Child and Adult Core Set Stakeholder Workgroup: 2020 Annual Review
In-Person Meeting Day 2 Transcript
May 8, 2019

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Now I'd like to introduce Margo Rosenbach from Mathematica. Margo, you know have the floor.

All right. Welcome everyone. We are starting our second day of work, and appreciate [inaudible]. So, thank you from all of us for everyone to come back. We have a big task in front of us, but I'm going to let David, the co-chair, has done a lot of this kind of work like this in the past, and he's going to kick us off this morning. And then we won't have that long introductory period, so now is the time [inaudible] and prepare for voting grain and get your thumb ready. So, we will move for caring and reporting of acute and chronic conditions this morning. It's a large body of measures and so we'll hopefully maintain the momentum from yesterday. So that's our next stop on our journey. But, first, David will kick us off.

Thanks, Gretchen. And I want to thank everybody for all the hard work yesterday, 20 measures and we've got 36 to wake you up today. Again, I just want to thank folks for all of the great discussion that we had, and I think that folks really thought about the measures, each one by one, in terms of some of the parameters that we laid out as far as actionability, alignment, appropriateness for state-level reporting, feasibility and strategic priorities. So, again, as we move through, again, a large number of measures today, we want to keep that in mind. I think that we had great discussion yesterday. I think all of us learned a lot from that discussion. With our federal partners in the room, I think that discussion is as important as what the final vote is, so really want to encourage that good robust discussion to continue respectfully.

Also, just want to ask that folks stick to our game rules that we established yesterday. I think reviewing a whole host of measures very efficiently [inaudible] process. I do want to open it up, though, and ask folks for any feedback about the process, as well as any of the results of yesterday, so kind of open it up for a bit of discussion here.

Federal liaisons… you'd like to add something, and this is reflection on the process from yesterday?

Thank you. This is Alice from the National Vaccine Program Office. So, for the measures, essentially, I'm not sure if this is the Thursday discussion, so please clarify, for the decisions that the workgroup made, how old would those measures be viewed in future cycles? That's one of the questions I had. The other

is, [inaudible] 39 percent, you know, not based on [inaudible] for that could barriers but potentially help states report out on those measures?

Sure. So, as I understand it, that there are multiple measures on this set that we're reviewing that were reviewed last year as well, and that's noted in our preparation materials. Some that were even recommended but not accepted by CMS, and so measures are always welcome to be resubmitted next year for the same review, whether they're identical but have additional testing underneath them or have a tweak because of interim activity. So, everything is open for review again.

And then you and I discussed this yesterday, and I think it's a reasonable request that tomorrow, when we get to the general discussion, I think there is an interest among some, and I'd test with the rest of the group, to maybe go back and test some of those votes that were very close and just understand what was the reason behind that; not necessarily revisit the vote, although we can certainly discuss if there's any reason somebody wants to do that. But those that were, you know, 11 percent to 89 percent, I think there's a lot there, and we don't need to unpack that. But for those that were close, I think it's reasonable for us to discuss, not from necessarily the personal voting perspective, but what is it about that measure that gave the group general concern? Was it a feasibility issue? Was it an actionability issue, just so that we understand and CMS would understand a little bit more about the group's mentality? I think the anonymous voting process has worked very well. It gives everybody the ability to voice their opinion, but I think some discussion there would be reasonable, so I'll put that out.

Also, just because we want to give a thumbs up for certain measures, states have the ability to put those measures in place. I said yesterday I am going to back and look at those two dental measures very, very interested in them. I think some of the immunization, electronic measures, something that states were very interested in, those were NCQA measures, they have the ability to, by contrast, take our plans, those types of measures, so we have the ability state by state to decide whether or not we want to push forward, and that's something that, at least in Pennsylvania, something we really want to move forward. We want to get out a chart review. Like New York and California, we get out a chart review and move into the electronic age. But different states are at different phases of where that can actually happen, and that gets a little bit in the feasibility issues.

Terrific. Yes, Laura?

Just really quickly, from a process standpoint, bringing the federal agencies together has been enormously helpful, and we very much appreciate it, and so a quick process question, which we can handle outside, if it's that a state chose to adopt something outside of the core measures, what would be the right way to keep federal the partners thinking together, because they would be learning technical opportunities, even if it falls outside of the core measures?

Yeah, I think that's something the federal agencies can work with national associations to figure out.

Yeah.

We'll remind folks to introduce yourself before, so our colleagues on the phone know.

[Inaudible].

Also, we got a request from those on the phone yesterday to speak directly into the microphone. There was a lot of trouble hearing us, which is typical of these types of engagements. But to make the engagement for those on the phone as meaningful as possible, we'll try and lean in a little bit.

Comments from committee members? You're a silent crowd. Put your cards up.

David, and everybody, I think one of the interesting things about this is that we chose or it was chosen -- I'm sorry. Jeff Schiff from Minnesota. It was chosen that two-thirds was the decision point, and I think that

that's something maybe we should talk about tomorrow as well, because I think there's no firm number that makes that correct. I think it's just a worthwhile thing to revisit.

I think that is a good. I think it's worth discussion about the process. Other comments?

I just wanted to say I think the process for this meeting has been very well done. Eliminating two minutes and really eliminating all the repetitive comments and supporting comments, that's a great process.

Thank you. We'll keep that as a mantra for today. Rich?

I also was intrigued. Oh, this is Rich Antonelli. I'm almost caffeinated. The interesting things to unpack, which I think is the woman's comment there about what about was relatively close, and you said, "Well, maybe we could put some language out there." That proposal, on its face, sounds good, but that scares me, in terms of our ability to move through three mountains worth of work in the next day-and-a-half. So, I'm sure that the staff is collecting the comments, but my suggestion -- actually, two suggestions to be able to honor that request, because I think is totally reasonable -- and I'm not talking about the 89%/11%, and I'm not talking about the ones squeezed in the middle -- is if the chairs don't hear something fairly solid, to maybe challenge us to say, okay, what would make this more desirable, and do it that way, and then, of course, in the report, I assume that the report will get drafted, shared with the committee, and then we can comment on that?

Yes.

But we literally could probably have spent all day today talking about the dental measures, for example.

Yes. Yeah. That conversation, just in terms of our mental capacities, we are going to maintain the same framework today as we did yesterday, which is we are looking at each of the measures en masse, and then individually, and all that reflection is for tomorrow, because we can't decide and reflect -- I can't decide and reflect at the same time. It's too complicated. So, we're going to decide today and reflect tomorrow, and that's what we've built the morning for, so thank you. I think well noted.

Carolyn did you have something to add?

Some similar comments, and I just wonder, given that folks come from different settings, different backgrounds, looking at these from different perspectives, I wonder if there is a way to -- and I don't want to put individuals on the spot with each vote, but some way to capture how each of those five or six fields are implicated so the feasibility, the actionability, the relevance, some way to kind of more formally maybe even use that as the template as we're gathering feedback so that folks understand which areas may be of our greatest concern.

Yes. Yeah, I think that's a great suggestion, and maybe what I'd suggest is we try a little informally today as you're offering comments, or in our debate, talk about what gives you pause. You know, this gives me pause because it's complete chart review, or whatever it may be. And then tomorrow, on those that are close, we should absolutely use that framework to guide the discussion, so that's great suggestion.

I think, not to get too much into the reflecting today, but I think, at least for me, and I think for some of that have been around similar tables before, a measure not being voted on isn't necessarily a criticism of the measure or something that the measure can do better. I think, at least in the past, you know, the whole concept of real estate was drilled into us, and it's just, you know, there's only so many measures that can be on the scorecard. Is this worthy of displacing something else?

I mean, we know that there's only so many measures that can be added, so it doesn't mean that it's a bad measure or that the measure needs to be better, it's just that there are other measures -- you know, and I know we're not comparing them today, but I think, you know, it's that is this the perfect fit for this purpose? It may be a great measure. It may be a great measure for lots of things, and it may not have anything that can be done to improve the measure, but is this the best measure for this purpose, and I think that's at

least what goes through my head as we think about the measures, and maybe it's true for some of the other people around the table.

And this is Gretchen Hammer. I would add to that. In addition to content of the measures, which is not necessarily my level of expertise, but the domain and the issue that the measures is addressing all fell within scope. So, I think that's important, especially for our CDC colleagues who have expressed some disappointment. I think that it's important to note that the conversation was robust because those measures all were meaningful, but there were other factors that might have been involved.

I'm going to -- is there any final, or should we transition to jumping right in?

I would just encourage that everybody, the committee members from the states, everyone [inaudible].

Terrific. So, again, this is Gretchen Hammer, and with that, we will dive right in. We are going to tackle, as I mentioned earlier, the first set of measures, which is care of acute and chronic conditions. We're going to follow the same process, where Alli is going to send us a reminder about what's currently in the Core Set, review those measures for removal, and then review the measures for potential additions -- potential removal and potential addition, and so we'll just jump right in. Alli?

All right. Thank you, Gretchen. We'll start with the check for the measure stewards on the phone. So, if you're on the phone or in the room, just let us know. We're looking for NCQA in the room. There are a few differences between the measure information sheets and the way the measures are specified, so when it comes to those measures, we might want to just give high-level differences so the committee really understands what the measures are.

Can I ask, when were those changes made?

Those changes, I let you know right after we received the sheets, but they were PDFs, so it was hard for us to change them. And, also, they were being considered by our committee on performance measure yesterday, so they've since been approved. So, you know, I think the timing is right, because it's now been really finalized. So.

And I appreciate that. The only other thing I would share is there wasn't the recognition in the room yesterday that, at the point that we're just making recommendations to CMS, CMS would have all of those technical specs at the time they make a final determination, so high-level overview would be great but not too detailed.

Right.

Sure. Of course.

Okay. Thank you for that. We're also looking for HRSA in the room, Q-Metric.

Hi. Q-Metrics on the phone.

Okay. Great. We're looking for Pharmacy Quality Alliance.

Hi. This is Lisa Hines, and some others will be joining soon.

Okay. Great. And CMS is the last measure steward. All right. And just as a reminder, if you're having trouble unmuting yourself, contact the chat box. All right, so the next slide, please.

We'll kick off by presenting the measures currently in the Child and Adult Core Sets, currently in the acute and chronic conditions domain. For the Child Core Set, we have the asthma medication ratio. This is actually included in both the Adult and Child Core Sets, for ages 5 to 18 in the Child Core Set, and ages 19 to 64 in the Adult Core Set. The measure assesses the percentage of beneficiaries who are identified

as having persistent asthma and had a ratio of controller medications to asthma medications of .5 or greater during the measurement year; the ambulatory care ED visit measure assesses the rate of Emergency Department visits per 1,000 beneficiary months among children up to age 19, and then there are 11 measures currently in this domain in in Adult Core Set.

The controlling high blood pressure measure assesses the percentage of beneficiaries ages 18 to 85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled. The comprehensive diabetes care hemoglobin A1C testing measure assesses the percentage of beneficiaries ages 18 to 75 with diabetes who had an A1C test. This measure has been proposed for removal, so we'll discuss it more shortly. The comprehensive care hemoglobin A1C poor control measure assesses the percentage of beneficiaries ages 18 to 75 with diabetes who had a hemoglobin A1C and poor control: meaning an A1C over 9%. Next slide, please.

PQI 01, diabetes short-term complications admissions rate measures the number of in-patient hospital admissions for diabetes short-term complications per 100,000 beneficiary months, for beneficiaries ages 18 and older. PQI 05, COPD or asthma in adult admissions rates measures the number of in-patient hospital admissions for COPD or asthma per 100,000 beneficiary months, for beneficiaries ages 40 and older.

PQI 08, heart failure admission rate measures the number of in-patient hospital admissions for heart failure per 100,000 beneficiary months for beneficiaries ages 18 and older. PQI 15, asthma in younger adults admission rate measures the number of in-patient hospital admissions for asthma per 100,000 beneficiary months, for beneficiaries ages 18 to 39.

The plans all-cause admissions measure assesses the number of acute in-patient stays during the measurement year that were followed by unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Again, the asthma medication ratio is the same one that was described for the Child Core Set.

The HIV viral load suppression measure assesses the percentage of beneficiaries age 18 and older with a diagnosis of HIV who had HIV viral load less than 200 copies per milliliter as of the last HIV viral load test during the measurement year. This has been suggested for removal, so we'll discuss that more momentarily. And then finally, the annual monitoring for patients on persistent medication measures percentage of beneficiaries age 18 and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year, and at least one therapeutic monitoring event for that therapeutic agent in the measurement year, and this has also been suggested for removal, so we'll discuss that more as well. Next slide, please.

All right, so the first measure we'll discuss for removal is the HIV viral load suppression measure. This is a HRSA measure and it is NQF endorsed. It can be calculated using administrative or EHR data. The denominator is beneficiaries with a diagnosis of HIV in the measurement year, and at least one medical visit in the measurement year, and this is regardless of the date of the visit relative to HIV diagnosis. The numerator is the number of beneficiaries with an HIV viral load less than 200 copies per milliliter as of the last HIV test during the measurement year. Next slide, please.

A new measure has been recommended for substitution for this measure, which we'll discuss shortly. This measure was reported by three states in FFY 2015, five states in FFY 2016, and five states in FFY 2017. It was recommended for a removal by the workgroup member because states have experienced challenges reporting this measure. Only five states reported the measure last year just by being in the Core Set since 2014. Next slide, please.

The next measure suggested for removal is the hemoglobin A1C testing measure. This is a HEDIS measure and is NQF endorsed. The denominator includes beneficiaries ages 18 to 75 who had a diagnosis of diabetes during the measurement year, or the year prior, and the numerator includes beneficiaries who had an A1C test performed during the measurement year. The workgroup suggested removing this measure and leaving in the other comprehensive diabetes care measure, which is the

hemoglobin A1C poor control measure. 37 states reported this measure in 2015 and 2016, and 38 reported for FFY 2017. This measure was recommended for removal because states report high performance on this measure, according to the workgroup member, indicating little room for improvement, and there are other measures in the Core Set that focus on A1C tests and one of which also provides information on diabetes management. Next slide, please.

The annual monitoring for patients on persistent medications measure is also a HEDIS measure. It was previously NQF endorsed but is no longer endorsed, and it can be calculated using administrative data. There are two rates reported for this measure, as well as the total rate. So, the denominator for the first three is beneficiaries who received at least 180 treatment days of ACE inhibitors or angiotensin receptor blockers. The denominator for second rate is beneficiaries who received at least 180 treatment days of a diuretic. The numerator for both rates includes beneficiaries with at least one serum potassium and serum creatinine therapeutic monitoring test during the measurement year. Next slide, please.

No measure has been suggested for substitution. It was reported by 32 states for FFY 2015 and FFY 2016, and 36 states for FFY 2017. This measure was suggested for removal because, according to the workgroup members, states report high performance on the measure, and it also lost NQF endorsement in 2018. Next slide, please.

Do we want to open it up for clarifying questions before we move on?

Yeah. I think yesterday we found that talking about those that might be potentially removed and clarifying and then talking about the additions is helpful. We won't vote though, until the end. But are there clarifying questions or technical questions as it relates to the three removal -- proposed measures for removal from this domain? Lindsay?

So, I think you mentioned in the discussion that there is a replacement for viral load suppression?

Yes.

And I'm not seeing a measure.

I believe it was the proportion of days covered antiretroviral medication.

Oh, that's being proposed as a --

As an alternate way. I'm not a clinician, but it's an alternate way to sort of get at an alternate way to get at individuals with HIV. Yeah, Jennifer?

Jennifer Tracey from Healthy Steps. I know we got into this a little bit yesterday, talking about one of the previous HIV measures. But I am curious to hear from some of the state representatives again, the challenges noted in reporting on this measure, and, again, when you touched on them a little bit, I think we heard from a couple states that it is an issue. But I would love to hear from any states that feel like they can report on this measure, and it is doable, given all the constraints around confidentiality and HIPAA.

Does anyone know the five states that reported?

[Inaudible].

Oh, well, excellent. Aren't we lucky. So, Linette and Lindsay, share from California and New York.

So, our history around this measure is under the Adult Medicaid Quality Grant. We worked with our Department of Public Health, and we shared some of that grant money with them. And in terms of the data sharing, they could not share the confidential data with us, but we could share with them, because we needed the results for the Administration of Medi-Cal program, and so we shared the confidential data

from Medi-Cal with the Office of AIDS at Department of Public Health. They did the data linkage, and then they gave us back the summary with the report from CMS.

So, under the Adult Medicaid Quality Grant, we did provide some funding to do that initially. Since then, we have continued to do so. Because they have a lot of stakeholder interest, we see it as mutually beneficial, so we're not actually exchanging [inaudible]. But there's aspects around that assessment related to the individuals with HIV and Medi-Cal, so they're interested in being able to report as well, so it's a shared benefit.

And, Linette, have you done anything programmatically, given the information that you've learned?

So, yes, and that's where with our Office of AIDS and our Department of Public Health and the public strong stakeholder engagement in the state, and then working with the Medi-Cal program, so there have been a variety of things looking at that in different directions. So, the whole Getting to Zero initiative, folks are very involved, and we actually have a value-based payment program that started in one of the measures that came forward in terms of payment would be related to the viral load. So, it's not this measure exactly, but it feeds into.

And just to echo what Linette said, that's the exact same model we've set up with our Department of Health. We need minimum necessary to come back to us, so we push the information to them. They do the match. They send us back aggregated information at a plan level and at a state level for reporting. We also have -- our public health group has engaged and now is feeding non-suppressed individuals back to the health fund program. They really go after those who are not suppressed as more of a quality improvement initiative.

And I would just say, I'd love to hear the CDC's comment on this, because I think they said they'd like to help us with this. As we know, that the burden of individuals living with HIV and AIDS are on Medicaid, and I know states report viral load suppression information to the CDC. So, for those state who don't have the resources or the ability to do a linkage, if they could at least use that information at a summarized state level from CDC, it would give them, I think, actionable information and a way to kind of track. It's not going to be exact Medicaid rate, but you know at the end of the day, it's the majority of the people living with HIV/AIDS are on Medicaid, then it gives you a pretty good proxy of where you need to work.

Let me offer a comment. My HRSA colleague is going to offer a comment, and then I have SMEs on the phone if they need to add anything.

Could you introduce yourself.

Sorry. Laura Seeff, CDC. So, and I don't want to speak for CMS, but there has been a collaborative. I think I'm using the name wrong. But there was discussion at CDC end about reinvigorating that if states felt that they needed technical assistance, because we saw what some of the comments were as to why the reporting was low. So, there are absolutely ways, I think, building on what already exists, for a couple critical federal agencies to come together to help, you know, address the issues. And, frankly, I think California and New York also are very good mentor states, and so having you all continue to do what you just did and help other states would be a part of that, I would think. But let me turn it over to HRSA, and if I missed anything, Abby or Liz, please add.

Good morning. My name is Marlene Matowsky. I work at HRSA and HIV/AIDS Bureau. And I did want to comment a little bit more on the collaborative. So, CDC, HRSA, and CMS came together and did a learning collaborative. It ended right around the end of '17, early '18, and through that collaborative, we had 19 states participate. We heard about many of the challenges, and I think they are real challenges. But I heard also, yesterday, forward-thinking conversation about use of electronic data in EHRs, and this measure is definitely open in that area.

I don't think we've seen the full fruits of the labor that was put out through the collaborative, because, as you know, it takes a little bit of time to turn your CMS, and as well as the state's Medicaid program, to shift

to reach these goals. But since our colleagues in New York and California have mentioned it, you may be aware that during the State of the Union, the administration announced -- I could tell you the correct name -- Ending the HIV Epidemic: A Plan for America, which will start rolling out this fall, which will infuse a significant number of resources, approved by congress, to allow for the end of the HIV epidemic. It's one of the only diseases we have in this country that has a plan like this, and potential resources behind it. Additionally, many of your states already have Ending the Epidemic initiatives, and I think your work in this area is definitely supportive.

But going back to, I think, the original question and what my CDC colleagues said, we're continuing to support states and are very willing, as the measure steward, to make any additions, adoptions, amendments to the measures so you are able to report on this, because it is very important, and as you heard yesterday, the great majority of people living with HIV in this country are covered by Medicaid program.

Thank you. The one thing I would just clarify, I really appreciate that flexibility. We're not entertaining in this process any changes or additions to measures. The measures before us are the ones we're voting on. But, certainly understand that when you have only five states able to report at this time, there's probably something that does need to be changed. But what we vote on today is the removal of the measure as currently constructed. Are there other questions, technical comments around these removals? Rich? I just need some guidance, please, about the process. Lindsay's question about what's the measure that is proposed, essentially replaced? So, I don't know if the person who proposed this measure for removal, and then the other one, substitutions, for those of us that may not think that they're interchangeable, would our votes based on the merits of each individual measure? I know that was a theme yesterday, but I'm trying to get to the spirit of this nominating person. I just personally don't mind revealing. I don't think that they are apples and apples. I think one's an apple and one's a banana. So, are we voting on both aspects or do we need to explicitly say vote on the virtues of each measure individually, that, in fact, the interchangeability becomes an issue, for me anyway?

Yes. I'll answer the first one, and I think David can offer some comments. In the spirit of the process, I think we are voting on the HIV viral load suppression measure for removal based on the criteria that we've discussed. Again, just now I'll add my opinion. Only five states reporting seems to suggest there's some feasibility issues, and there may be actions that are being taken in partnership with Departments of Health that aren't related.

So, I think, to the extent that we're using those five criteria as guide posts for our evaluation for removal or addition, we do that on the HIV. I think it's where we go yesterday as we did with the BMI discussion, as we did with oral health, I think as we did with immunization discussion, conceptually, though, this is an area of interest for the Medicaid Program and the Medicaid Program has a unique role to play in our public health, our public health, and so I think that there is, then, the discussion of the conceptual issue of care and treatment for individuals with HIV, which, I think, I don't know how we reconcile, but there would be a potential measure that would fill that space.

May, also have the same feasibility challenges, et cetera. So, I think we do want to, in the spirit of the process, evaluate it on the merits of the measure, as we've been doing so, but then have probably an open discussion about the importance of the issue. David, do you have something to add?

Yeah. I will confess I wanted to delete this and add the other measure, so full disclosure. When you look at the characteristics to remove, actionability, clinical relevance ability, new alternative measures or performance, again, the biggest issue here is we're X number of years into this and only five states can do it. I believe I'm a very creative person and have worked with our Department of Health for many years. I have not been able, even working through the public health domain, to get this measure done. I've tried everything in my resourceful way of thinking to get this done, and I can't do it because of many barriers.

So, one of the things that we do, we actually have our plans doing an HIV dashboard that includes other things, and a lot of those things is looking at something similar to the other proposed measure that really looks at medication. I will say that they are not equivalent, so they should not be treated that way.

However, it is very easy, the other measure, as plans easily understand how to do that using data. Again, there are a whole host of assumptions “filled medications equals I took the meds.” That was my thinking. I have been diligently trying to get this measure, have been passionate about trying to get this done and just haven't been able to. And only five states have been able to report. And I wish I could report, but my hands are -- I'm handcuffed.

So, I don't want to get into the debate about the merits of the removal, but like I said, I'm struggling with the notion of interchangeability, and so I'm purposely being a stickler on the language that we use, since there will be a public record, so I just want to make sure that the other one would be a potential alternative or something like that. The issue on the table should not be, is the measure for addition equivalent to the measure for removal, because that would get dismissed out of hand.

Yes.

So, I just want to make sure that the staff and the way the votes are framed, and most importantly, the way that the arguments, pro and con, for the other measure, are framed in that space. And I think you just essentially described it. But, again, I just want to bring up the language that will have legacy that we can all hang our hats on. Thank you.

Thank you. We'll go to Lisa and then Diane and then Shevaun.

Yeah, if I can just ask, how many years has the viral load suppression measure been on? Part of the reason I'm asking is, because since it is voluntary reporting and states are making choices, to some degree, on what they're reporting, you know, it may not be a case of can't for some states but a choice not to report. And I just don't have a handle on what that really looks like.

So, Bailey, my left-hand woman here, has told me it's 2014, and the other states that report are, Delaware, Louisiana, New York, Rhode Island, and Texas, just to give you a sense of the matter, which would suggest those are not states that hang together in many ways, size or location or anything, and so it does appear to David's point, that there's probably unique circumstances in those states that allow those states to move forward. Yes?

Thanks. I wanted to ask a question about the hemoglobin A1C. This is Diana Jolles. Can we move to that measure, or are we --

Let me check. Shevaun, is yours on the HIV viral load measure? Okay. Then, Diana, please, let's move to the --

And, Kim, did you have a question?

Kim, are you still on? I thought that might have been historic.

So, I'm looking at the outdated chartpacks. Actually, I'm looking at 2016. But the notion that we were ready to retire the measure, I just wanted to hear more from experts about this. I last see that 82% of adults with diabetes were screened, but that's in 37 states. So, Arizona and Alaska being two of the states not reporting, Florida being another state, so we don't have all the states reporting. My population on the Navajo Reservation of childbearing women in Arizona, they have 30% diabetes rates, so we know this is a high prevalence large public health issue. This isn't measuring that your level was achieved and where it needs to be, it just simply means you were screened. So, how are we ready to retire this?

Yeah, Lindsay, go ahead.

Yeah, so we also have sort of moved this off of the list of measures that we use in our state, and I'll tell you why. So, the poor control measure actually includes a testing component. So, if you're not tested, you're automatically put in the bucket of out of control. So that's how we kind of reconciled. It wasn't that we were totally throwing out the baby with the bath water, but that we were focusing on the outcomes,

and being able to parse out some of that is some work that we do internally, so we often will take our poor control rate and then just bump it up against our own internal analytics to say, was this person tested, even tested? No. So that kind of is what helped us move forward with that decision, it's because it is kind of duplicative. It's covered in two measures.

Historically, and I know this wrong, but when we first rolled out the Adult Core Set, we put this process measure in place to say diabetes is important. Later, the poor control was actually added. And the early discussion was states aren't ready to do the core control measure because you've got to capture a lab value. So, obviously, we want it to say diabetes is important, let's do this simple process screening measure, and was always with the intent towards, say, it's probably better metric, because you're actually looking at the total; that you're actually capturing the first measure and the second. So, we don't have this in our state pay performance, or may have the hemoglobin A1C for both, mainly because we want to hold our plans accountable for not just the process of getting a test done but actually moving individuals for better control.

All right. Are there any other general discussion areas? If not, we'll move to the additions in this domain, which will give us that deeper dive on in particular that HIV-related measure, and then we'll move to vote after. So, Shevaun, go ahead, yes, please.

I just wanted to say I read the [inaudible] report David said. Florida is one of those states that's trying to work with our Department of Health on HIV, the viral load suppression measure to get the data from them, and we are very close. But it took a couple years. We've been working on it for a couple years. So, even if we decide to recommend to retain the measure, for those states who want to move in that direction, it does take time to move in that direction.

Terrific. Thank you. Yes?

Can I make two really quick comments, and this is just from a public health standpoint?

On the removal, yes.

Actually, both, on the diabetes and the HIV.

Sure.

And this is a little bit on process, and I should have said this when you were asking about process. So, this might be a conversation to return to Thursday, linking some of the additions and removals.

Yes, that's part of the process.

Because I think on the HIV, you know thinking in total, the screening, the viral load, and then the treatment, because I think is about what's the right way balancing the technical issues with the health burden, and, you know, so depending on how this all goes today, it feels like coming back -- I'm sorry, this is Laura Seeff, by the way. It might come back on Thursday to think about those in total. And I think same for the diabetes, the HB A1C is enormous public health problem. But I think the point that the measure that also tracks outcomes is a better measure, so I think seeing those together.

And one more thing about the viral load, that is an outcome measure, so obviously, when you're looking at feasibility and outcome versus process. So, I think thinking about them in total, I think, would be helpful, all of the technical challenges, notwithstanding.

Thank you.

I had a quick comment, this is Alice from the National Vaccine Program Office again, and I echo, our CDC colleague mentioning of the totality, and when you consider the maternal and perinatal health domain coming up, again, prenatal immunization measures….

So we'll come back to those when we're there. Thank you. Okay. So I'll let -- yes, one more. Yes, David.

Thanks. One comment I just wanted to make about the removal of the HIV viral load suppression. I have some concerns that part of the reason why it's so difficult to obtain these measures from a lot of states is because HIV disease is so highly stigmatized. And whenever an effort to try to make a discussion of stigmatized diseases more transparent, that reinforces the stigma associated with that disease category. And I'm worried that even though we are citing the states and the state laws as being the main barrier to getting this information, we're still a part of that conversation, and I'm worried that if we brought this measure, what states are going to hear from us is that we're no longer considering this a really important priority, which I recognize is not the point at all of the what we're trying to do. But I think that we're part of the effort of trying to make this more transparent and less stigmatized, and if we drop that effort, then we will contribute further.

Thank you for that perspective. Yes, Fred?

Fred Oraene with Oklahoma Medicaid. And so I just wanted to kind of echo what has been said, just around the challenges with the HIV measure. But, also, I wanted to add that, for us, we'll actually been talking about this one, after kind of doing our due diligence, you know, around privacy and all of the things, all of the concerns around this measure and feel like from the admin -- you know, using admin data, that we might be actually able or getting close to a point where, as a state, feel like we are at a good place to probably report this measure. Because kind of like our colleagues in New York and California mentioned, the fact that it's summary information; right, kind of helps with some of those concerns around privacy. So, as a state, we feel like we are, you know, getting close, or probably real close to a place where we can actually start reporting this measure. So, hopefully, pretty soon, you guys will see us as one of the five states.

Terrific. Thank you. It sounds like Florida is close, so, clearly, states are working on it. Thank you. Okay. In the interest of time, I'm going to move us forward to the additions, and there are six in this bucket again, and we'll hold the vote on all nine of these measures when we're done with this conversation. So, Alli?

All right. Thank you. So, the first two measures that I'll present are the two NCQA measures. So, at the end of presenting all six, we'll provide the opportunity to provide any clarifications that were raised by NCQA. So, the first measure is avoidance of antibiotic treatment for acute bronchitis/bronchiolitis, which is a HEDIS measure and is NQF endorsed. It can be calculated using administrative or EHR data. The denominator is all members who had an outpatient visit, telephone visit, online assessment, observation visit, or ED visit with a diagnosis of acute bronchitis or bronchiolitis. The numerator includes dispense medications for antibiotic medication on or three days after the episode date.

The existing measure has been in use since 2006, but the measure described on the slide reflects some 2020 updates, and it was suggested for addition to address a gap of assessing appropriate use of antibiotics. Additionally, approving antibiotic use is a key strategy to combat antibiotic resistance and improve patient safety, and then finally, respiratory infections are a key driver of unnecessary antibiotic use. Next slide, please.

The next measure suggested for addition is appropriate treatment for upper respiratory infection. This is also a HEDIS measure and is NQF endorsed. It can be calculated using administrative or EHR data. The denominator includes all members who had an outpatient visit, telephone visit, online assessment, observation visit, or ED visit with a diagnosis of upper respiratory infection. The numerator includes dispensed prescriptions for an antibiotic medication on or three days after the episode date.

Again, the existing measure has been used since 2004, but the measure described here on the slide aligns with 2020 updates. But we'll hear more from our NCQA colleagues in a few minutes about that. It was suggested for addition as well, to address a gap of assessing appropriate use of antibiotics.

Respiratory infections, including upper respiratory infections are key drivers of unnecessary antibiotic use. Next slide, please.

The next measure is the Transcranial Doppler ultrasonography screening for children with sickle cell anemia measure. This is stewarded by Q-METRIC at the University of Michigan. The measure is NQF endorsed and can be calculated using administrative data. The denominator includes children who have sickle cell anemia during the measurement year, and it's captured slightly differently, depending on whether ICD-9 or ICD-10 codes are being used. The numerator is the number of children ages 2 through 15, with sickle cell anemia who received at least one Transcranial Doppler ultrasonography screening during the measurement year.

The measure was suggested for addition because it aligns with NIH guidelines for annual TCD screening among children with sickle cell anemia. The workgroup member also noted that the measure addresses disparities in care for a population at risk for stroke at an early age. Additionally, preventative services, such as Transcranial Doppler screening could reduce neurologic morbidity for these individuals. Next slide, please.

All right, this measure is appropriate antibiotic prophylaxis for children with sickle cell anemia. It's also stewarded Q-METRIC and is NQF endorsed. It can also be calculated using administrative data. The denominator is the number of children who have sickle cell anemia during the measurement year, and the numerator includes children who received antibiotic prophylaxis for at least 300 days.

The measure was suggested for addition because it could potentially have a large impact on the treatment of children with sickle cell anemia. Individuals with sickle cell anemia are particularly susceptible to infection and antibiotic prophylaxis, which is known to reduce incidents of invasive pneumococcal disease is underutilized. Next slide, please.

All right, so this is proportion of days covered: antiretroviral medications. It is stewarded by PQA, and it is not NQF endorsed. It was suggested as an alternative, potentially, for the HIV viral load suppression measure, and it could be calculated using administrative data. The denominator includes individuals 18 years or older who filled a prescription for at least three distinct antiretroviral medications on two different dates of service during the measurement year, and the treatment period must be at least 91 days during the measurement year. The numerator is the number of individuals who met the proportion of days covered, threshold of 90% during the measurement year.

The measure was suggested for addition as a way to look at the quality of care among beneficiaries with HIV and can be used to assess adherence to HIV medications that lead to viral load suppression if taken correctly. Next slide, please.

All right, and this is the sixth measure suggested for addition in this category. It's the statin therapy for prevention and treatment of cardiovascular disease. This measure is stewarded by CMS. It is not endorsed and it was not recommended to replace an existing measure. It can be calculated using EHR and registry data. Next slide, please.

