

Linette, did you have a question?

Linette in California...we've been working with our public health program on the childhood lead. Our California statute doesn't allow them to share the confidential data with us. So we share with them, and we've matched up. So we've been working on joint analysis. But we use our claims data as part of the CMS 416 reporting for childhood lead. But when we combine it with the registry data, we get about 10% more. So we know that claims data underreports.

Then to follow up if I could...for those of you in State Medicaid programs, if this was added does it make your job easier; or does it have a beneficial impact on the children or do you still have to work out interagency agreements to actually get us to that level?

This is Linette from California. In looking at this, one of the challenges that we have right now is that the current reporting related to childhood lead is the CMS-416, which has that challenge of three months eligibility, one-year lookback. So it demonstrates a lower screening level that actually occurs. This actually would have a match between eligibility and the lookback period. So it's another way of doing the measurement.

And I would just say from a program administrator's perspective, we looked at those numbers on the 416 with concern. So there was a desire to move those numbers but recognize the measurement challenge. You certainly could put payment incentives or quality incentives in place. But an aligned mechanisms like this would make that easier than just a standard reporting forms that's currently used.

Just to follow up on that, our CMS 416 folks were citing that we had 25% of people getting screened. When we look in the HEDIS, it's more like 60%-plus getting screened. When we combine with childhood lead data at public health, it's upwards of 70% getting screened at least once. So, yes, the way you do a measure matters.

Again, I think the NCQA measure had been around for several years. So managed care plans most likely are reporting this.

Other technical questions around either the colorectal cancer screening, the addition that was in some ways paired with the removal of some of those BMI, the follow-up with the patient family after developmental screening or the HIV screening...any technical components there?

Please, Lindsay.

I had a question related to the denominator exclusion for the HIV screening. It says to remove people diagnosed with HIV, but I wasn't sure how you identify people with HIV for that denominator.

Yes, there's a subject matter expert who's waiting in the wings, we're told, to answer that question. So if that's you, if you could speak.

Or, Brice, if there's someone in the Chat function who identifies themselves as prepared to answer that question from the CDC.

[Pause]

Are there any subject matter experts on for the Centers for Disease Control Prevention?

[Pause for response]

Just a reminder, if you are connected to the teleconference, you'll need to press "5 star" in order to raise your hand.

[Pause for response]

Okay, we'll circle back on that.

(Multiple voices)

Go ahead.

Apologies, this is Liz DiNenno from CDC. Sorry, I was having difficulty getting unmuted. Can you hear me?

Yes.

Apologies...so the question I think I heard was...if you could repeat it, I think it was about do we remove people with previously diagnosed HIV infections; is that correct?

Yes, that's correct. I'm interested in knowing exactly how you do that because with the addition of pre-exposure prophylaxis and other...if you're just using a single diagnostic code of HIV, I just want to know how you are parsing that out in the exclusion.

Right, I guess I'll try to answer the question. Just to be clear, this is really to try to get persons in that age range screened at least once for HIV. So there has to be a documented test, as well as documented HIV diagnosis to be excluded and to be documented...not self-report.

Will you tell us a little bit about how that's documented though? This is where I was struggling with the technical specifications...to understand how that documentation—

Can you guys hear me? This is Abigail?

Yes.

In terms of the technical documentation, so this is an eCQM, people are removed if they have had an HIV diagnosis in any year prior to the measurement year or I think there's actually a specific window around the test as well, but certainly any year prior to. And we use a combination of ICD 9/ICD 10 codes because you're doing a lookback period and so you do have to take into account ICD 9. Because it was an eCQM, there are also SNOMED codes that are part of the technical specifications for the measure to identify people who have a diagnosis of HIV or diagnoses of some other condition that has an HIV association with it. So we try mightily to exclude people with HIV.

We don't rely on drug codes or NDC-type information to determine if people are diagnosed with HIV. So there's no reason that a person who is on preexposure prophylaxis should have an ICD 9/ICD 10 type code indicative of HIV because that would be an inappropriate coding.

Does that answer your question, Lindsay?

Yes, it does; and it's one test ever...right? It's one test ever, not in relation to risk or anything like that.

Your CDC colleagues are nodding over here...yes, one test ever.

And I had a technical question as it related to the Follow-Up with Patient Family After Developmental Screening. I don't know if this is for the clinicians in the room, or if someone can just explain the numerator to me a little bit more. We had a terrible time at the Colorado Medicaid Program getting a level of documentation of a discussion that happened in the middle of a clinical visit. So I was concerned about how we would feel confident in the numerator being patients whose family received a discussion of the developmental screen by a primary care clinician.

We had a series of prevention codes that nobody ever billed us for. It was very frustrating, and we all worked really hard on it; but it just never got coded. It wasn't that those sort of prevention conversations weren't happening; it was just that nobody was coding for them. So is there any perspective on that numerator component of that measure?

I could provide some perspective if it's helpful.

(Multiple voices)

Go ahead.

We tested this measure as an eMeasure, calculated it in the EHR as well as a chart measure. Even when an EHR had a discreet field for this follow-up with the family, about 25% of the time you could only find it in the notes. But it was a noted element. Unfortunately, so we start with the notion of a patient having received a developmental screening with a validated tool. We looked across a number of different types of settings, and approximately 60% of the providers used a validated tool. So that gives you a start.

And then approximately 64% of cases noted in the chart that the clinician discussed the result with the patient/family, which resulted in approximately 38% of the total charts. So it's a measure with a *huge* performance gap.

In addition though, we work with the American Board of Pediatrics to implement this measure and two other measures actually related to developmental screening. In their MOC Part 4 PIMs. When last we looked, which was over a year ago, there were nearly 400 clinicians and approximately 21,000 children included in the PIM. There is a distinct curve towards improvement. So while this is such a fundamental aspect of pediatric care, it is being documented to some extent.

Improving documentation is often one of the challenges and opportunities for quality measurement and making sure that children are receiving a developmental screen with a validated tool, that the parents or family are being consulted. I would suggest to CMS that they also consider looking at for a child with a positive developmental screen—

We're going to actually make the comments stick to the measures. We're going to limit your comments just to the measures under consideration for today, please. Thank you for that technical update.

There were others. I think, Amy and Rich, you had perspectives.

Yes, as a family physician, I'll just be really succinct; it's a checkbox. You do it and you forget to check the box, or you don't do it and you check the box anyway.

Okay...the view from the field.

[Laughter]

I guess I'll come at this from both being a clinician as well as somebody who thinks about measurement. From the clinical side, when these are done this measure actually says document that you had a discussion of the results of the activity that literally just transpired or at least in theory probably just transpired.

Coming at it from the family's perspective would be much more compelling from my perspective. So when Meaningful Use went live, for the entire first year of my involvement as a provider, I was able to document that no two-year-olds were cigarette smokers.

[Laughter]

How good is that? So I don't know that that actually added to quality, but it's an indication of checking boxes. So I struggle with this. I'm not saying that screens don't happen, and families leave those encounters without evidence of the next step; but I am saying that the more compelling point to measure that would be from the family's perspective and not the provider with a checkbox.

Okay.

Bonnie?

I just had some more unique points. One was the measure didn't talk about what to do with a false positive. So there's the MD judgement. So you screen, but then the doc says, "No, you wrote it wrong; you didn't understand the questions."

The other thing that I wondered about with this measure was within a screening visit, was there variation within child so that some children more often screened had more likelihood to pass or not pass?

Are there any clinicians who would offer a perspective?

[Pause for responses]

So, yeah, I'm the developmental specialist at the table.

Thanks, Jill.

I have a couple of thoughts. There are always those kids who are a little bit different, who may not screen positive but that everybody is always kind of worried about. Yeah, you can bet there's a huge conversation going on. Does it get documented? Maybe not. I will tell you from the vantage point of having practiced both general pediatrics and developmental pediatrics, honestly, your child's development is enough because there are other things you need to talk about. That it's normal; that's really enough.

And who is going to, like, say, "I discussed with the family..."? It takes longer to write it down than it does to say it. The other thing was that as a developmental pediatrician when I spent probably more than half the time that I spent with the family talking about the results of developmental testing and what it means, I did not write, "I discussed...." I wrote what I discussed, but it wouldn't necessarily have said, "I discussed...."

So I think when you think about what actually happens in practice and what's valuable to happen in practice, it's like...is it valuable to check the box that a two year old doesn't smoke; or is it more valuable to think about this in a different way? And is it valuable to encourage docs to write, "I discussed that the development was normal," when in fact what you want them to do is you want them to say, "Oh, didn't pass the screen...refer."

Okay, thank you.

I think we've got a couple more on this topic or a couple of the other measures, and then we'll keep the discussion going for a little bit longer...so Jennifer and then Carolyn.

This is Donna. I'll be in the queue. I wanted to clarify for the last speaker.

Is it related to the technical specifications of the measure?

Yeah, this numerator is slightly different than what we created. We were looking for any evidence of the discussion with family. So just writing, "I talked to Mom about this or that," that would be evidence. It doesn't have to say, "I did talk to the parents" to be counted.

So noted.

Thank you for the clarification.

Go ahead, Jennifer.

