Child and Adult Core Set Stakeholder Workgroup: 2020 Annual Review
In-Person Meeting Day 3 Transcript
May 9, 2019

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[INAUDIBLE]

Want to take a moment to publicly acknowledge the amazing work of the Mathematica team who, um…[applause] not only has kept us incredibly well organized and well prepared for this endeavor, but also worked in the interim each evening to make sure we were successful the next day.

So, our game plan this morning, even though we said it was a little flexible, we do have a plan. So we will continue, we hope to have the important conversations we need to have. We'll do a quick check-in with everyone this morning. We're going to continue to have the slides, although we'll have a little deviation from them just given the – the content.

We are going to finish our voting on that last measure, the health-related social needs screening. Our goal is to do that by 9:00, so I'm going to stop talking pretty quickly here, and – and make sure that we – we give that measure its equal due.

Then we will go and talk about a review of our work. You see before you a mocked-up, not for distribution, for workgroup discussion purpose only, set of the Core Sets as recommended. They have 2020 on them, so for those of you who have those, please recognize they are mock ups. What we are attempting to do with that was give us a glimpse of what our recommendations look like in the context of the current

existing Core Set. We felt like that was an easier way for us to put our minds around what did we remove, and what did we recommend for removal, and what did we recommend for additions. So we'll talk a little bit about that.

We'll go through a prioritization process just because we know that CMS will still have a series of decisions to make and we want to indicate to them which – which of the priorities we would have as a work group given our robust discussion.

Then we will circle back to those measures that were close. The ones that were near the 60% voting margin. And talk a little bit about those, have a conversation about what led us to some of the decision making we made, again, not from an individual perspective, but a group perspective.

We will take a break, which will be needed, I am sure. And then talk about the gaps. We have long said that this morning would be reserved for discussing things that we as a work group still see as perceived gaps. We'll do that by broad subject area, so there will be some organization to that as well. Not by individual measure, and not by domain, per se, but by broad subject area.

We'll reserve a number – a few minutes for any additional public comment at the end of our meeting. And then we'll move to wrap up the next steps in the Mathematica team, give us that guidance.

So that's the game plan for today. But before we dive right in, are there any questions, areas of clarification, general reflections to start our morning?

Everyone's saying no, still drinking some coffee. And I think we're – oh, yes, please, Rich.

Thank you. I don't know what the agenda item is that will lead to the discussion on the prioritizations, but I guess I'd like to ask why and for what purpose? We've been through that – I've been through that before, and I'm always a bit concerned about if you take five, and you say but these are the – that have already gone through a pretty rigorous vetting, and especially in many cases they're not comparing apples to apples. So, will the agenda item about prioritization include a why are we doing this and possibly, to be provocative, should we do it, before we actually do it?

Yes. So, I think the why we are doing is in part because we made you all a promise that we would. And we wanted to fulfill that promise. If the group's will is we're comfortable with these five, we don't want to – because I agree with you, Rich, they're not all – it's not as if they are all in the same subject area. If we want to agree that perhaps star the ones that we put forth with no additional prioritization, it's these five for addition, and these seven for removal - I think those are correct. Okay? I think we can gain that time back. You know, I don't know if we need to take a formal vote of that just so that everybody feels their voice is heard on that issue and it's not just a few voices, but I think we're open to that. Margo? Yes, Margo's giving me the absolutely we're open to that. Yeah, no problem.

Yes?

Thank you. This is Alice Tsai from the National Vaccine Program Office, and this is more towards broader gap areas later down the discussion. And I just really appreciate all your feedback thoughts on the measures that have been discussed. As a federal liaison, I was more interested in learning more from you all about what the challenges are in your state. I understand each state is different. So if that is something that can be elaborated on later as a common theme, and we can see – identify areas and type of technical support that you may need from federal partners. Thank you.

Thank you.

Any other? All right, so if – with that, we will dive in with the potential to make adjustments along the way based on the will of the group, and we'll turn it over to Margo to begin the conversation of the health-related social needs screening. So, again, this is our last act of review and vote before we move to reflection.

All right. Thank you, Gretchen.

So one last measure, health-related social needs screening. I don't know how many of you are familiar with this. Show of hands, has anybody heard of this one before? Okay, great. Thank you. Yes.

So this is a ten-item screening tool designed to identify patient needs in five domains that can be addressed through community services. So the domains include housing instability, food insecurity, transportation difficulties, utility assistance needs, and interpersonal safety. CMS is the measure steward. It's not endorsed. It's within what we're calling the Other Measures domain. It's an outcome measure.