So, the denominator includes patients who meet the criteria for being at high risk for cardiovascular events, so this includes patients with a clinical ASCVD diagnosis, patients who have ever had an LDL measurement greater than 190, or who were previously diagnosed or have an active diagnosis of familial or pure hypercholesterolemia and patients with diabetes with an LDL measurement from 70 to 189. The numerator includes patients who are actively using or who receive a prescription for statin therapy. This is an eCQM measure, number 347, and, as such, has undergone requisite testing for a CMS measure to be E-specified.

It was suggested for addition because there is strong evidence for prescribing statins for prevention and treatment of cardiovascular disease, which is the leading cause of death in the U.S. Additionally, a study that surveyed cardiovascular practices in the U.S., found that nearly one-third of patients with an

indication for statins were not currently receiving them, and because of their generic status, that ends relatively inexpensive and readily available. So, now I will open it up for clarifying questions.

We'll come to the sort of technical clarifying questions first, and then we can move to general discussion. Laura? Whoa. Welcome, Laura. You can just use your outside voice, yeah. No. Try that one.

Sure. So, just a small process question, for the two appropriate treatment antibiotic measures. Given that the age range for those measures spans across children and adults, would a vote to add either of those measures go into both the Child and Adult Core Set?

The recommendation would be, from our workgroup, that this is a measure that is worth real estate on the Core Set, and it's up to CMS to decide where the final -- where it would lay.

Thank you.

So, ours would be that it met minimum calls and it was worthy of our recommendation, and then CMS makes that decision.

Got it.

Thank you for the question. Lindsay?

I have a clarifying question for the proportion-base covered of antiretrovirals. So, can the steward explain to me how you're handling preexposure prophylaxis with that measure?

Hi. This is Lisa Hines from PQA. So, the measure identifies individuals, it measures individuals who are on three antiviral medications, and that was intended to focus on antiretroviral therapy and not PrEP. Most of the PrEP regimens use two medications at once, and so they would not be included in the numerator. So, it's intended to target individuals.

So this is Lindsay Cogan from New York state. So, we're taking a really close look at this, and we are seeing an explosion in preexposure prophylaxis. And the drug list now that I have to keep an eye on is very long and there are single regimens. So, you know, that's fine if the intent of this measure is to truly just track antiretroviral usage and not focus particularly on those individuals diagnosed with HIV. I know a lot of your measures are simply medication adherence and not focused necessarily on that extra step of disease modality. But I just want to clarify, again, do you need a diagnosis of HIV or are we just looking at drug compliance?

It really does require a medication claims data, and it is serving as a proxy. And it was thought that adherence to PrEP regimens would not be appropriate measure, because that therapy may be intermittent.

Okay. Thank you. It can be rather long, so we're seeing 13 fills, five fills. And it's not wrong to track those people who are at high -- that would be considered at high risk. We want to keep an eye on them. But I just want to make sure that everyone is very clear about the intent of the measure, and it's an excellent sort of step in the cascade of looking at proper HIV, you know, care and interventions.

This is David. I don't think there's any evidence that three drug regimens should, and just looking at greater than or equal [inaudible]. There should be a way. I know we've looked at this. We've parsed out those individuals that we feel are one PrEP, looked at claims data, and there are folks that are on antiretrovirals that don't have to diagnose of HIV, and, again, that can be a stigma the providers don't want. And then there are other instance where I think that people are on PrEP, but effectively, that particular [inaudible].

It's important to note also that PEP is usually a three-drug regimen. PEP can often be exposure to social prophylaxis. PEP is likely distinguishable because it's a shorter course. Usually it would be only one fill. But because it's also a three-drug regimen, you'd have to be careful to distinguish that.

Thank you. Are there other technical questions? Jill?

So, I may have missed heard this. The statin measure, did it say people who have received a prescription or was it received and filled? There's no way to know if somebody received the prescription if they don't fill it, and I thought I had heard "received." I just wanted to make sure.

So, the measure steward is CMS. Does CMS want to respond?

Hi. This is Claudia Hall from Mathematica. Can you hear me?

Yes. Hello? Hi, yes.

We can hear you.

Okay. Great. The measure is looking for the Statin order. The order needs to be placed. So it's not looking for confirmation of receipt of dispensing.

There are a number of confused looks in the room, so maybe could you restate that. The question that Jill asked, is it just the prescription or is it a filling of the prescription?

Just the prescription. It's just the prescription. Just the order.

Go ahead, Marissa.

Yeah, the specs say receive an order for statin therapy at any point during the regimen period in the EHR measure.

Which means they might never have filled it and taken it; okay.

Correct.

Correct.

I want to ask and talk about any of the technical changes to the other two measures being related measures.

Sure. Hi. This is Sam Benton from NCQA.

Thank you.

So, the bronchitis and upper respiratory infection measure, the only clarifying point I just want to make is one change we did make was transitioning them from member- or patient-based measures to episode-based measures. So, I know the denominator description says "All members," but it's really a count of all episodes where the member had those diagnoses, so they could have multiple episodes throughout the measurement therapy. Thank you.

So, moving us, then, maybe into the discussion, I would just say the avoidance of antibiotic treatment measures, from putting my previous Medicaid director hat on, seem interesting and important. My concern is the breadth of at least in Colorado, we often incented our primary care delivery systems on certain measures, and our acute care delivery systems on other measures. That's not to say you couldn't put these kinds of measures into both quality, as well as perhaps value-based payment arrangements or other things. But that just is give me some pause of how maybe if you're in a full capitated managed care

structure, you put it in and the plan has to figure out how they're looking at all parts of the delivery system. But from a state that often worked directly with different portions of our delivery system, this one just gives me a little pause of successfully understanding how to take action on this, given that interaction with the different part, office our delivery system. So, just a general comment as it relates to the actionability issue.

Are there other general comments about this host of measures, again the sickle cell anemia related measures, those that relate to antibiotic use, and then the antiretroviral and statins? Yes?

Which ones are we commenting on? On the potential additions in the acute and chronic care. We talked through the removal of the now. Let's talk through the additions and then we can put them all back together before we move to vote. Yeah, thank you for helping us be oriented. Yes, Jeff?

Hey, Jeff Schiff from Minnesota. I want to talk about the antibiotic ones, the URI and the bronchitis. I have some concerns about those, because we had a pharyngitis-type measure like this, and it turned out that organizations worked hard to recode, and it became a coding exercise rather than a quality exercise to make sure that an inappropriate antibiotic was -- that an antibiotic, when prescribed, had a diagnosis of sinusitis or something else rather than diagnosis that would get you dinged. So, I think antibiotic stewardship is a really important issue. I just don't think that these measures will work effectively in that space.

Okay. Thank you. Rich and then David, Sally, and then Carolyn.

I, from a clinician point of view, completely agree with what Dr. Schiff just said. Technically speaking, a sinus infection, which, generally, if it's bacterial, needs an antibiotic, is an upper respiratory tract infection. URI in lay terms basically means a cold, which is a virus, et cetera. So, I am quite aware of people meeting this measure by tweaking their coding.

I'd like to actually address the two measures around sickle cell disease under our consideration. I do want to acknowledge the precious nature of the real estate on the Core Set; however, I want to share a story. I was at a national quality meeting in Atlanta six weeks ago, and a state was there to talk about their opioid crisis. The pressure on this particular state's leadership from both Medicaid and the Governor's Office was significant. In fact, the following statement was made in March of 2019, "We were going to be looking at, in particular, patients with sickle cell disease coming into the emergency rooms that are seeking opioids." And I was deeply disturbed that that statement could be made in 2019, maybe 1919, but that is beyond the pale for me. I politely said, "You are aware that there are quality measures for sickle cell disease which would prevent the system from exposing these patients to opioids over time," and they said, "No, we're not. But that's out of scope for us."

So, I really want to put a stake in the ground for this group to deeply consider these two measures. The penicillin prophylaxis costs about 19 or 20 cents a day. It is literally lifesaving. The Transcranial Doppler has significant implications for prevention of long-term, if not permanent, disability. These measures have disability written all over them, have disparity, deep roots of disparity. This is a population that the experience, in terms of compliance with antibiotic prophylaxis, lives around 20%, so 20% of children in this country with sickle cell anemia disease are getting literally lifesaving antibiotic; that's it. So, I know that part of our struggle in this group is what defines the criteria to get into the Core Set.

I would very much like to ask your reflection and your commitment to mitigate something that is truly preventable and do everything we can not to put patients with sickle cell disease into the opioid reduction crosshairs, because that would add truly insult to injury.

Thank you, Rich. David, nothing to add?

Rich basically answered my question. Thanks.

Okay. Just more information about the sickle cell measures and the priority and how to think about them and where they fit.

Thank you. Sally?

So, the sickle cell measure, the antibiotic prophylaxis was recommended for the Core Set last year. CMS didn't make any changes to the measure. [Inaudible]. We know, based on the work that the measure developer did, as well as others, that there are huge variation in performance, and it can be pretty low as well. For children's hospitals who care for a lot of children, and adults they care for, so we are aware that. We are aware that the prevalence of [inaudible] is relative, though there are more with sickle cell than with [inaudible] not a tiny population. It is a very painful disease when you have flare ups, and interventions for zero to five to prevent pneumonia, which risk for this population, as it is for healthy babies that get pneumonia, that's not something a baby should have, that is shown to be effective and [inaudible] very low cost, and certainly lower cost than having them end up in the hospital.

What we know, because it's a genetic disease, prevalence of the population varies by state. So it's very possible for some states, it's possible that for some states, prevalence -- well, we know that the prevalence will be lower in some states, higher in others, which may implicate priorities in which [inaudible] measure. These are administrative claims-based measures, so in regard of feasibility for a state to look at these measures and calculate them, certainly no cost -- no measures, no cost, we know that. But it is on that playing field, and it really makes a difference in the quality of life of the parents, being able to have healthy children, as well as Rich pointed out, progression of how often they are assessed in the hospital. So, we really support these measures. We think some states will have larger populations to receive priority. But we think, overall, as a Core Set, it's been a validated measure, and we would like to shine the light on populations such as we know there are issues. There's no way to make --

I'm going to ask you to wrap up.

Yeah. So, I think we just want to, again, impress that we [inaudible] on the Core Sets, both of them.

Thank you. Carolyn. And we've been requested, again, to speak directly into the microphone.

This is probably a question for our colleagues at NCQA. So, in reading some of the background information, I do think it's important, and I applaud you for adding specifically telehealth visits. I am very concerned. And the information in your background material also supports that we are seeing increased use of antibiotics by telehealth providers. So, I'm just wondering if you could comment, because I also share Dr. Schiff's and Dr. Antonelli's concerns that sometimes providers kind of game the system with the diagnoses. And I'm just wondering, you know, what you thought about it in terms of putting guardrails around this, because in your own background information, you mentioned that diagnosis of URI by telehealth providers seems to be less accurate than that of in-person visits.

So, in terms of the coding issues, you know, I think gaming of any quality measure is always a concern. I'm not sure that it is terribly specific, but maybe it is for this sort of thing, because, you know, of all these different diagnoses that can go in, and some qualify and some don't. You know, we have field tested measures. Also, all of our measures are audited, and so we try to do what we can to make sure that this is not about coding. You know, we've done testing early on, when they were first developed, to make sure that they were valid and reliable, and they've passed these criteria. But it's always a concern that we have to be vigilant about, I think, for any measure.

In terms of the telehealth, we added telehealth because these are overuse measures, and so when it comes to things like, you know, what we've seen is that some people are using telehealth and then getting prescribed antibiotics. But we want to make sure that, if that is happening, their health is the same standards of inappropriate prescribing. So, by pulling the telehealth visits into the measures, it means that they are now being watched to make sure that there no inappropriate prescribing. So it's not that we're condoning the use or not, it's just that if it is used, we want to make sure that it's not inappropriate.

Yeah, I would just add, anecdotally, I have seen increased prescribing of antibiotics by telehealth providers compared to in-person visits.

Thank you. Yes, Laura, did you have a direct response?

I did. So, this is Laura from CDC, and I'm now channeling my healthcare inquired infection colleagues who we work very closely, and this is, again, an issue of great public health importance. Antibiotic resistance is a very real issue, and so this, really, measure is about changing provider behavior, and I think I agree that people game all these measures across content areas. But this is being inserted into all measure sets. And to your point Gretchen, in inpatient settings, outpatient settings, long-term care facility settings, and in concert with provider education, and so it feels enormously, again, from a public health standpoint, a topic to consider.

Tricia, I know you have a question. I have one that just as a follow up. Given that they are similar but obviously clinically different, for the clinicians in the room, if there were going to just be one added to sort of test to see how the system responds, again, our recommendation, CMS makes the final, is there a differentiation between the URI and the acute bronchitis/bronchiolitis that would be clinically relevant or perhaps reduce the gaming and be less open, less likely to have that happen, or are they, in some ways, interchangeable and no clinical difference? Everyone's looking at you, Jeff.

I see that.

And Rich.

And Amy.

Jeff Schiff from Minnesota. In the children's ER, we have the Ten Commandments of bronchiolitis on the wall, one of which is, do not use antibiotics. But you can handle "titis" at the same time, ear infections at the same time as you have that, so I think I would say that there are probably less individuals diagnosed with bronchitis or bronchiolitis than there are with URI.

As we're having this discussion, I have to tell you, I have been thinking that what we need, in some ways, we need a balancing measure of, you know, the ratio of pneumonia -- this is off topic, I know, but give me two sentences -- a balancing measure ratio of pneumonia to bronchitis/bronchiolitis first, to find out whether or not people shift their diagnostic codes, and then you could look at the antibiotics, and the same thing you could say for URI and sinusitis. But I would say that the lower respiratory one is probably -- I mean, my colleagues may have different opinions -- is probably more relevant.

Yeah. Rich, did you have something to add to that?

Yeah. I don't want to prolong the discussion, but I think about the pharyngitis, which for those of you that aren't clinicians means a sore throat. And that measure is kind of interesting because it's tagged to doing a throat swab. The bronchiolitis, acute bronchitis measure, bronchiolitis is a very, very specific disease entity that's basically delimited to 24 months to birth, and most of those are probably 12 months of age and younger. So, it's essentially a different animal than acute bronchitis from, you know, two years of age and older. I've spoken with many clinicians who basically are saying, okay, to meet that measure, I'm probably going to do more chest x-rays, and then we get into the situation where, okay, is radiation exposure a reasonable tradeoff for reducing antibiotic abuse? Now, please, do not misinterpret what I just said. This is sort of frontline clinician experience. I absolutely hold to antibiotic stewardship a key goal for the global health, not just the United States there. But, you know, since you asked for my input as a clinician, that's the dilemma that hits frontline PCPs and frontline ED docs often.

Amy, do you have a perspective to share?

I totally agree with what you just said. I think that the question I think you asked, too, was, you know, which of these measures would make more sense possibly to put into the Core Set? And my opinion on that would be the upper respiratory infection, the avoidance of antibiotic use in upper respiratory infections and not -- because I think of what you just said, I mean you get too much nuance in the

bronchitis/bronchiolitis world that the URI is a little more clear-cut than that. So if I had to, like, pick one to say would be easier just to put into the Core Set that would be the one.

But just to keep us intellectually rigorous and honest, I still think if you had asked that question and pharyngitis was on this triad of measures, that would have been my first one, because it's linked to something that you can measure. There's an inherent balanced component built into it, so you're giving us choose the less worse of these two options, when the one that I would have promoted is actually the pharyngitis measure. You either prescribe with a throat culture in hand, or a rapid strep test in hand, or you don't. And if you prescribe without it, you've just dinged yourself.

Okay. Thank you for that clinical perspective.

[Inaudible].

Okay. I'm going to give us yet a guide, because you've been so -- I'm just going to give you a time guide. We are scheduled to continue this debate until 10:45, and I know that people wanted to go back to sort of marrying the removal and additions, so let's continue the discussion around these couple of additions, just until we get a level of comfort, and then I want to make sure we don't find ourselves up against the deadline and feel like we didn't do what we wanted to do earlier, so Tricia.

Hi. Good morning. Tricia Elliott with the Joint Commission. I just had a quick comment on the statin measure. Just from the organizational hospital perspective, the Joint Commission is a steward of a measure statin at discharge that is similar to this one, so we included part of our stroke measure sets, and have fairly high compliance with it.

So, I just wanted to offer that perspective, that this one seems to be driven at the provider perspective, obviously. So, we think, especially since it's an ECQM, we like that, and that's a direction that we're going.

Terrific. Thank you. Sally?

A few quick questions, both of them for folks -- one for CDC and for NCQA. My recollection is there was work and potential progress on state-level antibiotic stewardship measures being pediatric antibiotic stewardship, and I wondered if there was any update on how those were progressing. And my second was to NCQA about the pharyngitis and what's its current status. If it's part of HEDIS 2020 and whether it is it currently being used?

Terrific. So, who has the microphone? NCQA, let's start with you.

All right. And I just want to note one thing, that if you're talking about upper respiratory and bronchitis, that the bronchitis performed much worse than upper respiratory infection. That's one note. I'm going to pass this to my colleague.

Actually, could you just explain what you mean by "performed worse?" That doesn't make sense.

The performance is lower, so plans do worse on the bronchitis measure compared to the upper respiratory infection measure.

Suggesting inappropriate utilization for bronchitis and bronchiolitis.

Yes.

Christine, I was actually going to bring that up, if you don't mind.

Sure. Our state performs at -- the URI measure currently only covers children. Our state is in the high 90s and has been forever, which mean that is children are not being dispensed antibiotics. With the adult bronchitis measure, it's 30%. So higher is better.

Yes.

93 is good. 30, eh. But we do also note, you know, we've done extensive review and note as well that there are some methodological issues that we think with that bronchitis measure. So, you know, tipping to the URI a little bit as well. But just so you know, the URI, it's now going to be expanded to capture adults, but in your child core, in your child section the compliance rates are already very high. Thank you for that knowledge.

NCQA.

Can you describe the pharyngitis measure?

Yeah, so the pharyngitis measure is still in HEDIS. When we updated or reevaluated these two measures, we did it in tandem with the pharyngitis measure as well. We did expand that measure to the adult and older adult population, in addition to the child population, which it currently covers, and we did some other revisions to make it more aligned with these measures as well, including updating the exclusions.

As far as NQF endorsement, I think that was your question?

Yeah, and if you could quickly, is there room for improvement on pharyngitis and NQF endorsement?

Yes. Yes. I don't have the performance rates in front of me, but I believe it is similar to the bronchitis measure, where it's average performance, I believe, is around 50%, so there is room for improvement on that. It does not have NQF endorsement. It recently lost NQF endorsement, I believe, for three or four years ago. They were concerned that we couldn't account for the center criteria or the empirical diagnostics clinical tools to prescribe antibiotics empirically. Diagnosing strep was based on symptoms and not based on a strep test, so that was their reasoning, the committee, at that time, for losing endorsement. But when we reevaluated, our expert panel felt like we didn't need to include that again.

CDC, questions to the CDC?

Can we open the line? I have an SME to answer your question on the experience around whoever asked about pediatric data experience and the URI measure. You might need to repeat the question, but I've got Dr. Katherine Fleming-Dutra on the phone, if we could open the line.

My question was, my recollection was that there was work by the CDC on state-level or county-level antibiotic stewardship and that it included pediatric. I wasn't just interested in pediatric. So, basically what's the progress on state-level or county-level antibiotic stewardship performance?

Katherine, did you hear that, and can you answer? You should be unmuted.

If you're on the phone and still not unmuted, you can press "5*." You can also use the Q&A box, and then we can come back to you.

Just start speaking Katherine.

Hi. Can you hear me?

Yes. Can you turn up a little?

Yes. So, let me just make sure that I understand the question. So, the question was around progress on state and county level stewardship -- outpatient stewardship work; is that correct?

Yes. Okay. Just to introduce myself, I'm Katherine Fleming-Dutra, and I'm the deputy director here at the Office of Antibiotic Stewardship at CDC. We have been working in collaboration with state and local health departments for a number of years on implementing antibiotic stewardship across the state of health care, including in outpatient settings, and there has been quite a bit of progress in implementation of outpatient stewardship. In 2016, CDC released the core elements of outpatient antibiotic stewardship, which really provided a framework for implementing stewardship in outpatient settings and compiled a lot of evidence-based recommendations, or evidence-based interventions, I might say, into one guidance document that we published. And we've been working hard through various numbers of partners to increase implementation for core elements, including through CMS.

As you may know, the Quality Innovation Quality Improvement Networks, or QIN-QIOs, have been recruiting and implementing the core elements of outpatient antibiotic stewardship in outpatient facilities across the nation and have recruited over 7,600 outpatient facilities to implement these core elements, and our group has been providing technical assistance to QIN-QIOs in that work, which is mostly focused on adults and Medicaid beneficiaries, as the QIN-QIO work is.

Is there a particular -- did you have a particular question regarding the HEDIS measure around URI or other specifics that I can speak to that would be helpful for your information decision-making?

My recollection, which could be incorrect, was that there might be some measures coming out of that effort that would allow for an understanding of antibiotic stewardship performance at the state -- some kind of population-based level. But perhaps my recollection is incorrect.

So, in the outpatient setting, CDC publishes outpatient antibiotic prescribing rates per 1,000 population. We publish that in the Patient Safety Atlas each year. That's from a proprietary data source that we purchase, and then put the information on our website. CDC also tracks hospital-stewardship program implementation that aligns with the hospital core elements, and that's tracked through the National Healthcare Safety Network or NHSN annual survey, and that information is also published on the CDC's Patient and Safety Atlas or the Antibiotic Patient Safety Atlas on our website.

But at this point, we do not have a similar survey or tracking system that would apply to outpatient systems or outpatient facilities. So NHSN will cover hospitals, and they also survey nursing homes, but outpatient facilities are not part of that survey, and so we don't have that kind of tracking mechanism for implementation of outpatient stewardship efforts.

Thank you. Terrific. Thank you for that additional information. I very much appreciate you weighing in as the subject matter expert. Going to move to the conversation, and then I am conscious of wanting us to have ample time to discuss the pairing of those two HIV-related measures, and any other discussion. So, first, we'll go to Lindsay, and then, Jill, you've been waiting for a long time. Oh, sorry. Is it Linette? Sorry.

Thank you. Actually, I was just going to run down a couple comments on sort of each of those. So, Linette Scott from California. When we were thinking about a number of these, we were focusing on outcome, as opposed to process, when we were thinking about measures. So, on the HIV viral load suppression, as we talked about, we've been reporting it, and so that's an outcome measure; whereas the antiviral medication measure is not so much, and it has a lot of the complexities that were talked about earlier between PrEP and ongoing, and not that you necessarily can't, but it makes it a lot harder. So, we would support keeping the HIV viral suppression over the antiviral medications, as we've talked about it.

Similarly, in terms of the hemoglobin testing, Lindsay did a fantastic job of describing it. Our primary thought there was that it's incorporated in the control measure, and, again, thinking about the push that we heard from CMS at the quality conference, looking towards outcome measures, as opposed to

process measures, that was part of our interest in removing the testing measure, to make room for other type of measures.

In terms of thinking about the bronchitis versus the upper respiratory, our tendency was to go for the upper respiratory for some of the reasons stated earlier, also being a common primary care diagnosis that we see very frequently, and it would be interesting to hear Lindsay say that the child part of that, they've been forming high -- it would be interesting to see how that works as we expand to adults. One of the challenges, often in terms of the antibiotic conversation, is that providers are balancing between scoring well enough on their consumer satisfaction versus doing the right thing. And I know when I did some clinical work in the past, that was a very awkward position to be in, to have that experience. I know that the right thing to do is to not give an antibiotic right now, but I have people pressuring me and saying they're going to go elsewhere to get it if they can't get it from me. So, it is a very prevalent thing, so I would encourage us to only have one not two in this area, also just from a scoping perspective.

On the sickle cell, I would agree with the importance of having this population to have some focus here, but would probably go with the prophylaxis, as opposed to the ultrasound. Some of our clinicians expressed concerns just over the ultrasound. While very valuable in the right hands, it isn't necessarily universally performed as well in every situation, and so the prophylaxis piece is a lot easier and has clearly demonstrated room for improvement and has the outcomes that we're looking for. So, those were the common things.

Terrific. Jill?

So, I wanted to real quickly come back to the sickle cell and sort of do the same activity that you had done around the URI bronchitis and kind of ask, I'm clinically way too far away from having treated sickle cell acutely, or even chronically, doing just developmental stuff, but to ask Rich or Jeff which of those two measures -- they're both the best practices in treating folks. Not all have access to a children's hospital, so, you know, either way, encouraging people to do best practice is really helpful. But to ask the two of them, and maybe our family practitioner down the way, kind of what their thoughts would be in terms of, if you only had one measure, which would you choose?

This is Jeff from Minnesota. I would put the antibiotic on there. It's a measure of continuity of care for a chronic disease that's really crucial and probably has the greater impact in terms of morbidity and mortality. The Doppler is really important, but it's a one-time event that we're measuring rather than that then has to be linked to a further downstream process of care.

Thank you. Rich?

Rich Antonelli here. And I actually would agree to, to the degree that we want one footprint. But as Dave Kelley mentioned yesterday, and then again today, just because something is in the Core Set doesn't mean that these measures don't line up; right? So, the antibiotic prescription measure literally is a primary-care-based entity. Many of those patients, depending on the state which they're in, sickle cell is part of the newborn screen, so, from the moment those individuals enter the world, they theoretically get identified. So, there's a handoff from the nursery to the community.

The penicillin prescription or the antibiotic prescription measure actually could even be viewed as an integrated care-type measure. And then for state that is are doing a deeper dive on sickle cell writ large, you know, you can look at the Transcranial Doppler. So, less is more, especially when we're talking about the Core Set.

Thanks. Amy?

Antibiotic one. Perfect. So, I'm going to take us -- we have two things, the annual monitoring for patients on persistent medication, there was really no discussion. No technical questions came up. As a non-clinician, I need a little more help with understanding what that one's about. And then we'll go back to this HIV. I just want to say for our community, this conversation has gotten us maybe closest to advocating or

lobbying for certain measures, which is understandable, given that these are some technically clinically technical measures and we needed some help. But let's just try and remember that we're here on behalf of all of these measures and of the Medicaid program, so it is helpful to know that where people are having pause around actionability, feasibility, clinical relevance, those things, I think we're doing a good job, but let's just remember where that line is and stay close to it.

So, if we could talk about the annual monitoring of patients on persistent medication, if there's any group conversation, it is one that is proposed for removal, and if there's a perspective on why that might be a reasonable for recommendation of removal? Lindsay?

The performance rates for those measures are very high. We're talking in the high 90, so we've removed these from our pay for performance. We have no objection to removing these measures.

Okay. Others? David.

I will comment. Removal, again, of high performance [inaudible] fairly high performance and a process measure [inaudible] get to the outcomes, so [inaudible] states. [Inaudible].

Okay. Linette; yeah.

Traditionally, those were no longer endorsed.

Okay. Okay. Yes, NCQA has a perspective.

And I want to note, we are retiring it from HEDIS as well.

Okay. The negative column is lining up. I'm glad we had a discussion about it. Yes, Rich.

Rich Antonelli. I just want to make an observation. I think everybody -- and I apologize, I'm going to go back. I feel really stuck trying to prioritize which of the two antibiotic stewardship measures are there. I don't think that I've gotten a good indication as to why we wouldn't consider pharyngitis. I recognize it because it's nominated, so there's sort of a process for that. But I guess I just want to make sure that everybody around the table knows that this doesn't have to come down to we need to send the message about antibiotic stewardship, oh, well, we have to choose something. In my view, there is something that could be done. It sort of aligns with the work that CDC is doing, that Sally did some work around. But I really don't want people to think this is a, you know, do it now or forever hold our peace. There are other things that we could put in this space.

Yeah. And David has a perspective. I just want to say I asked that question just out of curiosity. There is no requirement of a quid pro quo here of one or the other. I just didn't know the difference well enough to understand, so don't interpret that we have a mandate to pick one, absolutely not. David?

I think the pharyngitis measure actually was fine as it was worded. Clarifying question again, as I'm looking at our performance on adults with bronchitis [inaudible] higher is better remind me that specifications on bronchitis is with bronchitis [inaudible] and then, conversely, looking at [inaudible] children with upper respiratory infection based on [inaudible]. So that would be my interpretation of the measure. One measure was mainly for adults really, really poor performance. One measure for kids, really high performance, and the goal was to spread out those measures across those age spans. Is that correct?

Yeah, that's correct.

I'm kind of trying to get some more clarity. And then maybe I'll ask folks to weigh in. Out of the two, what would you prefer? What's your preference?

I think we've heard a little, and there was a split vote amongst the clinicians' perspectives of some for URI. Again, I think if there's an additional perspective on that, again, we're voting on each of these measures independently, but since some are in relation to one another, this conversation just informs people's decision-making. Lisa?

Sure. Lisa Patton. This is kind of back to Rich's comment, and it's more of a process question for the group. So, because we're recommending measures through CMS, CMS could go back and say, hey, you know, we heard the thinking on this, and we want to put the pharyngeal measure back on. So that could happen. And do we know why it was removed? Is there any sense of the history of why that measure was removed?

Yes. And let me just say that, for those on the phone, the answer to the first question was, yes, CMS has independent decision-making authority here to pick the measures. Just those submitted were just for our consideration. I don't know the history of the removal.

I don't know if we want to cover that at this point.

Yeah.

That discussion.

Yeah, perhaps tomorrow we can learn.

Have discussion tomorrow for strategizing.

Yes. Thank you. So, I am conscious of the time, and I guess we'd just like to see if now that we've gone through both the discussions of the HIV-related measures, if there's any additional discussion. Rich did a nice job of reminding us that these are not replacement perfectly aligned measures. They measure different things. They just happen to both be about the experience of individuals receiving care who have HIV. So, is there any additional discussion there before we move to public comments, and then we'll come back and do the process that we did yesterday, which is formal motion to move ahead and talk about the removals and then a formal motion to move ahead and talk about the additions. We'll vote on them each independently, and I don't think we have -- do we have any disclosures on any of the votes.

No.

No. So, the number will be all 28 of us participating in the voting. Any final comments on HIV related before we move to public comments. Linette?

Sorry, it's not the HIV.

Okay. That's fine.

But on the statin therapy one, I know there were a lot of looks going around the table that weren't said out loud. Well, at least at this end.

We can't see that far. Yeah. In the context of the fact that it's looking for a prescription of being made not a claim occurring, and so it really is strictly an EHR-type measure or chart-review-type measure. From a feasibility perspective, that would be very hard to do at a statewide level. And if it's not already being done by managed care plans. So, for example, our fee-for-service population would not be something we would incorporate into that in California, and our fee-for-service population is still a couple million people. So, from a feasibility perspective, that one would be very hard.

Thank you for that perspective. Any others? Yes, sir.

Yeah, hi. Norris Turner from PQA. Yeah, one of the things with respect to the antiretroviral adherence measure is, of course, it is a measure of adherence; right, and it's imperfect. It's a proxy. But it does speak to, you know, a kind of taking your medication to a stage of completion where you achieve the therapeutic outcome. But when you don't take it, your medication sufficiently, it starts contributing to resistance, the development of resistance of, you know, of the virus, and so it helps indirectly address some of the challenges with HIV resistance.

Thank you. David?

David Kroll from Brigham Health in Boston. I would actually just add to that statement. I actually am conceptualizing these two measures as not necessarily totally linked. I mean, I think part of the story behind this is, David, you were talking about how to try to think as creatively as possible to get around this problem, and I think this is a really good example of thinking really creatively about how to better measure HIV care within the state. But this is actually a measure of something different. This is a measure of access to care. This is a measure of efforts to reduce antibiotic resistance, antiretroviral resistance, as you say, and one of the correlates of this measure is also likely the outcome of reduced heavy viral load.

But when I vote on it, I'm actually going to be vote on it within the consideration of separate measures and whether or not it comes off.

Yeah. Thank you.

Quick follow-up comment on that. Again, we actually do, we measure something very similar. We don't use exact QA. We have found, shockingly, that individuals living with HIV that are taking their meds 90% of the time, there is a huge gap there. So, it really is a standalone. It's something that all Medicaid programs should really be looking at. So, I really do view it as a standalone measure, and it does certainly look at different things. I would challenge states to go back and look at some of those and get onto the Core Set, find it. Go back and look at and hold your plan service provider.

Perfect. And I think that's the whole point of this dialogue, is to clarify the relation to these as we go to vote, so thank you for that. Yes, Rich?

This actually is a follow-up question for Lizette. Something that you just said caught me by surprise, and I just wanted to make sure that either I didn't misinterpret what you just said or maybe I'm over-interpreting it. But it seems to me if we're looking at a measure that you do an e-Prescription, were you suggesting why this wouldn't necessarily be broadly implementable in California. Is there a suggestion there that Medicaid beneficiaries are less likely to be receiving care in places that have EMR and e-Prescription capability?

No, it's just that so -- I mean, one of the problems we have, obviously, is the EHR implementation. We've paid out over a billion federal funds to providers to adopt EHRs, and we're pushing that. But the issue is interoperability and the ability to exchange it. So, I'm very hopeful that in the next two to four years that would change. But right now, I have no way of doing it, so, currently, like for our providers that are receiving the -- and they're doing that, we currently receive their quality measures through an online portal that they log into and they type in their numerator and denominator, and that's for their patient populations, not for their Medicaid population necessarily.

Okay. So, the heart of my question was, you know, is there a structure or reason for more disparity, and the answer, you're saying, is no. But, broadly, that would be an issue until we get to interoperability and true electronic reporting.

Correct. Yeah, my concern is around just where the industry is in terms of exchanging the information.

Got it.

That we would need to get at that, and need to do in a dependable way for measurement reporting.

Okay. So, if I can just make an observation for you and for the group, so one could argue that, really, any kind of an e-measure is going to be subject to the constrains that you just outlined.

Right. Well, and, again, this is the direction we're headed, and so I think I mentioned this yesterday. Yes, there's, you know, several states that are definitely making progress, and there's many of us that want to make progress. But, logistically, it's still very early in our process around that, so, yeah.