This is shifting gears back to the HIV screening. I'm familiar with Bright Future as a recommendation on screening; I'm not as familiar with HIV screening recommendations if there are any at all. So I had a question if there are physicians here. I was struggling a little bit with this measure.

If there aren't recommendations or there aren't best practices as to when and how you offer an HIV screening and if it's truly just the measurement is trying to capture once over the lifetime. We know that people shift, they move, have different health plans. How realistic is this measure, and are there standards of care that out there that speak to how often people should be offered an HIV screening within a primary care setting?

Okay.

I personally have never been at any of my annual checkups, so I'm not really sure if there are standards of care out there that physicians follow.

Go ahead, Jill.

So this is actually, I think, a relatively new recommendation that everybody...like everybody...be screened once in their life for HIV.

Do our CDC colleagues want to offer a perspective?

That is correct.

Gabby, are you on still?

This is Liz DiNenno. I can quickly add. I wouldn't say it's new-new. The USPSTF recommendation came out in 2014 or 2013, but CDC made this recommendation in 2006. It's still newer than some.

(Multiple voices)

Jennifer, the answer to the question is, "Yes." There is a standard of care out there that clinicians would be expected to meet.

There is a standard of care, and there is a national push right now...which I think states and feds are all paying attention to, which is to end the HIV epidemic of which screening is a key part. But, yes, this isn't new; there are standing recommendations around HIV screening.

Great, thank you.

Knowing that you may sometimes get screened more than once...but, yes, at least once ever.

Okay...Carolyn and then Jeff.

So I want to address some points that actually apply to both the developmental screening and the BMI. I think both Rich and Jill made a really excellent point. I'm concerned that we're maybe replacing one measure with another measure that is going to lead us down the same path. The old adage was that physicians didn't want these screening measures because if they had to screen, then they wouldn't know what to do with the results...which is no excuse; but that's sort of what we hear in terms of feedback concerns. If I have to screen, I don't know what to do with the results; or there's nobody to refer them to. You hear this a lot with behavioral health.

So I just want to be mindful. I think the BMI is really, really important for both pediatric and adult given the epidemic of obesity in our society; and I think that developmental screening is absolutely critical because it was stated in the proposal the earlier you catch this the earlier you can intervene. So my question is maybe for those who propose these measures, to Jill's point taking the developmental screening as an example, I'm not sure how meaningful...I'm trying to understand how meaningful it is to have a conversation between a pediatrician and a family.

Now, if it's Dr. Antonelli having that conversation, I'll bet you it has a lot of value; but I can tell you personally as a parent of a child with developmental disability, what meant the most to me was getting that referral to early intervention or to a specialist for a workup. So just documenting a conversation...I'm afraid it's just going to lead to another ‘check the box’.

Similarly with BMI...and I read the specifications for that...documenting a care plan, I'm just concerned that primary care physicians are just going to document, "Yes, provided counseling on exercise and diet." So I just want to be mindful that we're not replacing one measure with another measure that lands us back in the same check the box and really doesn't move the needle in these two areas in particular. So I don't know if anybody who proposed these measures or any subject matter experts would like to comment.

Thank you, Carolyn.

I can comment. This is Donna Woods. Many questions in that question. One, it is AAP Guidelines now for many, many years that a developmental screening should be done with a validated tool. That is frequently not done. We did some qualitative work to find out why pediatricians who were in excellent institutions who have great records didn't, and we heard two things.

One was that it costs too much, and it takes too much time; so they prefer to do the eyeball test. Also, in some of the West Coast states heard about don't know what to do; our state, the way they categorize early intervention, it's difficult...things like that.

But this is about the discussion. I agree with you that the referral is the key, and we've found that 14% of kids actually when you go through all things received a referral; so I recommend that you look at that. But still, to have a conversation with the parents at a minimum, doing the screening with a validated tool and having a conversation with the parents at a minimum should be done universally. We found in only 64% of the cases the clinician noted discussing it with parents. So there's a clear performance gap.

Donna, I appreciate that; and maybe some of my pediatric colleagues maybe want to comment further. But oftentimes what that follow-up discussion is let's just observe for another six months. Let's wait 12 months rather than get them into early intervention, be cautious, or get them an appropriate referral to a specialist if there is a specific concern. So again the broader point I'm making here is I just want to be clear. Absolutely, I think developmental screening has to be done; it absolutely should be done. My concern is I just don't want this turning into another check the box. I had the discussion with the parents without any meaningful outcomes coming from that discussion.

This is Gretchen. Lindsay and I are going to intervene...no pun intended...with intervention.

[Laughter]

But obviously, like our perinatal immunization and some other things, an area of great importance to the Medicaid program, an area of shared interest, some concerns about will this measure as constructed and as before us as a Workgroup actually drive the change we want on behalf of the Medicaid population and the providers who are committed to serving them. So this is very helpful.

We have a number of measures, though, that we need to continue to move forward. But we want to acknowledge and share the importance of this issue. So we're going to go around the table, and then begin to move ourselves towards the public comment period and others. So again, we've got both the removal; and then we're in this discussion about the measures for addition. We're just going to go straight down the line.

Lindsay, go ahead.

Our state has been collecting colorectal cancer screening data for several years now. I understand the challenge is the long lookback period, but we enhance health plan reported data with previous encounters for claims that we have in our data warehouse. It's worked out really well; and it's a hybrid measure, so there's a bit of a bump there in terms of opening the medical record. It's absolutely operationalizable in a Medicaid space. I kind of would encourage NCQA to think about that. I think it's hard to think about us coming up with a Core Set measure that's not currently being used in the Medicaid program, so I don't know if NCQA wants to talk to that.

Then my other point is that with lead screening, I don't think it really goes far enough. I don't know that we another immunization-like measure. That lead screening should be happening at the same visit that the child is getting their immunization; so I just want you to look at the correlation between the two. Optimally, it would be great to have a fouled up high blood lead level measure, which is where we want to go.

So I would encourage us to think about where we want to go as we're popping in these measures. Just because they're available, are they the best? Is that where we want to focus? Is that our area for improvement? So those are my two comments.

Thank you very much.

Lisa?

I was just going to comment that kind of the state of the art of quality measures—

You're going to have to speak up a little.

The state of the art of quality measures...we've seen such growth and progress; but at the same time, a lot of the existing measures serve as proxies. They're the best we can get right now. And so I think as we make our decisions and think about where we're moving, there was a time when we were all very excited to have a BMI number in there and be able to track that. And there's a real push to be able to move to meaningful follow-up.

But I think part of what this group does is really signal to the field, "This is where we're moving." We're in the process, if you will, of defining that meaningful feedback. Should be it be to the family? How are we going to measure that in the most meaningful way? Where this kind of gets us to is that conversation and further development on tracking that measure and being able to define that.

A quick ask if NCQA would like to comment on previous comments on the lead screening. Is there a gap in care there in just screening, looking for Medicaid average? And then what other issues? Why not do colon cancer screening within the perceived barriers in the Medicaid population? Can you comment on this as a follow-up to Lindsay's comments?

Hi, it's Christine. Can you hear me?

Yes.

Okay, great...I heard the conversation about colorectal cancer screening. So, yes, that measure is specified for Medicare and commercial health plans. And among those plans, we do see an opportunity for improvement. The rates are about 68%, I think, in commercial and a little bit higher for Medicare.

We are considering adding Medicaid, and we want to open that measure up this year actually to look at adding Medicaid reporting to that measure. So when we do that, our timeline would mean that the earliest would be probably proposing it and releasing it for public comment in spring of 2020. Then if it gets approved, it will be published that summer in 2020. So that would be the timeline, but we are planning to look at Medicaid for that measure.

Perfect, thank you.

Do you have any additional comments on the lead screening measure?

Yeah, so was there a specific question about lead screening? I missed that.

Looking at your average results for Medicaid for lead screening, I don't know where you're at with whether or not there's a huge opportunity there. Are we assuming that everybody's doing a lot of lead screening? Don't know.

The lead screening results are...yeah, so the average is about 69% if you look at the differences between the minimum and the maximum. In the 50th percentile, the rates are in the 30%s. In the 75th percentile, the rates are 80%. So that kind of gives you a sense of the range, so you can see there is quite a range there across Medicaid plans for lead screening.

Thank you.

Thank you.

Marissa?

I've got a question for the Medicaid directors and medical directors around the table. If my memory serves me correctly, which it might not, in the last couple of years we've discussed a similar if slightly different HIV measure. I seem to remember most people saying or most programs saying that while it was an important measure, it was information that they couldn't get to because of confidentiality concerns. It may have been that wasn't a "did you" test, but more along test results. I don't remember the details. But I just wanted to make sure that there weren't those concerns before we get to voting on that.

I would say that this is probably a little bit different in that the measure that's currently on the set, I believe, is looking for evidence of viral suppression...I believe. So that means that person is HIV positive, and there's a lot of...for instance, in our states it's one of the few we don't report because we have very strict confidentiality laws; so it's a barrier. So this is, I think, different because just looking for whether or not somebody got screened for an HIV blood test. So you're not divulging any confidential information.

Do our colleagues from the CDC want to add...yes?

That is correct. This is Liz from CDC. The other measure is the viral load measure that I think you're referring to.