So, essentially as a survey there are ten questions.

Next slide, please.

Okay. So, you can see here the – the list of questions organized essentially by domain of housing instability, food insecurity, transportation needs, utility needs, interpersonal safety.

This was suggested by a measure steward – sorry, by a workgroup member basically to account for social determinants of health. And to have another way of measuring social determinants of health. And it's linked to outcomes within Medicaid and CHIP.

This measure is currently being tested by the Accountable Health Communities model, which is led by CMMI. The measure – the tool – is available for use. It does need some permissions, but CMMI will be working through that to make it available should states and others be interested in it.

And I think the notion is that it could be tested over a several-year period as a starting point while alignment around measures related to social determinants and social needs is fully reached.

So with that I'll open it up to workgroup comments, questions, clarifying questions to start.

Carolyn, did you – can you speak into the microphone? Sorry. And for everybody here, we've been getting some feedback that people can't be heard quite as well. These microphones, I think, need to be close up.

Since this is a survey, we were just curious about some of the subjective interpretations. I mean, number ten, somebody in the family screaming. Anybody who has a teenager probably - .

For the technical questions, again, the process would be that the Medicaid members and CHIP members would be screened, and the – the responses would – or the numerator would be broken down per response with an indication of yes. Or no.

Yeah, Marissa, did you –

You may have just answered my question. I think you did just answer my questions. Because originally I was trying to figure out is this – is the – what's being reported how many people completed the survey, or – so it – actually the score would be the yes answers on each. Like what – what would the states be reporting?

I can answer that. Yes. So the way this survey would be scored, it would be the percentage of individuals with each of these elements. And the notion being that this could be linked to electronic health records or be used, I think, as a combination of an assessment of social needs within the population, and then ultimately from an actionability point of view, linked back to information that could be used to help drive the social needs support of the Medicaid and CHIP beneficiary population.

I – I understand that that was how it would be used by the state, but I wasn't sure what the state would report. So it's the individual scores, not 50% of our people completed the survey?

That's correct.

Okay.

That's correct.

Lisa?

Yeah, I just wanted to share, I'm Lisa Patton I'm co-Chairing the NQS Social Determinants of Health Data Integration workgroup at this time. And we're in the – the – we have about two or three more months to complete the work. But through that work, you know, there is a lot of state and community local-level uptake of the AHC screen, the HRSN screen that we see before us now. And so there's also a wide variety of adaptations of that. But I think in our conversations with that stakeholder panel, and really looking at sort of the state of the art of social determinants of health measurement, there has been tremendous support for this one. And I think the communities seem to like it that have utilized it. And so I think, you know, there's a lot of momentum there now to really make a statement about this and to move into this arena.

Perfect. Thank you. Linette or Lindsay – I can't tell which – who has their – Lindsay.

Yes, Lindsay Cogan from New York. So, it's definitely a topic that as a state we have a high level of interest in. And there is work going on at ONC looking at how to collect this information electronically. So, this would be something that – it's not a survey, it's more of an assessment tool. Am I correct in that? Yeah. So this would be either at the point of care or a community-based organization would be, you know, in front of the patient, guided – you know guided – guided, sort of either they answer or they guide them through. So I wonder if CMMI is on and could speak a little bit to some of the early results. And so, Margo, to echo what you said, it would be really helpful when these are coming up to have test, you know, test data. Have, you know, numbers, information, kind of data behind this to help make an informed decision. My only reservation as a state is that we do need to do something in this space, but I wouldn't want to go forward with something that contradicts, you know, where we're going to go in the future. And I'm not necessarily sure that that is, and believe me, I want somebody to figure this out more than anyone. I don't want to have to do any – do something one off in this space. But that's my really only concern. And I don't know if CMMI is on.

Yeah, and I'll just add, Margo, quickly, and then perhaps someone else from Mathematica can speak to this, but there are about 30-plus bridge organizations across the U.S. that are implementing it now. And as I said, a lot of other communities have already adopted it.

Laura, do you want to say something.

Yeah. So, I just want to – I don't think CMMI is on, but CDC and CMMI have been speaking, so I want to share what they've said, but I'm just – is anyone from CMMI on the phone? I think they were not planning to join.