Okay. So, I'm going to wrap our group dialogue at this point and move to public comment. So, for those who may want to have a public comment, we have a limit of roughly two minutes. We've been a little loose, but around two minutes of comment for any of these. We'll start in the room. Are there any individuals who would like to make public comment around either the removal or addition measures under consideration by the workgroup at this time? Seeing none, Brice, if there is anyone on the phone, if you could let us know if there's anyone who has identified themselves as wanting to make public comment on the measures under consideration, the care of acute and chronic conditions.

We don't currently have any hand raised at this moment. But as a reminder folks listening to through commuter speakers need to dial into the teleconference before they can be heard. And for the folks already connected to the teleconference, you need to press "5*" in order to raise your hand, and we can unmute you for public comment.

Brice, I'm assuming that we still have no one identifying themselves?

That's correct.

Okay. Then, at this time, I'm going to suggest that we end the public comment period and would entertain a motion to move to a vote on the three measures that are up for removal. Jill?

I move that we vote on the three removal measures.

Perfect.

Second.

Terrific. Thank you. So, if everyone could turn on their handy dandy clicker, and Bailey will lead us through the vote. As a reminder, again, all members are eligible to vote on these measures.

Great. Thank you, Gretchen. So, just a quick reminder on the I-clicker, if everyone could pick up their I-clicker, turn it on using the orange button. You should see a ready message come up. Everyone good? If you have any issues, again, please raise your hand. We can help with any I-clicker issues. Okay.

So, our first vote this morning is going to be a removal vote, and it's on the HIV viral load suppression adult measure, and, again, you're voting A, ”Yes,” if you recommend removing the measure; and, B, ”No,” if you do not recommend removing the measure. So, Steve, please open voting. Great. And the results for the vote, this HIV load suppression measure, 43% of the workgroup voted, ”Yes, they recommended removing this measure,” and 57% voted, ”No, I do not recommend removing this measure.” This measure was not recommended for removal from the Core Set.

Moving onto our next vote, again, this will be for 28. If everyone could please press that blue refresh button so we're ready. This is another removal vote, and it's voting on the comprehensive diabetes care hemoglobin A1C testing measure. You're voting A, ”Yes,” if you recommend removing the measure; and, B, ”No,” if you do not recommend removing the measure. Steve, please open voting. Okay. Results for this measure, we have 79% of the workgroup vote to recommend to remove this measure; 21% to vote to not recommend to remove this measure. This measure is recommended for removal from the Core Set.

And moving on to our final removal for this domain, and this is the annual monitoring for patients on persistent medications. This is an adult measure. Everyone please press their blue button again if you have not already. You are pressing A if you recommend removing the measure and B if you do not recommend removing the measure. Steve, please open voting. Wow. Okay. Sorry. So, this measure 96% of the workgroup voted to remove this measure and 4% voted to not remove this measure. This measure is recommended for removal from the Core Set.

Okay, so the next set are those that are recommended for addition in this domain. Is there a motion to move to voting for them? Thank you.

Second. Thank you. So, we will go through the process as it relates to the six votes for addition.

Great. Okay. If everyone could press that blue button again to refresh your remote if you have not already. This is the first vote for addition to this domain. It's the avoidance of antibiotic treatment for acute bronchitis and bronchiolitis measure. You are voting A, "Yes, if you recommend adding the measure," and B, "No", if you do not recommend adding the measure. Steve, please open voting. Okay. For the avoidance of antibiotic treatment measure, 14% of the workgroup voted, "Yes, I recommend adding the measure," 86% voted, "No, I do not recommend adding the measure." This measure was not voted for recommendation to the Core Set.

Moving on to the next measure for addition, this is the appropriate treatment for upper respiratory infection measure. If everyone can hit that blue button again to refresh your remote. Again, you're voting A for, "Yes, I recommend," B, "No, I do not recommend adding this measure." Steve, if you could open voting. Okay. So, this is 61% of the workgroup voted, "Yes, I recommend adding this measure," and 39% voted, "No, I do not recommend." Using the two-third criteria, this measure is not recommended for addition to the Core Set.

Moving on to the next measure for addition. Oh, sure.

Can you remind me how many?

Yeah, so for this first pass, we're looking for a criteria of two-thirds, which is 19 workgroup members, so that one was one off. There's been a couple measures like -- oh, two off. Sorry. Two off. There's been a couple others like that, and I think Gretchen and David will address that tomorrow.

So, yeah, moving on to the next measure, this is measure vote 26, I think that puts us almost halfway through. I was trying to do the math in my head. So, this is a measure for addition again. This is the Transcranial Doppler ultrasonography screening for children with sickle cell anemia. Again, 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." If everyone could hit that blue button, if you haven't already. Okay. Great. And let's open voting. Okay. The results for this vote for the Transcranial Doppler measure is 18% of the workgroup voted, yes, I recommend adding this measure. 82% voted, "No, I do not recommend adding this measure." This measure was not recommended for addition to the Core Set.

Moving on to next measure vote, this is, again, for addition, and this is the appropriate antibiotic prophylaxis for children with sickle cell anemia measure. If everyone could hit that blue button again, if you haven't already. A is, "Yes, I recommend adding this measure," B, is "No, I do not recommend adding this measure." Steve, please open voting. Okay. So, this one is, again appropriate antibiotic prophylaxis for children with sickle cell anemia, and 82% of the workgroup voted, "Yes", to recommend adding this measure. 18% voted, "No", so this is our first measure recommended for addition.

Moving on to the next measure for addition, this is the proportion of days covered antiretroviral medications measure. Everyone hit that blue button again if you haven't already. And this is A, "Yes, I recommend adding this measure," and, B, "No, I do not recommend adding this measure." Steve, please open voting. Okay. So, the results for this proportion of days covered measure, 54% of the workgroup

voted, ”Yes, I recommend adding this measure.” 46% voted, “No, I do not recommend adding this measure.” This measure is not recommended for addition to the Core Set.

And the final vote for this domain is the statin therapy for the prevention and treatment of cardiovascular disease measure. This is an addition. Again, just press that blue button. A, is, ”Yes, I recommend adding this measure,” and B is, ”No, I do not recommend adding this measure.” Steve, open voting. Okay. So, the results for this vote, the statin therapy measure is, 21% of the workgroup voted, ”Yes, I recommend adding this measure”; 79 voted, ”No, I do not recommend.” This measure is not recommended for addition.

Okay. So, thanks everyone for our first body of work. We are going to take a break now. As we do that, I'd ask that folks limit that break to about ten minutes, and we'll turn our attention to maternal and perinatal health when we return.

[BREAK].

Okay. If people could begin to find their seats, please. Okay. As people find their seats, I'm going to give you an overview. We are going to have lunch a little bit later today, so for those of you watching the chloric, we are not aiming for a 45-minute conversation about these measures. We'll be breaking for lunch at approximately 12:30, so we have time, if people could find their seats.

So, the next domain of measures that we'll be discussing as a workgroup are the maternal and perinatal health, and, again, to the earlier question that Laura made, you know, there is this awkward reality of maternal and baby dyads are sort of split between the Adult and Child Core Set, and so there is a subsequent measure set that is described that is the perinatal health one, so our goal here is to just look at these measures on their merits, and then CMS will make the final determination of where and how they organize them in the eventual final Core Set.

There are three measures for removal, and three measures for addition, so we will continue through our process that I think we are becoming a well-honed machine around. And so, with that, I'll turn it over to Bailey to give us the overview, again, of the orientation of the measures that are currently on the Core Set so we have an understanding of that and then the three for removal and the three for addition. Bailey.

Thank you. And just our quick measure steward check. I know we have the CDC and NCQA here. Is there a representative from the Joint Commission on the phone, or Tricia, will you be --

Hi. This is Tricia. I'm here in person, and I have my clinical backups on the line.

Great. And do we have a representative from OPA on the line or in the room? Okay. Again, if you're on the line and having trouble unmuting yourself, you have a little time to work with our technical staff. Please use the Q&A box and we'll get to you when there's technical questions.

So, jumping right into the current Core Set measures in the maternal and Perinatal domain, there are seven Child Core Set measures and four Adult Core Set measures. These are in the 2019 Core Sets, and I'll walk through them quickly. So, the first is the pediatric central line associated bloodstream infection measure. This measure looks at the number of central line associated blood stream infections or CLABSIs in pediatric and neonatal intensive care units. The standardized infection ratio compares the observed number of infections reported to the predicted number of infections, and this measure is up for removal, so I'll be talking about it in-depth in a minute. The next measure is the PC-02 cesarean birth measure, and this is the percentage of null or parse women with the term singleton birth in a vertex position delivered by a cesarean birth.

The next measure in the Child Core Set is the audiological diagnosis no later than three months of age, and this looks at the percentage of newborns who did not pass hearing screenings and have an audiological diagnosis no later than three months of age or 90 days.

The next measure in the Child Core Set is the live births weighing less than 2,500 grams, and this is the percentage of live births weighing less than 2,500 grams in the state during the measurement period.

The next measure is the timeliness of prenatal care measure, and this is the percentage of deliveries of live births on or between November 6th the year prior to the measurement year, and November 5th of the measurement year, so a one-year period, that received a prenatal visit in the first trimester, or within 42 days of enrollment.

And then the next measure is the contraceptive care postpartum measure, and this is for women ages 15 through 20, and this looks at the percentage of postpartum women who had a live birth and who were provided either the most effective or moderately effective method of contraception within 30 and 60 days of delivery, or a long-acting reversible method of contraception, which is known as LARC, and I'll use the acronym moving forward.

The next is the contraceptive care measure for all women, and this is ages 15 through 20 again. And next slide, if we haven't moved there. And this is the percentage of women at risk of unintended pregnancy who were provided a most effective or mildly effective method of contraception, or a LARC, and that was the final Child Core Set measure.

And now moving on to the four Adult Core Set measures, the first is the PC-01 measure. This is an elective measure, and it looks at the percentage of women with elective vaginal deliveries or elective cesarean C-sections between 37 weeks and less than 39 weeks of gestation. And this measure is also up for removal, so I'll discuss it more in detail in a minute.

The next measure is the postpartum care measure, and this is the percentage of live births over a one-year period again, that had a postpartum visit on or between 21 and 56 days after delivery.

The next measure is the contraceptive care postpartum measure. Again, this is an Adult Core Set. But in this case, it's for ages 21 to 44, and this is up for removal, so we'll discuss that measure in a couple minutes. And then, again, the contraceptive care for all women, but, again, with the different age groups, so same as the Child Core Set, but ages 21 to 44. And those are the four measures in the Adult Core Set. And now we'll move on to discuss a bit more about the measures that are up for removal. Next slide, please.

So, the first measure up for removal, the CLABSI measure. This measure, again, is a measure of the CLABSIs in the pediatric and neonatal intensive care units, and it's based on the number of observed infections to predicted. The steward is the Centers for Disease Control and Prevention, and it is endorsed. And the data collection for this one is a little bit different than most of the measures in the Core Set, in the fact that states do not report it directly to CMS. It is taken from the data reported to CDC, and in the National Health care Safety Network. So that is provided to CMS and reporting. And the data collection method is through the medical records and hospitals report to CDC. Next slide, please.

Another measure has not been proposed as an alternate measure or substitution for this measure, and reporting, because of the different method, is a little bit different here. But for 2016, so that was calendar year, and that aligns with FFY 2017 reporting. 42 states had sufficient number of facilities for data to be reported for the Core Set. The measure is not in the Medicaid and CHIP scorecard, and a couple other things to note about this measure that makes it a little bit different. It is not limited to Medicaid and CHIP. It's all payer, as it comes through CDC. And while the specifications include both neonatal and pediatric ICUs, CDC only reports for neonatal ICUs, so the publicly reported data for this measure are only for neonatal ICUs. Next slide.

The next measure up for removal is the PC-01, elective delivery measure. This measure, as I noted, looks at the percentage of women with elective vaginal deliveries at 37 weeks through less than 39 weeks. The Joint Commission is the steward. It is NQF endorsed. The data collection methods are either hybrid or EHR. And there are two measures that have been suggested, either as substitutions or as a sufficient measure within the Core Set. One of them is the current measure, which is PC-02, the cesarean birth

measure, and then the measure suggested for substitution is a new measure that we'll discuss in a minute, the exclusive breastfeeding PC-05 measure. This measure for reporting, there were 12 states that reported this in FFY 015; 11 in FFY 2016; and 9 in FFY 2017.

The reason this measure was suggested for removal is because, although there are outliers involved in early elective delivery, this is far outside the accepted standard and should be regulated outside of national reporting of quality measures. Other measures have more warranted variation and impact a greater number of beneficiaries. A few reasons that states have struggled with reporting this measure include that the claims data that are required to obtain the numerator for this measure are not available. Also, because medical record review is needed, it can be very resource intensive, and, also, the vital statistics linkages were not always available to the states. Next slide, please.

And the final measure for removal is the contraceptive care postpartum women, ages 21 through 44. To note, this measure is also on the Child Core Set, so as you're discussing it, I just wanted to know that. And so this one is the adult measure, ages 21 to 44. It looks at women who had a live birth and whether they were provided either the most effective or moderately effective method of contraception within 3 and 60 days of delivery or the LARC within 3 and 60 days of delivery. The measure steward is the Office of Population Affairs. This measure is NQF endorsed and it's an administrative measure. Next slide, please.

The measure that was suggested for substitution is a current measure, and that's the contraceptive care for all women ages 21 to 44. Again, this measure suggested for substitution is the adult measure. That measure is also on the Child Core Set for a different age group. For reporting this measure, this measure was not part of the Core Set, the 2016 Core Set or the 20 -- sorry -- the 2015 or the 2016 Core Set. The first year of reporting was FFY 2017, and 21 states reported that measure for FFY 2017. The reason that this measure was suggested for removal by a workgroup member is because another measure that focusses on contraceptive care provided to all women already covers the measure concept.

And now I'll move on to the three measures that were submitted for addition. The first one is PC-05, the exclusive breastfeeding measure, and this measure is reported.

Stop. This one first.

Oh, sorry. Thank you for correcting me.

No. No. Let's maybe stop for technical questions, as it relates to these removal measures to just pause. Are there any clarifying or technical questions to ask either the measure stewards or Bailey or the general community here, as it relates to the three in in domain that are proposed for recommendations for removal? Yes.

Sorry, this is just my lack of keeping up. You said that there's another measure that measures the same thing as the contraceptive care postpartum, but for the full population? Is that what I heard? Because that's not what I -- okay.

So there's two of contraception measures on this Core Set. One of them, their CCP and CCW, and one measures postpartum women and one measures the whole population, yeah. Including pregnant women, yeah. Thank you.

Just by way of clarification, the way you present -- this is Rich Antonelli. You're presenting what the proposer feels is the truth. But what we have to unpack is do we agree?

Yes. Okay.

I think that may be -- as my teenage patients would say, just saying.

Yeah, the reasons that we report from the workgroup members were taken directly from the submission. They're not our opinion at Mathematica. The other information is our presentation of what we view as the

facts, so what's the numerator, the denominator, the reporting. But the reasons for removal were submitted to us through the workgroup members.

[Inaudible].

Exactly. And that's up for your discussion.

This is Margo Rosenbach. Perhaps I could make another clarification to that. And as you can see up on the slide currently, that the measure for ages 15 to 20, for the postpartum, was not recommended for removal, but for older women was recommended for removal for the postpartum period, so, yeah.

Okay. Other technical questions? Yes, Jill.

So, just to ask an additional question. So, that assumes, then, that from the "all women," we can distinguish postpartum women, that we can divide it out into groups, or is it that the "all women" is just all women and the "postpartum women" is just postpartum women, and you can't do subgroups except maybe ages in the all women?

For those on the phones, there's a lot of head nodding, which means that Jill's interpretation is being reflected on as accurate. That the postpartum women cannot be distinguished in the larger all women contraceptive care measure. Sally, go ahead.

I just had, not being a clinician, a quick question about the difference between the elected --

Sally, could you speak a little louder.

Oh, I'm curious about the technical differences between the elective delivery for removal and the one -- the PC-02 cesarean births, if there's both clinical and technical difference, because it says it could replace it. But they sound different. Am I missing something?

Diana?

I think, in concept, what it's trying to say is if you remove early elective delivery, you're still going to represent the concepts of unwarranted variation effectively, and poor quality. So that removal of this will not leave a hole in the measurement profile. It is a very different measure, you're correct. But, in essence, what it was a measure of was unwarranted variation in practice. In this case, absolute negligence in practice. This is unacceptable practice. You shouldn't get quality points for not doing it. You should actually be regulated if you are doing it.

Or elective.

Oh, this is early elective early delivery, so it's very specific. There are no medical indications for these elective deliveries and they drive NICU utilization. Okay, so it is a very important measure. I'm not suggesting it's not. It's just not -- it's got a lot of real estate. And as you see, our perinatal measures are poorly reported, and this is a high-impact population health issue, and we need to improve our reporting on our existing measures.

Okay. Jill?

So, this is related to that one as well. What I see as the difference between the cesarean one and the elective delivery is that the elective delivery includes both inductions that are early and cesarean, and the other one is just cesarean. Did it interpret that right?

So, perhaps we should have taken off the cesarean and breastfeeding as replacers. They're just actually conceptual placeholders to say we haven't removed these over utilization measures.

But induction leading to vaginal delivery before 39 weeks is not a good practice either, and if we don't have this measure, we can't measure that; right?

Correct. Early elective induction in the absence of medical indication, it leads to many very harmful outcomes. It's a driver of cesarean. It's a driver of NICU utilization, so for that reason, you may want to keep it on the measure set.

Terrific. So we've got this side of the table, Tricia, then Rich, and then Lindsay. And, Lauren, I don't know if you have a perspective to share as well.

Great. Thank you, this is Tricia Elliott with the Joint Commission. We are the measure steward on this, so, Diana, thank you for the clinical description of the measure. It totally supports what we're doing. There's, you know, been three decades of work that points to the fact that the early elective deliveries should not occur, and the results tend to increase the C-section rates and poor outcomes for the baby when they are done too early.

And we did somewhat react to the comments that were put here in terms of replacement measures. We don't feel that the measures are similar to the PC-01, which is the early delivery, and the PC-02, which is cesarean births. So, the population of PC-02, the cesarean birth, is limited to the cesarean births in nulliparous women, where PC-01 includes multiparous, and vaginal deliveries as well. Just thought I'd offer that clarification. And we don't think that the PC-05 measure, the breastfeeding, is a corollary. It's a totally different concept there, so I think it's just the way that was framed. As replacement, we don't feel those really replace each.

Yeah. So, let's use the watercolor definition of replacement, in that I think Diana was discussing, there was a conceptual relationship, like the HIV one that we discussed earlier, and maybe if there is an actual, like, this measure isn't working but this measure is same thing, replacement, we'll acknowledge that. But I appreciate the perspective, and it is important for us to understand that distinction. And just one last comment, that we feel that if we stop collecting on the PC-01 side and reporting on this measure, it would easily slip back into patterns of early delivery; that we need to keep it in the forefront and cesarean is an issue. We fill there would be slippage if it is.

Okay. Thank you. Rich then Lindsay, and Lauren if you have a perspective from ACOG.

So technical, I was wondering if CDC could give us some more information about the CLABSI reporting. That data is going somewhere, and I guess my question is, does consideration of removal from the Core Set set us back in any way? Is there a complementary? We need to be mindful, or, in fact, is this redone with the data? So could the CDC sing a few bars about that, please?

Thank you. Laura, CDC, so I was actually waiting to share this. But thanks for the question. So, yeah, the data are reported from healthcare facilities to CDC, NHSN. But the numbers are a little bit inaccurate. 45 states have these agreements, and then 4 more are actively obtaining them. States use these data to great pains and great outcomes, and are actually tracking and working across states, and have found pediatric CLABSI was reduced. So, yeah, CDC, both the stewardship folks and the reproductive health folks are paying attention to perinatal health feel like this would be a major setback, an actively used measure.

Laura, may I ask that question. Actively used by Medicaid programs or departments of Health?

I can't see who asked that. I would say by states with Medicaid and probably they're shown in tandem. But I think it's being used by the state across Medicaid and public health. So, in Colorado, we live eight miles apart, so we sometimes get that right and sometimes don't.

So, you're raising a larger issue. No, I'm just asking when you're using the term "the state," you're mostly talking about Departments of Public Health who use hospitals and other regulatory authority over hospitals and quality metrics over hospitals.

I think at a technical level, it's probably the public health got DUA, but it's absolutely done in concert, using these data. But, yes.

So, at the risk of being dense, I'm still not sure I understand why potential removal from the Core Set sets anything back.

You mean, as opposed to putting it elsewhere and not having it in the Core Set.

Correct. If you have relationships with the states, what it is about the connection to the Medicaid program that drives safety, drives quality, ensures reportability, accountability, et cetera? I'm still not clear on that.

So, I think quality rates are higher among Medicaid beneficiaries than elsewhere. But that feels like a CMS question. You know, do you lose the impact if it's no longer a core? I feel that's slightly outside of CDC perspective. But from a burden standpoint, it's more relevance to Medicaid population than not, so it feels very important from that standpoint. What you lose when it's no longer a core, I'm not as good at answering.

Thank you. Linette, then Lindsay, then Laura, the Ls, the L corner.

Okay. I think one of the things that we struggle with on the CLABSI measure is that it is reported to the CDC. We don't know which part of the population is Medicaid. And in California, you know, I think probably just because of our size, if we can't take something down to the county or the plan level, it's not actionable. I mean, it's not that we don't care. It's not that it's not valuable to compare state to state, but with 13-million Medicaid members, if we can't get to a more granular level, then it's very hard to drive quality improvement. So, the fact that the data is being reported to CDC, it's published at a state level, it doesn't identify who the Medicaid is in that, we don't have an active engagement around that. And I think the thing, though, to highlight to your point, is not that it's not important, and our Department of Public health, I think, is very engaged. I think there's a lot of activity around it working with our hospitals, but it's not necessarily in the Medicaid program, per se. And, again, not that Medicaid isn't necessarily engaged. But in terms of what we hold our plans accountable, what we hold folks accountable to, if we don't have a dataflow that allows us to do that granularity, then it's very hard for us to take advantage of that. So, I don't think it would actually lose anything by not being in a Core Set, because it is a well-established measure that folks are very focused on.

Thank you, Linette. Lindsay?

Yeah, so, along those lines, I mean, CMS has been collecting this measure for several years, but I have not seen anything go out about it, so I don't know if they could comment on it's -- I mean I couldn't find any results.

This is Margo.

Who? Somebody?

It is in the chart pack with the chart packs published on Medicaid.gov. It does include the CLABSI results that are taken from CDC.

I'll find it.

And we can send you a link. It's Page 45. Okay. And there's some results in your measure information sheet as well.

Great. And then my second point was about the early elected delivery. So, this is one that we have gone back and forth with internally as well. So, we, in the state right now, have a linkage set out between our Medicaid data and our vital statistics, and that is currently how we're reporting this measure. Now we

know it is flawed, because medical indications are not accurately represented as vital statistics. So, our rate of about 11% is nowhere near the Joint Commission's results for the hospitals in New York are, which is probably around [inaudible]. So, you can see there's issues methodologically, depending on which you use. At the same time, not every hospital in New York is reporting to Joint Commission. So we go back and forth of which source we would like to use. The Joint Commission, because we're going into the medical record, they probably have a more accurate number.

We also, in the Medicaid program, have bill payment reform, where we no longer pay for an early elective delivery. We are using other channels to impact, and monitoring this measure on our own. So, again, it goes back to its ask ability in the Core Set and what you may be seeing, you know, if this is truly where you want the Core Set to be used, you may see differential rates among the state and then want to know, from the state's perspective, are you doing something more or whatnot to drive and then open that conversation. But, again, it's how -- I don't know that we've brought this up yet, but some of how that measure is now being used when you bring it up to that national level, and then it's more than just ask ability within the state but how you could use it across state comparisons, I guess, would be a dimension we haven't covered yet.

Terrific. Thank you. Lauren?

Yeah, so I second a lot of what is said. From the ACOG perspective, we're supportive of all of the measures in the perinatal care Core Set but don't, like has been said, don't necessarily have replacements for each other. For the PC-01, I guess my comment or question to the group, it looks like the number of states reporting that has decreased, and I think from the comment, it seemed like maybe is it a topped out thing, and I think that that maybe is related to the nonpayment. There's nonpayment for early elective deliveries before 39 weeks without indication, so I don't know if we're just seeing high rates of that not happening and then that is why this is being recommended for removal. I don't know.

Is there any perspective on question? David.

I'd say that, while hopefully we're not paying for the events, unlike Texas, there are only a few states that actually do a hard non-payment. But the states, at least we have not taken a hardcore stand. We are not paying, simply because, from claims, it's hard to make that judgment. So, I don't know. I'm fully supportive of the measure. I know we have been challenged. But I do think we report this measure. And our results, it took us a long time to get there, because our plans had a lot of resistance from hospitals in going and in pulling charts for review, and we went through this third process. I think we're now reporting [inaudible] 4.-something percent. So, 4.69% is the rate. But the variation is 15.5%, to a low of 1.51 %. The health plan is multiply owned by several hospitals and health systems. Health partners happen to be in an urban area where a lot of high-risk events, so that works for me. So, the measure is important. It is difficult. There are challenges to it. But I think it is really helpful in driving the quality improvement of one, it involves [inaudible].

All right. I'm going to keep us on track and have just a few more comments on the three that are up for removal, and then we'll move to the presentation by Bailey on the ones that are up for additions, so we'll continue to make our way counterclockwise around the table. Lauren?

I think just one more comment on the contraceptive care measure. I think, so we asked NCQA for consideration of adding all three measures into HEDIS, and I think I don't know if there's comments from NCQA on this, but I think that original thought is that that particular, the postpartum contraceptive measure is the cleanest denominator because you can get it all out of claims. You know for sure that a woman delivered. From the others, you're do looking in the EHR to see, like, that person's intention piece, which is a lot more cumbersome if you're really looking at excluding the correct women, women who want to get pregnant should not be in the denominator for that measure, so I think that that one is under consideration for inclusion in HEDIS, the postpartum.

Okay. Thank you very much. Appreciate your perspectives. Jennifer?

Hi. Jennifer Tracey with Healthy Steps. One quick question on the PC-01 as a follow up. David and Lindsay, the comments were super helpful. I'm just curious, from other state perspectives, are there state difficulties in actually collecting the data that is really preventing only nine states reporting on this? Because it sounds like it's, obviously, a very serious issue, but just trying to tease out is this not a useful measure, but states really can't get at the data in a meaningful way?

Linette?

So, I'm kind of echoing Lindsay's comment, in that we have not reported on it in California, and part of that goes to the issue of how do you determine [inaudible], and we can't get that out of claims. And even if we link to birth records, which we're working on actively from a reporting measure, that doesn't answer the question either. So, inherently, you're ending up with some sort of review for us, and that's [inaudible].

And I would just share from the Colorado perspective, I think I go a little bit to where David was on the HIV measure. While there may be difficulty, it's an important proclamation of intent that we follow evidence-based guidelines, and that since Medicaid, at least in Colorado, pays for 42% of all birth in the state, it is a place where we have market influence, and so those are technical. It's always hard to understand clinical intent in any of these measures. Inappropriate utilization is like the unicorn. And so, I think that, to me, it isn't the same thing, but it is an important proclamation of quality of care for women, especially since Medicaid plays such a large role as a payer of delivery. So, that's just my, as a non-chair, but as the former Colorado Medicaid director's perspective. Jeff?

Jeff Schiff from Minnesota. We did a 22-state study of early elective deliveries back about four or five years ago with the Medicaid medical directors. In those 22 states, 8.4% of those deliveries were early elective, and about two-thirds of those resulted it in C-sections, and one-third resulted in vaginal deliveries. And, so that's about the importance of it. The feasibility is a challenge because of what everyone has said, and there's two methodologies. The PC-01 methodology from Joint Commission relies on chart review. There is another methodology developed by a guy in Florida, Bill Sappenfield, which relies on vital records, which is almost as good. At least it trends the same way. But I think right now we have this other measure, so I would support keeping it on, because it's an important issue.

The non-payment, we did something different. We made everybody who didn't deliver, who had an early delivery that was elective, they either had to do an internal process at their hospital to eliminate these quality improvement process, or we made them report on every delivery, and all but about one hospital decided that it was way better not to be harassed by having to report on every delivery. It was a really effective strategy. And the newspaper came out and said something around Medicaid, you know, will harass people with paperwork if they don't comply, so I highly suggest that strategy. I want to say, so I just think it's a challenge. I think, you know, it's a really important issue for what I said, reasons I said.

The second thing is, the postpartum contraception is a unique challenge because birth spacing is a big issue for low birth weight. Birth spacing is related to you can increase birth spacing by people having a reproductive life plan and a reproductive choice. About half of Medicaid pregnancies are not planned, and in our population with substance use disorder, that is a way, way higher, so paying attention to what we can do immediately postpartum is a really important issue.

This is Gretchen. I'll just add, I also would raise just concern about taking it off of for ages 21 to 44, but retaining it for ages 15 to 20. That just creates some dissonance in my head that I haven't reconciled. We are going to wrap with, I think, Tricia as the measure steward and close to this. And then, Linette, did you have additional things to add? Great. Then, Tricia, yes, and then our CDC federal partners would like to add something, and then we will move onto the addition conversation.

Great. Thanks for the opportunity. We really appreciate participating in this conversation. We feel this is a really important measure, and some of the feasibility issues, this is one of the early measures that we did convert to an eCQM, so we have availability, and we are doing work to compare the eCQM to chart-based so we can really continue that validity and feasibility, and we're starting to see some better

correlation between the two. The sticking point, of course, is the gestational age, and I think that's what gets folks for organizational -- the information. But we strongly support it. Thank you.

From our federal colleagues? Just really quickly, I wanted to second, I was actually saying the same thing as my colleague from Minnesota. So, I wouldn't see this measure as analogous to the measure of contraceptive of care for all women, because it's specifically targeting postpartum exactly to the point of birth spacing and low birth weight and was put together by CMCS, OPA, and CDC for that purpose. So, I wanted to second that.

Thank you. All right, I'm going to turn it over to Bailey now for conversation about the additions.

Great. So, on the next slide, the first measure that I'll discuss for addition is the PC-05, exclusive breastmilk feeding measure. This measure is reported as an overall rate, which includes all newborns that were exclusively fed breast milk during the newborn's entire hospitalization, and exclusive breastfeeding is defined as a newborn having only breast milk and no other liquids, solids, except for drops of certain different types of needed substances. The measure steward is the Joint Commission, and it is NQF endorsed. It's a process measure.

Again, there was a measure that was suggested as a possible substitution and that's the PC-01, elective delivery measure. The methods for this measure is EHR or hospital chart review, so medical record review, and there's a couple acceptable data sources, a diet flowchart, a feeding flowchart, and intake or output sheets, and sampling is permitted. Next slide, please. The denominator is all single-term newborn discharged alive from the hospital, and the numerator is whether there is documentation of newborns being exclusively being fed breast milk during the entire time in the hospital.

The reason that this measure was suggested by a workgroup member for inclusion is because there is no evidence to -- there is evidence. Sorry. No. There is evidence to support exclusive breast-feeding in that breast milk feeding improves life course health and decreases disparity. Exclusive breastfeeding for the first six months of neonatal life has long been the express goal of WHO, DHS, APA, and ACOG, and there's been some reviews that have substantiated the benefits, and this measure functions to hold systems accountable but reflects understanding that the goal is not 100% and that women and families have the right to choose breast milk or formula.

Moving on to the next measure suggested for addition, this is the prenatal depression screening measure, and also the follow up component. And this is the percentage of deliveries in which women were screened for clinical depression while pregnant, and if they screened positive, they received follow up care, and it has two reported rates. There's a depression screening rate, so the rate of screening, as well as the follow up if there is a positive screen. NCQA is the measure steward. The measure is not currently endorsed and it's a process measure. It's not recommended to replace any measures on the Core Set, and it uses the Electronic Clinical Data System or ECDS. I'll use that abbreviation going forward. And ECDS includes data from administrative claims, electronic health records, case management systems, and health information exchanges or clinical registries. Next slide, please.

The one other important piece to note, and I'll ask NCQA for an update when I'm done, is that this measure was proposed for HEDIS 2020, so it's not currently in HEDIS but was proposed. And this measure was suggested for addition by a workgroup member because it could be used to assess the contents of prenatal care and improve outcomes for mothers and children, and evidence shows that when identified early, perinatal depression can be treated successfully and improves outcomes for mothers and children.

And the final measure suggested for addition within this domain is a similar measure to the one that I just discussed but for the postpartum population, and this is postpartum depression screening and follow up, and it looks, again, at the deliveries in which women were screened for clinical depression during the postpartum period and, if screened positive, was follow up care received. It has two rates again, whether the screening happens, if follow up happens if they were screened positive. Is, again, an NCQA measure. It's a process measure. It's not endorsed, and it uses ECDS as its data collection method. And this one,

like the prenatal measure, is proposed for inclusion in HEDIS 2020, and we'll get an update of what the outcome of what that was. And the workgroup member that suggested this measure for addition noted this measure would address gap areas around postnatal care, including postpartum depression and health of the mother/child relationship. Postpartum depression impacts maternal wellbeing and child development, and there are higher rates of depression in women of color and women with low incomes, which make its critical that Medicaid and CHIP programs address this condition. This measure would incent meeting minimum performance thresholds for screening. And I'll turn it over to Gretchen to lead the discussion.

Great. So, we'll start, if we can, with some technical clarification and questions and then move on. So, Amy.