This is Abigail. There was, long ago, some state laws that raised additional challenges around confidentiality. Those have largely gone away since CDC introduced its recommendations in 2006. So there really are no challenges that we're aware of with this measure related to confidentiality.

I appreciate that perspective. This is Gretchen Hammer. I think there are folks in the room who are working in states who disagree with that assessment.

What I was going to add is there was a discussion at the CVCN that's how to help sort of overcome that perception or barrier.

There is an understanding about its perception.

No, I understand. We discussed this within the last few years, and there were states that said they couldn't. And I just wanted to hear from the states to make sure that I don't hear the same thing again.

So, yes, it is clearly a barrier still in some places.

And I just want to make sure that we're also not conflating this with the viral load measure, as Liz noted. That gets discussed tomorrow, and that *has* been raised in that context.

There shouldn't be any perceived barriers from a confidentiality clause as I'm reading this...even in a state that has a very, very strict HIV confidentiality law.

Terrific, thanks.

Rich?

Again, in the spirit of parsimony...EPSDT periodicity lead screening in the first year to two is the requirement. Is that, in fact, not universal across all the states? If the answer to that is it's not universal, then it's an interesting measure to consider. If it is universal, and I'd love to know what state isn't promoting lead screening for children in 2019, that might be a different conversation. But I'm still trying really hard. That data has got to be somewhere, and I'm not convinced that putting a measure into the Core Set is going to make it easier to get data; but I *know* it's an EPSDT indicator.

It is, and I think Linette made some references to the way in which the EPSDT is calculated...may be not reflective of clinical practice and of the reality of that. I also think that there are some states that view EPSDT as the baseline set of benefits available to a child...not necessarily something we're driving. So

there's a difference between is it available versus a measure that would be in a quality frame versus a benefit frame.

So EPSDT can be considered from sort of a benefit perspective of this is what's available to a child who's enrolled in Medicaid versus driving toward a quality measure with a goal of improvement. So it's a monitoring versus driving frame that I think could also be different. I don't know if there are any other Medicaid directors who would respond differently.

Sally?

I have a question about the HIV measure. I'm struggling with the intersection in thinking about a really important state and national surveillance measure versus a quality measure for the Core Set. I think what lands me there in particular is the very broad age span of where the measure starts measuring. I know they've added a few years onto the recommendation but starting at 15 through 65.

I think as a surveillance measure, my initial reaction is it's really important, fantastic. I'm just wondering if there needs to be for a quality measure on the Core Set some consideration on how to specify this. I really do want to normalize a lot of these tests. I think adults, married or not, should be tested for all STDs, HIV regularly. It's your body, like your blood pressure. Married or not, no assumptions of it being tied to promiscuity or bad decisions. It should just be part of what it is.

But I still feel that this measure would be this really broad age span...which again, I think is important for surveillance and understanding. I'm curious from the states as a quality measure on the Core Set, would that be something you would be able to take action on where you're starting with at least one HIV test starting at age 15 through 65. It could also give you...it could be that someone should have gotten another HIV test at 40, and they had one at 22.

So again, I think it's a really important surveillance measure; but I'm struggling with that intersection on whether or not it's suitable for the Core Sets. I'd love others to weigh in because I truly am struggling.

I'm just going to further what Sally said a little bit. We tried to implement a screening in our EPSDT from age 16 to 18 and had a big pushback and had to create some – appropriately, I think – needed criteria for refusal or really those adolescents and their families who didn't think they were at risk. But I think that puts the measure in some jeopardy because we don't have a mechanism in this measure to document refusal where like in our own system we've actually allowed for people to say that if you did the EPSDT and you can document refusal instead of a test, you've fulfilled this.

I think that gets tricky. Not that refusal may be suboptimal, but the reality is that we have a lot of people who would look at this as way too early or inappropriate for some of those.

Thank you for that perspective.

Are there other states who would weigh in on this sort of question versus public health surveillance versus sort of health plan quality measurement strategy?

Jill?

I sort know what Jeff said, but I also sort of worry about if you screen them at 16, maybe they're not sexually active; or maybe they're not doing risky behaviors. And then at 25, maybe they are. And it's not cheap screening. I mean, an HIV test is not cheap; and then you have to go through all the counseling. It's not just they do the blood test; and so I think that from the vantage point of where does it fit in clinical practice, I'm not sure people are there and comfortable with it for it to be a measure that we're expecting everybody to do.

I mean, we put it in there; people will do it. But I'm not sure it will get done in the way it was meant to be done.

Okay, terrific.

Jeff, do you have additional comments?

No.

Okay, Tricia Brooks?

I just wanted to go back to the developmental screening measure for just a minute only because I was the one that recommended it. Not that I was absolutely certain that this measure was ready for prime time, but I just want to reiterate the importance of measuring post developmental screening as well as what happens in the next step; and it really does – there's a lot of work that has to be done in that area.

Thank you for that comment.

Some of us would certainly agree with that and we already have that developmental screening on the Core Set...that it's really what happens afterwards. Appreciate the comment.

I'm going to just give us a little preview. I understand there are comments, but we are supposed to be done with this part of our voting, public comment, and voting by 3:30 p.m....3:25 p.m. I know we took a little break, which we desperately needed after the immunization discussion, so we have a little flexibility; but I'm going to ask people to start to wrap their conversation.

I'll let Linette and then Lindsay and then folks from the CDC. Then we'll move to public comment and then to the motion phase of this work.

Thanks.

I just wanted to highlight from the feasibility aspect around calculating these measures. So again, I'm not declining the importance for other reasons; but the developmental screen, the HIV screening, they both seem to come from EHRs or medical record review. So that's either an intensive cost around medical record review or EHRs. And we are not ready – I mean, just up front, not going to be getting that done in the next two years...hopefully maybe in three years.

So while it's a destination we're headed towards, we're not there yet. While we have a few states that have started to do clinical measures from EHRs, it's only a few states. So again, the signal is there. I think we're all working towards it. But I'd be really concerned about the ability of folks to be able to do those, just from a practical perspective.

The childhood lead, I think the CMS-416 may have opportunities for revision at some point too. So there may be opportunities to think about that in that context. But this highlights the need to do that.

Again, the same thing with the body mass index follow-up. Again, the need to look at the EHRs is problematic.

Then the question I had with the colorectal screening, given that NCQA is going to be doing the Medicaid piece, is it just premature at this point that we should let NCQA do the Medicaid piece and then it comes back? Or can it go forward now without that and still have validity? Thanks.

Terrific...does anybody want to weigh in on that NCQA?

The other thing I would just add is my concern around the colorectal cancer screening is, again, it highlights states that have and have not expanded Medicaid as a baseline of the population for whom they are serving, which may give a different picture in a state where the adult population is either eligible for Medicaid because of their disability or lives at 18% of the federal poverty level...which is different than 132% of the federal poverty level.

So that colorectal cancer screening may have some underlying differences based on the state of the expansion in each state.

Hi, this is Christine. Oh, I'm sorry. Can you hear me?

Yes, please.

So the age span affects adults; so we had 400,000 people that were age, blind, disabled that we're still sitting in Medicaid for some time; and so they move over to Medicare. But we added 700,000 more; there were more than a fair number that were over 55. So I think that was Gretchen's point was that once states have expanded, there's a much larger denominator. But even though they didn't expand, there was still a denominator sitting there; and folks are usually sitting there. If they're age, blind, and disabled, they sit there for a while until they go over to Medicare.

I also think it's where Lindsay started us today, which is in the prioritization of a program that hasn't expanded Medicaid, a colorectal cancer screening measure that is for an age that has very few Medicaid enrollees will not be a high priority. So the states that will not report and don't have a large focus on adult preventive care because they just don't have a large enough population to justify that investment...not that it's not important for those Medicaid enrollees who are adults, but just from a state prioritization process. States that haven't expanded aren't as focused on adult health care needs because it's not the population that they cover primarily.

We're going to move on. Go ahead, Lindsay and then the CDC and then public comment.

I kind of wanted to circle back around to the Preventive Care and Screening Body Mass Index and Follow-Up Plan. This is a measure that is on several of our own internal state Core Sets, but we haven't yet figured out how to operationalize this at a population level. We do think it gets further than just, say, BMA CMI documented. But I don't know if either the measure steward or others would like to comment on the follow-up plan.

It looks and feels very much like our screening for clinical depression and follow-up plan measure. It's along the same sort of thread. I think it's the same measure steward. It gets us more towards not just was the BMI done, but what was that next step taken. So I do think that there's a merit in looking more at this a little bit closely. I don't know if anybody else has any comments. I know Carolyn started us, but if anybody has any comments about this measure.

Any thoughts about that follow-up component?

Yes, Jeff?

I think I'm just trying to put this in parallel with the pediatric one to find out if there's any evidence that documentation of a follow-up is done, at least any further results. I think this is – I think, I guess in contrast to the depression, where I think there's a pathway to treat and to screen and to treat in primary care with positive results. I don't know if we have such a thing for obesity in adults in primary care component systems.

Thank you, I think that's an interesting perspective that the depression measure has a clinical response; whereas a BMI measure may have a societal response or a broader context of response, which is difficult for just the healthcare system to move in that respect. So that's helpful, thank you.

Others?

All right, our CDC colleagues have a clarifying comment or two; and then we're going to move to public comment.