So this was a proposal by CDC, and CMMI is quite interested, I think, in applying this to Medicaid. So they would need to share lessons learned. One of the things they did share with me that's on the Federal Register right now is a question on do people want to use this tool as defined or do they want to use a similar tool that gets to these aims with flexibility. But I think that could happen – the response to the Federal Register and if states decided to adopt this, which would be incredibly wonderful, I think there's still that latitude. So, an idea – I don't mean to jump to discussion, but I mean I think there are ways to, as Margo said, test this for use.

Another really critical point from CMMI is the purpose of this measure would be to do the screen and referral. You don't want to just, obviously, use it – the screen for social needs and not do anything about it. So what the Accountable Health Community model test grantees are being held to is getting all the way to that referral. They can't be held to actually getting the individual into the service because that's where we need other sectors at the table, but this would be a fabulous way to sort of coax those other sectors to the table. So, and I think CMMI and CDC and other federal agents – agencies are quite interested in supporting TA and learning with you if this were adopted in any way.

Thank you much.

Linette and then Carolyn, Rich, I actually have perspective as well (inaudible).

Okay, thanks. And – and my questions are primarily technical. So just to confirm, this is a population assessment tool, not a survey. Not a survey with a sampling frame? Okay. So that – that's correct.

So, as a population-based assessment tool, when – when we've been looking at this in some of the other contexts, it's been more about did the assessment occur, not what was the result of the assessment. So, Lindsay asked this, and so I – I guess I'm a little bit stuck. This is – the reporting for this would be the result of the assessment, not did the assessment occur?

Correct. That is how it is presented to us today.

So I'll just put out there a population-based assessment tool that needs to report the results of the assessment is going to take a long time for us to implement. It's like – like when we think about procurement, development, we're talking years. So just as an FYI.

Linette, a clarifying question. Because I – I think there is a question of what would get reported for if this were brought into the Core Set. And I think that, you know, given that this tool is not specifically in some ways a measure for the Core Set yet, what – I just want to clarify what you're saying, that if the report were to be what percentage of the population was screened, or assessed, is that doable in a shorter period of time?

So – so some of this goes to how would we get the information that the assessment occurred. If it's going to come through on a claim, then we have infrastructure to receive claims. And once we get people to use it and report it, we would be able to do that. If it's got to come in on something other than a standard 837 claim, then we have to figure out how are we going to receive it, what format do we put it in, what are the standards, what is the system, creating the additional storage space in the data warehouse. There's a whole lot of system stuff that has to happen to be able to do that data collection. So – so that's – that's the caveat there.

And, again, ditto on everything Lindsay said, importance, need something, all that. But logistically I'm not sure how to accomplish this at this point. But it may be something that, you know, given the testing, given the response, given the Federal Register, that, you know, in another year or two, it may be something so – that we would be able to look at doing. We'd have that context.

But – but what we're voting on today is a population-based assessment reporting the results?

Correct.

Okay. Thank you.

No. No, not the referral.

But it's not – we're not saying the individual has received the service.

You're just saying the number of respondents indicating that they have (inaudible), yes or no.

That's – yes. But if you're – so, I was just – if your concern is the mechanistic slowdown versus – the thing that would take years – so we're not expecting the response to reflect if the persons get into housing, for instance. That's not what you're talking about, right? Okay.

No. We have 1.3 million enrollees in Colorado. If we need to collect 1.3 million assessments, and be able to report back the answers –

Yes.

On those assessments, for ten different questions.

Okay.

That requires infrastructure.

So, in addition to reporting the answer, are we having to report if someone said yes, did we make a referral?

No.

Oh. Because I heard her say yes.

So, ideal – I think ideally, ultimately that would be the goal, but that's not what this tool is asking right now.

That's correct.

To the question from New York, 'what did CMMI learned,' one of the things they're learning is there needs to – that loop does need to be closed, but this tool right now is not asking for that.

So let's continue this quickly just because we were aiming for around a 9:00. So, we're going to go down and then around. So, Jill. Oh, I'm sorry, Kim.

So, at least in the LTSS space, we have developed a uniform core assessment that includes elements like this from other tools. My concern is one that – that's a huge effort in and of itself, but to – but to have done it with a tool that was available when we did it, and then to have another one be the one that's the accepted one is a bit of a problem. And the, you know, here are ten questions here, and five questions there, and this survey, and that tool. And I just worry that there's a lot of different individual things that are really hard to keep track of.

Terrific. Thank you. Kim?

Working for an external quality review organization, we do work with many different Medicaid programs in many different states. And what I would say is almost everyone, if not all, of them are really struggling with the social determinants of health issue. So having a tool that at least starts giving them some standardized information that they can eventually make usable makes a lot of sense.