So, I have a question about the breast-feeding measure. Before people start throwing things at me, I believe breastfeeding is a good thing, just so you know; however, and because I have to say that, that kind of sets the stage for what I'm going to say after my however. Women that don't breastfeed their babies get shamed into thinking they're doing the wrong thing, and if you have a measure that measures this and puts extra pressure on them in the hospital to only exclusively breastfeed their baby, we're going to have a lot of use of this postpartum depression screening measure. The rates on that are going to skyrocket.

So, question about the exclusive breastfeeding, not one drop of liquid other than breast milk, other than drops in the hospital, wow, that's pretty exclusive. Is there any, you know, exclusivity or anything built into the measure to account for cultural preference or mom is on a medication in the hospital that excludes her from being able to breastfeed, like I was when I was many the hospital, or, wow, having another baby, I had a baby that tries for days and could not get baby to take one ounce of breast milk, also increased that postpartum depression screening measure. So, I just think this this measure sets moms up to feel worse than they actually do leaving the hospital. I have visceral reactions to this measure, obviously.

Terrific. Thank you for those questions. I don't know if there's a response from either the measure steward or experts in the room. Yes, Tricia, please.

This is Tricia from the Joint Commission. This is another one of our measures. We specifically do not set a benchmark on this measure, and we don't think a hundred percent is achievable, so typically we tell the field that uses the measure for the hospital IQR program is that 70% is an achievable rate, for some of the reasons that you described, Amy.

Okay. Thank you. Sally?

It's also about the exclusive breast milk feeding measure and it goes the same question, the extent of the exclusivity. From what I had heard from clinicians about topping off in the hospital, this seems a little stringent and was curious whether the developers and those who have been supporting this measure in its technical development looked at, you know, is a few drops here versus something else, and then also, with just my SME hat and measurement in patient-centeredness want to -- also, what Amy said, in agreement.

And, in fact, we've learned that being too dogmatic on how things should be done can actually swing the other way, and I just wondered, from the clinicians who do care for babies in the hospital after they're born, if a mom is learning or is having challenges and there's some use of formula during that time to help persuade and convince them and get them prepared, if that's something that happens adequately enough that this measure would adversely impact education and support during the inpatient stay?

Terrific. Thank you. Is there an immediate response to that? Jill, please.

So, this is Jill Morrow from Massachusetts. I really worry about the same thing, being very dogmatic. Anybody whose milk is a little bit slow coming in, are we going to put the baby at risk because we're not going to give the baby anything else because we're waiting for mom's milk to come in, but in the

meantime the baby's getting dehydrated. Dehydrated babies get jaundice. Dehydrated babies don't feed, and so I think this kind of sets it up to fail. I would have failed this both times, absolutely. And I breast-fed for, like, longer than my husband thought I should have in public. And I don't think the evidence is solely breastfeeding or you're not going to be successful at it, or solely breastfeeding and that's the only way the baby gets all the immunoglobulins and that sort of thing.

I'll just acknowledge, I think there's been some consensus around maybe the extremeness perhaps of the measure, and so to the extent that's what you wanted to comment on, I think it's a acknowledged, and so we can either continue to respond to that or take different components to it. The other Jill. Yes, Jill? Thank you.

The other Jill. It's the Ls and the Js.

So, yeah, having heard a lot of personal experiences about this, I wanted to bring it back to whether or not it's appropriate for the population, specifically for Medicaid and whether it's something worth tracking. I think a lot of the perinatal core measures, why they're so valuable, is they do show that geographic variation in care and accessibility of services, and I know that a lot of people in Medicaid population are adversely affected by not having access to services in the, hospital or just variation in quality of care. So, I just kind of want to bring it back to, it's not just about any measure is endorsed by NQF. It's a joint Commission perinatal core measure. It's also WHO, ACOG's on board, American Academy of Pediatricians, so it's not really so much about the measure itself. It's just about applicability to this population.

Thank you. Are there other comments on -- while I have the opportunity, one of the areas I had around the concern of exclusive breast milk feeding was the data collection methodology. It seemed in the wrong direction from some of -- to the extent it could be found in EHR; yes. But the level of detail didn't seem like it would meet the measure standard, so a separate perspective about the concerns on that one.

Are there others, the two perinatal depression measures, but I don't want to cut off conversation about the exclusive breastfeeding measure? So, are there any other comments on that? Yes, Carolyn.

This is Bonnie from UCLA.

Or Bonnie.

I just wanted to get some clarification from NCQA on the postpartum depression screen, because there's some discrepancy in the information. Specifications are that it's follow-up care. How is that operationally defined? Because in the response it says "referral."

Yeah, my colleague, Lindsey Roth, is on the line, and she can answer those questions, and also give you her updates, because it was proposed. Lindsay.

Hi. This is Lindsay from NCQA. Can you hear me?

Yes. Okay. Great. So, there are several different things that would qualify measures. They're having an outpatient encounter, either in-person or by telephone, with a diagnosis of depression or another behavioral health condition. Also, having a case management encounter or a behavioral health encounter would meet the numerator. We also allow dispensing of an antidepressant medication, and then finally, we also allow having a subsequent assessment on the same day as the positive screen, showing that there actually are no symptoms that would require follow up.

So, again, the question, like on a case management encounter, can that be on the same day as screening?

Yes, that can be on the same day as the screen.

Okay, terrific. Go ahead, Carolyn.

Yeah, you know, I think that the issue of the follow-up care versus the referral always raises the attribution or questions in a measure like this.

Thank you, Bonnie. Diana?

It was about breastfeeding, so we'll come back to it if you don't mind.

Yes, certainly. And Bonnie had also requested the update on the HEDIS outcomes, so I don't know if NCQA could provide that as well.

Yes. So, are you referring to our final specification following public comment?

Yes.

Okay. So, yes, we have finalized our measure specifications based on all of the input that we had received. We really only had one change that we've made since public comments. For the postpartum measure, we have decided to specify a continuous enrollment period of a minimum of 60 days following delivery, and this was based on the public comment and expert panel feedback that we had received about that.

And then one other thing I just want to clarify, based on the specifications that were provided for the meeting today, is that our measures do not have -- we have not specified any age limit for our measure denominators, so the denominators are based on the total number of deliveries during measurement period and there is no age restriction.

Great. Lindsey, can you clarify that the two measures have been determined to be that they will be included in HEDIS 2020?

Yes. So, the measures have been approved by NCQA's Committee on Performance Measurement, and they'll be published in HEDIS this year, and then they would apply to measurement year 2019.

Okay. Terrific. Thank you. The only other piece I would just note, so Colorado has been very active in this space, and one of the reasons that these measures were exciting to us from the state perspective, in addition to just general area, is the way in which some the current measures require documentation in the pediatric chart, which is very confusing for place like federally Qualified Health Centers or family physicians' offices where they have both charts available, and then there's HIPAA, and then there's a whole bunch of confusion around the area of documentation, and so appropriately aligning the postpartum depression screening in particular with the woman's chart and her experience of both screening in care was a component, in addition to potentially stretching to have it be that electronic clinical data system measure, which gave providers more comfort in recognizing the validity of the measure, so that was our experience in Colorado.

Our SIM grant, we had a $65 million SIM grant related to integrating physical and behavioral health, and our clinicians worked really hard on this, and we saw some improvement. But some of the places in which the measure -- we were stuck in a couple of places because of the way the measurement or the current perinatal depression screening is done. It really stymied some of our providers to be able to move forward.

Yes, Rich, please go ahead. Your soccer voice, please.

I think I've abused my microphone privileges. What you just stated is incredibly important and one of the things that I struggle with about this. In fact, in the last few years, the pediatric community has actually stepped up to make it almost as close to a standard of care of maternal postpartum depression in the pediatric setting, and so where that gets recorded, how that handoff is, and something that’s specific to

Massachusetts, our so-called -- which is an integrated behavioral health model, there actually is a McPAP, which is an integrated behavioral health model. There actually is a McPAP for moms now, which is sort of infrastructural and resource alignment with the pediatric community stepping into the space.

So, Gretchen, the point that you just raised is incredibly important, and it has everything to do with accountability, transparency, the locus of measurement and all of that, so this is a big, big, big, big deal issue, but I think it's at a profound level of implementation measure. We have to really think carefully about this, especially for accountable care or value-based arrangements.

Yes. Okay. So, are there others, since we're in the space of open discussion around the two perinatal depression measures, are there other comments on that? Then we'll circle back to breastfeeding, and then our destination is 12:15 to finish this level of dialogue. So perinatal-depression-related comments, so Marissa, Lisa, Lindsay, Jennifer, oh, and Linette.

So, mine is just a clarifying question, and I think I know the answer but I just want to make sure, especially since there was some discussion about the level of challenges in implementing. This measure, I assume that it if it's going into HEDIS 2020, that it has not been used previously. Is that a correct assumption? So, we don't have any self-assessment?

Yes.

And then the other question, so they're both at the same time, the fact that it's not NQF endorsed just means that it hasn't gone through the NQF endorsement yet; is that correct?

Right. And this is the theme [inaudible], and I'll start. And Lindsey Roth, if you have anything to add. So, we do field test all of our measures, so we did field test these. I think there has not be a HEDIS measure, but that perinatal depression is a focus of a lot of states, as you just heard about the SIM project and others, particularly for Medicaid, considering how many births they cover, it's of high interest. So, we specified it as a HEDIS measure, and at a health plan level. So, to the comments about, you know, coming from different places, for a health plan, they can pull it from wherever that can get the information. So, it's not that we're requiring things to be documented in a PDR chart versus the mother's chart. It's that if it's in any of those places, and the health plan can see it, then they can count that as a numerator pit.

You know, health plans may also have case management registries. I know when I was pregnant, I was screened by my health plan, and my health plan had a really great case management registry, where they talked to me, you know, about all it will screenings I was getting, and so at that level, and so I would think, you know, you have to think about, at the state, level how that information would be coming in. I know states are doing different things when it comes to paying for screening for the pediatricians to do as well. So, that's the level of accountability that you might want to keep in mind. It has not been submitted to NQF, so you're right about that.

And David has a slide from Pennsylvania update.

So, to Marissa's question about has anybody done anything with this, we actually, for many years now, have tracked, by chart review, a very similar set of measures for both postpartum and prenatal depression, and also have done the referral, not just referral but actual treatment, looking at behavioral health plan, pharmacy claims. And I can tell you, when we started out, our rates were very low. Now we're screening by chart review. Postpartum depression screens around 73% and those that screen positive, about 15 -- about 87% directly get referred to treatment. But those numbers were really low when we first started on this journey. So, these are measures that are double. We do require our plans to go out and actually do chart review. But this is something that is feasible and you really can drive improvement.

Terrific. Thank you. Okay. So, Lisa and then Lindsay, and around the horn.

Sure. Lisa Patton here. So, I'm just going to mention, so NQF endorsed 1401 was removed for exactly the reason Gretchen was talking about, maternal depression screening, because it was captured in the

quality inset record, and the data linkages were just really impossible to do in many instances. And what I was going to share about that is, over the past year, we worked extensively with a variety of states, trying to improve those data linkages between the inside and records, and we've seen a lot of progress. But these measures really get at addressing that stuff and being able to get the data in a meaningful way today. And while states are really working on that, particularly around the opioid epidemic and a lot of infant and parent records on that front, it's going to be a long time coming.

Thank you. Lindsay?

We've just got to know that when these are just being proposed and [inaudible] can be difficult perspective. Anyway, again, going into HEDIS [inaudible] is common among people choosing to actually support communities.

Yes; that is correct. You know, we put them into HEDIS and we want to make sure that they get -- actually, all measures would get considered for things like health plan accreditation as a separate process. We really do see this as a start and a push to try to get better data for some of these measures. You know, we really think that we understand that this is an area where women are going to different places, and we just want the screening to happen, and we want to encourage the data sharing around that.

Terrific. Thank you. Jennifer.

Yes, Jennifer Tracey from Healthy Steps. I just wanted to bring it back to the discussion around Medicaid, because I do think it's really important in 2017, when CMS put out the guidance, that you could build for depression screens in the child's chart. The mother wasn't Medicaid eligible. I think this is getting to how well states are doing that and trying to collect some good data. I know there's been challenges with states trying to figure out how to implement that, how to pay for that. But I also think it's important for a lot of women who are on Medicaid, and they have their delivery, they don't make it to their six-week postpartum visit with their OB. And so, oftentimes, they are receiving these screening in other settings such as pediatric settings, and so to hear from NCQA that there will be probably pickup from other settings where these screenings are happening, I think, is really critical, especially from Medicaid, because we know a lot of moms do not make it back to their OB to even get the screening, so I think it's going to be really important to pick up on other sets.

Terrific. We're going to move right down the line here, Diana, David, Carolyn, Bonnie, and then we'll start to wrap back to the breastfeeding again. Okay, so let's finish the perinatal depression, then we'll go back to the breast-feeding.

Thanks. So, this is David Kroll. I just wanted to provide a little bit of context about this measure within this group of general framework of depression care. We're talking about the perinatal depression screening. You are probably aware that there is also a general depression screening measure that takes place at the primary care level. The reason there's such an emphasis on depression care is because depression is the leading cause of disability in the United States, and I think the most prevalent condition in the Medicaid population, if not one of the most prevalent conditions, which is why there's so much attention to it.

In the primary care level, it is effectively to screen all adults for depression. There is a lot of confusion about how frequently and when to do it, so there are a lot of gaps in that at the practical level. Similar or analogous to the discussion we had about contraception management, the perinatal time is especially vulnerable time for depression, not just because of the increased acuity of depression but also because of its impact on development of the child and the woman's life after early experience of motherhood, and so it's especially high yield and relatively narrow time in which you capture this information.

Now, access to psychiatric care or any kind of behavioral healthcare across the Medicaid population is a crisis almost anywhere, even in Boston. I often say in Boston, you can't shake a stick without hitting a psychiatrist or psychologist or other mental health provider, but even so, if you're a Medicaid recipient, you're not likely to be able to access any of that. So, especially when you have this acute problem of

acute depression in the perinatal setting in a relatively small timeframe with which you can get that patient into care, it's incredibly hard to do. So, I think what the measure is saying is really emphasizing the importance of this particular moment in the evolution or care cycle of depression.

Thank you. Carolyn, and then Bonnie.

So, I wanted to echo, actually, a point that Dr. Kroll raised, which is I'm very concerned, particularly in the Medicaid population, about access to behavioral health services. There's already, you know, a lack among well-insured, commercially insured, and you can imagine how much more difficult it is for Medicaid members to get access to these services. So, I think what this measure is attempting to assess is really important. My question really goes more to how this is going to play out in the field in terms of how we collect the data. So, Dr. Antonelli mentioned that in Massachusetts we're trying to expand access, you know, creative means, like this hotline, for primary care providers to access psychiatrists for mom. I'm not clear how often pediatricians or primary care providers call that line, how often that is getting captured in the EMR or on care management notes, so I'm just concerned about the data collection.

We're also doing a lot of creative things around alternative payment models and new care delivery systems, so trying to think creatively about how we can use community health workers and care professionals and physician extenders who provide greater access. So, I just think we need to think through the follow-up care piece of this to make sure that that activity is getting recognized and captured.

Terrific. Thank you. Bonnie?

Yeah this is Bonnie from UCLA. I just had a question, maybe for NCQA, and that is on the ECDS, how well does that capture claims in specialty mental health?

I think my colleague can answer that.

Hi, this is Lindsey from NCQA.

Go ahead, Lindsey. Sorry. There's a little delay on the phone, which is why sometimes.

Yes. Okay, yeah, sorry, I'm having issues with my delay. I just want to say that our measures do capture administrative claims codes, so those would count towards the numerator.

Follow-up question, Bonnie?

Yeah. You know, one of the issues that comes up a lot in managed care Medicaid is that specialty mental health is actually being provided by the County Department of Mental Health, and that's captured, oftentimes, through the managed care Medicaid plan.

Yes. Go ahead, Linette, and then we're going to start to wrap, because lunch is waiting.

So, just to speak to that actually. So, I mentioned this yesterday. They bring together all the [inaudible]. But that is one of the top [inaudible] levels, how do we share the appropriate data. And there's a lot of measures that cross over.

Yeah, let me just add one more comment to that. The national trend is towards reintegration, so in Medicaid lingo, carve-out, carve-in. Everyone's carving mental health back into their managed care contract, so, to me, it feels a little bit like the conversation we had around follow up to an emergency department for carry. There is an indication that, actually, the healthcare system is supposed to be working holistically for folks, and that this may help us drive towards that holistic approach to care for folks. So, Linette.

Okay. I just wanted to follow up on a couple other things related to the feasibility of the collecting data for some of these measures. For the breastfeeding one, again, intensity of data collection, I don't have any

idea how to do that from a state perspective, so it would basically be a chart review sampling methodology, and because of the way it's documented, that would probably be time and cost intensive.

In terms of the depression measures and such, with the leaning on the ECDS and the potential to look at various kinds of sources, both pediatric and adults essentially, I don't know how that would play out, and I'm not sure CMS would end up having specifications that would modify the HEDIS at all, in terms of what would we do if we had to do it only from plans versus having additional data sources. Sometimes when we have specifications that are not specific and not the standard source, it gets confusing, and sometimes that plays out that then when we try to push that through to our plans or what have you for the Medicaid spec as compared to the commercial spec, then we have to watch and make sure people keep up with the right spec, and then the comparability is lost. So that's just one of the challenges that sort of sits in the backdrop of some of these measures.

The other thing we've run up against around some of the perinatal measures in general is actually identifying the date of birth associated with mom. To do all these measures is really hard, which is one of the reasons we really want to get our vital records in place, because, yes, there's a date of birth on mom and mom's claims and eligibility but not necessarily a date of birth for baby, and so how we get those connected is one of the challenges that we often have and creates a lot more complexity around running the measure from the data than you might think.

Terrific. Thank you. So, I'm going to circle back to Diana, because she's been incredibly patient as it relates to the breastfeeding measure, and then if you can look at your tent. If it's up and you want it to be up -- thank you. I thought there were a few that were hanging out there. So, Jill, Diana, and then Jill, and then we'll move to public comment, please.

Thank you for the opportunity to comment. I just wanted to thank you for bringing up the fact that there is a lot of emotion around this measure. It is a non-medical issue, and it's really important, as we look at our core measurement set, that we include non-medical issues in our core measures, because this is where the social determinants of health come in. It's actionable, it aligned, and it is a strategic priority. So, the issues are, its appropriate state-level measurement and feasibility. I just want to clarify just to close any discussion, because I don't think that it was said from a content expert perspective that this is highly actionable.

There are evidence-based practices that start with prenatal care that go through the intrapartum and postpartum period. Your system is promulgating health disparities. And when we sit at these tables and suggest that black women don't breastfeed and Hispanic women don't exclusively breastfeed, we need to stop, because it's not true, and they do. Here in D.C. we had the highest rate of exclusive breastfeeding on discharge of any practice in the city, with 80% African American women. So, our practices that Medicaid is supporting, or not supporting, the way we achieved that was through breastfeeding peer counselors, which Medicaid doesn't fund, or didn't in our state. So, I just want to bring it up as an issue for future consideration. It's really important that we keep our eye on these measures and that we keep looking at how we're going to break down disparities. This is an upstream issue. This affects your diabetes, your cancer, and your obesity rates.

Terrific. Thank you for that perspective. Jill?

This is Jill Arnold [inaudible]. One of the things that happens with C-sections is, early on, is that you're trying to force women to give birth. And so what it took was these organizations [inaudible] and framing it more and supporting it. And I think with the breastfeeding, it's very similar. The idea is not to try to force 100% breast-feeding on everyone. It is to capture the data around intended breastfeeding. And I think the importance for this population is that if you can capture that data, and you can see the difference between a hospital with a 75% exclusive breastfeeding rate and one that's 20%. You know where to direct your innovation, and your peer level programs and your lactation consultants and that. So, for this population, it's very many important, and I'm glad to see [inaudible].

Terrific. Thank you. So, I'm going to conclude our dialogue as a committee. Again, we are looking to move towards the voting on the three removals and the three additions in this domain of maternal and perinatal health. Great discussion. We'll open it up for public comment, first for those in the room. Yes, we have a public comment.

Hi. I'm Renee Fox. I'm from CMCS, and I just wanted to make a comment about the postpartum contraceptive measure and tell the committee a little bit about how we ended up with these measures. We funded the contraceptive grant through the Affordable Care Act and with our partner, CDC, Office of Population Affairs, and 11 states were in the pilot. It was developmental measures. As yours, they had to report the measures. They looked at lot of the obstacles to postpartum, postpartum care, contraception, and the states chose things, and then it was put into the Core Set, and it's a really -- somebody said it earlier, and it's a very important period, because short inter-pregnancy intervals really contribute to poor outcomes for both mothers and babies. So, I just wanted everybody to be aware that it's actually able to be reported, and it was submitted, started [inaudible] a couple years ago [inaudible].

Terrific. Thank you. Any additional public comment in the room.

Hi. This is Alice Tsai from the National Vaccine Program office, and thank you for the two minutes. Just food for thought for tomorrow's discussion, but since we are on the maternal perinatal health domain, I would like to, again, emphasize that half of all U.S. births are covered by Medicaid, and the maternal perinatal immunization offers protection against influenza and pertussis transplacenta.

So, Alice, we're talking about just the measures under consideration for vote right now. Do you have any comment on these six measures?

I would kindly seek the workers consideration for inclusion for prenatal immunization measure as part of the maternal perinatal health domain.

Okay. Terrific. So I do think it's important to acknowledge, we group these just to organize our thinking. It's acknowledged that the perinatal immunization measure probably could have been here too, but we put it with the other immunization measure, so reflective of it being related to this domain, but not up for vote again today. Other areas of public comment? Okay. Brice, is anyone on the phone who has identified themselves as interested in public comment?

We don't have anyone at this time. So, as a reminder to folks listening into the webcast, if you are listening through your computer speakers, you will need to dial into the teleconference in order to put your hand up, and in order to put your hand up, you'll need to press "5*" once you have joined the teleconference.

Okay. Hearing none and knowing that we're up against a deadline, I'm going to proclaim the public comment period to be over. Is there a motion to vote on the three removal measures for the maternal and Perinatal health? Thank you. And second. Second. Great. There is just one other thing that Renee prompted, and we do have the opportunity for open discussion after the motions. On the contraceptive care, there's just one other nuance I thought I would share that we wrestled with in Colorado, and I know is a wrestling match for others. There is some unique payment policy that relates to LARC insertion in the immediate postpartum setting that it's super wheezy and complicated and relates to a whole bunch of things.

The point of me raising that is I do think that maintaining this measure will drive states to continue to solve that problem and to figure out what to do appropriately about the payment barriers that we've created as the program to the right clinical decision being made, and so it's a suggestion that it continues to force problem solving on a known identified problem. So, with that, is there any additional discussion, David?

I'll comment again. [Inaudible] by our managed care plans and all the measures, opportunity is very feasible [inaudible].

All right. Jill, did you have additional comment or is that a vestige? Yeah, thank you. Bailey is my eyes. Sally, go ahead.

Are we just saying things that are on our mind before we go into vote? So, the way it typically works --

I did not mean that to sound any way [inaudible].

Low blood sugar right before lunch appropriate question. No. Typically, in rules of order the motion is to put it on the table, and then there is still opportunity for discussion. It doesn't mean that there's no -- something that Renee said just triggered me to remind you all of this complex payment policy issue, and then David added. So, if there's any finals, then we're ready to vote. Yes, Sally?

I have one thing to add, and it's not meant to sway votes. But in terms of the exclusive breastfeeding, I did have a question that didn't get answered, but I don't think it will -- [inaudible].

I'm going to ask you to hold that.

But what I wanted to say is, one thing to think about, as we think about Medicaid programs, it includes how we title a measure and what that perception might be, and I'm thinking about the Medicaid beneficiaries. I am being very much sensitive that and what that signals from that state agencies. So it's not just applicable to that measure, but it kind of rears its head there.

It sure does. And I think that that words matter and that's a great reminder to everyone who creates measures and how we even discuss them, that being mindful of that title is probably a good idea, so terrific. With that, I will move to close the conversation and will move to voting on the three removal measures. Great.

And we do have a couple people not eligible to vote on these, so I will announce the denominator as well when I announce the vote. So, we're voting on the three removals. The first vote -- I guess, actually, I should everyone should turn on their remote, because they might have gone to sleep during the discussion.

Not the people.

Is it not on? The remotes are awake. People maybe not. And could everyone hear me? Okay. Great. So, the first measure that we're voting on for removal is the CLABSI measure. Again, you're pressing A if you recommend removing this measure, and B if you do not. This is the denominator of 28, so if everyone could just hit that blue button, they should be good, but just in case anything is left over, and then, Steve, if we could just open voting. So, the votes for removal of CLABSI, 75% of the workgroup voted that, ”Yes, they recommend removing the measure,” and 25% voted that, ”No, they do not,” so this measure has been recommended for removal.

Moving on to the next measure vote, this is for PC-01, which is elective delivery, which is an adult measure. This has a denominator of 27 for vote, so there's one ineligible member, and, again, this is, if you recommend removing the measure, press A; if you do not, press B, and please hit your blue buttons. Great. And please open voting. The results for this measure are 26%, seven people, voted, ”Yes, they recommend removing the measure,” and 74% voted that, ”No, they do not,” so this measure was not recommended for removal from the Core Set.

Moving on to the next vote, this is the denominator of 28. Everyone is eligible to vote. This is for voting on the removal of the contraceptive care, postpartum women, ages 21 to 44. The specific age group is in the Adult Core Set. Please press your blue button and voting A, :Yes, I recommend removing the measure,” and B, ”No, I do not recommend removing the measure.” And, Steve, you can go ahead and open voting. For this measure, the workgroup vote was 14% recommended to remove the measure and 86 recommended not to remove the measure. This measure is not recommended for removal of the Core Set, and I'll pause there.

Terrific. Is there a motion for additions, voting on the three measures for recommendation for addition to the Core Set? Moved. Second? Is there any open final lingering discussion for these three? Lindsay has one, yes.

I have one that I can bring up. So, I do have a little bit of concern about the continued criteria in the postpartum. Continued criteria is 60 days. I know that Medicaid coverage for many of the expanded populations also ended. The measure itself looks [inaudible], so there's just a little bit of a disconnect there that I want to make sure that people were just aware.

So, is there a technical response from NCQA -- or CMS is this one, I believe. No? Great.

Yes, that is true. So, we did struggle with the continuous enrollment, because, you know, it does mean that you have to go out further than where some Medicaid plans would cut off, and it really was felt that we had to step aside continuous enrollment, at least the floor of where Medicaid plans are covering women for pregnancy reasons, and so we put it at 60 days. So, what that means is that, for those plans, they would have to get the screenings done earlier, within those 60 days, if they knew they were going to lose the woman.

We did look at data from across several different states, and you do see quite a range in terms of how many women do drop off after the 60 days, so we acknowledge that. We thought that, you know, but still providing the 84 days out for plans that would retain the woman past 60 days, they would still have a little bit of time to get the depression screening done, and so that was really the compromise here. You know, you have some states who would be able to go out a little further. States would really try to get that in within just a few days postpartum.

Terrific. Thank you. So, for those, 60 days postpartum is the end of pregnancy-related eligibility and Medicaid programs that haven't expanded Medicaid, so. But even in states that haven't expanded Medicaid, some have parental eligibility that goes beyond because of state-based policy decisions, so the complexity of the Medicaid eligibility policy really impacts this timeframe for the postpartum women. Are there other comments? Then let's vote.

Great. Okay. So, we're going to be voting on measures for addition now. The first measure that we're going to vote on is the PC-05 exclusive breast milk feeding during the newborn's entire hospitalization measure. This measure has a denominator of 27. We have one person ineligible to vote. If everyone could please hit their blue buttons. And, again, A is, ”Yes, I recommend adding this measure to the Core Set,” and B is, ”No, I do not recommend adding this measure to the Core Set.” Steve. So, the vote for this measure was 30% of the workgroup voted, ”Yes, I recommend adding this measure.” 70% voted, ”No, I do not recommend adding this measure.” This measure was not recommended for addition to the Core Set.

Moving on to the next measure for addition. This is whether the prenatal depression screening measure and follow-up -- let me say that again, sorry. Prenatal depression screening and follow-up measure should be added to the Core Set. This one also had a denominator of 27. We have one ineligible member to vote. Again, if you could press your blue button, and then A, ”Yes, I recommend adding the measure to the Core Set,” and, B, ”No, I do not.” So, 56% said, ”Yes, I recommend adding this measure;” and 44% said, ”No, I do not recommend adding this measure.” This measure is not recommended for addition to the Core Set.

And the last measure of this domain and what's standing between everyone and lunch, so this is a vote for addition, a denominator of 27 again, and this is for the postpartum depression screening and follow-up measure, and if everyone could hit their blue button, A, ”Yes, I recommend adding this measure,” B, “I do not recommend adding this measure.” Steve. If everyone could just check their screen and make sure it has the letter on it that you want it to, either A or B. Great. So, this measure was very close, for those of you on the phone, as you heard from the room. 63%, or 17 people, voted, ”Yes, I recommend adding this measure to the Core Set;” and 37% said, ”No, I do not recommend adding this measure to the Core Set,”

and for this denominator of 27, we needed 18. It will be discussed tomorrow. But at this point, this measure is not recommended for addition to the Core Set.

Thank you all, and thank you. I know we're ready for a break. I do want to prepare us, though, that when we come back, we have 11 behavioral health measures before us, so we are going to take a 30-minute lunch. But if everyone can really be back at ten after, that would be great.

This concludes the morning session. At this time, we are going to disconnect the phone lines for a lunchbreak. We will reconnect the phone lines in a few minutes. Please dial back in using the same number and access code. Thank you.

[BREAK].

Thank you, everyone, for finding your seat. I will remind everyone, it's a beautiful 71 degrees outside. We have an afternoon of work before us, and then after that, a lovely evening in our Nation's Capital. So, thank you all for that prompt return to your seats. I know a half hour for lunch doesn't feel like it's ever enough time, but I think we would prefer to sort of continue to plow through and then have the opportunity for a break this evening before we come back tomorrow to do our final reflections as a workgroup.

So, again, I want to express my gratitude for everyone's thoughtful comments and your shepherding of our shared group norms around respectful dialogue, but at the same time, sharing important information. The dedication to the Medicaid program and to the individuals who Medicaid program serves is evidenced among us, which means Mathematica really did something right, in terms of our invitation to participate in in group, so we hold that to be important. That will be particularly important as we tackle the next two, which are areas I think of continued opportunities for debate and improvement in the Medicaid program.

The behavioral health services made available through Medicaid in particular, traditionally for individuals with severe and persistent mental illness was an eligibility opportunity for folks to get access to services. In some states access through Medicaid has been more robust than in other places because of parity and other issues. Similarly, as it relates to long-term services and supports, unique role for the Medicaid program in supporting individuals to live successfully and fully, both in the community and with the supports they need if that level of care is higher than a community-based setting can handle. So, very important populations that we'll be talking about this afternoon, so I just want to remind us of, in particular, these two areas the Medicaid program has perhaps some unique opportunities and responsibilities.

So, our game plan this afternoon is 11 measures as it relates the behavioral health. Michaela is going to walk us through those. 11 measures is hard to keep track of, we get that, so we're going to do our best to have the two removal conversation and then the nine addition conversation and try our best to be thoughtful about that. After that, we'll do the eight long-term services and supports. Those eight sort of break out -- despite the fact they're all additions, they sort of break out into two groups, those that are shepherded by CMS and those that are really more about understanding the patients' lived experience and the members' lived experience through surveys, so we're going to break those into two, simply for ease of discussion.

And then there are two we lumped and then we unlumped, and then we have two that linger. And so the two lingering ones, which are equal in their importance, relate to continuity of insurance and health-related social needs screenings, so other areas that are of note and of interest of the Medicaid program. So that is our journey that we're on in afternoon. We will do our best to end on time, but that sort of depends on all of us maintaining our discipline as we go through these discussions. Are there any questions or thoughts before we dive in? All right. Michaela, I'll turn it over to you.

Okay. Thanks, Gretchen. Before I get going on the behavioral healthcare measures, I wanted to make sure that the measure stewards are either in the room or on the phone. I think that we have some folks from Brandeis that may be on the phone? If you are, can you let us know by speaking.

This is Lisa Hines.

I'm sorry. Who was that? Lisa Hines from the Pharmacy Quality Alliance.

So, for measure stewards on the phone, if could be prepared to acknowledge your presence and speak more loudly than you are. It's difficult for those of us in the room to hear. So, measure stewards, if you could be prepared, that would be great.

Okay, so we have someone from PQA on the phone. Do we have anyone from Brandeis on the phone? Okay. Do we have anyone -- I think we have folks from NCQA in the room. Anyone from University of Southern California on the phone? Okay. Anyone from PCPI on the phone? All right. So, if anyone is having trouble unmuting themselves, you can always chat in and our webinar moderator will help you unmute. In the meantime, I'm just going to walk through the measures that are currently in the Core Set that are related to behavioral health care. I'm not going to specify the measure descriptions for each measure, because there's a lot to get through. But if you have any questions about the current behavioral health measures, we're happy to answer those after I've gone through.

So, there are currently four Child Core Set behavioral health measures. These are the follow-up care for children newly prescribed attention-deficit hyperactivity disorder medication; the follow up after hospitalization for mental illness in children ages 6 to 17 measure; and the use of first-line psychosocial care for children and adolescents on antipsychotics measure. There's one additional measure. The use of multiple concurrent antipsychotics in children and adolescents measure, and that measure has been recommended for removal from the Core Set. We'll be about that more in a few minutes.