Hi, Suma Nair from HRSA. I just wanted to add a piece of context around the HIV screening measure. We will be in 2020 requiring all federally-qualified health centers to report on that HIV screening, just as a part of ending the HIV epidemic initiative.

And will that be to the UDS?

Yes.

(Multiple voices)

Liz, can I say a couple of things; or did you want to speak up?

No, go ahead.

I'm going to speak for my colleagues, and let me know if I miss anything. Counseling is not part of the recommendation anymore; so if that was the cost you were concerned with, the test itself shouldn't be expensive. In fact, there's data that show it's cost-effective to screen. And it's a test once, at least once. Obviously the purpose is identifying those with HIV because it can be treated, and it looks like cured now. So I think there's really something we can do about HIV, and a huge proportion of HIV fits in the Medicaid population. So I think that's why that one, from a public health standpoint, is impactful.

On the colorectal it's, again, just to reinforce what you said earlier. It looks like prevalence is coming down; so obviously for non-expanded populations, it will be less relevant coming down in age and, again, screening has tracked with reductions in burden and cost of colorectal. So again, it's very, very effective...at least from a public health standpoint.

Terrific...we're going to then move to the public comment period. Are there any members of the public in the room who would like to make a public comment?

[Pause for audience response]

Brice, is there anyone on the phone who has identified or noted in the Chat box that they would like to make a public comment?

Not at this time...but just a reminder to those folks, you'll need to be connected to the teleconference to do so. Once you're connected to the teleconference, just press "5 star" to raise your hand.

[Pause for audience response]

Okay, we do have one question that's come in. I'm going to unmute that caller now.

Caller, you are now unmuted. You should have heard a brief message. Please state your name and affiliation before making your comment.

Hi, this is Dr. Alyson Goodman. I'm a pediatrician and epidemiologist at CDC in the Division of Nutrition, Physical Activity and Obesity. I just want to make a few comments regarding the Child and Adult CMI measures. I think the comment before regarding follow-up after BMI screening in primary care is a thoughtful one; but with that said, there's really significant evidence now that effective intervention exists and can be implemented in both primary care and community-based settings or tertiary care settings as well.

As to that follow-up and referral, it's really critical; and that is part of the AAP recommendations for child obesity and certainly part of the US Preventive Services Task Force Recommendation for Children and Adults. In particular, it does seem that the shift for both children and adults from your screening and counseling to screening and follow-up is worthy. I think there is a question of whether we're there just yet because of access to care issues. But with that said, there are plenty of effective interventions that can be done in the primary care setting that could count as that follow-up action.

My other big concern, particularly for children, would be that if the BMI measure is removed without a concomitant replacement with the BMI measurement plus referrals without follow-up, it could really send a false message to clinicians and to Medicaid programs, et cetera, regarding the importance of the topic and that clinicians should continue to do counseling, even if that is motivational interviewing to get to the next step of referral. So I just wanted to put that out there, and I'm happy to answer any questions.

Thank you, I appreciate that. I think that the piece is that the measure before us isn't related to the counseling or follow-up. It's simply related to a notation of the body mass index which others have said is also noted through a Meaningful Use structure. So we appreciate those comments that from a health perspective is reasonable, but the measure under consideration for removal is just in relation to the assessment of the BMI.

Are there any other public comments?

[Pause for audience response]

Okay, so I am recognizing that the energy in the room is very low. We're very tired. So everyone needs to do a little shake. Come on, no worries...everybody, everybody. I coached soccer for a really long time. You've got to do it because this is the part actually where the work matters. This debate has been great, but the voting is the important part. So I need like 10 minutes of focused energy to make sure we are voting appropriately and voting as the conversation has informed us. Then we will take a full 15-minute break.

So if everyone could do as Bailey is about to give us our clicker. Make sure you know the measures. We're doing both the removal and the addition, so I need someone to make that lump motion of making a motion to recommend removal or addition to the Core Set. Can someone please make that motion?

We have the motion to lump again. Is there a second?

Second.

Thank you. It is important. We want to note the progress of the committee in a formal way.

Could we vote on that because I'm a splitter?

I knew you were a troublemaker.

There's a whole pile of measures here.

Okay, so what's our best approach. There is no hard and fast rule. We need to vote in a way that makes us ensure we come to the best decision.

I'll go with the majority on the lumpers. But I just think we have to be so mindful. Think of it; we just spent 50 minutes talking deeply, pulling in SMEs on this stuff. I just think that if we can parse out these adds from the removes, that will give us a chance...at least for me, the way my brain works, is that I'll be able to reflect more on my vote as opposed to watching 12 measures go by on that screen.

Okay, so I am fine with that. The way these are actually listed is in that order...the three removals first and then the additions. So I think we will go in that order; that makes a lot of sense. So we'll do the three removal votes first and then the five addition votes. Is that comfortable for everyone in the room?

[Audience consent]

Okay, terrific. Great, the motion to lump the removals has been made, and we're going to move forward now. Thank you all.

So it sounds like the first thing based on a little bit is everyone check to make sure you have your remote. Check your name, right? Then first step, press that orange button; make sure it pops up with the "Ready."

We are going to vote on our three removal measures.

The first measure that is up for vote is whether the Child and Adolescents' Access to Primary Care Practitioners measure should be removed from the Core Set. As a reminder, when we're voting on removal, "A" means "Yes, I recommend removing the measure from the Core Set, and "B" means "No, I do *not* recommend removing the measure from the Core Set. As long as everyone's ready...it looks like people have their clickers out.

Steve, please open the vote.

[Pause for voting]

I should note we will have 28 votes for this group.

Getting quick! People want their snacks.

[Laughter]

Okay, so this vote...and I think as you'll hear on the phone, we had 75% of the room vote "Yes, I recommend removing this measure and 25% vote "No, I do *not* recommend removing this measure." So for the first time today, we have a measure that's recommended for removal from the Core Set.

Moving on to the next measure...this is, again, a measure for removal. This is the Weight Assessment and Counseling for Nutrition and Physical Activity for Child and Adolescents' Body Mass Index Assessment for Child and Adolescents measure. We are voting whether this measure should be removed from the Core Set. And "A" is "Yes, I recommend removal." "B" is "No, I do *not* recommend removal." Before we start, please press that blue button on your remote so we're ready.

Steve, please open voting...and 28 again for this one.

[Pause for voting]

Great, let's see. We have the same vote. We have 75% of the Workgroup voting, "Yes, I recommend removing this measure from the Core Set" and 25% voting to not remove the measure from the Core Set. This beats the two-thirds threshold, so it's recommended for removal for the Core Set.

Moving on to the third measure for removal. This is the Adult Body Mass Index Assessment measure. This is again for removal. "A" is "Yes, I recommend removing the measure. "B" is "No, I do *not* recommend removing the measure." Everyone can just press that blue button again quickly, and we'll go ahead and open voting for this measure...and 28 again.

[Pause for voting]

We have 28.

That's really quick.

[Laughter]

And this one...again, we had...well, not again...but 86% of the Workgroup recommended removing this measure from the Core Set, and 14% recommended not removing this measure from the Core Set. This measure has been recommended for removal from the Core Set by the Workgroup. I'll turn it over before we start additions to Gretchen. I think we need another motion.

We need now a motion for voting on the additions to the Core Set in this domain.

So moved.

Thank you, Shevaun...terrific, thank you.

Just want to make sure we're not going out of order. We're moving on to additions, so our first measure for addition is the Colorectal Cancer Screening measure. "A" is "Yes, I want to recommend the measure for the Core Set. "B" is "No, I do *not* recommend the measure for the Core Set." Hit that blue button, please.

Steve, go ahead and open the voting...and 28 again for this one.

[Pause for voting]

If everyone could just check their screen and see that they have that "A" or "B" on it.

Okay, so for the Colorectal Cancer Screening measure, we had 54% of the Workgroup say, "Yes, I recommend adding this measure," and 46% say, "No, I do *not* recommend adding this measure." So this measure was not recommended for addition to the Core Set based on the two-thirds threshold.

Moving on to the next measure to vote on for addition. This is the Preventative Care and Screening: Body Mass Index Screening and Follow-Up Plan measure. This is voting for addition; so, "Yes, I recommend adding the measure"; "No, I do *not* recommend adding the measure." "A" is "Yes," "B" is "No." Please press that blue button on your remote and let's open for voting.

[Pause for voting]

This is 28 again; I should have mentioned that.

An even split...so 50% of the Workgroup voted "Yes, I recommend adding this measure to the Core Set," and 50% voted "No, I do *not* recommend adding this measure to the Core Set*."*

A couple more...we're getting there. One more for voting for addition. This is the Follow-Up with Patient Family After Developmental Screening measure. "A" for "Yes, I recommend"; "B" for "No, I do *not* recommend." It will be 28 again, and please press that blue button to reset your clicker.

Steve, go ahead and open.

[Pause for voting]

Okay, so this measure, 11% of the Workgroup voted "A," "Yes, I do recommend adding this measure to the Core Set." That was 11%; even my brain is gone at this time. And then "B" is "No, 89% I do *not* recommend." So this measure did not meet the two-thirds threshold for recommendation to add.