Jennifer Tracey from Healthy Steps. I was just going to point out we are doing a lot of work with pediatric and family practice providers across the country that have implemented Healthy Steps and trying to track a lot of this information. And what we're hearing from providers is that they want to do this, but they don't even have a way to track responses in their EMRs. And to build out the templates, depending on whatever survey they pick, is challenging, and time-consuming, and costly. So, I would say for this one I think it's just going to be challenging at the provider level to implement this, even beyond the state level.

Thank you. Jeff?

Jeff Schiff from Minnesota. A few things. One is this is a – I think we all agree this is really needed. I think what I feel – I'm worried about is that there are some things that could be missing from here. Community connections. Work. And then another thing that would be really nice to ask on the social risk factor survey is about resiliency. You know, I don't think we're asking about the negatives, not the positives. And the last thing is if we ever got to the point where we even wanted to see how many people were sampled, we'd want some demographic cross section, so I'd like to know by race and ethnicity, by geography, and a whole bunch of other characters whether – how the samplings.

Thank you. Carolyn?

Yeah. So, in Massachusetts, under our Medicaid ACO initiative, we are required to do a – a health needs screening to identify social determinants. So, a couple things. And I won't repeat everything that Linette and Jeff said, but I do agree with Linette that the focus should be on the percentage of health needs screenings that are completed, not the outcomes at this point. The second piece, which Jeff, I think, highlighted so nicely, is we are dealing with very heterogenous populations. We need to make sure the questions reflect these different sub-populations, frail/elderly, disabled, BH, SUD, etc. What has worked well with our social needs screening is that we do have flexibility to tailor it, and, in fact, we did do somewhat of a PDSA cycle and found that we did have to shorten it and modify it because this is being administered over the phone. And then the final piece I'll say about this is we also have to be mindful of who should be administering this, or who might be required. So in our state it's actually the – the health

plan that's required to do this. We certainly engage our partners, and we have seen a lot of good results coming from doing the social needs screening leading to referrals to community-based organizations or community partners. So we have seen a lot of good outcomes from doing this. But I just think we need to be mindful of how this gets operationalized.

Yeah, my comment is just as it relates to the – my perception of the Core Set is the ability to compare performance. The ability to compare performance on the number of individuals in the state that don't have housing isn't necessarily in line with the other things that we're comparing performance around. So I concur that the number – the proportion of Medicaid enrollees or CHIP enrollees who are screened is a comparable issue. The other is I just, for everyone's knowledge, that federally-qualified health centers have the Prepare tool and are using it extensively, so to the question of if we were going to respond to the Federal Register, I would respond flexibility is critical. And then the last thing we wrestled with is, is I don't need necessarily to know these things at the state level. I'm not the individual who can take action to support an individual successful at managing whatever challenge they face in their life. So the person who is closest to the individual and has the community connections, especially in big, rural states like the west, is more important than the state having this information.

So, I agree with Jeff, we all agree it's a big area to be – for work to be done on, and certainly for kids, it means a lot for their trajectory in life. But, in addition to the infrastructure issues of collecting the data, there is the issue of a warm handoff or a loop back because it's been shown that you just say, oh, you should call this CBO and they can help you with housing, that that just doesn't happen. And I think we've got to do further work out from an assessment tool to figure out how do we make this – successfully make (inaudible). And bearing in mind that in many cases (inaudible).

Thank you. Rich?

Yeah, Rich Antonelli. NRPT, if I can be succinct, I don't think it's ready for prime time. That said, I would argue that what medical care delivery in the United States needs to get us to healthcare delivery in the United States is something like this. I – I think to sort of emphasize possibly a slightly different perspective from what Lindsay had said, we need the data, but I'd also like to hear about the experience about the implementation. I, for one, would be very comfortable promoting a measure that sets the stage for the assessment. And then each community, each state, each county figures out how to build the bridge so that we can measure the handoff. So, just to let people know, in my mind, the process method is like that. But I think there is so much heterogeneity here. And then I think for the first time in two days, I think I'm going to make a very explicit observation as a pediatrician. I don't know how this would be framed in the context of a family and how it would be reported. Would it be on the adult side and roll up and then the pediatric side would do the same thing and would roll up, etc. So, I think it needs a lot more work. But I – at its core, I think this is absolutely essential to get us into healthcare accountability.

Perfect. Thank you. Lisa?