There are currently 11 Adult Core Set measures related to behavioral healthcare. These are the IEP measures, that's initiation and engagement of alcohol and other drug abuse or dependence treatments. Next slide, please. The medical assistance of smoking and tobacco use cessation measure, this measure has also been recommended for removal, so we'll talk about that one a little bit more in a minute. The antidepressant medication management measure; the follow up after hospitalization mental illness and health ages 18 and older measure; the diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications measure; follow up after Emergency Department visit for alcohol and other drug abuse or dependence measure; follow up after emergency department visit for mental illness measure; the diabetes care for people with serious mental illness hemoglobin A1C poor control measure; the use of opioids at high dosages in persons without cancer measure; concurrent use of opioids and Benzodiazepines measure; and; finally, the adherence to antipsychotic medications for individuals with schizophrenia measure.

I went through those really quickly. Again, if you have any clarifying questions afterwards, but I'm going to get in, now to the measures for removal. We have two measures recommended for removal from the Core Set for FFY 2020. The first is the medical assistance for smoking and tobacco use cessation measure. So, this is an Adult Core Set survey measure that derived from the CAHPS 5.0H adult medication survey. NCQA is the measure steward for this measure, and it is NFQ endorsed. The measure denominator is the number of beneficiaries who responded to the CAHPS survey and who indicated that they were current smokers or tobacco users, and there are those three numerators for this measure. The first is the number of beneficiaries in the denominator who indicated they received advice to quit from a doctor or other healthcare provider. Second is the number of beneficiaries in the denominator who indicated their doctor or health provider recommended or discusses cessation; and the third is the number of beneficiaries in the denominator who indicated that their doctor or health provider discussed cessation methods with them.

So, this measure is not on the Medicaid and CHIP scorecard and was reported by 20 states for FFY 2017, and a workgroup member recommended the tobacco use and cessation intervention measure be added to replace the current MSC measure for 2020. That workgroup member suggested that since the MSC measure is derived from CAHPS 5.0H survey data, it's been difficult for some states to report due to poor response rates, high cost to conduct the survey, and touring that is not comparable for diverse population.

The second measure that's been recommended for removal from the Core Set is a Child Core Set measure. This is the use of multiple concurrent antipsychotics in children and adolescents measure. This is an administrative measure. NCQA is the measure steward, and the measure is not NQF endorsed. The denominator is the number of beneficiaries with 90 days of continuous antipsychotic medication treatment during the measurement year, and the numerator is the number of beneficiaries on two or more concurrent antipsychotic medications for at least 90 consecutive days during the measurement year.

Michaela, we're going to ask you to speak up a little.

Okay. The measure was reported by 37 states for FFY 2017, and the metabolic monitoring for children and adolescents on antipsychotic measure, which we'll discuss shortly, has been recommended to replace this measure. The workgroup that recommended this change noted that states have had consistently high performance on the measure, leaving little room for improvement and context the FFY 2017 median rate for this measure was 2.7 percent and lower rates are better. The workgroup member also noted that the denominator for this measure has decreased over time, suggesting that the overall number of children using antipsychotic medications has decreased, and I also wanted to note that this measure has been proposed for retirement from HEDIS for 2020.

Okay. So, I pause because the two that we have proposed for discussion on removal have two in the additions that do seem to be a little bit parallel, so I wonder if, for the good of the group, we'd ask Michaela to go through those two additions and discuss those four on that. Everyone's giving me the thumbs up. Terrific. Michaela, can you walk us through those two additions then?

Certainly. So, the measure that recommended to replace the medical assistance of smoking and tobacco use cessation measure is the tobacco use screening and cessation intervention measure. The measure steward for this measure is PCPI, and this measure is NQF endorsed. This is a process measure that can be selected using either administrative data or EHR data. The denominator for this measure is the number of patients ages 18 and older that were seen for at least two visits or at least one preventative visit during the measurement period, and the numerator for this measure is the number of patients who were screened for tobacco use at least once within 24 months, and who received tobacco cessation intervention if they were identified as a tobacco user.

And as we discussed previously, this measure is recommended to replace the medical assistance tobacco, with smoking and tobacco use cessation Adult Core Set measure, which is derived from the CAHPS health plan 5.0H survey, and the workgroup member who suggested this change, again, is because of forecast response rates, high cost of building the survey and lack of comparability.

The metabolic monitoring for children and adolescents on antipsychotic measure is recommended to replace the current Child Core Set use of multiple concurrent antipsychotics in children and adolescents measure, and this measure, the measure that suggested for addition is NQF endorsed, and the measure steward -- it's a process measure that's reported using administrative data. The denominator includes children and adolescents ages 1 to 17 who had at least two antipsychotic medication dispensing events of the same or different medication, and the numerator includes children and adolescents who had at least one test for blood glucose or HB A1C and at least one test for LDLC or cholesterol during the measurement year.

The workgroup member who recommended this change noted that it would help states address gaps in assessing the number of kids on multiple concurrent antipsychotics who had an appropriate monitoring for known side effects of these medications. In 2017, NCQA reported a Medicaid HEDIS national average of only 34 percent of children on these medications who had appropriate monitoring. They say this is a large gap, and the workgroup member also noted that this measure includes a larger denominator than the current existing Core Set measures that it is recommended to replace. I also wanted to note that an updated version of the measure is currently under consideration that would combine the 1-to-5 and 6-to-11-year age group and add separate rates for blood glucose and cholesterol.

Terrific. So, if it would work for the group, I'd like to start our discussion on the tobacco-related measures, the proposal for removal and the proposal for addition, and see if there are technical questions/general comments on those two measures. I'll start by just saying, from the Colorado Medicaid program, the smoking rates among Colorado Medicaid members was twice the state average in the State of Colorado, so, if we're just going to proclaim the issue to be important, I would suggest at least in Colorado's experience the issue of availability and treatment for tobacco cessation was a critical issue that we were trying to continue to work on. Sally, did you have something?

Question, probably for the measure developers on what their thinking is around vaping. Is there any discussion around vaping? And to the extent that that's in scope, great. To the extent that it's an emerging public health challenge but not addressed in the measure, please just acknowledge that and we'll move on.

Yeah, the measure is focused as an NCQA measure. It's focused on -- the wording in the CAHPS survey is just smoking or using tobacco, so it's not mentioned. Yeah, someone might [inaudible].

Marissa and Sally if you would share the dialogue with the group. I don't -- the comment was that tobacco would include vaping. I don't think that's correct. I think vaping doesn't include tobacco. Someone might define smoking as vaping. I don't know.

I think among -- the way we tried to address this, again in this State of Colorado, there are many adult cigarette smokers who do view vaping as an alternative to that and would potentially answer the question that way. I think young people are doing other things with Juuls and things related to the strawberry cream flavoring and things; right? So, I don't think that they would maybe think that, but this is an adult measure, so I think it's a guess; right? It would be a guess as to the personal interpretation of that phrase.

I don't think so.

Yes, Carolyn. So, just following up on Sally's point. I don't think we should be leaving this to guess work. I think it has to be specified that vaping has to be included in the specifications. I can't support this unless vaping is specifically articulated in this measure.

Hold on. Bailey has something to add.

Sorry. That was for the listing measure. The proposed measure is PCPI, and so I think we should just confirm whether they're on the phone or not. I'm not sure that they are. But PCPI, if you're on the phone, could you answer if your measure tobacco use screening and cessation intervention includes vaping. I don't believe they're on the phone right now.

I think it's an important conversation. I the only thing I would add, from Carolyn's perspective is, perhaps what we note in the report is that the CAHPS's survey needs to evolve to reflect the current reality of this issue. I appreciate the perspective that Carolyn shared with the group. But this is the CAHPS survey. Maybe that's one thing that should just be noted in the report, regardless of the way to remove or not remove goes.

Yeah, just to be clear, I would extend that to any proposals for removal or for addition, because a lot of young adults don't consider vaping smoking, and in use, it certainly leads to increased prevalence of moving on to other substances.

Yes. Terrific. Thank you. Other discussion of the tobacco use? Shevaun, yes, please. Thank you.

I have a technical question. I recognize the measure steward isn't on, but if any state or any experts have any experience with collecting the one for addition related to tobacco use at the health plan or state level, experience with collecting data at that level, since it's specified for provider level.

[Inaudible] your managed care plan.

Linette?

Linette in California, we are not doing this measure yet, but we are planning to use it as part of our value-based payment program.

Okay.

This is Lindsay Cogan from New York, and I just had a question about, again, measure on the provider side that doesn't include [inaudible], so when you look at measures [inaudible] Medicaid, that would have to be something [inaudible].

Okay. Thank you. Others on these two? Then maybe we can move to the concurrent medication removal proposal and the addition proposal, as it relates to monitoring children and adolescents who are currently prescribed in taking antipsychotics. Technical questions and/or perspectives? Oh, yes, please.

Hi, Bonnie from UCLA Child Psychiatry. I just wanted to provide a potential clinical explanation to my Medicaid colleagues about why the rate is so low. No psychiatrist is going to take this decision lightly to prescribe an antipsychotic to a child, and it's also particularly a very difficult decision for parents. So, I think within this 2%, you know, what's probably happening is a very thoughtful clinical justification that's also a decision often made with the primary caregiver; right? So, I think the low rates is probably the strong argument to remove, but I just wanted to provide that context.

You know, the other issue with the metabolic monitoring measure, what's really important here is this is one of the few measures where we actually are monitoring medication safety monitoring for children on psychotropic medication, and I think that's really important. And you can see in the literature a large gap, and I totally get it that, you know, maybe in child mental health we're a little behind, but, you know, I would like to see this one to go forward, and then, ideally, in five, ten years, we talk about a follow-up measure with in; right? Those are my comments.

It also occurred to me that this one felt a little analogous to the conversation I think we had around screening for blood glucose versus understanding whether or not the blood glucose is under poor control. It felt like this is the next iteration of that. I'm glad you're agreeing with that analogy that it came into my head seems reasonable to apply here. Yes, David.

So, I think as states, we've all had [inaudible] high priority. Several years ago, this measure [inaudible] significantly higher, so this is the low level to get there, but I think we're at that point to achieve clinical data [inaudible] for reutilization. Physicians are feeling comfortable with treating children [inaudible]. It's important. Ten years ago [inaudible] worked on this. [Inaudible].

David, in that respect, similar to the elective deliveries conversation then, do you have any concerns that we would lose focus on this measure if it were removed from the Core Set?

From our state standpoint, we would continue to look at similar measures, just because it's going off the Core Set. We would continue to look at similar measures, metabolic screen that we look at with kids in foster care. Kids in foster care have gotten other [inaudible] even if it comes off Core Set we're not going to stop measuring it.

Great. Bonnie.

Yeah, and, you know, I'm not concerned either, because, you know, this one is targeting physician behavior, and I think that we've come a long way in sort of training up physicians that you're not supposed to do this.

Okay. We'll go around clockwise this time, Jeff, Jill Linette, and then Lisa.

This is Jeff from Minnesota. I also would support that this could be removed, because while this is an important issue, I think what Bonnie said is really true. There's a few kids that need it, and the rates shouldn't be zero. And when it's being done, I don't think we have a concern. We did look at common and psychotherapy with antipsychotic use in our foster kids and found that we had sort of an adequate amount, and that's where I think the measure should go so these kids are getting health intervention and hopefully trauma-informed care.

Terrific. Thank you. Jill?

I had a question quick about the between the denominator in this one [inaudible], whether -- so the one is two or more antipsychotics in a 90-day period. But the addition one is --

Jill, if you could speak up.

Oh, I'm sorry.

Into the microphone. I'm equally guilty. Get really, really close to the microphone. So, my question is whether or not the denominator is different in terms of the kids that you would pick up between the current measure that's recommended for removal and the measure recommended for addition? So, the current measure recommended for removal has two or more antipsychotics in a 90-day period. The addition measure says "at least two antipsychotic medication dispensing events of the same or different medications on different dates of service during the measurement year." My question is, would that pick up more kids who are on antipsychotics?

Yes. It is the denominator. I'll let NCQA address that. And then also, NCQA, can you weigh in on where you're at with the first measure, the two medications?

Right. So, the measure that's up for removal, which is the multiple concurrent measure, the denominator is actually individuals with 90 consecutive days of antipsychotic use. The metabolic monitoring measure is looking for children or adolescents where we dispense two antipsychotics on different dates of service. So, there is a distinction. And I can tell you, looking at the results from our health plans, the denominator for the metabolic monitoring measure is on end larger than the multiple concurrent.

Terrific. Thank you. Yes, Linette.

So, in California, we've been monitoring both of these measures, plus a few others, for the last several years. So, for 2017, our denominator for the concurrent was about 12,000 children in Medi-Cal, and for the metabolic monitoring, it was about 16,000. So, yes, there's more, as you would expect. That being said, in terms of the concurrent to the point that made, we're down, in California. You know, we're kind of big. We're down to only 400 children with concurrent antipsychotics in Medi-Cal and about 40 in foster care, so, yes, the numbers have dropped. We need to continue to monitor it. But the idea of shifting to the metabolic monitoring, where we're only at 40 to 50%, getting the metabolic monitoring makes a lot of sense from a data perspective.

Terrific. Thank you. Lisa? Lisa Patton. Yeah, I just wanted to support what David was saying about the tremendous push on this measure in the past decade. So, we've seen these rates significantly drop. And the foster care issue does remain very important to look at. I don't know if Laura Jacobus-Kantor from SAMHSA is on the phone and, if not, unable mute. I'll just mention that at the [inaudible] scorecard meeting that SAMHSA was very clear, and Laura said they were in support of removing this measure as well.

Terrific. That's important knowledge as well. So, I feel like there's some sort of consensus around this discussion. We've gotten a lot of the issues on the table. I guess I would like to ask the group a question. Would you like to vote on these four measures? Yes. Okay. We'll clear our deck of the things that we can clear our deck on. If we're going to do that, which I'm comfortable with, we do need to create the opportunity for public comment on these four measures before we move to that vote, and I think we can in

this case, once you come together, we can re-lump the four and have one motion to vote on these four. But Rich, first, has something to say.

Yes, clarifying question. I'm not sure that I know [inaudible].

Well, you did not miss something. I guess I would just push us as a group. Sometimes we have to make the decision based on the best information we have available. I think the vaping issue is an emerging public health issue that the entire nation is wrestling with. So, I think, to some extent, we may have to make peace with. The definitions may not align with current reality of young people. But if that is a hang up for someone, that is certainly -- the goal of this is to vote on the metrics of the measure, and if it's not included and you can't vote on it, that's a reasonable interpretation of voting on the merits of the measure. So, I don't know quite how to help us reconcile that. But I don't think we have resolution. Carolyn?

Yeah, I was just going so say something similar. I find it really difficult to vote unless I know, you know, both for CPI and NCQA, if they were planning to clarify the specs, because right now, reading it, I don't think any of us can tell if vaping was intended to be included in the specs. And, Carolyn, do you mean clarify the specs.

It talks about tobacco, but, again, it would really -- I think it's really important to specifically articulate that this includes vaping.

So, maybe I could ask NCQA. Even if we don't have the vaping answer, what is the process for clarifying specs when the outside environment shifts that impacts the measure?

Right. So, first, I agree, we need to update the measures. I think across the board, and I think you're absolutely right, that measures, all of these measures, when they were developed, probably did not account for this issue of vaping, which is now a very important problem.

So, vaping is not specifically mentioned in the questions for CAHPS, so it's something that if someone interpreted it, you know, on their own as it not being smoking, they probably wouldn't answer yes, and then they wouldn't filter into the cessation. And there probably wouldn't even be a question about that to our policy clarification support system because it's something that the respondent has just, you know, internalized responded to, and provided the answer to. So, just to be frank, that is probably what would happen.

It's something that we would open up and reevaluate our measure and then, because this is a survey measure, would probably undergo some cognitive testing to make sure that, you know, we are understanding how those different terms get interpreted by the people who are responding. This is an adult measure, I think as was mentioned, so, you know, it doesn't mean that we shouldn't be looking at this as the current adolescents and children are aging into adulthood, so it's something that we need to look at for the future.

Carolyn?

This is out of scope, but I'll plant the seed. As long as you're doing that, throw in marijuana, because that's been legalized in a lot of states now.

Thank you, Carolyn.

Thank you. Stick to the measures are the measures that we need to look at, and how the measures are currently worded and what they may mean or not mean. This is open to the individual's interpretation. That being said, tobacco use is public health issue, and whether it's current forms of smoking cigarettes or other things, it's a public health problem that kills over half-a-million people directly or indirectly. So, if walk away from either of these measures just because it doesn't include vaping, to me, does not seem the right way to head; that we need to look at the measure as it is, especially when we're doing this in the context of behavioral health.

Tobacco companies are focused on people with mental health conditions. They specifically target them in any instance. Smoking, those populations are significantly higher than general populations, sometimes double that, or more than the general population. So, I don't want us to get lost in, let's say, the fuzziness of whether or not vaping is included in either of these measures. But we [inaudible] the overall public health management, that these measures are really measuring public health, and either one of them can be used. We do the CAHPS survey. Those results really move the intervention forward. So, don't throw the baby out with the bath water definition. It's a little fuzzy.

Perfect. Thank you. Jill and then Jeff, if yours is up for the survey. Jill, go ahead.

So, I just wanted to address the issue about marijuana. The reality is that these treatments, tobacco cessation, the drugs that are used, the patches, whatnot, don't address marijuana. They're nicotine and tobacco. So, that's a confounder. It doesn't belong in thinking about this measure in terms of the treatment. And I think what David said, you just can't emphasize enough that the smoking rates in the general Medicaid population are double or higher. The smoking rates in people with mental illness are -- I don't even know how many times it's high, but we know that they die 25 years sooner than the rest of the population, and the other reality is, the minute you stop smoking, your heart attack risk goes down, and so I just think this is incredibly important for a Medicaid population.

Thank you, Jill. I'm going to ask that we move on. The only other thing I would just say that also struck me before we move to public comment is, as it relates to the CAHPS survey, we had, I think, an important discussion about the fact that many people get their flu shot in a whole bunch of places, and the public health goal is that the flu shot is given. Important for Medicaid to know that. There are tobacco cessation approaches at the community level and at the State Health Department level that the CAHPS survey may give us a broader perspective on that experience if individuals beyond just that which they get through their individual primary care provider if they interpret the question to be any provider, which could be somebody else that they talk to.

I think we can continue the discussion, perhaps tomorrow we look at gaps.

Yes.

And what can be changed. Maybe a better discussion.

So, I'm going to give you the last comment on this, and we're going to move to public comment. The only other thing I would say is there are a variety of other surveys that look at tobacco use, so we have lots. It's not just the CAHPS.

Correct. Yes. Thank you. That general surveillance is important; right, which we've wrestled with, what's in [inaudible] and what's in public health surveillance versus Medicaid. So, if there is anyone who wants to make public comment on the four measures, the two that relate to tobacco and the two that relate to children and adolescents receiving antipsychotic medications, please let us know in the room. Dr. Seeff?

Oh, yes? I couldn't see the bag. I could only see your hand.

Terrific. So, a good discipline of not repeating. Thank you. We appreciate it. Anyone else in the room? Okay, is there anyone on the phone who would like to make a public comment about these four measures?

We don't have anybody with their hands raised now. Just a reminder to those folks on the phone, press "5*" to raise your hand.

Okay. In the interest of discussion, is there a motion to move to a vote on these four measures, the two proposed for removal and the two proposed for addition? So moved. Second? Okay. So, we'll vote in the order, because that's how the slides are, the two removals and then the two additions.

There are no refusals. I'll confirm we're on the right slide. So, this vote will be for removal of the Medicaid assistance of smoking and tobacco use cessation measure that's in the Adult Core Set. I ask that everyone turn on their remote. Make sure it says "Ready." You're voting A, ”Yes, I recommend removing this measure,” B, ”No, I don't recommend removing this measure,” and, Steve, open voting. Okay. So, the vote on this measure is 46% of the workgroup said, ”Yes, they recommend removing the measure.” 54% said, ”No, they do not recommend removing the measure.” This measure was not recommended for removal.

Moving on to the next is measure, so next slide, please. So, this is also a vote for removal. We have no recusal, and this is whether the use of multiple concurrent antipsychotics in children and adolescents, it's a child measure, should be removed from the Core Set. Please hit your blue button, if you haven't already. A is, ”Yes, I recommend removing the measure,” and B is, ”No, that I do not recommend removing the measure.” Steve. Just check your screen that it has an A or a B on it. Maybe everyone just hit you’re A or B again. So, the results of this, 93% of the workgroup said, ”Yes, I recommend removing this measure.” 7% said, ”No, I do not recommend removing this measure.” This measure has been recommended for removal.

We'll now move on to the measures that are proposed for addition to the Core Set. The first measure is should the tobacco use screening and cessation intervention measure be added to the Core Set? So, if everyone could hit their blue button. You're voting A, ”Yes, if you recommend adding this measure to the Core Set,” and, B, ”No, if you do not recommend adding it.” And the results of this vote are 46% of the workgroup said, ”Yes, I recommend adding this measure.” 54% said, ”No, I do not recommend adding this measure.” This measure has not been recommended for addition to the Core Set.

And moving on, the slide change, to the last vote for this section. This is an addition again. This is the metabolic monitoring for children and adolescents on antipsychotic medication, and the question is whether this measure should be added to the Core Set. Press your blue button if you haven't already. A is, ”Yes, I recommend adding this measure,” B is, ”No, I do not recommend adding this measure.” Steve. And the results of this vote are 82% said, ”Yes, I recommend adding this measure.” 18% said, ”No, I do not recommend this measure.” This measure has been recommended for addition to the Core Set. And I'll turn it back to Gretchen.

Thank you. I would just note, one of the things that I would say we've done very well as a committee has been very judicious about adding. I think we've added two and removed a number, so Diana, we're onto your super power of reducing the size, at least from our perspective set of recommendations to remove some of the components of the Core Set but add, I think, some important ones as well.

So, the next set that we will be working through remain in the behavioral health domain. There are a number that relate to opioid use, which, again, is another emerging public health crisis, long standing, but a public health crisis that our understanding of and treatment of and ability to manage is still evolving, so we'll have some of that conversation, as well as some general substance use disorder related measures. So, with that, I will turn it over to Michaela to walk us through these additions, these seven additions.

Thanks, Gretchen. All right. So, the first of the measures we have left to discuss is the preventive care and screening, unhealthy alcohol use screening and grief counseling measure. So, this measure is NQF endorsed. PCPI is the measure steward. This is a process measure that can be reported using EHR data or registry data. The denominator includes all patients ages 18 and older who were seen for at least two visits, at least one preventative visit during the measurement period. And the numerator includes patients who are screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months, and who received grief counseling if identified as an unhealthy alcohol user.

So, the workgroup member who suggested this measure for addition, said it would address gaps in assessing alcohol screening and brief intervention in the non-alcohol dependent majority of adults who drink too much. They noted that nine out of ten people who drink too much in the United States do not meet the threshold for alcohol dependency or severe alcohol use disorder using the current DSM-5

diagnosis criteria, and that excessive alcohol use is a costly and significant preventative cause of morbidity and mortality in all states. They also noted that screening for excessive alcohol use was especially important among pregnant women, since intervention in this population can improve fetal outcomes. Next slide, please.

The next measure recommended for addition is the use of opioids from multiple providers and persons without cancer measure. This measure is also NQF endorsed and the Pharmacy Quality Alliance is the measure steward. It's a process measure that is reported using administrative data. The denominator includes individuals with two or more prescription claims for opioids that were filled on at least two separate days, with at least a 15-day supply and an opioid episode of at least 90 days. The numerator includes individuals in the denominator who received opioid prescription claims from at least four prescribers and at least four pharmacies. And the workgroup member who recommended this measure for addition suggested that it could address gaps in the Core Set related to opioid use disorder and said that states could use the measure data to provide evidence of the effectiveness of state and health programs related to the opioid epidemic.

The next measures, so the next couple measures are looking at pharmacotherapy for opioid use disorder. The first is use of pharmacotherapy for opioid use disorder. This is a CMS measures that is NQF endorsed. It's a process measure, and the data source is administrative data. The denominator includes the number of Medicaid beneficiaries ages 18 to 64 with at least one encounter with a diagnosis of opioid abuse dependence or remission, primary or other, at any time during the measurement year. The numerator is the number of beneficiaries who filled a prescription for or administered or ordered an FDA-approved medication for this disorder during the year. The workgroup member who recommended this measure said it would address a gap in the Core Set related to the appropriate treatment of opioid use disorder. Currently, there is no measure in the Adult Core Set that would allow states to monitor pharmacotherapy for OUD, and this is critical step to helping curb the epidemic. Given the changing epidemic, it's critical to track provision of people in the Medicaid population who have OUD. Next slide, please.

The next two measures suggested for addition are also measures for pharmacotherapy for opioid use disorder. We have them both on this slide because they're related. So, the measure in the first column is the continuity of pharmacotherapy for opioid use disorder measure, which was developed by Rand and stewarded by the University of Southern California. This measure is NQF endorsed. The measure in the second column is the pharmacotherapy for opioid use disorder measure, which was adapted by NCQA from the USC measure. It is not NQF endorsed, but it is under consideration for HEDIS for 2020.

So, I think the USC measure assesses the percentage of adults ages 18 to 64 with pharmacotherapy with OUD who have at least 180 days of continuous treatment, and the NCQA measure expands that age range to 16 years or older and assesses the percentage of new pharmacotherapy treatment episodes, so that's the difference between the two. Both are process measures and are reported using administrative data. Next slide, please.

So, the workgroup member who recommended the original USC measure noted that it could address gaps in assessing retention in care and continuity of care among individuals with opioid use disorder, which can serve as a proxy for recovery outcomes, which are currently not assessed in the Core Set. The workgroup member also said that measuring continuity of care could serve as a first step in measuring recovery and healthcare outcomes for this population, which is at high risk for overdose and death. Next slide, please.

The next measure considered for addition is query of prescription drug monitoring program. So, this is a CMS measure, and it is not NQF endorsed. It's a process measure that can be reported using either administrative data or EHR data. The measure's numerator is the number of scheduled to opioid electronically prescribed using the certified electronic health record technology by a MIPS-eligible clinician during the performance period, and the denominator is the number of scheduled to opioid prescription in the denominator -- the numerator is the number of two opioid scheduled denominator from

which data is used to conduct a query of a PDMP for a prescription drug history, except where prohibited and in accordance with applicable law.

This measure was also added to MIPS for the 2019 reporting period, and the workgroup member who recommended this measure noted it would address gaps and tracking providers use PDMPs, which can improve controlled substance prescribing as a key step in controlling the opioid epidemic, and they also noted that PDMP implementation is associated with decreased opioid related overdose deaths. Next slide, please.

And this is the last measure that was recommended for addition. It is follow up after high intensity care for substance use disorder. NCQA is also the measure steward for this measure. This is a process measure, and it is not NQF endorsed. Next slide, please. It's an administrative measure that's been proposed for HEDIS 2020. The denominator is the number of individuals aged 13 and older who had an acute in-patient hospitalization, residential treatment, or detoxification visit for diagnosis of substance use disorder.

This measure has two rates. The 30-day rate numerator includes the number of individuals from the denominator, with a follow-up visit or event with any practitioner for a principal diagnosis with substance use disorder within the 30 days after an episode for substance use disorder, and the numerator for the seven-day rate includes the number of individuals from the denominator, with a follow-up visit within the 30 days after an episode for substance use disorder. The workgroup member who recommended this measure said it would address gaps in assessing receipt of follow-up care after intensive substance use disorder treatment services, which is critical to ensure that individuals receive the supports they need to successfully recover, and ensures investments in treatment are fully realized.
I'll turn it back to you, Gretchen.

Terrific. Thank you. So, just, again, to give folks a bit of a head's up on where we are, our goal is to finish this by around 3:00 o'clock. So, we were a little behind with our lunch, and these are really important measures, but just to keep us on track, Margo did inform me we have a hard stop at 5:00, because the audio recording ends at that point in time, and given that we have a commitment to an open and transparent public process. So, we'll aim for that hard stop, but if everyone could keep mind of the hour. Shevaun, go ahead.

Thank you, Gretchen. I have two quick questions. So, for the use of opioids from multiple providers and persons with cancer, I recognize -- I read in the material that was recommended last year, and CMS chose not to include it. Any rationale there? Were there any concerns? I recognize it's their choice. Just wondering.

Margo, do you have any insights into that?

I can start off, and if I don't get this quite right, call on our colleagues from CMCS. My understanding is that we have two other PQA measures, and so part of this is a real estate issue, in that we have the OHD measure and the COB measure. We can give you the full names as to what they are. But then the idea would be, do we also need a measure of multiple providers for the Core Set?

Marissa?

I think I want to have CMS [inaudible]. Sorry. I just wanted to clarify, there is a very significant difference between the other two measures and this measure. At least this is the way I think of it, not necessarily these steps. But I see the other two measures really looking at individuals that may be missing opioids, that may have gotten themselves into a situation where they're taking the opioids either by quantity or opioids and Benzodiazepine. This measure specifically looks at people who are getting opioids from, I think, it's four physicians and five pharmacies. That's a totally different kind of situation. This is really looking at patients -- at individuals who are in a situation where they're abusing opioids. The two measures do very different things.

Terrific. And Shevaun reminded me, she had some additional questions. Sorry. I moved on too quickly. That's okay. On the PDMP measure, just curious, if the measure steward is here, how you see that reported at a plan level.

Is a representative from CMS for the query of Prescription Drug Monitoring Program measure on the phone? If they let us know, we'll come back to that question. Are there any states -- that querying of the PDMP was like the perennial topic the State of Colorado. Are there other states who have implemented this measure in terms of trying to incent their providers to check the PDMP prior to prescriptions? Yes, go ahead.

Well, I'll say in Florida, we haven't adopted this measure. We have required, as part of our prior authorization process for any opioids, that the provider demonstrate that they attest that they've checked the PDMP. But we have a lot of issues -- well, we have some state law constraints with our health plans having access to that data, so that's what prompted my question.

So, for those who have are on the phone, everyone who works in a Medicaid program is nodding vigorously to the state law constraint comment of access from a Medicaid perspective to the PDMP at their state. Often housed in a different state agency, lots of perspectives, at least in the Colorado general assembly about who should have access to that. So, David, did you have something you wanted to add?

I just wanted to add that we're in a similar situation where, we as an agency, can't look at PDMP by law trying to amend that [inaudible]. We're trying to amend that, but failing [inaudible] barrier.

Yes, Linette and Jami are confirming that in Arizona and California, there are some legal constraint there, and Massachusetts as well. But, Linette, did you have something else to add?

The only other thing, since we're talking about the PDMP as well, is that as part of the SUPPORTAact there were reporting requirements included related to the PDMP, but each state shall include the annual report submitted to the secretary, and include the number of things for their most recent 12-month period. So that's coming up in 2023. So, as an FYI, there's other PDMP reporting requirements coming. We're all going to have to figure out what these statutory rules mean for that new federal law and how that affects us, so there's that context as well.

Thank you. Lindsay, did you have something to add? Okay. Are there others around the PDMP measure? Please, Carolyn.

I just wanted to add onto what Shevaun said, and specifically with reference to the addition of the measures for the use of opioids for multiple providers. This is a claims-based measure, and my concern there is that many times, we'll never see a claim. A lot of these individuals self-pay. They pay out of pocket, so this would likely lead to significant underreporting, so I know nobody from PQA is here, but -- oh, they are. Oh, sorry. So, I'm just curious if you've considered retooling this and maybe requiring use of the PDMP of a claims-based measure?

Hi, this is Lisa Hines can you hear me? Go ahead, Lisa. So, it does capture claims cash pay the measure, so that is specifically it's related to Medicaid coverage, and with Medicaid being the payer. That is one area that we're exploring, even related to the SUPPORT Act [inaudible] for a measure, rather than a religion for this existing measure to leverage PDMP data. It's a good suggestion. Norris, do you want to add to that?

Yeah. I attended ONC, it was either earlier this year or late last year, and there was a session on PDMP, and when I talked to them about measurement, you know, the important role measurement should play environment for opioid, they challenged me. They said, you know, we're familiar with your measures. They said they're claims-based measures, but cash claims are a critical part of that picture. So, yeah, like Lisa just alluded to, we're thinking about how we need to re-specify our measure at different levels or have it be more inclusive of different claims so that it can be relevant. Not just at the health-plan level but also having the PDMP data factored into, including claims.

Okay. Yes, and I appreciate, again, the reality of the cash payment issue. It's a big one. The measure before us, though, is focused specifically on the use of the four claims that would be paid for by Medicaid, so there's likely other things than what we're looking for. Marissa did you have something else to add?

I was just going to mention my primary experience with this [inaudible], but I realize [inaudible]. But we do what we can. The problem right now is with [inaudible] last go round about PDMP, even though there are PDMPs, the ability of that PDMP [inaudible]. Law enforcement, there's so much [inaudible] that this is now the best [inaudible]. We definitely want to get better at it.

Okay. Yeah, go ahead, Lindsay.

Computationally, this [inaudible] ordering prescribing provider fields is terrible, so it's been completely unreliable. So, we are calculating, not releasing the data. We really don't trust it. So, that being said, you know, the intent of the measure is -- the intent of the measure, of course, is valuable. But at the same time, does it belong in a Core Set to compare across states? I'm at a loss. I think it's really at a local level and, you know, for trying to really drive behavior or understand where your points of intervention are, but I just don't trust the data at this point enough to really even bring it to the occasion of public reporting level and sending it to [inaudible].

Okay. Could I quickly ask what measure is the one that you're discussing?

The use of opioids with multiple providers in persons without cancer.

Okay. Was it the PDMP one?

Yes. We kind of overlapped talking about that.

Thank you. Thank you. Yes. Carolyn?

Could you just clarify, because you were referencing Medicaid. I just wasn't clear the point you were trying to make, because this is a problem that is across all patients, so Medicaid and others as well. But Medicaid patients are just as likely to go pay out of pocket as non-Medicaid patients, so I just didn't understand.