Two more...we can do this. Okay, so this is the HIV Screening measure. The question is whether it should be added to the Core Set. If you think it should, you press "A," "I recommend adding the measure." If you do not, "B," "No, I do *not* recommend adding the measure*."* Please push that blue button to reset your clicker.

Steve, go ahead and open.

[Pause for voting]

Oh, and this is 28 again. I think we're getting quicker each time.

Okay, this one is 14% for "Yes, I recommend adding the measure to the Core Set," and 86% for "No, I do *not* recommend adding the measure to the Core Set." So this measure did not pass the threshold for addition to the Core Sets.

The last measure in this group is the Lead Screening in Children measure. This is also a measure for addition. "A" is "Yes, I recommend adding this measure." "B" is "No, I do not recommend adding this measure.″ If everyone would press the blue button, and we'll do our last vote for this domain.

Steve, please open.

[Pause for voting]

And this was 28 again.

So for the Lead Screening measure, 54% of the Workgroup voted "Yes, I recommend adding this measure," and 46% voted –

[Laughter]

So just for the people on the phone, 46% said, "No, I do *not* recommend adding this measure," so this measure was not recommended for adding to the Core Set.

As was just stated, we're exactly at 3:30 p.m. for our break; so enjoy your break.

[Break]

Hello, everyone. So Amy just reminded us the sooner we start, the sooner we get to go outside and breathe fresh air and walk around. That's quick; people are quicker. So we are coming up to the last hour of our time together. We have, per the agenda, four measures that we're going to review between now and five o'clock...the Experience of Care measures. There are two for removal and two for addition.

I want to acknowledge that there are additional Experience of Care measures tomorrow as part of the HCBS conversations for the long-term services and supports. So while we called this bucket "Experience of Care," there will be other places in which we have that conversation as well. But these four are what we'll be discussing today.

We do want to create a little bit of time at the end of the meeting today to do a little group reflection...what's been working about today, what hasn't worked as well, what adjustments we can make, et cetera...so a little time for self-reflection. We'll also start tomorrow with that same frame just because sometimes when you walk home and reflect or have the chance to sleep on it, there may be something else that we'd want to suggest that would make our work a little bit better tomorrow.

But for now, I'm going to ask everyone to strap back in. We will move through these last four and then complete our time. There is a reception for the Workgroup members at the Hilton Garden Inn...from 5:30 p.m. to 6:30 p.m.?

Yes.

5:30 p.m. to 6:30 p.m., so that gives people the time to make the transition. With that, I will turn it back over to Margo.

Yes, I am what's between you and the reception.

[Laughter]

We are going to talk about first the two CAHPS measures that are part of the current Child and Adult Core Sets. The CAHPS Health Plan Survey, 5.0H, Child Version Including Medicaid and Children with

Chronic Conditions Supplemental Items, as reported by 40 states for FFY 2017, and then the CAHPS Health Plan Survey, 5.0H, Adult Version reported by 29 states in the Adult Core Set.

I'm going to start with a – next slide, please.

To give you a little bit more background on the CAHPS Health Plan Survey 5.0H Child Version, I think as most of you know, this measure provides information on parents' experiences with their child's health care and gives a general indication of how the health care meets their expectations. There are a variety of results using ratings, composites, and individual question summary rates.

The Child Core Set does include the Children with Chronic Conditions or the CCP supplemental items. As we were talking more about the developmental screening measures and other measures related to follow-up care and the content of care, it did make me think a little bit more... particularly about the children with chronic condition supplemental items...when somebody mentioned, "We want to know what the family's perceptions are." So that is one of the things that you find in the CAHPS child version.

The measure steward is NCQA. This measure is not endorsed. It is a survey measure, and the denominator is the survey sample that includes parents and guardians of children ages zero to 17. Just to give you a sense of some of the measures, there are four global ratings: rating of all health care, rating of health plan, rating of personal doctor, and rating of specialists seen most often.

[Pause]

I've got too many papers here at the end of the day.

Just to give you a little bit more background on the reporting of these measures or reasons for not reporting, we have a number of states that have not reported the measure because of budget and staff constraints, as we mentioned previously. In some cases, states reported but not every year. If you're not a managed care state, some states don't report it because they don't do it through their managed care plan.

So that's the first measure, and I would say – no, actually I'm looking for my notes. I'm sorry. That's okay. I just got completely bollixed here. Here we go.

In terms of the reason for recommending the measure be removed, it was because of such factors as it has relatively low response rate; it has differential scoring by subpopulation; and some other factors related to the method. This measure was suggested for removal. Then we moved to the Adult CAHPS survey...next slide...yes, thank you.

That measure also was suggested for removal for very similar reasons. This measure has very similar composites and scores related to the ratings. It has also some aspects related to customer service...getting care quickly, getting needed care, how will doctors communicate their decision-making, and then some items related to health promotion and education and coordination of care.

Again, reasons for suggesting that this measure be removed is that it doesn't provide useful or actionable results for state Medicaid and CHIP agencies; significant challenges reporting the measure; poor response rates; high cost; scoring not comparable for diverse populations.

So perhaps any clarifying questions about these measures?

[Pause for audience response]

Did you want to say something, Jill?

Yeah, I just have one clarifying point. State CHIP programs are required to report on the CAHPS measure on an annual basis. So removing this...like whatever you guys consider, I just want to make sure that you guys know that there are statutory requirements for CHIP CAHPS. Even if it's not going to apply to Medicaid, this is a part of the conversation.

And that's for child?

For child.

For states that have combination Medicaid and CHIPS programs, is that relevant to that? In Colorado, we have a separate program; so having those two be separate would not be problematic for us other than it's my personal perspective on the measure, which is separate than that comment. But in states where their merged programs, they would all be treated the same still?

I can answer that with regard to CHIP...that the sample for CHIP has to include Title XXI programs, Medicaid expansion, as well as separate programs. If you are doing both Medicaid and CHIP, you need to have a separate CHIP sample that is not a combined sample. States are reporting their CHIPs data into another system, into the CART system, as part of their mandatory reporting.

This is Jill...but you can tell the difference between them.

Right, our CHIP and Medicaid data are all together; but you can tell who's CHIP and who's Medicaid.

Yes.

Okay, thank you.

Other technical questions?

Do you want to open up a conversation about removal of these measures before we move into the other measures since they really are somewhat different?

That's the will of the group to discuss the removal first? Yes? The will of the group is "Yes," so let's open up that discussion...not just beyond the technical questions but...yes?

So I did want to talk about this. I know the CAHPS well, both as a state official but also as an advocate in the state. Now, I can say that I ran the State Association/Advocacy Organization for Providers Serving People with Developmental Disabilities. I served on that for over six years as Vice Chair. I can say that we used the CAHPS in New Jersey a lot. We actually over weighted samples for us because we are a managed care state...very old. From the mid '90s, we're a managed care state; and we used it in the advocacy to actually over sample so that we could actually see how each HMO was doing trending on specific things.

From an advocate's point of view, I think they're extremely important. We looked at how each MCO dealt with VME and a variety of other services for people with disabilities. It was extremely useful; and I think that not just we, but the State, actually found it to be very helpful in understanding everything. So I just wanted to raise that as an issue. I understand there may be issues. Right now, what was it...something like 40 states for adults currently use it. I understand that there may be some issues, but I'm very concerned if we don't keep it.

Okay, thank you.

Rich?

In preparing for today, I was reading through the comments; and it actually caught me a little bit by surprise that people would want to remove these measures. But I guess I'd like to hear from some of our state colleagues about—they are low response rates. They are valuable questions. I for one think that the

North Star of the outcome is asking the patients and families and caregivers, so I've totally endorsed that concept.

But I'm curious that it almost seems like it's the norm to have relatively low response rates. So I guess I'd just like to hear a little bit...not so much to have that vetted because I think I've heard enough to believe it; but what can we do about that? I'm not sure that cutting the measures is going to deliver the kind of value that we need compared to improving what we would do with the measures that are there.

Then to Gigi's point, they have to stay in for certain places for statutory reasons.

Terrific.

Jami, do you want to respond or share your comments?

Yeah, I think that Arizona has found the CAHPS survey to be incredibly valuable in terms of informing our perspective on system performance as well as health plan performance. Kind of the most notable example more recently, we've been engaged in this multiyear integrated care effort to integrate the provision of physical and behavioral health services. We just actually finalized our first report from that effort, and we really found the CAHPS survey to kind of round out our perspective on that integration effort and whether it was successful or not. That data was probably more useful and more informative than even some of the other data that we collected as a result of that particular study.

So I would hate to see sort of operational hurdles that we experienced with the administration of the CAHPS survey get in the way of us really maximizing the use of what I see as a really rich data source.

I don't know that we've had a targeted effort to improve response rates. We've had fairly decent responsiveness. So we've been pretty happy today. We do use our managed care organization to assist in the administration.

Yes, Lindsay?

Lowell and Rich, I can assure you that regardless of whether this stays on the Core Set or not, it's not going anywhere. So as a state...so it may just be the utility of this at a national level. There are going to be some things that we do at a state level that don't transcend well to being sort of aggregated at that national level. I don't know exactly what CMS does with our CAHPS data, so I'd love to hear more about that.