Yeah. Just a couple of points. I don't think anyone would argue that this is sort of a first cut at capturing some of this. And, you know, I think it had to be priority for the AHC model put into place for a variety of reasons. And, so, as I shared earlier, a lot of the places that have adopted this already tailor it. And have prioritized, if you will. And a lot of the overarching lessons (inaudible) support group have been that depending on particular SDOH gaps in communities (inaudible) that, you know, perhaps one state is going to look more closely at violence, another at food insecurity, depending on the needs (inaudible) so there is a lot of room tailoring.

Thank you. Ya, Dr. Kelley?

So, Pennsylvania, we're actually putting out an RFP to get software for our managed care plans and community partners who actually have a common platform to push the data into. That is our strategic plan, anyway. Whether – whether or how quickly that happens is always up to lots of other variables. Gretchen's point about the HRSA survey, Prepare, we've looked at that, we like that. It's – be nice if, even across the federal agencies, everyone would align, get on the same page with the same survey.

Try it.

I know. it's easier said than done. I understand that. But, again, I don't think this is quite ready for prime time. We have actually primed the pump by making our patient-centered medical homes before the end of this year actually have to screen for at least once social determinants of health. They're going to give us a billing code. Tested positive, tested negative. If they're positive, we're asking them to give us the ICD-10 codes within certain domains. So we're – we're trying to get providers kind of cued up. And these are patient-centered medical homes that have infrastructure and processes in place that they can do this. Many of them do have EHRs. The FQHCs have been doing this for a while. So, I'll go back to Rich's NRPT. But, you know, I think this is vitally important. It's the way the Medicaid programs really need to (inaudible).

Thanks. I'm going to conclude – (inaudible). That's all right. Yes, I see. Hopefully, I'm going to conclude the workgroup conversation, allow Dr. Seeff to make the last comment, and then we'll open it up for public comment. Dr. Seeff.

Sorry, Gretchen. I come – so, maybe this is a request for thoughts to go back to Mathematica and CMCS on if it is not ready for prime time, what would it look like for people to, you know, what's the glide path in a shorter term to sort of acknowledge the importance and the fact that it's not really ready. And maybe that's not for today. But, um –

But maybe in our later discussion around gaps.

We could talk about it in the gaps.

Because I think there's – there's infrastructure issues, there's data collection issues, and there's – I'll say provider burden to capture this. And then, really, outcome. We're more focused on let's get the referral than did they actually get there. I think that's for later.

I think that we can reflect, too, because there is momentum within the Medicaid program. So, we'll add that as a potential area of conversation when we get to the gaps discussion so that I think it is appropriate for today.

Are there others in the room who would like to make public comment, or those on the phones who would like to make public comment?

Seeing none, we will move – or if I could get a motion to vote on this measure? Thank you. Second? Thank you. Appreciate that. So, is there any final discussion after the motion is made, there's an opportunity for final discussion. Seeing none, Bailey.

Great. So this is your forty-sixth vote. Well done. Fifty-sixth! I shortchanged you by ten. I am tired. Okay. So, this vote is for addition, and it's for the health-related social needs screening. If everyone can hit their button to wake up their remote, it's the orange button. Say ready on it. If anyone is having a problem, just raise your hand and we can swap out your remote. Awesome.

Okay. So you're voting yes, A, if you think the measure should be added to the Core Set. B, no, if you don't think the matter should be added to the Core Set. And open voting.

So, this should be – yes, it's 2, the tally.

So the results of this vote are that 11%, and this is of the 27 members present, 11% voted yes, I recommend adding this measure. And 89% voted no, I do not recommend adding this measure, so this measure is not recommended for addition to the Core Set.

Thank you. And let's give ourselves a round of applause.

[Applause.]

This is Margo. I would just like to thank Steve and Derrick for all of the work that they have done with the voting. You all have no idea how much went into this planning.

[Applause]

There are – there are actually two computers, and they have to shift between computers when the voting is going on to be able to project. So, thanks to them. And thanks to all the other staff at Mathematica who helped to figure this out. It took a village, for sure.

Fantastic. So now – now we can – we're going to continue to stay focused on the Core Set. Now what we are going to do is begin the review of our work. And this is a place where there is flexibility. We want to assure you we are prepared to have a structure, but also want to make sure there is flexibility.

So, what we thought was most important is the ability to review our work in the context of the rest of the Core Set. We promised you we were going to disassemble everything and then reassemble it.