Yeah. Yes, correct. We agree. We tried at the data -- the cover our story, we tried to get to access to the PDMP so we could identify individuals who were paying out of pocket and perhaps bring substitute disorder case management and counseling, and that was met with significant and severe resistance at our general assembly, for a whole host of reasons that aren't worth discussing. So, my clarifying point was only this measure would only be claims paid by Medicaid is what we'd have visibility to. That was all. Right. Yeah.

So, I want to just continue to remind us of the other measures in this set. There are the three that relate to the use of pharmacotherapy for opioid use disorder, then there is the one that also relates to screening and brief counseling for alcohol, as well as follow up at high intensity care for substance use disorder. So, I don't want to cut off this conversation about the PDMP query and the multiple provider, but there are a couple others, so just keeping us on track. Rich, do you want to start, and we'll just continue our conversation around.

I'm happy to go next, but, unfortunately, I'm not ready to segue. I apologize. No, I wasn't suggesting a segue, just reminding us the body of measure.

Yeah, I guess I want to commit this measure, and it could be I'm being naïve and also that I'm clinical and so I might know enough to be dangerous. There are non-cancer patients that would fall under palliative care that would actually need pain controls, and so I wonder how hard and fast these measure specs for

a patient that has cancer and a patient that is in hospice. At the risk of insulting the non-clinical people that are around the table, hospice care and palliative care often are confused, but they're not the same.

Perfect. Marissa?

On to the other three measures.

No, that's okay.

I don't want to give up my chance on the other three.

Yeah, of course.

I think the big thing on this one, though, I mean, from what I understand, as this measure was developed, things like that were discussed. I think the big thing for pharmacies, for those in palliative care or hospice care or some other type of care related to a significant illness, you know, it's four or five physicians, whatever, it's a lot of pharmacies and a lot of physicians, so think that kind of weeds out the -- for, you know, most people who are in a hospice or palliative care, even if they need to see multiple physicians, because different people are on different calls at different times. But the four pharmacies really does kind of get to the heart of the issue if there's a problem.

Can I clarify? This is Lisa from PQA.

Sure. Yes, please. So, the measure excludes patients with a cancer diagnosis, and excludes patients in hospice. We don't have a way to accurately identify palliative care, but when we do, we can exclude those patients as well. Also, it includes four or more prescribers and four or more pharmacies, and that is within a six-month period of time, and that actually does correlate with an increased risk of overdose and kind of a dose-related fashion, and including the doctors and the pharmacies, further increases the risk that correlates with the risk of overdose, so we find this is kind of a coordination-of-care issue and can get at, in a more feasible way, some of the issues with having measures with the PDMP.

Terrific. Thank you.

Marissa, did you have others that you wanted comment on?

Yeah, I did comment on the other -- the three pharmacotherapy opioid use disorders, and, well, one side commented that may be related, may not be related. But there was a talk earlier about how mental health is now getting more carved-in in Medicaid. What we're seeing is it may not have hit all the Medicaid programs yet, but what we're seeing in state legislatures and executive orders across the country is we seem to be moving to pharmacy being carved-out, and so that's definitely the trend at the moment, which probably means a couple years from now it will be carved back in. But just, I think, keep in mind as we are talking about some of these, a majority of states could be carved-out by the time we get to implementing some of them.

So, I won't pretend to be the expert, but I think as we look at the differences between the three pharmacotherapy for opioid use disorders, obviously this is a very important area we need to be treating, opioid use, the first measure being just looking at what percentage of patients are getting the treatment they need, where the other two are, once people get the treatment, are they staying on it? My take, from just what I've been following is, at least for right now, I think we need to be concentrating -- we have getting people onto therapy. I mean would be great if those people on therapy stay on it for the time they need to stay on it. But I think right now the big focus is not having the adequate providers to get people on the therapy they need, so I would guess that that is the picture.

A step-wise fashion like we've seen with others, this would be the first issue; okay. Terrific. Lindsay?

So, along the same alcohol use screening that is another high priority in our state, try to examine that a little bit closer. It's not something we report on now. And I don't know -- and I know the measure steward, but I didn't know if any other states commented on measure specific [inaudible] the AUDIT screening instruments, and so we've done an environmental scan of other tools, so there are other tools available and being used in states, so there's that [inaudible] to name a couple. So, I didn't know if anybody had any concerns about one particular tool being specified as that which needed to be used in order to be counted in the [inaudible].

Is there a response to that? Certainly in our experience in Colorado, we have taken the approach of requiring that the tool to be validated but not often naming the specific tool, because we find our federally qualified health centers are often part of national initiatives that test tools, and then our primary care providers are outside the FQHC system, and so we have required a validation -- a tool that is validated to be used but not been that specific, and I think that's probably standard across -- or other states have taken that.

That reminds, too, so we have some staff from HRSA that might be able to talk about, the federally qualified health center reporting and what tools [inaudible]. But I don't know if you could comment on it for alcohol.

Okay. Great. Hi. Daniel Duplantier from HRSA, Pleasure, thanks for the comment. So, we have clinical qualify measures on alcohol use specifically. We don't, as far as I can know off the top of my head, we don't have a specific one on that. We do have a tobacco cessation measure that we use, but I don't believe we have a clinical quality measure on alcohol cessation -- or, yes, alcohol use.

A quick note, I have a mic and the chance to talk, we're also looking into PDMP use. We don't now. I didn't realize that there was a measure specified for it. We were just going to do a simple yes/no question in our health information technology appendix. So, we have the uniform data system, which is a collection vehicle for all the federally qualified health centers that receive HRSA funding. It's 2,000 different data elements, and then 12 tables and three appendices, one of those appendices is kind of like a survey. We just ask very simple questions that you can't ready pull out of the EMR. Thank you.

We'll go down this line. I think Jeff you're next.

Jeff Schiff from Minnesota. I just wanted to remind folks we are having a technical expert panel on part of the SUPPORT Act, so the entire focus on that [inaudible] sharing that. So, I think that being the case, I think that that group is looking at measures to prevent addiction, treat addiction, measures for emerging [inaudible], and measures around addiction and, of course, big buckets, and we're hitting on two out of those four here. With regard to prevention of addiction, that's the multiple prescribers, we looked at this measure, and we had some concerns, because any prescription, the four plus four is any ER doc sees you two days [inaudible] until you come on Saturday. That counts. And we found that we actually modified this for quality program. That wouldn't work. And we actually had three or more providers have to have a [inaudible], because we really found that this [inaudible] when we looked at the analysis, we were getting that out of it, as specified.

We have another measure that, unfortunately, didn't make it to the list, I just have to say, so one sentence, and that's about new chronic use. But we're willing to have chronic use around next time for use in Minnesota with three way. As far as treatment, I think that I would agree with Marissa, looking for a certain amount of space, I think, is real important. Right away, people are getting medication-assisted treatment, because medication-assisted treatment is still very much thought of as not universally as the appropriate treatment, and yet the science is there, versus continuity of both. [Inaudible]. That will stop.

Thank you. David?

Thank you. I actually want to comment on two measure, which, fortunately, respond to the comments of Marissa and Lindsay. This is David Kroll, by the way. Starting with the alcohol screen, so, one, I actually do think that the lack of specificity around screening tool used is a weakness of this measure, and I say

this in the sense of I don't want to throw the baby out with the bath water, to paraphrase David, because I do think it is a good measure in the spirit, essentially, to do SBIRT in the clinical office, and it's especially important, because almost virtually all physicians, regardless of their specialty, don't think of addiction as their problem. Primary care doctors often think this is the domain of a psychiatrist. The psychiatrist thinks of this as a domain of the quote, unquote, of the addiction specialist, which almost never exists. I mean, a lot of these patients end up in the Emergency Department, and so encouraging everyone to do SBIRT is critically important. However, clinically, there is no such thing as unhealthy alcohol use.

When you're looking specifically, the AUDITs probably, arguably, if not the best certainly the most widespread screening tool for this type of intervention. What the AUDIT identified is something called at-risk alcohol use, which is an identification of patients who are potentially at risk of developing clinical or social problems related to their drinking, which is this much lower bar than the DSM criteria of an alcohol use disorder. And the field of addiction medicine and addiction psychiatry has really moved away from trying to label people as having problematic alcohol use, in the same way we've moved away from labeling people as alcoholics, because that's such a nebulous definition that doesn't apply to people who don't perceive themselves as having a problem or a health problem. And so I would encourage the stewards of this measure to rather than ask them to really explain it now, just really ask them to update the measure, try to make sure they're in sync with the most modern way of thinking about what a positive screen is.

With regard to the opiate use disorder and the continuity, I do agree that access to opiate use or medication-assisted treatment is critically important; however, what we also know is that when patients lose access to treatment or they discontinue medications with the treatment, their relapse rate skyrockets, and so I agree with Jeff that it's actually really important to have both measures, and both measures are critically important to measuring access to care, because continuity of care is just as important as getting that first [inaudible].

Terrific. David has something, and then I actually have a comment as well. But David has on the issue of the tool.

I pulled up the NQF definitions for what counts as far as the tool [inaudible], NQF website, audit screening, the audit screening instrument, [inaudible]; audit C, meaning instruments and, third is a single question screening, how many times have you had [inaudible]? Had five for men, four for women, all adults older than 65, more drinks, and those are the worst and best [inaudible].

But that's what the clinical assessment risk level, not the [inaudible].

But I think there was an earlier question asked about, well, whether specific advocate [inaudible] part of this.

What I was going to raise on this measure, and then I want to also touch on the high intensity care for substance use disorder and follow up, my concern on the alcohol measure is the actionability of the measure. We have had SBIRT in the State of Colorado on our Medicaid program for a really long time. We even have $750,000 of money from the general assembly every year to train physicians, and we have seen no movement in the measure of screening brief intervention and referral to treatment. So, that may be different now. I've been gone for six months, so if my Colorado Medicaid program is going to fuss at me, sorry.

But when I was there, it was such -- so I just don't know -- I can't quite figure out what the challenge is. It's a clinical workflow challenge. It's a challenge of when you ask someone about food insecurity, what do you do when the answer is something you don't know what to do with; right? So I don't know if it's that. I'm not a clinician. But this actionability, so maybe the response is that's why we put it on the Core Set, to drive a different conversation with our clinicians about what to do, and the importance of this. But I also worry that we could put it on and see not an actionable response for Medicaid programs to try and drive that.

The second is the follow-up after high-intensity care for substance use disorder. And full disclosure, I was the workgroup member who suggested that, in part because Medicaid has created a new option for the IND waiver inclusion to allow individuals to receive substance use disorders treatment and to have that paid for in a complicated Medicaid policy. What that means, though, is nationally there are more investment in inpatient services for substance use disorder, which is at a significant expense to both the federal government and the states, and I worry that we don't have enough of a continuity of care there, that when we move to this intensive intervention, which is very appropriate and needed, if we don't also incent in some way for there to be a catch after such an intensive intervention; one, we won't know if we're wasting money; and, two, we won't understand the cyclical nature of this need for treatment, where there's probably a couple of different approaches that are required to help people find what works for them for recovery. So that was my reasoning behind that. I recognize it's probably in that bucket of not ready for prime time. But given that there has been a massive federal shift under the guidance of the Trump Administration, it feels like something that was worth raising for the group to consider. Jill?

I just wanted to sort of add onto what you said. I think the follow up at 7 days or 30 days is something that is pretty standard, but there are other measures that do that for other things. So, from that vantage point, whether this measure itself has been used a lot or not, the concept certainly has been.

Perfect. Thanks. Shevaun?

I want to say that I think it's commendable, the recommendation for the pharmacotherapy measures. Certainly, I agree that the prevailing wisdom is to deploy medication-assistive treatment. I will say, though, I have one concern. I'm not throwing the baby out with the bath water. But, you know, medication treatment is not just prescription of the medications. There's a therapy component, and we see issues with the therapy component is not happening. We think it goes hand in hand, but it doesn't, and the measures just don't address that. So, I would like to just put a plug, as measure stewards are developing other measures, I think that that component gets us more into the outcome that we're hoping for.

Thank you. You have a comment?

Sure. This is Lauren Niles from NCQA. Your point is a really good one, I think psychosocial supports in pharmacotherapy. You have a measure, it's our initiation and engagement of alcohol and other drug abuse dependence measure. It's currently on the Core Set, and it gets to that exact thing, and so medication therapy.

If I can just provide a little bit of clarification on the measure that we have. It was directly compared to the Rand USC measure on the screen, they were side by side. We actually adapted the measure from the Rand measure, so the numerator is the same. It's looking for continued pharmacotherapy. We're looking for discontinuation of treatment, which is gaps of more than seven days. That's what actually takes you out of the numerator. That's noncompliance. And then the other thing I'll just note is, our measure is about new episodes of pharmacotherapy. The USC measure is looking at folks that are in any recovery, so you have folks in that measure that are potentially in a long-standing maintenance of their opioid use disorder, and you also have folks that may be [inaudible], so the measures are just really different with regard to the denominator.

Thank you for that technical clarification, very important. Sally, did you have your --

Hi, this is Soeren Mattke from USC, just to clarify that distinction. We made that deliberate choice to not restrict to new episodes because the issue becomes that you shrink the eligible patients if you only consider the new episodes, and as you know, if somebody is on medication assisted treatment, that is usually a very lengthy treatment, some argue for lifetime, but is often multiple years. And the problem with medication assisted treatment is really the continuity, in that people who drop out of MAT without sort of a deliberate and supervised approach to this are at higher risk of overdose, and this assistance on continuous treatment with no gaps more than seven days. And we think that risk persists even if somebody is in long-term treatment. So, as long as somebody is on treatment, they should be continuously by treated and get uninterrupted medication. We acknowledge that there's a certain problem

in that we cannot capture any claims that the cases that Lauren just mentioned. Those that were deliberately faced off MAT, but we felt that tradeoff was adequate. There's also a derived measure in MIPS at the moment that has been specified for registry that allows the physician to indicate cases in which they deliberately phased out MAT.

Thank you for that clarification. Marissa? Oh, sorry, yes, Sally, go ahead. That's okay.

I'm exhausted, as I know a lot of you are. I'm also not a clinician, nor have I spent a lot of my non-clinician time focusing on substance use disorder [inaudible] It's very important. I'm thoroughly confused and will be hesitant to vote at this point. I'm not getting the picture of which measures are associated with MAT, because if it's not called that in the measures. I'm not getting an understanding of the continuity. I get one is looking at new episodes, one is not. Are they competing with each other, or are they actually very complementary? I'm just not able to represent. If we were to vote now, I actually, wouldn't be able to vote.

Okay. Terrific. I appreciate that. I think that those three in particular are very conflated and confused, so I appreciate that. I think we're going to have David walk us through that in some way, so thank you for naming a slot attention of non-clinician for feelings. I want to, though, see as we look at our timeframe and where we want to move, perhaps I'll go around and ask if there's any questions not related to measure 30 -- I'm going to use the numbers, 3,400, 3,175, and NA, which isn't helpful, but those three pharmacotherapy. The ones that have pharmacotherapy in the description, if we could pause on those, because I agree there is some confusion, and talk about any of the others in this, that would be great. Lisa?

Yeah, Lisa Patton here. I wanted to just mention that in 2017, SAMHSA, CDC, and NCQA began our learning collaborative to look at the issues you were raising, Gretchen, around uptake and adoption of the alcohol use, so I have to admit, not having tracked that work, so I don't know where it stands. I don't know if anyone here on the phone could speak to that. But there was a lot of exchange around what's prohibiting that, what are the barriers to tackle some of that.

On the continuity, I'll speak to the continuity. So that one is the continuity measure, the [inaudible] perhaps you might say, so that gets at 180 days retention in a fellow person from the claims has had 180 days or six months of medication assisted treatment, with no more than a seven-day lapse. And so, Sally, kind of to your question, we did look at this last year, and there was a lot I heard in the mix. I'll admit to it. And there was a lot of discussion last year. It was fairly newly endorsed, I think 2016, but really being able to get at whether 90 days, 180, or 270 days of MAT retention successful. And I think David spoke to what Pennsylvania was finding in their data at the time, and a lot of states weighed in that 180 days seem to be the right cut point. And I know the work RAND did and USC really got at that. I don't know a lot about the pharmacotherapy measure. We didn't get to look at that last year. It wasn't available. I don't know when 3,400, when that was sort of the land from last year.

Terrific. I appreciate that perspective. Are there others? Yeah. So maybe if we could get those with subject matter expertise and/or clinical expertise to help us distinguish between the three. Again, we will vote on each of them on their merits as a measure, but considering that two of them, at least, overlap significantly, and there's one that looks like it's the entry point, and then the continuity, try and understand that. David?

[Inaudible]. Those two are both MAT. They're both looking at duration. The main difference with the NCQA measure [inaudible]. The denominator is a little bit different. But all of them are really -- those two are looking at duration, and as they -- and, actually, we have a multistate. There are nine of us now that have looked at this measure and find it very helpful. I think we actually used because the NCQA one wasn't finalized, we actually used the Stanford -- I'm sorry, the USC measure. Sorry about that. People from California are going to hate me, or half the people from California are going to hate me.

The most controversial thing said all day.

Sorry.

That was a Freudian slip.

Sorry about that. We actually used the USC measure, and we did different cut points, and multiple states did those, cut points of 90 days, 120 days, and 270 days, which we felt was really, really important. We saw that there were actually a significant number of folks that continued through that 270-day period. So, in a nutshell, they're all about -- all three are about MAT. The first one is really just, I got started on MAT, very simple kind of process measure. The USC measure is looking across the entire spectrum of people that are on MAT, so not just [inaudible] that have perhaps already been on MAT, but through duration. Then the NCQA measure looks at those newer episodes, and those later two really look at the actual duration of treatments. I think both of them accept seven-day gap. But NCQA or USC could recommend. Did I get that right?

Yes.

Allie from USC, did I characterize measure correctly?

David?

I'm afraid you cut out on the last question. The audio isn't particularly good. So, let me describe what supplies that before [inaudible]?

Good technical question. Did everybody hear that?

Yes.

I'm sorry, I can't hear it. It cuts out. The question was, “What is a new episode of pharmacotherapy for opioid use disorder?” For our measure, we're using a 31-day look-back period.

Which is really quite interesting.

Yeah, we don't use [inaudible], because we don't look at new episodes, but anybody who is on MAT, we don't have a look back. We take anybody with enough data.

And does your measure allow if a seven-day gap?

Yes, that's the same. We say maximum seven-day gap if somebody is on treatment.

Terrific. Thank you for that clarification.

The interesting thing about the 31-day gap is that it really does make the measure more inclusive, because if it was a really much longer gap, you would be excluding a lot of individuals that were on any. It still does not capture those that are on a very long treatment course. The USC measure does capture that. But because this measure just has the 31-day, that allows individuals who perhaps -- and we know that these individuals go on and off treatment, they move towards recovery, and having that short gap is actually, in my mind, a good thing, because then you're capturing that next episode, and then that goes into the picture.

Terrific. So, I want to acknowledge this is a complex set of measures. I also want to remind us of our task, which is a set of recommendations to CMS. So, we are not holding the weight of the world on our shoulders on these votes. CMS staff have been listening carefully. They understand our dialogue, so if you have anxiety about where to vote, do your best and recognize that experts will be taking these recommendations and interpreting them on our behalf, so it's important. Our votes matter. But the nuance here is close, and so our intent around what we want to communicate will be interpreted as well. So, thank you, David, for that. We'll go around. And, Sally, you still look like you had something to add or no?

Can I actually add a technical expertise context?

Oh, please. Please, David.

As David was making his -- this is David Kroll again, by the way. As David was giving his explanation about the measures, there's one piece I recognized I forgot had not been indicated, which is a bit of a response to Shevaun's point, which is, in order to legally prescribe Buprenorphine or methadone [inaudible] for a substance use disorder, that needs to be in conjunction with psychotherapy and other aspects of a therapy program in order to maintain [inaudible]. So, in addition to the benefits of the medication itself, a prescription of one of those two medications for an opioid use disorder is an indicator of being enrolled in a program that is multimodal. That would not apply to Naltrexone in either the PO IV formula ordinarily, although the two most important -- most common medications are those two. It would be pretty rare that anybody would be able to get Naltrexone without being in the context of the [inaudible] program.

David, your comment applies then, we could have confidence that all three of these measures would account for that requirement to have additional supports?

Yes, that's what I'm saying. And I don't mean that, practically speaking, in every instance that's always going to be true in the real world, because Shevaun's giving me a look, and she's absolutely right. But it is a good proxy.

Great. Perfect. Thank you. Yes, please, Rich. It's okay. I see you.

Rich Antonelli. So, David, I'd like to follow up on that. We actually have a community-based primary care practice in southeastern Massachusetts. We went through the training to be [inaudible]. If this goes into that, would the current configuration, where you have the appropriate training, so licensure to try, how likely will those things track to get -- I actually think [inaudible] the things, but all of a sudden there [inaudible] has to come along, is there significant risk of actually having non-trained people who prescribe without the accompanying tracking them?

I wouldn't expect that to be the case. I would make the argument that the demand is already there, and that the barriers to be able to prescribe are still high. And I can't speak to the pediatrics population, but anybody who gets the flavor from the FDA to prescribe Naloxone is going to be aware of the rules that you have to follow. Now, again, in practice, especially at our hospital system screened a, lot of infectious disease professionals and the primary care providers to also get their [inaudible] waivers and prescribe outside the mental health treatment. And the requirement for the additional programmatic non-medical supports tends to be followed a little more loosely in those practices. They usually involve a social worker, but it's not usually quite as robust an addiction program measure. So, I see that happening already. I don't imagine that putting this in the Core Set would likely make a [inaudible].

Yeah, I think there's some quality of care issues that have been raised, but this really relates to sort of the initiation. I'm going to continue to move us ahead, because we've got a very important set of long-term services and reports and the two lingering measures to talk about as well. Jennifer, and then Jeff, and then David, if you have any additional comments; okay? And then we'll see where we are.

Jennifer Tracey. So, David, you said something, my lack of knowledge in this area. But leading between the USC ways measure, is there sort of [inaudible] is sort of happening, because I'm trying to figure out, so does a continuous treatment more applicable than maybe a 31-day lookback have any numbers or averages around how long medication and therapy [inaudible]?

So, there is no magic answer to that. We actually did publish a study from Medicaid data with the University of Pittsburgh, looking at just Buprenorphine, and what we found was that longer was better, and that up to a year was even better. The measure at 180 days, I think, is a fine measurement point. As I said, in our multi-state initiative, we went shorter and we also went longer just to take a look at what was actually happening within our program. So, I'm not an addiction specialist, but I think most would agree

that longer is better, and that less than 180 days, for most individuals, probably is not adequate. But, again, it really comes down to the individual's clinical situation.

All right, Jeff.

A clinical point, we have a big office space program, and we don't require [inaudible]. We require [inaudible] start the medication first. Sometimes it takes a while to [inaudible] behavioral health. Those are getting [inaudible].

Okay. Yeah, I think we're ready. David is whispering. Time to vote.

I'll be very quick.

Please, Lisa, go ahead.

So, just as Jeff was pointing out, we're hearing that from a lot of states that delinking happening, and [inaudible] because of the high demand and trying to build better networks. And then to Jennifer's point, a lot of the discussion [inaudible], and agree across the field, we have don't have a right number, but longer seems better.

Okay. Terrific. So, a lot of clinical nuance here, just as in the vaping discussion, a lot of sort of societal reality nuance. But, again, the task for us to vote on the measures as they're described here under the current clinical requirements for the clinicians who participate in care delivered that's being measured. So, we are going conclude our general conversation and open it up to public comment on the seven -- six -- I can't keep track -- the seven measures that are before us. All of them are additional measures, so, again, we're thinking about the criteria of feasibility, actionability, strategic priority, real estate, the kinds of things that we've been using as we've been reviewing measures for addition. We will start with public comment in the room. We ask that you really do keep your comments to maybe a minute, high-level points only. And then if you are on the phone and you are interested in making a comment, please raise your hand and/or be prepared to unmute yourself to participate.

Are there any comments, public comment in the room? Since you've been listening for the last hour, I'm going to suggest that you would have been ready to jump up, so thank you, no. And if there are anyone on the phone who is interested in submitting or sharing public comment as it relates to these seven measures?

It doesn't look like we have any hands raised at this point.

Thank you, Brice. With that, then, I'm going to ask that we move to a motion to vote on the addition of these seven measures in the behavioral health domain. Thank you. Second? Thank you. Second. So, we will move through these, again, recognizing there are a few that are here that are very complex. CMS has been listening. It makes the best vote on the criteria that we have been using consistently. We will have the chance to revisit those measures that we want to revisit tomorrow, so there is a second opportunity if there's still some confusion.

Thank you, Gretchen. There's a couple standing up. If other people want to stand up to be awake for this vote, we won't be offended. So we're voting on additions. We're going to start. There are no folks excluded from voting. We're going to start with measure vote 40, so we're making good progress. And this is an addition measure again, and this is should the preventative care and screening unhealthy alcohol use screening and brief counseling measure be added to the Core Set? Make sure your clicker is on and cleared with the blue button. You're voting A, if “Yes, you recommend adding the measure to the Core Set,” or B, “No, you do not recommend adding the measure to the Core Set.” Steve, please open voting. So, the results for this measure are 25% of the workgroup said, “Yes, I recommend adding this measure,” 75% said, “No, I do not recommend adding this measure.” This measure is not recommended for addition to the Core Set.

Moving on to the next measure for addition, again, this one has 28. No one is excluded. This is, should the use of opioids from multiple providers and persons without cancer measure be added to the Core Set? Make sure you hit your blue button and then, A, for, “Yes, I recommend,” B, “No, I do not recommend.” Steve, please open voting. Everyone's getting quick. Everybody's ready for a break. Okay, so the results of this were 36% said, “Yes, I recommend adding this measure,” and 64% said, “No, I do not recommend adding this measure,” so this measure was not recommended for addition to the Core Set.

So, I'm also going to give the stewards for these next three measures, since there was some confusion with the names. But if there's any additional information that would help people know what we're voting on, please let me know. So, this vote is for our measure vote number 42, and this is, should the use of pharmacology for opioid use disorder be added to the Core Set? The steward for this one is CMS CMCS, and this is, again, for additions, so hit your blue button. And if you recommend adding this measure, please hit A. If you do not, please hit B. Steve, please open the vote. So this measure, the results were 75% said, ”Yes, I recommend adding this measure,” 25% said, ”No, I do not,” so this measure was recommended for addition to the Core Set.

The next measure, this is an addition as well. This is the USC measure. This is the one that did not include the new, so that's the difference between the one we'll vote on in the second, without the new. And so this is continuity of pharmacology for opioid use disorder measure. Again, USC steward. And hit your blue button.

[Inaudible]. Yeah, sorry. So, I'm causing more confusion, but, yes, this is the more inclusive measure we're voting now. Thank you for that clarification. And, again, if it helps, it's the USC steward, and the name is the continuity of pharmacology for opioid use disorder measure.

Pharmacotherapy.

Pharmacotherapy measure. I need a break. So, thank you all. Okay. So, again hit your blue button, just so we make sure all the voting goes through. A for ”Yes.” B for ”No.” Check your screen to make sure you have the vote on there that you want, and press your button again. This measure, 54% said, ”Yes, I recommend,” 46% said, ”No, I do not,” so, at this point, not recommended.

Okay, moving on to the HEDIS measure, this is the one that's less inclusive. Should the pharmacotherapy for opioid use disorder measure be added to the Core Set? Hit your blue button. A is ”Yes,” B is ”No.” Great. So, this one has 39% that said, ”Yes, I recommend adding.” 61% said, “No, I do not recommend adding.” This measure is not recommended for addition to the Core Set.

Last two, so this next one is addition again. If everyone could hit their blue button. This is for the query of prescription drug monitoring program measure and whether it should be added to the Core Set. A is ”Yes”; B is ”No,” or whether you're recommending, I should say. And so, Steve, open voting. So, the results for this one, 14% said, ”Yes, I recommend adding this measure to the Core Set,” and 86% said, ”No, I do not recommend adding this measure to the Core Set,” so this measure was not recommended for addition to the Core Set.

And the last measure of this domain is another addition. If everyone could hit their blue button to clear their remote. And this is whether the follow up after high-intensity care for substance use disorder measure should be added to the Core Set. Yes is A,”Yes, I recommend,” B, is, ”No, I do not recommend.” Steve. Yeah. So, what we realize is there's a little bit of a delay in the room, so you heard a kind of -- so this one was 50/50. 50% said, “Yes, I recommend adding this measure.” 50% said, ”No, I do not recommend adding this measure,” so this one was not recommended for addition. Thanks for your patience through this voting.

Thank you all. We'll take a, again, a ten-minute break. You guys are pretty good at the ten-minute break, but please monitor yourself and let's be ready to begin again at 3:10.

[BREAK].

Okay, I'm going to suggest that we please take our seats. For those of you in the room, if you could please find your seats. Again, we have a hard stop at 5:00, in particular, because Denver has just been predicted to get six to eight inches of snow. And so while I'm here in sunny Washington D.C., I'd like to go outside, as we all would, because it's gorgeous out and 70 degrees, per my watch. So, if people could find their seats, we have a very important set of measures under consideration. Really appreciate the time and attention we've spent on the behavioral health measures. There are already a number of behavioral health measures on the Core Set, and I think we had a robust discussion that will inform CMS's thinking, as well made a recommendation that's important in addressing current public health crisis, as it relates to opioid use disorder.

The next set are in relation to long-term services and supports. Again, an area of vast importance to the Medicaid program, and an area where there has been a long-identified gap in measures. Multiple people are trying to address that. The scorecard, while I was at the Medicaid program, we wrestled mightily with the measures as it relates to the CMS score card. And so as we wrestle the Core Set today, this is just an important area. Margo is going to lead us through.

As I mentioned, these are all proposed for additions, perhaps making that nod to that potential gap area. But there are a group that hang together as it relates to some long-term services and supports from CMS, and then a group that hangs together that really are about people's experience and sort of self-declaration about the kind of care they're receiving and whether or not that helps them live successfully in the community and to thrive in the way that they see fit. So, we are going to break these up in that way, just so that Margo has a break and we can make sure we answer technical questions. We'll manage how we vote on them once we get the conversation going.

Again, I will be sort of a stickler on time, just because we have these measures and then we have two additional ones. We will not be taking a break between those two and between now and 5:00 o'clock. So if you have the need for a break, please just go ahead and take that and don't wait, because the break will be the 5:00 o'clock ending. So, with that, I'll turn it over to Margo.

Thank you, Gretchen, and thanks for the introduction. That saves me a little bit of time here. So, the first thing I want to do is make sure that we have measure stewards or subject-matter experts on the phone or in the room. So, first, Roxanne Dupert-Frank from CMS and Debra Lipson from Mathematica, are you on the phone? And if you are, please unmute yourselves by pressing "5*." I'm going to keep going.

This is Debra Lipson.

Hey, Debra, thank you. Roxanne? Okay, we'll keep it on going. Kerry Lida and Mary Botticelli, also from CMS, and Michael Corrothers from Westat, are you on the phone? Remember, "5*" to unmute, or raise your hand and Brice knows you're out there. Was that, Kerry?

This is Kerry Lida, and Mary Botticelli is on the line, too.

Fabulous. Thank you. Okay, then we have Mary Kay Rizzolo from Council on Quality and Leadership. Are you on the phone?

Can you hear me?

Oh, good. Thank you. Yes, we can hear you. And please mute yourselves again for the rest of the conversation, until we're ready for questions. And then we have some people in the room, Mary Lou Bourne, April Young, and Julie Bershadsky are all in the room, so we've got everybody here and ready to go. So, I'm going to start with the first measure, which is successful transition after long-term institutional stay, and this measure is described as the proportion of long-term institutional facility stays among Medicaid managed long-term services and supports, or MLTSS, plan members age 18 and older, which

result in successful transitions to the community, which is defined as community residents for 60 or more days.

This measure is reported as an adverse rate and risk adjusted rate, and note that we had learned that the description has been updated to reflect the specifications that will be posted in May. The measure steward is CMS. It is not endorsed. It is an outcome measure. Data collection method is administrative. The denominator is long-term institutional stay defined based on a new institutional facility admission or a prior institutional facility admission. And a new institutional admission is an admission with a length of stay 101 days, or more, between July 1 of the year prior to the measurement year, and June 30 of the measurement year, or a prior institutional facility admission, where the length of stay was at least 101 days inclusive of July 1 of the year prior to the measurement year.

And note that the denominator for this measure is based on discharges, not members. The numerator is the account of discharges from an institutional facility to the community between July 1 of the year prior to the measurement year, and October 31st of the measurement year that results in successful transition to the community for 60 consecutive days, and discharges result in death, hospitalization, or readmission to the institution within 60 days of discharge are excluded from the numerator. The technical specifications, as I mentioned, for this measure, are being updated and we have made every effort to update them for the purpose of this discussion.

The reasons for suggesting this measure are as follows: The measure supports community-first services for individuals with disabilities, and the measure would help states measure the movement of people out of institutions, both for those that have been there for a long time but could live in the community, and for those that may have been there for a few months but also could return to supported community living. Slide.

Okay, the next measure is comprehensive assessments and update. This is percentage of MLTSS plan members 18 years of age and older who have documentation of a comprehensive assessment in a specified timeframe that includes documentation of core elements, and the following rates are reported: assessment of core elements, assessment of supplemental elements, and two rates have required exclusions, which I'll describe in a minute. The measure steward is CMS. The measure is not NQF endorsed. It's a process measure. The data collection method is case management record review. The denominator is a systematic sample drawn from the eligible population of members receiving long-term serves and supports.

So, the numerator includes four rates. The first rate is the assessment of core elements. The number of MLTSS plan member who had either of the following: For new members, a comprehensive LTSS assessment completed within 90 days of enrollment with all nine core elements documented, or for established members, a comprehensive LTSS assessment completed at least once during the measurement year, with all nine core elements documented. Assessment must be a face-to-face discussion with the member in the member's home. Assessment of phone or video conference or in another location that is not the member's home is permitted in certain circumstances, and the date of the assessment must be documented.