Correct me if I'm wrong...we submit this as like an attached PDF right now, right? So I mean maybe it would be helpful for us to understand how does CMS use it and what would make it more useful, because I don't know that it's being pushed out in any way, space, or form.

That's right. There have been challenges with getting state-level rates. We do ask states to submit data in aggregate form, and it usually does come in through a PDF. But there's a new effort underway at this point to try and work through the AHRQ database and to try and have states and health plans submit their data to the CAHPS database. Then we'd be able to extract it that way. We hope that that will streamline reporting by states and by health plans...that it's kind of a one-stop shop.

There's already a very highly developed system in place. Many states already are submitting and many health plans already are submitting. For those of you who looked more closely at the measure information sheets, you will have seen a link to the reporting on our CAHPS database...so some really interesting data being reported at the national level on Child CAHPS and Adult CAHPS. The goal would be to have a more systematic submission, which I think we've been seeing gains year by year in the number of states and the number of plans submitting for Medicaid.

There will be a more systematic effort; actually, some of you may be getting contacted by folks in this area in your future to have more of the data submitted and made available for public reporting. I think that's the strategy that now is underway from the standpoint of streamlining the submission of CAHPS

data so that it wouldn't be reported through MACPro, which is the Web-based reporting system in disaggregated form but just indicating we submitted our data to the CAHPS database with essentially a Data Use Agreement to be able to make it available for public reporting.

So we're pretty excited about that as a future step to the extent that this measure remains in the Core Set.

Again, from the State perspective, we find the CAHPS survey to be very valuable. Through the Adult and Pediatric, we actually add some additional questions around dental care for kids. We report it publicly. So all nine of my plans, there's a public report on our website. We actually put on that website which plans are less than our health choice's average. We also use it in our report carding.

So we think it's a valuable tool. We think it's well worth the survey for each of the plans. The response rate has always been a challenge, but I don't think...others can correct me...but I think the validity of the response rates that we see, you can still draw some assumptions even in this lower range of response rates. So we think it's a valuable tool in having an understanding of what's happen. We actually look at it by each of our health plans.

Now, with that being said, I ought to restate as managed care that really when you think of state programs and their multi millions or even billions of dollars to do a basic survey; and the cost of that survey is not that expensive compared to the millions or even billions of dollars that are being spent on the program. So, yes, administratively it can be burdensome; and there are costs to doing the survey. But at least in Pennsylvania, we're a multi-billion-dollar enterprise as far as expenditures going out the door. We think it's really important to have an understanding of how consumers are actually experiencing the care that they get.

Are they getting service from our managed care organizations the way they should?

Okay, is there any additional comment around this? We're not going to go...oh, Sally and Linette.

Go ahead, Sally.

I have to say my interest was piqued in what it would mean to remove the CAHPS surveys. We have long heard and spoken of the burden of which they are both on the system, as well as the patients themselves, the consumers, and the links in social -- more recently that the social norms don't support these lengthy surveys and that we really need to get to a better place in how to get the experience of care and patient reported outcomes.

So I'm curious from the states knowing that there is burden, there are two questions. One, it seems that in the comments for the recommendation, it was from a state voice. So no one needs to say who it was. I'm not asking for that. But I'm curious...is it a complete barrier for some states, or are these the same states that are having challenges reporting on any and all or most of the Core Sets? So is it really about the CAHPS survey?

Then my other question was going to be how useful it is. But I'm hearing from the State folks here that it does seem to provide meaningful information. Is that always true of the states implemented, or is it really if you have a sufficient volume? So my interest really is making sure that we're not holding onto something because it's already there; that it's useful.

But then also, given the recommendation to remove it, it was stated in a State voice. So I'm curious.

I'll just respond as a former State Medicaid Director. I agree with David's perspective. We have a public obligation to serve people well, and I would argue that private health plans always feel the same way because they're being paid premiums. But we're being paid through taxpayer dollars and the premiums are the care. So I think a fundamental component of any good program administration is understanding the experience of those accessing the program.

So from a Medicaid Director perspective, I think I share Jami and David's perspective. It's critical for us to understand the experience of care. So it's very important from that perspective.

I'm glad to hear that, and I agree with you on that wholeheartedly. I guess the question is whether or not this is...CAHPS has been around for a long time. Is this the type of experience of care that we should be looking at right now, given increased consumer engagement? Is it still giving that meaningful information to differentiate and for quality improvement?

Linette, do you want to share your perspective?

Yes, so maybe this is where I step up and say I submitted it.

[Laughter]

I mean, I guess a couple of different perspectives to that...one is we absolutely want to know consumer experience and such, but we've done that in a number of ways. CAHPS is a tool out there, but there are a number of other ways we've done that. So it's program implementation, whether it's focus groups or other response surveys. In California, we also have the California Health Interview Survey, which is a population-based survey that includes the ability to stratify by Medicaid numbers. We specifically fund content there to get that response.

So there are a number of ways in which we look to get consumer response because that is absolutely important. One of our challenges with CAHPS...and I don't know if this is where our size is shooting us in the foot, so to speak, or not. We generally run it every three years. I don't think we've ever reported it on MACPro because either the way we run it doesn't match exactly or it's the timing or what have you. So that's been a challenge.

But the other thing when we look at some of it, part of what we see though is that it generally tells us the demographics of the state. There are certain demographics that do not score highly on surveys. So we can tell you that those plans...the reason they're performing poorly are there demographics, not their performance. And that's one of the challenges when you do comparison...plan to plan, state to state comparisons. When you have biases introduced based on certain demographics, then it doesn't actually give you a true response on how well you're doing. It just reflects that.

So those are some of the things that we've worried about in terms of how that comes out. And as it was added to the scorecard, part of the explanation we provided was that demographic variation and how that influences people's responses to the survey. It literally is...the way they respond to the survey is different than other demographic groups, and that produces the results we see. So in that context, it makes it harder to make it directly usable in certain respects because of that.

In terms of the CAHPS survey, it has been a challenge in terms of, again, just size and cost.

Sorry, I remembered the other thing. In terms of survey response, this is a universal survey issue. We talk about it...I sit on the Board of Scientific Counselors to the National Center for Health Statistics with all of our national survey responses and issues. They've been immensely concerned with survey responses have been dropping. Our California Health Interview Survey, which surveys about 40,000 people in the state over two years, also has had that. Folks are doing a lot of experimentation around what are the best ways to reach people...trying out combinations of texts, online, voice, in-person, what have you in terms of response.

But survey response has been dropping; and getting a productive change in that trend line has been very, very hard. So that's not specific to CAHPS in any way, shape, or form. It's just another one of the surveys with that challenge. So that's something else that we should keep in mind as we think about how do we invest in terms of data collection for measurement and how do we understand people's experience in a productive way. It's both a burden on the person responding if the survey is too long. If something is more than 5 to 10 minutes, do you stick with it and do it? Probably not unless you're truly dedicated and you have a really, really strong feeling about it...right?

So that's another part of the challenge we face in terms of how do we find out? We want to know how people's experience is, but it's hard to do that in a way that people are willing to engage...and engage and in a productive way. So that's why it landed on Melissa for discussion. Thank you very much.

Yes, thank you. And thank you for asking the question in such a pointed way. I think that is an important frame for us to all have.

Go ahead, Margo.

…(inaudible). And part of it is related (inaudible).

Is there a microphone?

So we have just this past week had approval to reduce the number of items, the CAHPS survey. So we've taken out the part that was the HEDIS supplemental items. We're going back to the core survey. The reason for that is because of the concerns we've heard about the length of the survey. So that means fair decision-making and education and coordination of care.

However, I will tell you...none of those measures actually met our requirements for plan level reliability either. What we found is that performance is high or just not variable. You can't really use it to distinguish among plans. So our desire to make sure that all the measures that we have are reliable and valid and distinguish performance of the plan. And the desire to get to reducing those items, and they'll be taken out of both the Child CAHPS and Adult CAHPS.

Just to clarify, when you say they didn't meet plan to plan variability, was that the parts being removed or the parts staying in or both?

The parts being removed are the ones that did not meet our requirement of plan-level reliability. So those are the ones. The other items, actually...particularly the ratings, access to care...those items.

Terrific...Jill?

You may not be able to answer this, but can we ask if these items are on the ones that you're removing because they're not reliable?

It says five composite score, customer service, getting care quickly, getting needed care, how well doctors communicate...those four composites remain. It's the shared decision-making has been removed, as well as health promotion/education as a single item and coordination of care. Those were removed. We actually worked hard to get that new content, but it's just not giving us what we need about the health plans. Ratings will also remain...the rating of doctor, rating of your health care, rating of your health plan.

Shevaun?

It's interesting; the ones that remain are the ones that we typically post on our website because we think that those are the ones that people care the most about.

Yes.

Okay, so I'm going to move us along because it's 4:15 p.m. or a little past. Since we only have four measures, it was really important to do those removals. But now we're going to have Margo talk us through the two additions. Then at that point, we can open it up to public comment and the vote since it's just four.

Yes, go ahead, please.

It's a procedural question. Based on the information that Sara just shared about modifying, I'm in a conundrum because I don't know what I'm being asked to vote on...because what's here is removal of a

measure that has measures that we've been told are not valid; they're going to be removed. But I think it's going to be extremely important, Margo, that your staff capture this because based on what she just said, I'd be voting on the space "No." But to give us back a better measure, we should probably frame the conversation as not to vote in that space.