So, we took the – the sort of priority of putting – imagining that everything that we had talked about for removal and recommendation was accepted by CMS. We also took the liberty of putting them on the Child and Adult Core Set. But I will remind you that's the complete jurisdiction of CMS to make that final decision. But the ones that we added and removed were pretty clear, so it was not like Margo had to – to think very hard about that.

So, if I could, I would ask that we quickly walk through the Adult Core Set. Again, the document you're looking at says Do Not Distribute For Workgroup Discussion Purposes Only. This is just for us as a working document to see what this all would look like.

So in the area of primary care access and preventive care, we have proposed for removal the adult body mass index assessment. Again, there were some concerns about the changing nature of that measure in that there were some technical specifications there, and the vote of the group was for recommendation of removal.

Did not make any changes to the maternal and perinatal health set on the Core Set. Those remain, although we had discussions about a couple of them. Those measures were not voted to have any action taken.

For care and acute chronic conditions, we removed the diabetic testing but with a very clear conversation about how the poor control measures still give us insight into the testing. So, still our recommendation gets the importance to diabetic management.

We did not make any additional changes other than a request for a recommendation of removal of the annual monitoring of patients on persistent medication. So, short name, the care and acute chronic conditions a little bit there, which I think states would potentially appreciate.

In terms of behavioral health care, we did not make any changes. There were not many for us to discuss on the Core Set indicating that most workgroup members felt that the Core Set was currently important. with the exception of the adding of the use of the pharmacotherapy for opioid use disorder, which I think is an important statement by our group of we need to have something in the Medicaid space that relates to the national issue of opioid use disorder. So a recommendation as it sits there.

And then we added some measures as it relates to long-term services and supports. So the two national core indicators, which really are both about beneficiary – or are about beneficiary experience. And for both individuals with intellectual and developmental disability did those, as well as those with aging – aging adults and other disabilities.

So, those were the additions we made. Does anybody have any comment or reflection now that you see the adult core set as it could potentially be in the future based on our recommendations. Again, we're early in this process of finalizing, but, is there anything to reflect on with the Adult Core Set?

Linette?

So, I think – I think the main thing that sort of comes out, and it wouldn't have come through in terms of the additions and removals, is that under the behavioral health at this point that's probably where we have the most number of measures, and three of the measures are opioids. So, we weren't – we weren't put – you know, that choice wasn't put in front of us in terms of how to address that. And, again, as measures change over time, in some of the other areas we had recommendations for removal and additions that reflect change over time. In this one, that wasn't the case. So I don't know that that's something we would take on here at this point, but it is – it is noteworthy that – that there is a predominance there. And I'm not sure that there is enough uniqueness to each of those three that CMS might want to look at, you know, how to – how to address that. That perspective.

Yeah, Jill.

So, the other thing in looking at primary care and preventive care. We have three measures that are for women, and we've got one sort of partial immunization measure because it's the flu vaccine and it's – it's not the whole population of adults. And then the depression screening. That just feels a little light to me.

Okay.

Thank you.

Yes, Amy.

I just have – I'm going to kind of reflect back on that comment. As a primary care physician, as I'm looking at this Core Set, I'm thinking all of these measures apply to primary care. In general. So – so the set looks pretty primary-care heavy to me. And – because everything that walks in my office – all of this can apply to any of my patients.

Perfect. Thank you for that. Which may be interesting that there's not as many acute care given where most of the money (inaudible) one-tenth of the entire state budget in the state of Colorado goes to hospitals and (inaudible). And so maybe that is something to be mindful of is that there may be a gap as it relates to acute care management.

Yes, Carolyn.

So I appreciate the conversation we had about adult BMI, and I do recognize concerns about how it was really just a documentation issue and sometimes a check-the-box thing. I am concerned, though, given that obesity is an epidemic, I still see that as a gap in this Core Set.

Terrific. Thank you.

I've just got a follow-up comment or thoughts related to the comments that were made about the opioid measures. I think – first of all, I think the opioid measures being added and a number of them being added was in direct response to that being seen in past years as a gap. And – and I think for those who work on fraud, government regulations, I think every agency is being pressured to put some kind of opioid measure in, even on some things – on some programs where it doesn't even fit, where I think for this one it does.

But I do want to emphasize that what we added today, what I think was real – or yesterday, whenever – was real important, was the previous measures all looked at opioid misuse and – and measuring how many people are misusing opioids. And what we added for the first time was the treatment of opioid use. And I think that's very, very different and that that should be acknowledged.

Perfect. Thank you. Jeff, did you have something?