Rate two is assessment of supplemental items, the number of MLTSS plan members who had either of the following: for new members, a comprehensive LTS assessment completed within 90 days of enrollment with 9 core and at least 12 supplemental elements documented, or for established members, a comprehensive LTSS assessment completed during the measurement year, with 9 core and at least 12 supplemental elements documented.

Rate three is the number of members that could not be contacted for care planning, and rate four is the number of members that refused to participate in care planning, and those are two exclusions with the rates of exclusions reported. This measure was a first-year measure in HEDIS 2019.

So the reasons for suggesting this measure, comprehensive assessment is an important part of care for members with LTSS needs, of the nationally recognized measures for LTSS, a workgroup member

suggested this is one of the most feasible to implement, while states are not yet reporting according to these specifications, many states already have some type of similar measure in place to look at assessment completion rates.

The measure can be used for the following purposes according to the workgroup member: States would be able to monitor members' access to timely care management supports to ensure there is no disruption in essential LTSS services for members and that any services to be provided are based on completion on comprehensive assessments. Dates could compare rates across MLTSS plans or care management entities to identify any issues or delays in provision of care management, and this measure helps monitor quality of care by assuring that assessments have the required elements and are completed in a timely fashion. Next slide.

Okay. So, the next measure is comprehensive care plan and update. It's the percentage of MLTSS plan members 18 years of age and older who have documented patient of a comprehensive LTSS care plan in a specified timeframe that includes documentation of core elements. The following rates are reported: a care plan with core elements documented and a care plan with supplemental elements documented. CMS is the measure steward. It is not endorsed. It is a process measure. The data collection method is case management record review. The denominator is a systematic sample drawn from the eligible population of members receiving long-term services and supports.

The measure reports two numerators; the first-rate care plan with core elements documented. For new members, this is a comprehensive LTSS care plan completed within 120 days of enrollment, with all nine core elements documented, and for established members, a comprehensive LTSS care plan completed at least once during the measure year, with all nine core elements documented. Care plans must be discussed during a face-to-face encounter between the care manager and the member unless exceptions apply. The care plan is not required to be created in this member's home, and video conferencing is allowable as evidence of a face-to-face discussion, and the discussion of the care plan may be done by phone in certain circumstances.

The second rate is care plan with supplemental elements documented, and this is the number of MLTSS plan members who had either of the following: For new member, a comprehensive LTSS care plan completed within 120 day of enrollment, with nine core elements and at least four supplemental elements documented. But for established members, a comprehensive LTSS care plan created during the measurement year, with nine core elements and at least four supplemental elements documented. The care plan must be completed within 120 days of enrollment and updated annually thereafter. Care plans must be discussed during a face-to-face encounter between the care manager and the member unless exceptions apply. The case plan is not required to be created in the member's home. Video conferencing is allowable as evidence of a face-to-face discussion, and the care plan may be discussed during the same encounter as the assessment. Discussion of the care plan may be done by phone in certain circumstances. And this measure was a first-year measure in HEDIS 2019.

The workgroup member noted that while many states are not yet reporting according to these HEDIS specifications, most states already track some type of similar measure around care plan completion for LTSS. Workgroup member noted that it is essential that LTSS eligible beneficiaries have a care plan in place as soon as possible. Delays in care plan development could lead to gaps in care, resulting in beneficiaries being admitted to hospitals or nursing facilities and/or limiting beneficiaries independence and quality of life. States could use this measure to compare performance across MLTSS plans or care management organizations to ensure expectations for care management quality are being met. This would assure that planning and plan development for individuals with LTSS needs would include certain minimal elements, as well as that the planning including a face-toe-face component.

So, the fourth measure is reassessment care plan update after inpatient discharge, and this is the percentage of discharges from inpatient facilities for MLTSS plan members 18 years of age and older for whom a reassessment and care plan update occurred within 30 days of discharges. Two performance rates are reported; reassessment after inpatient discharge, reassessment and care plan update after inpatient discharge. In addition, two rates of required exclusion should be reported, the member could not

be contacted for assessment and our care planning and the member refused to participate in assessment and/or care planning. CMS is the measure steward. It's not endorsed. The measure type is a process measure. Data collection method is case management record review.

The denominator is a systematic sample of inpatient discharge drawn from the eligible population of members receiving long-term services and supports and medical benefits through the MLTSS plan. The denominator for this measure is based on discharges not on members, and members may appear more than once in the sample.

The numerator for the first three, reassessment after inpatient discharge, LTSS reassessment on the date of date of discharge, or within 30 days after discharge. Reassessment must be a face-to-face discussion between the member and the care manager. Reassessment may not be conducted over the telephone unless there is a documentation that the member refused a face-to-face encounter. Reassessment in the inpatient facility on the day of discharge meets the requirement. The member's reassessment must include documentation of nine core elements and the date of the reassessment.

Rate two, reassessment and care plan update after inpatient discharge, the LTSS reassessment and care plan update on the date of discharge or within 30 days after discharge. The reassessment must document evidence of nine core elements and the reassessment date. The care plan must be conducted during a face-to-face encounter between the care manager and the member, unless there is documentation that the member refused a face-to-face encounter. The care plan developed in the inpatient facility on the day of discharge meets the requirement, and the care plan update must include documentation of nine core elements and the date of the care plan. And, as mentioned earlier, there are two rates related to exclusions, the number of members that could not be contacted for assessment and/or care planning, and the number of members that refused to participate in assessment and/or care planning. And this measure was also a first-year measure in HEDIS 2019.

The reasons for suggesting the measure include, this measure you are would assure that individuals with disabilities and LTSS needs have their needs assessed and their plan changed, as needed, in relation to a hospitalization, and this measure would help states assure that people are evaluated for changes in their plan, including medication post-hospital discharge, and that their new needs were met in a timely manner. So those are the first four LTSS measures. Thanks.

Thank you, Margo. So, a lot of consistency in the numerator, denominator, et cetera, so maybe focusing, to the extent that there's technical questions there, but also the nuance of the distinction of after an institutional stay at the time of comprehensive assessment, continuation of that and updating, and then after an inpatient discharge is distinguishing components of these measures.

I had one technical question to kick us off, and then what if a state doesn't use managed long-term services supports for delivery of their home and community-based services and nursing facility services?

Great question. I'm going to turn to Roxanne and Debra to answer that.

This is Debra. Can you hear me?

We can. Oh, good. We specifically designed this measure for use with states that are using MLTSS as a delivery system for LTSS services.

Can you provide an update on the number of states?

There are currently about two dozen. 24 states have some sort of various kinds. Some states have more than one type of managed long-term services support program that varying degrees of integration with acute care benefits for the beneficiaries, many of whom, three quarters of whom are duals. So, it could be, again -- okay. It's not designed for fee-for-service, but it could be adapted with some changes.

Perfect. Thank you. Steve?

To sort of jump on that, because that was my first question as well, I think that does present some challenges, because space to provide LTSS in a variety of [inaudible]. I think there are different populations. While I think these are two dozen states, I would bet that that number is [inaudible] LTSS. In Delaware, our non-IED until long-term care or [inaudible]. Also, I believe [inaudible] may not be [inaudible] in that benefit package, so it does give me [inaudible].

Terrific, thank you, Steve. Richard, is that -- yes. Okay.

So, for 25 years, I've been hoping for something that will feel like a care plan, so my technical question is, could we speak a little bit about what went into the formulation of this care plan, being very mindful that the evidence base in the literature is pretty slim in terms of the efficacy of the care plan. Having said that, whenever I talk to patients and families and caregivers that have significant needs, they want the care plan. So, I'm not talking about the merits of the measure but just what went into formulation. I think a lot of these elements include, you know, did you ask these nine, and then the supplement, et cetera. So, a little bit of input into that would help me figure out if this is a unicorn or whether it's the beginning of a horse.

Debra, can you answer that.

Sure. Again, can you hear me over the audio?

Briefly.

I just want to make sure I'm clear.

You're fine.

Thank you. We went through a process of comparing assessment incidents used in many different programs, Medicare, Medicaid, states across the country, identifying those elements in assessments and care plans that were common. We then used an expert panel that included professionals, consumers, health plan representatives, state officials to evaluate the importance of -- I think it was 31 different elements, and they had a chance to vote, like you do, on the core elements. And we ultimately, through that process, identified the 9 core elements, as well as those 12 supplemental for the assessment. And I think is was nine and four for the care plan.

Rich, I would just add -- I'll be honest, all of these measures give me significant pause as a former Medicaid director, in part, because there are requirements for assessment and care planning on our state plan side, long-term home health benefits in the State of Colorado. There are also, for now ten waivers, home and community-based waivers, as well as nursing facility care. So, I think that our state would struggle with a federally mandated approach to care planning, and that would not be an easy sell.

Yes. And recognizing that LTSS patients across the age spectrum are among the most vulnerable folks that there are, so that was sort of the genesis for my making that observation. That said, this is admirable work and it should inform us directionally. Thank you.

Yes. Marissa?

Well, I'll start out by being the person this round to say this is speaking a foreign language for me, although it's an area I'm very much trying to learn because I know how important it is. As someone where this is a foreign language, so I'm just looking if the answer not being a technical answer but for those that are in Medicaid programs around the table to maybe give me some direction. Looking at this, not knowing a whole lot else, I look at one being an administrative measure and the others being case management record review, and so for knowing that 26 states are not MLTSS, how would you get to that information? Can you get to that information? And that's all I have to go on, so I'm interested in hearing that.

Are there statements, please, Shevaun.

So, Florida is one of the states that have adopted the four measures that we're talking about, but only in our long-term care program, with is in managed care. We're not doing it for anything else. The expectation would not be that this would be done in fee for service; right? I thought I heard you say earlier it's built for managed care, so I think that's an important distinction.

Yes. So, there's other states that don't have managed care, just won't be able to report on it. Got it.

Can I just add one thing? One of the reasons that we adopted the measures and the re-procurement of our contracts with our health plans, we felt like it gave us some uniformity in comparing plans, because they all have their own ways of going about things, and we felt that this was an opportunity to not only compare plans against each other but have the opportunity to compare them against other plans across the country.

Yes, Gretchen, can I just ask, actually, our CMS colleagues for a little bit of clarification here, because I think it's really important to level set about the use of these measures. I'm not sure Karen or Roxanne or somebody else in the room, whether these are measures that could just be approved for use in MLTSS programs and not necessarily for Adult and Child Core Sets. We have, as many of you know, a home health Core Set that are used with the home health spas, and they, as states, have approved spas related to health homes. They become incorporated into the health home Core Set reporting process, which is a separate Core Set from adult and child.

Sorry. Just to clarify, we don't include these in the Adult and Child Core Set. But there's nothing to stop states from using them. So, yeah.

You could do what Florida has done.

Right.

Or other states that have MLTSS. This could be used. So, adding the Core Set or not adding it to the Core Set really doesn't influence that ability to use.

Correct. As with any HEDIS measure we've discussed. That applies to the Perinatal depression ones, for example. Those could still be used by states and tried. Lowell, you've been waiting patiently.

So, I'm going to speak from my time in New Jersey, where we both implemented -- we both planned and then implemented MLTSS, and I can say that these were actually requirements that we put in the contract for the MCOs. I can't remember which ones were required by our STCs that CMS put together for our 1115, but there were several of them that were. In addition, these are really best practices. Center for Healthcare Strategies and others have found that these kinds of outcome measurements are actually really good best practices for states in the MLTSS to utilize.

And to Richard's point about people with regards to, is this a care plan and kind of look, and I'll say I believe it is. I think that I've spoken -- I'm not just speaking for New Jersey, but when I worked with a number of different states MLTSS, both when I was an official, and outside of that, and I think that a lot of states, most states, have created some really nice pieces of more care plans using that.

Terrific. Thank you for that perspective. Linette?

So, I was wondering how does -- and the answer may be this is out of scope for this conversation, but how does this relate to the minimum dataset? And I know there's been some conversation around having some measures on the CMS scorecard, the latest minimum datasets, so I'm just conscious of this space. I know that those weren't necessarily proposed here, but I don't know if there's a relation to that and if there's anything that we can take into account in terms of consideration from that.

Do the CMS colleagues have a response to that question?

This is Debra Lipson. I can offer some response. Is that all right?

Yes, please.

The minimum data set was actually one of the assessment instruments that we looked at when we were developing the comprehensive assessment measure. It is important to note that the MDS is only for nursing home residents. So, you know, we can look at that to model some of these components, but, again, because MLTSS enrollees, the majority of them are living in the community not in nursing homes or other institutions, they would be two different requirements for different -- you know, two different sets of assessments.

And since I worked on the scorecard workgroup with CMS and NAMD, this was an area, and that exact issue was the issue that the MDS [inaudible] we went through a national focus on rebalancing, and providing more care in the community, it was a recognized gap.

Laura?

Yeah.

So, I just wanted to say that while the measures obviously were designed for an MLTSS context and tested in an MLTSS context, at least the two around assessment completion and care plan completion could theoretically be done in a fee-for-service context. Obviously, it depends on the state and the processes by which they collect or kind of manage their care management program and collect their care management data from whatever entities are doing care management in the fee-for or service system. But there's not necessarily a reason why it cannot be applicable, right? I think it obviously would take some work for a state to choose to operationalize it in that manner. But I don't think it's impossible for it to apply.

I think where it gets a little bit more nuanced is, you know, the inpatient discharge one, you know, does require that the member is receiving their medical coverage from the same entity as their LTSS coverage, so in cases where those things are carved apart, that would be hard to operationalize. And I think similarly on the transition measure, if a state has separate management of its home and community-based population from its nursing facility population, that one also would be hard to kind of align and manage. But I do think that for the assessment and care plan kind of initial measures and ongoing measures, those are possible outside of managed care.

So, Laura, I agree. I think that that is correct, and this is national best practice. The challenge I think I would have is that the measure as it's specified would only include members in long-term services supports. The numerator and denominator use the word "members," so these measures would only be applicable to MLTSS. Although I agree with you completely that a state could apply conceptually the same structure. It just wouldn't meet the criteria for reporting on this measure. Jill?

So, I wanted to echo what Laura just said, that absolutely I think this, and even case management record review. We have fee for service programs that have an element of case management built into the service, so you could review those records. You could do this.

I think the other thing I wanted to say a little bit about is, well, while the developers may have looked only at the MDS 3.0, which is the nursing facility version, if you have looked at the other interRAI tools, which includes MDS HC 2.0 and the InterRAI by HC 9.1, both of which are home-care tools, there are a lot of similarities between them, and, in fact, there is a case mix index for the nursing facility one, and then there is a case mix index that has been developed for the home care one using the nursing facility one, so I think that that is really not a barrier in terms of assessment. And having looked at a lot of other assessments, there are a lot of common elements.

Terrific. Thank you. We'll go Jami, Carolyn, and then Sally, and then in the interest of time, and because we're sort of talking about our shared perspectives on these in similar ways, I'm going to ask that we be ready to move forward, so if you have something else to add, please be prepared. But we'll do Jami, Carolyn, and then Sally.

Sure. And I'm going to echo Shevaun's sentiment. So, we don't currently include this measure set, the care planning and assessment measure set in our contract our MCO contracts, but we do have policies that speak to assessment and care planning, but we've been really desperate to create some consistency in that space, and so I think adding the assessment and care planning measures to the Core Set would facilitate that process, and then allow us to conduct some comparative analysis across our events care.

Thank you. Carolyn?

I just want to spring off of a comment that Steve made earlier, and this is maybe more of a request for some technical clarification from CMS. So, Steve mentioned before that different populations may have different -- manage differently, and maybe this is less relevant in terms of the assessment and care plan piece. But for some of the other proposed measures, there is -- first of all, I guess let me take a step back. Is there a need for CMS to define what LTSS is, because in our state, LTSS is everything? It's DME. It's PT/OT. It's home health care. It's orthotics. It's PCA services. ASC Day Hab and so forth, and these are not all necessarily managed by the same entity. So, we, as an MCO, manage some of those services, but the PCA, Day Hab, AFC services are wrapped services that are covered by our Medicaid program. So, maybe it would be helpful just to make sure we're level set in terms of our understanding of what is included within the definition of LTSS, and does it matter that, in different states, different services and different benefits may be covered, and even when they're covering the same benefits, they may be managed by separate and distinct entities? So I'll just pause there.

CMS, do you have a response to that?

Again, this is Debra Lipson. If our CMS colleagues are not on the line, I can address that.

Please.

Okay. For these particular measures, it does not really matter the scope of benefits that are covered by the plan, except for the -- I'm sorry, for the reassessment and care plan update, what we're looking at on the slides here after discharge, that does require some acute care benefits, or at least information about inpatient use and discharge. For the other three, you know, I would think your care managers, you know, when they're looking at needs, try to look across the spectrum. And even if your plan would not cover particular services, they may be carved-out. They may be covered by another plan. They may be covered by fee for service, that at least, you know, trying to put that all done in one place, and your care manager is making an effort to try and at least refer, coordinate, do what is needed to make sure that person's needs and preferences are addressed, I think, is the intent of these measures.

Okay. Note that's helpful. And, you know, certainly in our assessment in our care plans that we do today, we do address many services even beyond those that are covered benefits. I just thought it would be helpful to level set so that folks understand, particularly those who are not familiar with the LTSS world, that world understand all the difference types of services that we might be talking about.

Thank you.

On those technical specifications, we do have a -- sorry.

Go ahead.

I'll say the technical specifications do describe LTSS services generally, not in all the particulars, but we do discuss that in the technical specifications.

Okay. Perfect. David, did you have something to add?

Yes. Thank you. This is David Kroll. One other question, a technical specification, so, this doesn't apply to the first measure about transitions but the others. There are exclusions; that individuals who cannot be reached by phone are not included in the measure. Not knowing a lot about the data behind this measure, I would expect that inability to reach individual clients by phone is one of the largest contributors to failure to update a treatment plan. Because that's been my experience with other kinds of treatment plan updates. And I'm wondering if there's any data with regards to how many individuals get excluded based on that exclusion and any response to that?

I'm going to ask my colleague, Lara Rosen if she has any insight into that.

So, the team on the line may have the official rates that came through in testing.

Go ahead. We have Laura in the room who is going to respond.

You'd have to go back and look at that.

Yeah, go ahead, Laura.

I would just say, relative to other populations, those rates are extremely low for the LTSS population, because people typically really need the services, and they need to go through that process in order to access the services, and even just getting yourselves eligible for LTSS, for a waiver, et cetera, is such a process that usually people are willing to be found in this population and know that that is part of the process in order to get to those services, and so it is a little bit less than you would see in other populations that are hard to reach.

I would concur with that. If someone needs a personal care attendant every day to get prepared to go to work, they're actively involved in their treatment, which is different than a periodic visit to a pediatrician or another care provider, but daily care attendance and other services and supports are much more daily present in the lives of individuals receiving long-term services and supports.

In Pennsylvania, we actually service -- our service coordinators are an administrative function of the plan, so we require that they go out and see these individuals face to face as service coordinators. So, our managed care plans have a lot of control over that, and we expect them to be able to do these measures and to measure up. So we really don't want to see the telephonic aspect at all. We really want to see the face to face.

I'm going to suggest that last call for any perspectives on these four, and then I don't know if we want to vote on these four or not, so be contemplating that question while Sally shares her perspective.

I'm struggling with these. I understand quite -- I'm struggling here. And I want to hear from the folks at the table. I do understand wanting to compare plans in their ability to meet certain quality and measures, and these quality measures are on the Medicaid managed long-term services with technical specifications, not all of them, bull even more already have technical specifications. You know, even before agreeing to contracting, as I heard from some out of our state colleagues, and I can also see in the contract requiring that certain levels of performance continue to be met. What I am not understanding, in all sincerity, is what the utility of state-to-state level performance on these measures, and maybe some more than others, would be. The quality measure used in a contract agreement is not necessarily relevant at the state level. So, I need some help understanding how some of these would work at comparing state-to-state performance, and what would the action be around that?

Great. So, I'm going to have Jami respond to that first question. Go ahead, Jami.

Sure. Well, I think as we all know, our partners at CMS have a vested interest in state-to-state comparisons now. And so, as we start to venture into looking at measures that speak specifically to

performance in the LTSS arena, I think it would benefit all of us to have some consistency in terms of measurement, because I think that they're looking, too, to incorporate some of those measures first in the scorecard.

And I would add -- go ahead.

I would just add that there is not a robust list of measures for long-term care in this space, and so it's a starting point, and that's why we adopted them in our program. I think it just helps to start having those conversations and those compare points.

I would also add that, again, there are different models of care, and we have a service coordination model, where that's administrative function of the plan. Others may not have that, so it may be informative. If we're underperforming or overperforming, how do we compare to other states? So, where there are differences in the models of care, that may actually be helpful in a comparative way. Also, there are plans that do this book of business across multiple states, and especially if you drill down to the plan level, it's sometimes interesting to see how well they perform or don't perform by state.

The last thing -- go ahead, Steve, please.

So, I just want to preface this with, I'm not necessarily speaking for myself or for Delaware, because we are managed care state. We do most of our LTSS managed care. And I also don't want anyone to think that I don't completely advocate for some measures in this space, because they are critically needed. However, that being said, I do question the utility in response to your question about using this in a comparative fashion, when half of the states do not utilize this.

Yeah.

So, the other question was about a particular measure, actually, and I thank you for all that feedback, and I agree, it's very important. A lot of work has gone into this. I feel that we've gotten a little bit shortchanged, because it's almost like it's a Core Set, even though since there's nothing in that space, there's a lot to talk about and learn. But the measure that looks at the successful transition to community I'm going to borrow from other measures that have been looked at for decades, where you try to prevent a readmission, and I just wonder if the developers or conceptual builders or users have any experience to think that that might be delaying a readmission, or I see that death is an exclusion. Is that creating holding onto -- I mean, I'm just wondering if there are any known adverse consequences to that measure in particular that we should be aware of, or if those have been resolved through the specs or such lo low incidents that there's nothing to really worry about?

I can let the measure developers -- I would just say we had a concentrated effort in the State of Colorado to support transitions, and it's an incredibly complex experience. We were able to successfully transition someone who had been in a mental health institute for 45 years so that he could be with his family. And he did pass away within a couple of months of that. And then there's the sort of stabilization post and acute event, and then support back into the community, so it is very complex. It is very time incentive. And I think it is quite different, typically, than our hospital transitions. These are long-term services and supports, and the home- and community-based services that are required to have in place to support a successful transition can take months to put together, so it is not -- I appreciate the comparison, but --

My concern was 60 days may be -- I mean, it's exactly to that. Is it some of the exclusions? What is the transition to get someone home for a very good reason, in order to die at home? It's exactly the reasons. The comparison was, that there were adverse consequences, not that -- so, yeah, that's what I'm asking about.

Shevaun, go ahead.

So, I will just say -- and I'm not really advocating either way. I mean, obviously we're doing it regardless of whatever happens here. But I do want to clarify one thing. I said there's not a robust list of measures. All

states, I mean, if you're doing this, CMS has required you to come up with some kind of measure. It's just that they're homegrown and they're not comparable state to state. So I just wanted to clarify that point.

But I know a lot of conversation has been had on the fact that it's focused on managed care. And I don't see that bright of a line in adopting a measure focused on managed care, excluding fee-for-service, when I think about a measure that may include a benefit that a state doesn't cover across all adults, or a measure that might be more easily adopted if you are a managed care state versus having to do it as a state level, like if there is an EHR component. So, I just don't know that I see the bright line there.

Appreciate that perspective. Lowell?

So, with regards to the question about successful transition, Money Follows the Person has been a very long and has a very long and tortured situation, and still does, and waiting for congress to actually make a final decision on its long-term efficacy. I can speak for the State of New Jersey when I was there. I can speak for other states as well, when I speak to colleagues and former colleagues, that is something that is extremely important and is very indicative in understanding not just an MLTSS, but, in general, it's something for seniors, as well as for people with disabilities, and I think that it's an important indicator as to how states are shifting the balance on community based.

Terrific. Thank you. Rich, I'm going to ask you, do you have anything super concise to add? Thank you.

Concise as always, captain. So, I really thinking about the criteria for recommending Core Set location, and it's the feasibility. This seems like a very heavy lift to me. So, let's assume all nine of those elements have or are about to become evidence-based, then there's the supplement. And then one of the reasons why care plan, as an outcome, or in this case, it could even be a structural measure, and by the way, I'm not sure that I necessarily agree with the process measures. The existence of a care plan could simply be a structural measure. It's the curation piece. So, there actually is a measure in here about update the care plan. The triggering event for that is an admission. For patients that have complex needs, both pediatrics and adults, a lot of significant life-impacting decisions could be made in the ambulatory environment. That doesn't necessarily trigger an update.

So, I'm concerned that if we just measure at a high level, we're going to miss a lot the important things that could have an impact on these folks' day-to-day life, their quality and their safety. I'm not saying we shouldn't be thinking about this deeply, but I, for one, am real little concerned about an annual measure that could miss 364-and-a-half days of activities and care integration opportunities. So, in short, feasibility, for me, is a huge lift, and I'm deeply concerned about that, and I think we need to hear more from the states that are doing this and how do they truly align with outcome measures, not just whether you're using them.

Terrific. Thank you for that perspective. Is it the will of the group to vote on these and then move to the addition? Again, we have some in this same domain, but in a sort of slightly different construct. Vote now, yes? Everyone votes that we vote now? Yes, Laura, did you have a perspective? Of course you can. Yes, please.

So, just to address a couple of questions super quickly. So I would just echo the need to kind of start somewhere on this, and I would say that because these are HEDIS measures, to the extent that people are using these as managed care measures, the plans already need to figure out how to go align all of their assessments and care plan forms to the critical elements that are in the measures, so that process is already happening today. So, from a feasibility standpoint, I would argue that the assessment and the care plan measures are kind of under development already actively, if they're not already completely done and ready to go.

And then to the extent -- to the question about state-to-state comparison, I would just say the transition measure in particular is a pretty valuable one to look at for state-to-state comparisons, because states have a lot of levers in the way they structure their rates with managed care plans in order to incentivize

transitions and to kind of help encourage the plans to eliminate the barriers to getting people successfully out into the community, and so that actually is a pretty meaningful one to look at at the state level.

Terrific. Kim, did you have something to add?

Yeah. I was just going to say that we really have been struggling in every committee meeting I've been in NQF, et cetera, on measures and finding something that really fits the space for MLTSS and for our stable population. We do need to start somewhere, and some of these measures really are very basic right at the bottom level, where most states that do managed care, if not necessarily fee for service, will be using these types of tools. And the managed care rule also strongly supports this and talks about not only this care plan but when it needs to be updated. So, I think this is all in support of that.

Terrific. Thank you. I'm going to suggest that we close the conversation among the members of the committee, and if there is anyone in the room who would like to submit public comment on these measures, as it relates to the long-term services supports transitions, assessment, assessment update, and reassessment. Yes, please. If you could limit your comments to two minutes.

Will do.

Thanks.

Hi, Camille Dobson, deputy executive director of NASUAD. We represent the eight-state aging and disability directors who deliver LTSS. Some of our members are sitting around the table. I want to strongly support these measures. They are, in fact, best practices. When I was at CMS building these measures, before I left, one of the things that we hear most about, the complaints about MLTSS is there's no measurement about their performance in the space. More and more states are moving in this direction. While I recognize that it is about half of the states, we recognize that even existing in the current Core Sets, there are states only 17, 18 states reporting some of those measures. I'm recommending that that not be a barrier to start somewhere, specifically the care planning and the assessment. Those tests worked incredibly hard in working as many state assessments as possible to pick those elements that there is no controversy should be included in either the assessment of an individual, as well as in their care plans.

And then last, on the transition with the cessation of the Money Follows the Person program, our fear is that transitions are going to start to taper off because of the investment that's necessary, and this is one of the states specifically mentioned, transitions from nursing homes is one of the goals of their MLTSS programs to a state primarily, and this is one of the only ways of assessing that in a comprehensive consistent way.

Thank you. Anyone else for public comment? Brice, is there anyone else on the line?

No hands raised at this point, so, as a reminder, folks, "5*" to raise your hand.

Okay. Terrific. Thank you. If I could entertain a motion, then, for a vote on the addition of these four long-term service and support measures. Thank you. Second. Thank you.

Okay, great. So, as a reminder, these are four measures for addition. If everyone could turn on their remote, make sure it says "Ready." Okay, great. So, the first addition to vote on is the long-term services and supports: Successful transition after long-term institutional stay. No one is excluded from voting on this measure. You're voting A for, “Yes, you recommend it,” and B, for, ”No, you do not.” Steve, please open the voting. And the results of this are 50/50, so, “Yes,” 50% recommended adding the measure and 50% did not recommend adding the measure. This one is not recommended for addition to the Core Set at this time.

Moving on to the next one, again, everyone is allowed to vote on this. The next measure for addition is long-term services and supports, comprehensive assessment and update. You are voting A, ”Yes,” if you

recommend adding the measure; B, ”No,” if you do not. Please press that blue button if you have not already, and Steve, please open voting. And the results of this one are 57% of the workgroup said, ”Yes, I recommend adding this measure,” and 43% said, ”No, I do not recommend adding this measure.” This measure is not recommended for addition.

Moving on to the next vote for addition. Again, no one is excluded from this vote, and this is for the long ole term services and supports comprehensive care plan and update measure. This is, again, A, ”Yes, I recommend,” B, ”No, I do not.” Please hit that blue button if you have not already, and Steve, please open voting. Everyone can check that A and B. This one, you heard the sigh. So, this one is 64%. 18 members said, ”Yes, I recommend adding this measure;” 36% said “No.” Based on our current threshold, this one was not recommended for addition to the Core Set, and as you heard, we'll revisit, or maybe not revisit, but discuss tomorrow.

Moving on to the last one for this little section, this is an addition. Again, this is the long-term services and supports reassessment care plan update after inpatient discharge. Everyone is allowed to vote. If you, A, “Yes I recommend,” B, ”No, I do not.” Hit that blue button, if you haven't, and, Steve, please open voting. And the results for this one are 36% of the workgroup said, ”Yes, I recommend,” 64% said they do not. This measure is not recommended for addition at this time, and I'll turn it back to Gretchen and David.

Perfect. So, in the interest of time, we're going to move quickly. Margo is going to walk us through the next with a little less detail, so if you want to look at your materials, please do so, but we're not going to read the measure specs, so go ahead Margo.

Okay. And we're fortunate that we have a lot of experts in the room here. So, the first one is consumer assessment of healthcare providers and systems, home and community-based services survey, or HCBS CAHPS. It's the first cost disability survey, the experience of HCBS beneficiaries receiving LTSS. It is designed to facilitate comparisons across the hundreds of state Medicaid HCBS programs throughout the country. It targets adults with disabilities, including frail elderly individuals with physical disabilities, persons with developmental or intellectual disabilities, those with acquired brain injury, and persons with is severe mental illness. The HCBS CAHPS survey is available for voluntary use in HCBS programs as part of quality assurance and improvement activities and public reporting. CMS is the measure steward. It is NQF endorsed, with 19 CAHPS HCBS measures. It is an outcome measure, and data collection course is survey.

We've going to move to the next one.

Margo, really quickly, we're having trouble matching that to our grid, because we have one that's listed as national core indicators and then one that's national core indicators for aging and disabilities adults survey.

I just did HCBS, and now up to National Core Indicators.

All right. Sorry. Several of us are lost down here, so just want to make sure we're tracking with you.

It might be because we moved this after some of the materials were prepared, first, based on workgroup caught us. So, it was in the experience -- yeah, it was in the experience of care domain, and it was moved to LTSS for this meeting, based on comments. So, sorry about that confusion. But look in experience of care.

And if you look at the slides, the slides are the order that I'm going in right now, national core indicators seen next, NCI. So, the purpose of NCI is to gather a standard set of performance and outcome measures that can be used to track agencies' performance, the surveys including in-person surveys, family surveys, and staff stability survey. The core indicators are standard measures used across states to assess the outcomes of services provided to individuals with intellectual and developmental disabilities, and their families. Indicators address key areas of concern, including employment, rights, service planning, community inclusion, choice, and health and safety. The measure steward is HSRI, and

NASDDDS. The measure is not endorsed. It is an outcome measure, and other information, 46 states in D.C. participate in the NCI program.

Moving along to the next one, National Core Indicators for Aging and Disabilities adult consumer survey or NCI-AD, NCI-AD is a voluntary effort by state Medicaid aging and disability agencies to measure and track their own performance. The core indicators are standard measures used across states to assess the outcomes of services provided to individuals with physical disabilities and their families. Indicators address key areas of concern, including service planning, rights, community inclusion, choice, health and care coordination, safety, and relationships. The measures steward is HSRI and NASUAD. It is not endorsed, and outcome measure. Data collection method is survey. And another piece of information, 17 states collected NCI-AD data in 2018 and '19.

And then finally in this group, personal outcome measure. Personal outcome measures are a tool to ensure services and supports are person-centered in a personal outcomes measures interview. 21 indicators are used to understand the presence, importance, and achievement of the outcomes involving choice, health, safety, social capital, relationships, rights, goals, dreams, employment and more, and measures are organized into five topic areas; human security, community, relationships, choices and goals. The measure steward is Council on Quality and Leadership. It is not endorsed. It is an outcome measure. The data collection is in-depth interview, and the survey instruments have been validated but do not include validated measures, and those are the four survey and interview measures.

Okay. Are there any technical questions from the group before we dive into the content discussion? Lowell, did you have a technical question, or did you want to dive into the content?