So I'll go back to what I said very early this morning about the evolving nature of quality measurement and how just last week we were learning about changes to measures that we did try to capture based on the publicly available or most current information available. I would suggest that we vote on this new information. This is what will be in HEDIS 2020. And it's just very reflective of the kinds of changes that occur every year. Even on measures that you don't vote on or you don't consider, it's just the nature of changes that occur.

The other thing I would just remind us is what we're voting to recommend to CMS is to either remove or retain. It is at the final decision of CMS what the exact specifications are of the measures. So to the extent that the underlying measure has changed, CMS...I am hoping...will reconcile those two realities in the final core set. So I think we can take comfort in our recommendation is whether or not we agree to have the CAHPS stay or be removed.

I was wondering the same thing, Rich; I'm really glad that you said that. And I think Margo added that.

I just know that that's part of our annual update process; and where we think it's going to be easy, there's always some complexity that occurs.

Before we proceed, I want to check whether Sara Toomey, the measure steward for Child HCAHPS is on the phone; and if you are, could you unmute yourself?

[Pause for response]

Brice, does she dial "5 star?"

I think I did. This is Sara Toomey. Mark Schuster is also on one of the other lines.

Thank you.

Yep, no problem...good to be here.

Okay, thank you so much.

So shall we proceed?

Okay, so the Child Hospital CAHPS or HCAHPS Survey is a standard survey instrument that asks parents and guardians of children under 18 years old to report on their and their child's experience with inpatient hospital care. It consists of 39 items organized by groups into 18 composite and single-item measures. The domains, as you can see, include communication with parents; communication with child; attention to safety and comfort; hospital environment; and a global rating.

AHRQ is the measure steward. The measure developer was Boston Children's Hospital. Sara Toomey is on the phone, along with some of her colleagues. It is NQF-endorsed. It's an outcome measure. It is not recommended to replace a current measure. The data collection method is a survey. In terms of the number of states for...I'm sorry. I would say again the survey was developed for facility-level reporting, and it's currently being used by at least 350 hospitals.

Some of you may recall this measure from previous years' consideration. The recommendation was for additional testing. The measure is currently undergoing additional testing, and Sara can talk a little bit more about that. They are working with states using some test data to determine whether it would be possible to determine a state-level measure. So there is work in progress, although it is not actively being used by states at this point. So that's the Child Hospital CAHPS survey.

Healthy Days Core Module – Health-Related Quality of Life...this is a measure that CDC is the measure steward. It is not endorsed. It's an outcome measure. Again, it's not recommended to replace a current measure. A survey...it has four items. It's been used with BRFSS for many years since 1993. The questions pertain to the number of respondents indicating that their general health is excellent or very good depending upon the survey; the number of days during the past 30 days that the respondent's physical health was not good; the number of days during the past 30 days the respondent's mental health was not good; and the number of days during the past 30 days the respondent's poor physical or mental health kept them from doing their usual activities.

Among the reasons for addition is that it's a measure of perceived overall health and wellbeing of individuals in communities and a fundamental benchmark of health. It measures some of the underlying determinants of health and reflects the total needs of the patient beyond what can be delivered in a clinical setting.

Clarifying questions about these two measures?

This is Lindsay. The Child HCAHPS is an all-payer measure, correct? So this would be all payer, not Medicaid-specific.

The intent would be that it would be Medicaid specific...that a sample would be drawn for Medicaid beneficiaries. That is something that would presumably need to be specified for survey vendors as part of a contract for the administration of the survey. But the idea would be that it would be Medicaid-specific if it were adopted for the Core Set.

And if it is, would it be risk-stratified and/or differentiated for children who are receiving home and community-based services or long-term service support, waiver supports in addition...my line of thinking being that many children who may be enrolled in Medicaid because of a disability will have high hospital engagement. That's sort of how it works, unfortunately; and so in an all-payer model, there may be some spread that many children have significant health care needs. But in a Medicaid-specific, how would that be accounted for?

Sara, can you answer that?

Sure, I think there are two ways. One is in terms of our case mix adjustment model, health status is considered within that similarly to the Adult HCAHPS measure. So it should, in some regards, be accounted for there. In addition, certainly there could be requirements placed for which there could be stratification for dual eligible versus core Medicaid. I'm certain that could be a possibility.

And just to clarify, is that available currently; or would that need to be developed for Medicaid?

In terms of the specification that would occur in terms of what Margo was referring to, all hospitals have obviously information regarding the insurance status of their patients. So that administrative data would get pulled into the analytic dataset. So in that context, it would be pretty straightforward in terms of accounting for those differences.

I appreciate that perspective. I'm not sure that our children's hospital has a full understanding of waiver services that a child may be receiving. So I appreciate the intent there, but there may be other waiver-based services that a child is receiving that's not relevant to their acute care benefits that the children's hospital may not be aware of. So if you continue to explore that, I would just ask you to engage with your children's hospital about their knowledge of the long-term services/support benefits that children are eligible for beyond just their acute care Medicaid benefits.

Thank you.

Other technical questions? Tricia?

Is this just for children's hospitals or hospitals in general?

Good question...Sara, the question is it just for children's hospitals or all hospitals who treat children?

This survey applies to anybody under the age of 18...so in all hospitals. The 350 hospitals that Margo mentioned include many hospitals that are not freestanding children's hospitals.

And have you done any state-level measurement or just hospital-level measurement?

What we've done to try to simulate state-level measurement is that we've partnered in the context of our PQMP funding with two states to see if they can take data in a simulated fashion from actually our national field test datasets to see if they could generate sort of measure reports taking the data. One of the states has completed the task; the other one is near completion. With the sort of general guidance given in regard to our technical specs, with some minimal technical support from our team they've been able to do the analysis and be able to provide the similar sort of report to what we had had.

Perfect, thank you.

Are there other technical questions, clarifying questions on the Child Hospital CAHPS Survey or the Healthy Days Core Module?

I had a question about the Healthy Days Core Module. So if it's in BRFSS, is this an available data source that we could just pull in; or is this going to require us to actually resurvey our members using these questions?

Again, there are costs involved in the Child CAHPS survey because if they're not doing it, then we would have to provide funding. But I'm just wondering if the BRFSS exists if we could just kind of pull it in?

Yeah, is there a response from CDC?

[Pause for response]

Craig Thomas, if you're on the question is would Medicaid programs be required to re-ask the questions that are already asked through the BRFSS; or is this the opportunity to match the BRFSS data as collected at the state level with Medicaid eligibility data already?

[Pause for response]

I think one of the questions that we also have is whether it's part of the core module or a supplemental optional module, and I believe it's core.

It is core.

So I think, Lindsay, since we don't have Craig on the phone, at least right now, I think the answer is it would be done as part of your core BRFSS.

Can I just state one obvious context...which is that if you put it in the experience of care but really part of the intent was to address the very important challenge CMS put to everybody, which is how to think about social determinants, this is a way to get at that and is a long-standing measure. So that was the context for it.

Hi, this is Craig. I'm sorry I'm calling in. I was on mute, and I had the worst time getting off.

I just wanted to say that regarding the BRFSS data that we don't have an identifier. These are randomly selected members of the state at a state level...members of their communities and populations that they serve. So it would be difficult to match or identify or link those datasets, if that helps.

Yeah, I didn't know if you have like an income level or anything about that would somehow give us a proxy to at least look at what those results are?

Oh, we certainly could do that. We also have a question about the kind of insurance that they receive...whether it's Medicaid or Medicare.

(Multiple voices)

And can you clarify...is that part of the core, or is that an optional question for states?

I will have to double-check that, actually. I was just asking staff that very question. But income is also included in that as well.

Yeah, I think the clarifying point though would also be that this would not be every Medicaid beneficiary's perspective on these questions. It would be a random sample, like other surveys that give us a North Star if like is any of this helping people actually live a healthy life. But that's an important distinction in terms of the ability of a Medicaid program to drive toward an outcome when the data that would be collected would be based on a random sample that the public health surveillance (inaudible).

Jill, go ahead.

I really love the concept of Healthy Days, both from a practitioner's standpoint because it gives you a sense of how well someone is doing and from a broader standpoint. But are the questions available to people with disabilities? So if you don't speak, if you don't read, if you don't see, if you don't hear, are there modifications to the questions? Are they delivered in a modified manner in order that we capture this information related to the population of people with disabilities...which is in the Medicaid Program?

Craig, do you have a response to that?

So if I'm clear, you're asking if we have other means of collecting the data for those that might have a disability; is that correct?

Yes.

Unfortunately, we do not. We don't do things like computer-assisted interviews and along those lines. We do have the BRFSS Healthy Days questions translated in multiple languages, but unfortunately have not done anything in terms of dealing with special populations that have unique needs.

Thank you...good question.

Jeff?

Just a technical question, Craig. How long has the insurance been on the survey? I think it's pretty recent.

We're looking it up as we're having this conversation. I think it's been a while...yeah about 1990.

Back in my consumer advocacy days, we used it all the time...so, yeah.

Carolyn?

(Audio break)

Craig, did you get those?