Very articulately said by Marissa.

Dr. Seeff, did you have something?

Sure. This is Alice from the National Vaccine Program. Thank you for the preview of the potential revisions here. So about Core Set and while I understand ASPE's point on the primary care part, but when I look at the maternal and perinatal health, they has not been an immunization measure for prenatal – for prenatal care, and there is a prenatal immunization status measure that's available for use. And it's a concern because vaccinations – vaccinating a woman against influenza during pregnancy significantly reduces the risk of influenza infection for both mother and child.

Alice, we're going to talk about that measure in the Close Vote conversation, so –

Okay.

We can revisit and you can share your perspective during that conversation.

And my second point is – and my second point is related to the juxtaposition between the child and adult sets. So if we can take a look, compare those two as well, because right now in the Child Set they are Childhood Immunization Status as well as Immunization Status for Adolescents. And the adult population is missing along with pregnant woman. Thank you.

Yep. Thank you. Laura?

Just really quick. I'll hold my comment on the vaccinations for the Close Vote because I think we're still looking at a gap. And I just want to concur – so if you look at this total list, now there's nothing on BMI, and it's the closest we come to pre-diabetes screening until we put those measures in. And there's a tsunami of pre-diabetics coming down on us. So, that does feel like a concerning gap.

Perfect. Thank you. Rich?

I'd like to actually call out the point that Amy just made a couple of commenters ago, which is – it has to do with the taxonomy of these domains. So, if you read the literature, in particular in pediatric chronic conditions, so-called children and youth with special health care needs, but it also applies to adults. It's the notion of the medical home. The primary care person. Barbara Starfield would say that's the single point of access, starts the coordination of care, etc. But Amy, your comment and observation is so profound. A high-performing PCP gets involved, or, in an integrated model, clearly identifies that they're not involved, but there is a warm handoff to a subspecialist. So I really want us – and I'm not even going to talk about measure, I want to talk about the taxonomy of these domains. I want to urge a deep degree of caution around the primary care domain and having that appear underpopulated I – I think sets the stage for a structural gap in providing care for children, youth, and adults with chronic – significant chronic conditions.

And I don't know, it's probably not in scope to talk about tweaking the domain, but I really want to go on the record as talking about primary care should not be the wastebasket, and then all the chronic stuff is out here somewhere. If we move to integration, these domains need to be able to allow for those measures to cross over to each other.

Rich, do you suggested renaming? Or just you maybe want to think about that.

Yeah, let me think about that. I mean, frankly I would say –

(Inaudible) I'd even say access.

I would say access and preventive – access and preventive care, for me, does it. And then you can literally go down that column and say, comprehensive diabetes care, oh that's a primary care function if it's being done, etc. So, my humble, quick on the spot would be just lop off primary care and make it access and preventive care.

Okay.

Does anyone else have some more suggestions or –

I would support – I would support that.

Seeing heads nod.

I think child psychiatry would support that as well.

And I – I just – this is a little bit of a preview of what Margo's going to talk about, but there is an opportunity, once this – the report from our work here is complete, there is an opportunity for public comment that we all also have the opportunity to participate in. So, if, upon reflection, you have something else that you would say, there will be a formal opportunity. It will be open to the public as well as our workgroup members, so there will be a second opportunity – formal, structured, public comment opportunity for written comment on the final report.

So, I am going to move us along. I just wanted to give us this picture. Tricia, did you have something to add?

Yes, very quickly, I just wanted to note that on dental and oral health, we call it services and not care.

Okay. Go ahead.

I just want to again commend the committee for the hard work. I really think that we did our due diligence in removing measures that needed to be removed. And I'll say with the exception of the BMI measures for both adults and kids. But I think we did remove some measures that it was time for them to be retired. And for that we'll provide real estate for true additions.

I like where we landed with the additions. The point about moving towards actually treating opiate use disorder I think is very important. The other two measures are focused more on patient safety than opiate prescribing. And, again, I think we really did our due diligence. Again, I think later on we will have a great, hopefully, opportunity to discuss where the gaps are. I'm sure that immunizations will fall into that discussion.

Yes. So just quickly turning to the – to the Child Core Set, I think that's what Tricia's comment was about, which is great. I think, you know, you could make the same conversation that Rich did already about the naming and then the oral health services versus oral health care. But, again, removing of the BMI measure, probably an area for ongoing conversation. But I'll remind you, one of the reasons we made that decision, at least what I interpreted from the conversation, is there were some technical changes coming to that measure, and the EMR already gives us that information through Meaningful Use. So real estate on the Core Set may not mean it's not an important, it just means we get that information from other places and that there may, in fact, be more actionable measures that could come up over time as it relates to weight management and healthy weight for children and adults.