Actually, a little bit of both. I, first, want to say, you know, I put forward these four, and I wanted people to understand why. I actually have used the NCI-AD and the NCI in New Jersey, both as an advocate for people with developmental disabilities in the NCI to trend both in state, and out of state. But I'll use also the NCI-AD as the state official. What I can say also is that the HCBS CAHPS, I was asked by people from the outside to add it as another measurement tool, so I was happy to do that. That doesn't necessarily mean I endorse that necessarily. And the question, technical question I have for the steward are, how many states are actually using the HCBS CAHPS? Because we know how many are using the others. Well, we know not the outcome -- not the POMS, but the other two, and also for the POMS, I mean if anyone knows how many states are actually using that for the developmental disabilities.

Great. Kerry, are you on the line? Can you answer that? Kerry, did you hear the question?

Yeah. Can you hear me? Yes.

Yes, did you hear -- you can hear me. Okay. And, Mary Botticelli and Jen Boden are also on the line. Right now, because the HCBS CAPHS survey is a new survey, and we are preparing a national database to be used, starting January 2020, next year, we've had about 17 states who have used the survey at this time, including test demonstration states, and also, MLTSS states. We are considering it's still new, and the stages of development, until we have our database furthered in the new year, and that's being developed through the Agency for Healthcare Research and Quality, AHRQ, and their contractor, Westat. And Westat is also available on the line to address technical questions. But at this time, there have been 17 states who have used it, anticipating more.

Great. Thank you for that clarification. Lowell, I know you have more to add, but we'll move to Lindsay to get the technical questions out. Go ahead, Lindsay.

I think you started to address some of them, but just from a logistical feasibility state Medicaid, so, again, it would have to be a survey that we either built into the requirements for a managed long term care plan or fielded or funded ourselves as a state Medicaid agency; is that correct?

Yes. I know in the State of Colorado, we got state funding to do the NCI, out of belief that it was an important tool for us to understand and report to CMS. Are there other questions? Jill, yes, please.

So, I know that both the NCI tools are accessible to people with disabilities who are nonverbal who are blind, deaf, et cetera. Is that true of the HCBS CAHPS?

So, if question for the stewards is that the HCBS accessible to the population that it's designed to engage?

Yes, it is. We also received -- yes, can you hear me?

Yes.

Yes, the HCBS CAHPS has the approval of the CAHPS consortium to use proxies, as needed, for the administration of the survey. We do have criteria that are followed if a proxy does need to support the administration of the survey. But it is designed to be accessible for individuals, because it is also an individual, we have an option for the individual interview, and not only a telephone mode of administration, which is directly addressed to the individuals that we serve through the survey.

Terrific. Kim and then Shevaun. Okay. Neither was Shevaun. Never mind. I guess I have a question, and, you know, this got us a little bit tied up earlier, and so I'm cautious of that. But, given that what I understand from CMS's comments, that you're building toward a broader use of the HCBS CAHPS, yet, 46 states, plus the District, are already submitting on NCI, and then another smaller number on NCI-AD, is there a programmatic preference or is there something for the committee to be aware of, of there's been a decision that one methodology of understanding people's perspective is better than the other? I don't know if that's an answerable question, but I'm struggling with that piece.

And I would like to address that question to our director, Jen Boden. And, Jen, if you could hit 5* please. She is on the line, available to answer questions also. Jen, if you are speaking, we cannot hear you. Okay. She might be having technical issues. She is on the line. But I am not able to address that question. Jen, are you there?

Hi, Kerry. Yeah, this is Jen Boden. Sorry, I was having a little trouble getting on with you. So, I would say, from a CMS perspective, we don't necessarily have a preference for states, and I think some of the reasons, you know, there are three different survey instruments. They were all -- the survey development work was initiated at different times, and the HCBS CAHPS was explicitly designed as a cross-disability survey, and I think, historically, some of that came about because of a preference or desire to have a survey instrument that could be used, you know, across populations, and not specific to, say, the IDD population or older adults and people with disabilities, but rather something that could be used with all populations. But they are different instruments that, you know, to some extent, they overlap, but they also cover different survey areas as well.

Okay. Thank you for that clarification. We haven't yet talked about the personal outcome measure. Is there anyone who has a technical question or a perspective on that measure? Steve?

I guess I would just ask what in-depth means? So, what is the --

Terror to Medicaid.

Well, and what does that mean in terms of individuals completing or, you know, because in-depth kind of sounds to me kind of like response rates may be a challenge.

Is there a perspective on that?

Sure. Yeah, this is Mary Kay Rizzolo, and it is in-depth, actually. So, if they're looking for something short and sweet, this might not fit the bill. But it was originally designed to guide the person-centered plan, so it's a conversation with the person receiving support, so, I mean, it covers 21 different areas, so it could take anywhere, you know, from 30 minutes to over an hour, depending on how much the person wants to

talk, and then we talk to the person who knows about their services the best so that they can determine whether the supports are being provided to help them achieve their outcomes. Did you hear that?

Yes. Thank you.

So, it varies, yeah.

Do you know or could you provide context on the number of states who are already implementing the personal outcome measures?

Sure. So, at the state level, some states use it, like, New York and Illinois, they incorporate it into every person who -- you know, into their person-centered plan each year. So, some states just do a sample like South Dakota, Tennessee, North Dakota. We've trained people to use the tool in 45 states. But the thing is, we put the tool online for anybody to down load, so, you know, we only know of the people that he we've trained. We do know that a thousand different organizations use them in their day-to-day kind of operations, but others could be using it, and we just wouldn't know.

Okay.

But it is an in-depth interview.

Okay. Thank you very much for that clarification. Are there other than -- moving to sort of notion of general comments, I would offer a guess that continued desire to have a better understanding of the lived experience, unlike some of the clinical quality measures that we talked about, about whether or not someone had their blood sugar appropriately assessed and then there's a determination of control and non-control, in this space, the determination of thriving and community, to the best of my ability, with people that I trust caring for me is a much more complex thing to understand, and so these -- while I joke that things like in-depth bring terror to Medicaid directors, this actually is a place where we need an in-depth understanding, because it's a complex area, and it's an area where states are spending a significant amount of both administrative resources, as well as dollars, and so I didn't want my joke to go across -- this really is important, and we need to have some real estate dedicated to home and community-based services at some point in time, if not today, at some point in the future, given the shared commitment across the nation for home and community-based living, so that would just be my perspective on the importance of these measures. Sally?

I just want to take the opportunity to add onto what you said. Regardless of the outcomes of any individual measure today, it's clear this is a very important area. It also is in pediatrics, but, you know, in the adult space and for Medicaid and Medicaid beneficiaries, kind of repeating what I said, you know, something to think about for future is maybe spending more time thinking through what is needed for Medicaid, CMS, the beneficiaries to help, at least -- maybe it's just me -- to transition from the typical place we are with measurement to something that's a little bit of an unknown frontier, perhaps. So just, again, even if everything were to pass, which we've already voted on some, I would say in the future, it would be good to have that kind of level setting setup.

Yeah. And I guess I would reflect. I appreciate that perspective. I would reflect that to some extent, this feels that way to the notion of value-based payments, where states are trying a million different things, because we're all trying to figure out how to pay differently. My sense is states are trying a whole bunch of different things in this measurement of long-term services and supports as well, so it may be a state level up, to federal level is still needed, a little like we're seeing value based payments, although that has a real context around it. But I appreciate the perspective. Lowell?

Yeah, so I just want to give some perspective, because I know for myself, as a non-expert over this last day-and-half, can tell you, you know, remember in LTSS, 41.8% of all LTSS users, 41.8% of Medicaid Advantage Users are LTSS users. 32% of Medicaid funding is for LTSS, and 57% of Medicaid in LTSS is home and community based. So, I'm going to now just, as context, and why it's a major gap that has to

be, in my own mind, utilized. So, let me go through, and I'm only going to talk on two particulars of the measurement tools.

Quickly.

Okay. NCI and NCI-AD, they're both actionable. They are measures used to provide useful for state and CHIP programs. They actually also have alignments in the measures used in other reporting program, i.e., NCI-AD allows for states to look at Older Americans Act, pay state funded home- and community-based service as well. It's also valid and reliable. There's technical assistance provided with that, so it's valid and reliable, interrated, interrater reliability as well. Appropriateness for state-level reporting is being done across states, as you've already heard, feasibility also. Strategic priority, I think I raised that when I put the percentages.

These are utilized by a lot of states, and I think are important. The NCI was started, first, for the IDD population, and then seniors and people with physical disabilities, the NCI-AD built upon that. States with the NCI-AD can actually add some specific questions for state specific, as well, they can over sample if they're a managed care. Many states have done that. They've oversampled so they can actually look by MCOs to see how things are doing, as well as they can trend it not just internally in the state but also nationally. And I did that for the NCI as an advocate internal to the state, but also how the state was doing for that, so I think all of those things. I'm just going to say, I know now I'm lobbying. I know they're is a line, but I'm just saying, I think that these are important measurements that really should be looked at now to be part of it.

And the only thing I'd add is just for the NCI -- and you weren't suggesting this, but non-managed care delivery systems can use the NCI as well, so one can.

And the NCI-AD can use it as well.

Unlike the first set of measures that had a limit to that, these do not, so I just wanted to clarify that. Lindsay, and then Linette, and Jill and Carolyn, thank you for acknowledging

This is more of an operational, in thinking how to infuse some of these measures into the Core Set. So, currently, CMS allows us to kind of derivate from sometimes the measure specifications, so we check a box and we said did [inaudible] measure then describe. So that might be a space where you could put in a measure, and then if someone is using the CAPHS, community-based service, or the NCI-AD, they would just indicate that, so that you would still be getting information, but then you'd know which used the home and community-based service versus another survey, and then you still would have meaningful information. It may be not complete 100% alignment across the tool if the questions are similar in context. So, it's just a way to kind of think through, baby stepping our way into this area a little bit.

Perfect. So I hope our CMS colleagues were contemplating that as an option.

Jill?

So, I know I'm here from Massachusetts, but I spent much more time in Pennsylvania, and we used NCI in the ID community, and in addition to being able to kind of look on the website, get cross-state comparisons, have a standard place where all the data goes, have it all analyzed, we actually took this data, like the individual person-level, at the provider level, at the regional level, county, whatever, and changed people's lives using it. So, through quality improvement activities, based on the answers to the questions, made a difference in people's lives. So. it's absolutely feasible. It's absolutely actionable, and there's years and years and years of comparative data.

Terrific. Jami, then Carolyn, then Steve, then Linette. Oh, sorry, Jeff. I'm sorry. The J and the S look similar from here. This is Jeff Schiff from Minnesota. I just wanted to put an exclamation point perhaps on the idea the NCIs are outcome measures, actually assess people's function and wellbeing. And it seems like in other areas we really struggled for what are outcomes for cardiovascular disease or diabetes for

quality of life. So, the idea that where we spend half of our money, we could leapfrog to an outcome measure, that, I think, is something that we ought to take advantage of.

Terrific. Carolyn, thank you for your patience.

Yeah, I just want to kind of support what Lowell, Jill, and Jeff said. You know, the measures around the LTSS space have really lagged compared to medical measures, and regardless of the outcome of our discussion and vote today, I do think we need to move the needle on this. As Lowell said, LTSS is one of the largest areas and continues to grow in the Medicaid space. We need to understand the impact that it has. And your comment, Gretchen, reminded me, your comment about the hemoglobin A1C versus the lived experience, you know, we have historically tended to measure things because we could measure them. They're easy to get from the claims. But I think we do need to move beyond that to what matters most to our members, and I'll just conclude my remarks by giving a very similar analogy to yours.

When we were rolling out the ACO initiative in Massachusetts and trying to develop our quality slate, I will never forget one of the stakeholder meetings we had, one of the workgroups where an advocate for the disability community said, you know, hemoglobin A1C, yes, it's important, but let me tell you what really matters to me. What matters to me is that, because I have a PCA, I can get up in the morning and get dressed, and I can go to my job, or I can go to church, and that's really what I want you to measure. So, it's nice to remember the face of our members and remember what matters most to them.

Terrific. Thank you very much. Steve and Linette, I'm going to give you the last, but ask you not to repeat the “this is sort of an important gap to be filled” discussion.

Darn.

You can say, so noted.

Actually, I was not going to repeat because others have said it much better, but I did feel it was important to just acknowledge that I share what I've heard about the national core indicators, and also going back to what we talked about this morning, to put these decisions in terms of the characteristics that we're supposed to consider, I think that both of the national core indicator measures fairly align with those characteristics. Thank you.

Thank you. Linette?

So, ditto, and then I just want to kind of queue up, and I know it won't necessarily change the decision today, because all the measures presented to us is essentially survey measures, and those are time intensive, they're expensive, and it doesn't necessarily diminish their value, so I want to totally acknowledge everything everybody said. But I hope that as we move forward, we can continue to look at how do we leverage the interoperability work, the system work, and what are the other kinds of measures that may be more straightforward to take care of and to curate and to report and have consistency, but to make sure those are looking for things like how do people integrate with the community, how do people interact, not just medical claims; right? But there's a lot of push through our various waiver programs, different initiatives, whole-person care, et cetera, that are trying to work on that, so if we can keep our mind out for measures to fill that space, so we can move away from these very time-intensive costly surveys, that we keep that in mind for future.

Terrific. Thank you. So, I'm going to close our conversation and ask if there's anyone who has public comment on the four measures we've been discussing that's in the room, if you could please identify yourself. We have one in the corner.

Hi. Camille Dobson again. I'm not speaking as one of the stewards of the measures, but I wanted to emphasize safe flexibility and recognizing sort of everything that's been spoken today. Some states find the NCI-AD useful. Some states want to use the HCBS CAHPS because they use the CAHPS suite. And what we would recommend is that you not sort of land on one versus the other, but recognize that any

state that wants to survey their members and find out how they live and how their services are helping them is an important and positive step, I'd encourage them on that path.

Terrific. Thank you for your comments. Yes, Steve?

So, Mary Lou, director of NCI, and is it appropriate as a steward that I make public comment? It is, as long as it's short and --

I'll keep it very short. So, just two things that I think were touched on, but the developmental disability state directors themselves recognized the need for outcome measures 22 years ago, so these have been under development and refined, and we have a very specific revision and refinement process. And from the feasibility standpoint, I think it's really important to note that the 46 plus 1, but, actually, even recently it was more than that. West Virginia had to drop out a few years back. They had also used it too. But more than all of that, I really want to thank all of you for the opportunity to consider this. We think that the experience of people in their lives, and this is just one other. The HCBS, so the waiver programs in your states that do make up 50% of the LTSS services, 70% of the funding is specifically for people with developmental disabilities, and 43% of the people are folks with intellectual and developmental disabilities, so we really appreciate that you're considering, really listening to their voices and the work that we've done to hear them.

Thank you. Yes, if you have something --

This is Jeff Silber I just had a quick question if I can be heard.

Yes.

Is the schedule such that informed participation will be talked about later, or was there a mix up on the schedule? I apologize.

We haven't gotten to that part of the agenda yet, so if you could wait.

Oh, good. I was worried that I came in and didn't understand.

Thank you.

Thank you very much.

Someone in the room?

Yeah. I'll go real quick. Julie Bershadsky, director of NCI-AD, but this has nothing to do with NCI-AD. This is just to follow up on the last comment. LTSS and measuring LTSS, especially outcomes of LTSS, is, by nature, much more difficult and complicated. So, while, yes, we would love to find some easier less expensive measures, you know, don't wait for that. It's probably not going to happen any time soon.

We appreciate the perspective. Okay, so back to the public comment of anyone on the telephone related to the measures under discussion, related to HCBS CAHPS, national core indicators, and personal outcome measure?

No one with a hand raised at this point, so reminder, "5*" to raise your hand.

Terrific. So, thank you for that. Is there a motion to vote on these core measures? Yes, Lowell and Linette, quick, quick, thank you. Second. Thank you. So, I know we are feeling rushed, but at the same time, we haven't done all this work to not have this done appropriately, so everyone take a deep breath and be prepared to vote mindfully as we go through these four very important votes.

Okay. Wonderful. No one is excluded from voting on any of these measures. We have four measures for addition. If everyone could turn on their clicker. Make sure it says ready. Our first measure vote is going to be on the consumer assessment of health care providers and system home and community-based services survey, HCBS CAHPS, be added to the Core Set? A for, “Yes, I recommend adding this measure,” and B, for ”No, for not adding this measure.” Steve, please open voting. Okay. And the results for the HCBS measure is 61% recommended the measure for addition, 39% did not. This is not recommended for addition to the Core Set at this time.

Moving on to the next one, this is, again, the measure for addition, the national core indicators and whether it should be added it. A, ”Yes, I recommend adding it,” B, ”No, I do not.” Please hit your blue button if you have not already, and, Steve, open voting. Great. Okay. So this one 75% voted, ”Yes”, to recommend adding this, 25% voted ”No.” This one is recommended for addition to the Core Set.

Moving on to the next one, this is the national core indicators for aging and disabilities adult consumer survey. This is an addition again. “Yes, I recommend adding,” hit A; B, ”No, I do not recommend adding.” Please hit your blue button, and, Steve, please open. Okay. And then this one, 71% said, ”Yes, I recommend adding this,” 29% said, ”No”. This measure is recommended for addition to the Core Set.

And the final measure for this domain is the personal outcome measure or tool, and the question is, should it be recommended to add to the Core Set. A, ”Yes, I recommend,” B, “No, I do not.” Hit those blue buttons in case you haven't, and, Steve, please open voting. Okay. So, this one, 11% said, ”Yes, I recommend adding the Core Set,” and 89% said, ”No,” so this measure is not recommended for addition to the Core Set.

So, I think I just want to take a poll. We have two measures left, one is in relation to continuity of insurance and one is related health-related social needs screening. There is approximately 15 minutes left in the discussion. There are a couple of ways we could do this. We could certainly create the opportunity for public comment after introduction, just so that those participating by phone and who have joined us have the opportunity to do that, and then we could make our discussion in this still public setting and potentially end up voting a little bit after 5:00, or we could acknowledge that we've done a lot of work today and that these two measures need a fresh set of eyes tomorrow and try and make the adjustments to those who participated by phone who thought they would have this discussion today. I don't have a personal preference as chair, or co-chair, but I would like to sort of -- yes, Tricia?

[Inaudible].

That is a great opportunity. Does everybody agree with that? Terrific. Tricia, thank you. Which measure is the steward on?

It's called Continuity of Insurance.

Okay. So, does that work for everyone in the room? So we're going to take one measure. We'll have one lingering tomorrow, and I think it will probably set us up well to talk about future end gaps in the future, so go ahead with the Continuity of Insurance, Margo.

Okay. Well, it has a new name. It's called appendicitis-based participation, ABP rate, and this measure assesses the continuity of enrollment of children in publicly financed insurance programs in Medicaid and CHIP, as defined by the ratio of enrolled months, eligible months. The measure uses an experiment based on the random event appendicitis to inform the estimate of coverage in a given state. The measure steward is the Children's Hospital of Philadelphia, or CHOP. It is NQF endorsed. It was NQF endorsed in its previous version, and I'll come back to that. It is an outcome measure. It is based on administrative data, and when it was originally developed, it used the Medicaid analytic extract or Max data, and it was designed to overcome a limitation of MAX data to determine the reason for disenrollment.

So let me tell you a little bit more. Jeff Silber is on the phone. He is the measure developer. So, essentially, this measure, it was developed under the Pediatric Quality Measures Program. It was

published in the Journal Academic Pediatrics, and in the process of publication it was actually revised somewhat, so let me tell you a little bit about it's more streamlined now in its approach to using an appendicitis as a proxy for participation.

The measure developers chose appendicitis because it is a random unbiased condition that almost always lands patients in the hospital. The researchers looked back three months before the admission and determined whether the child was insured or not insured by Medicaid three months before the hospital admission. Those who were not insured were considered eligible but not enrolled, and they term this the appendectomy-based participation rate, or ABP. The authors conclude that the ABP rate provide a valid estimate to provide public insurance participation rates in eligible children and should aid state planning efforts aimed at achieving goals surrounding enrollment targets. The ABP can complement available information to state policymakers, aiming to improve the quality of care for all children eligible for public insurance.

The reason this measure was suggested for consideration by the workgroup is the continuity of insurance coverage among children is an important component of quality care but identifying the reasons for disenrollment from public insurance and potential policy solutions is difficult, because Medicaid and CHIP administrative data typically do not contain information about the reason for disenrollment. This measure uses observation of enrollment among the randomness of population of pediatric appendectomy patients to estimate the ratio of insured to eligible months among children in a state in a given year, and this measure addresses the gap in the Child Core Set related to duration of coverage. Jeff, I know you're on the phone. Is there anything that you want to add about this measure?

That was a great summary, and I think I'll hold off for now, unless there are other questions.

Terrific. Tricia?

Okay, I just want to put a plug in for this particular measure, because I've been in this space for 25 years, and it's just extremely frustrating that we don't have something that tells us about the continuity of insurance. And as you well know, we can't include our whole Medicaid population in our quality measurement if they aren't continuously enrolled with short gaps. The evidence of kids losing coverage and anywhere over time from 30 to 60% being reenrolled within 90 days, or within a year, illustrates that many of these kids fall off of coverage for administrative reasons and not because they are not eligible. And I just think it's critically important that we start to figure out some way to measure this. The folks at CHOP are certainly far better than I am at deciding the technical pieces of this particular measure, but I really think we need to do something about having a way to measure continuity.

Thank you for that perspective. Marissa? I just want to make sure I'm understanding, because it looks like the denominator is all children and the numerator is children in Medicaid and CHIP. So what happens to the -- like, where are the kids with, like, private insurance? So, it's a percentage of kids on Medicaid across the total population?

Jeff, can you speak to that?

I'm sorry. Yes, can you hear me?

Yes.

Okay. So, the population are children who had appendicitis and who, in retrospect, were eligible. That's the denominator. The numerator are the kids who were found not to have insurance but they were eligible in those that had appendicitis. So, it's using appendectomy because it's a random event, that if you get it, you're going to have to go to the hospital, and then if you were eligible for Medicaid, you would get your Medicaid. They would back -- if they found you were eligible, you would be put on the rolls and, in fact, backdated. So we make sure that we get everyone who got appendicitis who would have been eligible, and then we look to see who actually was not enrolled at the time that they developed appendicitis. So,

it's a point-in-time metric that gives you an estimate of the percent are insured and eligible of those that were eligible. It's using appendicitis as the estimator. And appendicitis is a random event.

Got it. Terrific. We understand. Thank you. Are there other questions about this measure? Rich and then Linette, and then go ahead, Rich.

Yeah, this is Rich Antonelli. People that are moving toward potentially treating appendicitis with antibiotics instead of surgical intervention, would those kids still stay in your measure?

Yeah. We would -- first of all, I think it's a small fraction of people. But, secondly, if you got a bill for that treatment, and if people wanted to be reimbursed, they would have checked to see if that child who had that event of appendicitis was eligible for getting Medicaid. So, they would still be observable, and we could still use that.

Great. Thank you.

Thank you. Linette?

I thought there was mention that this somehow gets why people were disenrolled, but I'm not sure I see that. It looks like it's just that people were somehow not enrolled at the time that they could have been eligible. Do I understand that correctly?

Our point was that you never know why someone was disenrolled. But in our estimate, we can get around that. We can find that group of patients that were eligible but not enrolled. We're not getting into a survey that would understand, you know, why it was that the parent had not reenrolled their child or had not ever had their child in the system, so in that sense, I think I don't want it to be overstated.

Yeah, I think it's the interpretation that the action the state would take, based on the data that would become available, would give them insight into what proportion of the kids should have been eligible and be able to dig into that. But the measure itself doesn't give you that. It just gives you the place to start your investigation. Are there other questions? Yes, please, Carolyn.

So, I just want to clarify, because I think I'm a little confused still. Would kids who fell off the Medicaid rolls because the parents picked up commercial insurance be excluded from the numerator or denominator?

They don't confuse the metric, because those children would have insurance, and so they wouldn't be billing Medicaid, and Medicaid wouldn't be ending up staying in the max data that they had Medicaid when that were not eligible for Medicaid, because their parents had insurance. So, the fact that you got a Medicaid bill is what we're using to say that you managed to get the Medicaid payment, that meant that you must have been eligible in retrospect, going back four months prior to the point when you got an appendectomy.

So, because this is a retrospective review, if the child had been eligible for commercial, they would not be picked up in either the numerator or the denominator?

If the child was eligible for Medicaid, they would be picked up. But if they weren't eligible, they would not be picked up.

And so you have to link, potentially, two different datasets. You have to rely on the claims, but you may also have to rely on the eligibility dataset.

No. I don't think that's right.

Yeah, if the child shows up uninsured for an appendectomy, it is presumed that CHOP hospital is going to work as hard as they can to get the Medicaid enrolled before discharge so they can bill for the service.

That's been the period of time that they make the assumption. So it's just from the claims payment system.

Even if they have commercial insurance, they're obviously not going to show up in the denominator, so they wouldn't be in the numerator as well, because if they have commercial insurance, then there's not going to be a Medicaid claim. Or if they're not eligible for Medicaid, they're not going to be in the denominator as well.

So, I hate to cloud it with some technicalities, but the devil is always in the details. There are some kids who, if you do a retrospective look back, will be eligible because it's considered an emergency service, whereas as prospectively, they would not be eligible, and I'm thinking, for example, of non-qualified aliens who may be eligible for Medicaid for emergent conditions. Those may cloud your numbers, and --

I think we handled that. We handled that, because we look at a point in time four months before the patient came to the hospital for appendectomy. And we ask, at that point in time, did the patient have Medicaid? So, we're making sure that kind of backdating Medicaid will be sure that the patient looked like they didn't have insurance, and that would be the numerator.

Jeff, if I might --

Yeah.

So, we are running up against the timeline of the inability to have the conversation continue over the phone line, so I want to open it up. I think there's been some technical questions. We can continue that. But is there anyone who wanted to submit public comment on this who is on the phone line with us?

There are no hands raised at the moment. "5*" if you'd like to speak.

Okay. Thank you. So, I just want to acknowledge, we tried the public comment. If there are still people in the room who would like to submit public comment, we can continue that conversation, but I just wanted to do that. Carolyn, do you want to continue with the discussion.

Just one last little technical specification piece. We don't have to discuss it, but in many states, kids have Medicaid as a secondary payer, so just want to see if that would be excluded under your specifications. I assume these are only kids who are Medicaid prime.

Yes, that's the way we had envisioned it. But I would actually have to double check my code on that, but I believe that it was the primary.

Terrific. Thank you. Thank you, Carolyn, for the question. Jill?

So, is the assumption that this number is a proxy for all of the kids in the state who might possibly be eligible for Medicaid who are not enrolled? And while we may be able to do this, how does that help us figure out who these kids are? I mean, we all know, right, that there are kids that are eligible who aren't enrolled for various reasons. We know there are kids that fall off for various reasons. But I'm just trying to understand what additional information this gives us that we don't already have from a state perspective.

And, Tricia, do you want to go over this scenario.

Oh, I'm sorry. I thought you wanted me to.

No, I think Tricia can respond as a member of the workgroup.

Sure.

I think that it's really about defining what share of kids are falling off and should have been eligible so that we can wrap our heads around the proportion of the problem and do more work on keeping eligible enrolled and not falling off.

Okay, terrific. Are there any other comments among the workgroup members on this measure? Please, yes.

I just wanted to make a note that I think this is a really highly innovative approach of using a tracer condition, and I think that there's a good potential here that this measure could provide a benchmark, and then from there, we could compare impact for other disorders that might have more social determinants or family components like asthma or ADHD or depression.

Thank you.

May I make one comment?

Yes, please go ahead. I wanted to remind the panel that our metric is highly correlated with the more expensive survey data, and we put that in the paper and in the NQF documents. So, it does apply to the whole population in the same way that the ACS surveys would apply to the whole population. So, it was reassuring to us that we had high validity in terms of its correlation with ACS, higher than the other kinds of measures that we mentioned in our paper that are currently in use.

Thank you. Rich?

Could we hear from at least one or two Medicaid voices from around the table, please, about how your respective programs would view this?

Linette?

I admit I've been struggling with this one a little bit, in terms of just trying to think through -- I mean Carolyn mentioned a number of the things that come to mind, restrictive scope, other health coverage, presumptive eligibility. There's a variety of things that come into play in terms of the eligibility pathway. There's a lot of things that we're doing in other spaces around looking at enrollment, continuous eligibility, the pathways as people come through each year to reconfirm. So there's a lot of other work in this space, and so I'm not sure how I would use this right now. It sounds like it's still early and hasn't really been used a whole lot, so it tests well. But I'm not sure that -- you know, it would be nice to see some states maybe try it and to see how it would practical, in terms of driving action. But I'm not quite sure otherwise what to do right now.

Yes, Shevaun.

Ditto.

Ditto. Thank you. I would just add, to me, as someone who's worked in eligibility for a long time, this feels just like the wrong place for it. The Core Set has typically been around the experience of care once the member is been enrolled in the Medicare program or the CHIP program. While the issue is of critical importance and we have to figure out, all of the levers we've talked about pulling in terms of MPO plans and quality assurance metrics and other things aren't the levers you would pull to try and address what you would find from this. To me, that feels where it's a disconnect. Jill?

So, I would echo that. This feels, to me, as well, like we would come up with the percentage, and that's very nice. But, you know, all of the activities that we're doing are very disparate, because the reasons for this are very disparate. And I'm not sure that knowing the percentage is very helpful. And once we're here; right, once we're here, Core Set, how is the state performing in terms of the services and whatnot? I agree, that doesn't really fit in with the other things that we're looking at.

Okay. I am conscious that we are now five minutes over time, so, Jeff, do you have some additional points at this time?

Yeah, I would just like to make a point that we were asked to develop this measure as part of the requests from AHRQ working with CMS, so we developed this. It was a challenging problem, because how do you measure what you don't see in the claims? This is looking at the group that's not in the claims until except for this natural experiment. And my thought was, the reason why we were asked to develop something like this was that they wanted to compare states and look across states and see how their rates varied, and that's what he we published and that's in both the NQF documents and in the published paper. You can see as a state how you're doing relative to others on the metric of making sure that your eligible kids are enrolled. And, again, it's highly correlated with survey data. So, I just want to point out there was a reason why we developed it. We asked to solve this problem, and we thought this was a good solution.

Terrific. And I think many are impressed with the innovation of the measure, and I think the discussion that we're having is whether or not that means it's relevant to the Core Set that we're debating. But thank you for your innovation and for clarifying the request for that. I'm going to turn back to the members of the workgroup, Jeff Schiff.

Hi. Jeff Schiff from Minnesota. I was curious if CMS would weigh in on whether or not a measure of the quality -- because it's sort of the measure of the enrollment process and whether that's a desired part of the Core Set or not, because I think we've all heard this is an innovative measure. The question is whether it belongs here or not, and I think that that's -- I mean, I guess I'm curious if you guys want to weigh in or not.

So, I'm happy to make that request. I feel a little out there putting CMS on the line, because you could ask that question about half the measures we debated today, about whether or not they're relevant. So, I don't know if you want to respond? No, Karen is going the decline. Decline the request. Sorry, Karen. No, it's very reasonable. This is the most innovative that we have potentially talked about, so it's a very reasonable question. But I think we're going to let CMS stay silent on that perspective, and if there are any other questions among the member of the workgroup.

Are there any folks in the room who would like to make public comment on this measure? Seeing none, I would entertain a motion to vote on this measure. Oh, excuse me, yes? Is that, yes? That's a vote to motion? Great. We'll move to motion, yes. We're all losing our time. Okay. Jami had a plane to catch. No, she asked that I vote for her. If you trust that I can do that, I'll do that. I am comfortable with that. You have two clickers, yeah?

Great. Are we okay? Jami has indicated, just for the purposes of transparency. I'm from Chicago, what's the problem?

For the purposes of transparency, Jeff will be voting for both Jami Snyder and himself, the JSs, and we're all comfortable with that. So, go ahead, Bailey.

Okay. So, we are voting on a measure for additions. This is in the other domain, and the measure is, should the continuity of insurance informed participation measure -- and I know the measure name was updated, but I don't want to mess it up. I just have it right in front of me, so the measure “formerly known as…”. And I want to make sure everybody turned on their clicker and press the blue refresh button. And you're pressing A for, “Yes, I recommend,” and B, “No I do not.” And no one is conflicted from this vote. And Jeff [inaudible]. Don't put that on the record. Don't put it on the record. Sorry.

So, this is voted, 25% of the workgroup says, “Yes, I recommend adding this measure,” 75% says, ”No.” This measure is not recommended for addition to the Core Set.

Terrific. So, thank you. We have done an amazing amount of work over the last period of time. We purposely left ourselves a little bit of ambiguity in terms of time management on Thursday, not because

we were not confident in our abilities, but we wanted to understand doubt. So, we do have time, first thing to note, we start at 8:30 tomorrow. There are many people who will be leaving on the dot at noon to catch airplanes home, so we are moving up our start time 30 minutes, so please be in your seat ready to participate at 8:30 tomorrow morning. We'll do a quick review of this, and then we will have a structured process for going through the one remaining measure. We'll use the same process that we've been using, and then we will re-circle on some of the measures.

There was, you know, some anticipation that we would add 18 measures, in which case there would be a prioritization process. We were not undisciplined. We were very disciplined about those for removal and those for additions. But there were also some very close votes, and as we've discussed as a workgroup, some of those votes, we just want to make sure what we communicate those votes is appropriate. So, we will likely revisit and have a conversation about, as requested what led to some of those close votes and discuss even the threshold number. CMS and the report will get all of the votes, and so, to some extent, they can move the line of recommendation. But we can have that conversation. So, there will be a chance for us to have that.

We'll take a break, and then we have noted many times that there are still gap areas. So, while we have everybody's brain in in space and we've done all this hard work, we'd like to capture the group's best thinking as it relates to gap areas and areas for measure development. There will be a final public comment opportunity, and we will end on the nose at noon. Is everybody comfortable with that? Great. See you tomorrow.

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 with the following registration. If you have any questions, they can be directed to the MACCoreSetReview@mathematica-mpr.com. Thank you.