I did not; I'm sorry. It's almost dead silence during the last like three minutes.

That's okay. I think there were two questions. The first is to what extent have we had an example of using this data to drive actionable change and see an actionable change.

Then, Carolyn, do you want to repeat your first one? It had a little more nuance.

So my first question was simply patients' perceptions about terms such as "fair," "good, "excellent," health can be very subjective; and I appreciate that you did have a couple specific questions...do they need assistance doing household chores; do they have pain; and if they have an impairment, what is their major impairment. But just wondering if you give any guidance to respondents of this survey on how you define "fair," "good, "excellent."

And then the second question was just simply as just stated. Have you had a chance to actually administer this in the field; and, if so, has it led to actionable interventions with specific populations?

I'll answer the second question first. We have had quite a bit of – we, ourselves, obviously use it as a surveillance system. Although we use it for planning and for understanding trends in chronic disease prevalence rates, et cetera. That is oftentimes used in public health to inform decisions on policy at a programmatic level.

But I know that other healthcare plans, like Humana, is using this as an important dependent variable for measuring the effectiveness of their interventions to address social determinants of health...particularly in the area of food insecurity and social isolation. This indicator has been very valuable to them. Actually, they've found reductions as a result of these community-based interventions that they're implementing. So there are examples of how these data can be used to take action, and there's some literature on this as well if you'd be interested in seeing that.

In terms of the response, when asked --this is telephone survey...so of course we train the interviewers on specific techniques for how to ask the question. I don't know if they specifically go over the response categories clearly or not; that would be a question I could follow up with you about. I'd have to talk to our members of the BRFSS Team.

Thank you.

This is Matthew (last name inaudible) at CDC with Craig. Generally, the people are read some of the responses. They are not read responses, like "don't know" or "refuse to answer" or things like that. But for instance with the self-rated health question, which you specifically asked about...excellent, very good, good, fair, and poor...the interviewer will usually state what those categories are but will not try to push the person to say one way or the other. – To define it -- It's sort of a subjective reply. So they try not to lead the respondent in any particular direction.

In my knowledge of this survey, which is somewhat limited, but there has been some validation data of folks' actual health needs and their response to those.

I think in the interest of time, Linette, I'm going to give you the sort of final word before we open up for public comment both on the proposed removal of the two CAHPS, the addition of the Child Hospital CAHPS, and then this conversation for addition...those last two for additions.

Okay, I think this is a quick question. On the BRFSS when you ask about Medicaid/Medicare, do you give specifics about what Medicaid means? The reason I'm asking is that we've found when we're surveying folks in California, often if you don't refer to the plan people don't think of themselves as being in Medicaid. They're in Kaiser; they're in Anthem; they're in BlueCross. So unless you explain what Medicaid means, you won't actually catch our Medicaid members.

So there are some instructions provided when they do ask the question about the type of insurance they might be receiving through an employer or a union or through another person's employer, a plan that you or another family member buys or you own, Medicare/Medicaid or other state program, TRICARE, et cetera. It goes on and on; I don't know if this gets to your question about the type of health insurance, but there is some level of detail provided from the interviewer.

And to go back to the question about is this on the core, somebody asked if the health care insurance, Medicare, was on the core. It is not. It's an optional module, which makes it unfortunate. That doesn't mean everyone gets to report on that. There is a question on the core about do you have health

insurance; but the additional information about Medicaid and Medicare coverage is asked in a separate module.

I think it was both. I think Jeff's question was clarifying if that's data that would be available. I think it is both; I think we asked in both ways.

It's noted on the slide as being part of the core module, so I'm going to suggest that the submission created that clarity.

Thank you.

Okay, so I'm going to suggest we're waning again. Everybody sit up straight like your mother is here watching you. We are going to have any additional dialogue amongst the members of the Workgroup. Then we're going to close our Workgroup discussion about these last four measures we've been discussing since after the break and open it up for public comment.

Is there anyone in the room who would like to make a public comment about either the two proposed for removal or the two proposed for addition?

[Pause for audience response]

You're going to have to jump quick.

Okay, seeing none, is there anyone, Brice, on the phone who has indicated an interest in providing public comment on the four measures under current consideration?

No hands raised at this time. Quick reminder..."5 star" to raise your hand.

[Pause for audience response]

Okay, at this point in time if people are still with us, they're good folks; and they would have jumped quickly if they still had something to say. I'm going to suggest that that closes the public comment period and would entertain a motion. I think we did do better thinking about first the batch of removal and then the batch of addition, so thank you for that adjustment.

If I could get a motion to vote on the recommendation of the removal of the two measures before us?

So moved and a second, thank you.

The first vote will be on those two. Is there any final discussion though before we move to that voting process?

Great, Bailey take it away. Are there any conflicts or disclosures on these? So our number that we're looking for is 28.

Okay, so the first two measures will be voted on for removal. The first measure that we'll be voting on for removal is the Consumer Assessment of Healthcare Providers and Systems Health Plan Survey 5.0H Child Version, which includes Chronic Conditions Supplemental Items. This is removal again; so "Yes" is "I recommend removing this measure from the Core Set." "No" is "I do *not* recommend removing the measure for the Core Set. "Yes" is "A." "B" is "No."

Everyone, if you could turn on your remotes again using that orange button. Make sure it says "Ready." You guys have got it down. We'll go ahead and vote.

Steve, please open the voting.

[Pause for voting]

And the votes are in about whether the CAHPS Child should be removed from the Core Set. And 11% voted "A," "Yes, I recommend removing the measure from the Core Set"; 89% voted, "No, I do not recommend removing the measure from the Core Set." So this measure was not recommended for removal.

Moving on to the next vote, and this is the CAHPS Survey for the Adult Population, same vote of removal. "A" is "Yes, I recommend removing." "B" is "No, I do *not* recommend removing." Press that blue button quickly. Make sure you're ready.

Steve, please open.

[Pause for voting]

Very impressive...and our results are similar. "Yes" was 11% for recommended for removal; "No" was 89% for recommended for removal"...so the no recommendation for removal.

Now we're going to move on to voting on the measures for addition.

First we need a motion. Is there a motion to move—thank you. We have a motion. Is there a second? Thank you, we have a motion and a second.

This is the measure vote for addition. This is for Child HCAHPS Survey and whether it should be added to the Core Sets. "A" is "Yes, I recommend adding it." "B" is "No, I do *not* recommend adding it." Press those blue buttons.

And I think we want to recognize this is the hospital consumer...so not the regular HCAHPS but the hospital one which is different. I wanted to just clarify.

Thank you for clarifying; I think that is very important.

Okay, so the Child Hospital Consumer Survey measure for addition to the Core Set. "A," "Yes, recommend." "B", "No, do *not* recommend." Blue buttons have been pressed...awesome.

[Pause for voting]

Let's see...so for this measure for the Child Hospital CAHPS Survey, 36% said, "Yes, I recommend adding the measure"' 64% said, "No, I do not recommend adding the measure." So this measure is not recommended for addition to the Core Set.

Moving on to our last vote of the day...very well done, everyone...is another measure for addition. This is the Healthy Days Core Module – Health-Related Quality of Life measure for addition to the Core Set. "A" is "Yes, I recommend." "B" is "No, I do *not* recommend adding it." Press those blue buttons if you haven't already, and we'll open for voting.

[Pause for voting]

Great, let's hear a final result for the day. The results of this are 32% recommended it for addition and 68% did not. So this measure was not recommended for addition to the Core Set.

We have a couple of wrap-up items. I know Gretchen wants to talk a little bit about process. I just want to do a couple of points of things for people to keep track.

Workgroup members, you're welcome to leave your name tags and any additional items that you'd like to leave in this room. We'll be here tomorrow. Registration will start again at 8:30 a.m., and we'll start the meeting promptly at 9:00 a.m. For members of the public, you're welcome to drop your name tags in the bucket out there; they'll be there for you tomorrow.

As Gretchen noted, there's a reception at the restaurant. If you walk upstairs to the second floor of the Hilton, they can direct you to where to go. Federal liaisons are also welcome to join us if they would like. Then we'll be discussing the last five additional domains tomorrow, so sleep well tonight. I'll turn it over to Gretchen for a couple of other wrap-ups.

Thank you. David probably has a more astute wrap-up than I do; but first of all, thank you all. That was incredible work. Thank you to the Mathematica Team for the voting process. I think that has proven to be a best practice already...very well done. I think it feels like it is authentic and the ability to share our perspectives.

Our goal is to just check in with anyone. Is there any major area where we want to spend some time overnight thinking about improvement or doing something different tomorrow? Again, there are five measures. Any areas of concern or recommendation for a change in approach.

[Pause for audience response]

All right, we'll make tweaks again along the way as we go.

David, I'll let you wrap it up, sir.

Thanks, everyone. I appreciate all the attention and energy. Keep your thinking caps on for tomorrow and enjoy the evening. Thanks.

And we can wrap!

[Laughter]

This concludes the webcast for today. Please submit feedback to the Presentation Team using the survey in your browser window when the event concludes. The on-demand recording will be available approximately one day after the webcast and can be accessed using the same audience link that was sent to you following registration.

If you have any questions, they can be directed to the MACCoreSetReview@Mathematica-mpr.com.mailbox. Thank you.