The access one was also removed. And then – the CLABSI one. And then appropriately, I think, we had a nice conversation about a critical issue where there's a real opportunity for improvement of care, and that's for children with sickle cell anemia. And of the two we were offered, we chose to add one and that felt like the one that could make the large impact in the lifelong trajectory of children with sickle cell anemia.

And then moved away from just the concurrent antipsychotic to a measure that we felt like people had really changed, the national approach to that had changed, as well as there was pretty high performance, and going to something that was a little bit of a better opportunity for us to really improve, and that was around metabolic monitoring for children and adolescents on antipsychotics.

We did not make any changes to oral health care, nor did we make any changes to experience of care.

So that was our work as relates to the Child Core Set. Is there any additional?

My only comment would be, as it relates to behavioral health care, I would hope, and maybe this is gap conversation, but my reflection is many of these are not for young children, and so as we understand the importance of social and emotional development for children, and, you know, I think I counted when I was at Colorado, we had 178,000 children under the age of five insured by the Colorado Medicaid program, zero to five kids, and then the 42% of all births, so perhaps over time there will be measures that better help us understand the social and emotional development of very young children. We don't have those as well described here.

We do have the developmental screening measure, so that's one, but, again, there are –

Socioemotional development as being one component of developmental screening, though, as it relates to – other components of the child's development.

That may be room for the gap discussion as well.

All right. Any other reflections, then? Yes. I'm sorry. Go ahead.

I don't know if it should be better under the gap session or here. I just want to point out that, so we have two measures that are in the dental and oral health care area. They both obviously deal with prevention, and nobody is going to speak against measures that look at prevention. But when you really think about prevention in oral health in children, you're talking about dental caries as the primary disease. And the two real modalities are fluoride and sealants. And we have sealants on top of preventive services. I know there's some work being done by a group who's looking at – at other measures, and may be trying to even make sure that when we say preventive services it really highlights those two avenues that I spoke about, the two – fluorides and sealants. I mean, that's really where the crux of it is. Having said that, I would said that I think what we're looking at, at least to the Dental Quality Alliance, is a broader – something that goes beyond prevention, right? Frankly. Because prevention is really – preventive services use is really highly tied to just basic utilization, right? So when you have preventive services, you have a very good marker of – of utilization. But there are other significant issues because, you know, in California I can tell you, you know, like by kindergarten we've got over half the kids have got caries experience, and by third grade it's over 70%. And those are all the kids. That's not just the Medicaid kids, and you know it's three to five times more significant in the Medicaid population.

So looking at a fuller sort of scope of dental services and having measures, and even the measures we introduced about ED, where you're looking about whether or not, you know, when the prevention does what it can, but beyond that, then what's happening you know to really look after the disease that we know is one of the most, if not the most, common chronic disease in childhood still.

One of those –

It feels like there's something missing.

Absolutely. And I know in Pennsylvania, at least, we're really focused on the probably the first three years of life. And many dentists will say, you want me to do what? So – and that has been an education process. But, really, if you're looking at both prevention and education of the family early on, I mean that's – to me that's the prevention model that – and that's one of the things we're focusing on, is that particular age band.

Yeah, appreciate the comment.

Really – really couldn't agree more, and that, you know, is some work we've been doing some at FQHCs and now try to do it at a broader level. That is where you get to a more integrated model of health care, right, because there's room for primary care to be, you know, counseling, assessing, prevention, and referring. And then you want to sort of know, is that happening? And the earlier you can make that happen, the better off these kids will be.

If you can make that experience with the dentist a comfortable, nice one instead of the sound of the drill, I mean, it goes a long way.

All right.

I'm serious about that.

Works for everyone.

Including the dentist. So, we'll go from Jeff to Rich to Tricia, and then we'll wrap up our conversation about the Child Core Set. Oh, just from Jeff to Rich.

Jeff Schiff from Minnesota. I was very involved in the very first Core Set, but I – Margo, I said that to Margo earlier, and she said, well, you're a dinosaur but you're not extinct. So – so I am happy to have that honor.

But I just wanted to make two observations about the – about the – how these Core Sets have evolved, and I think they're really good observations. One is I think we are more comfortable having a gap than a bad measure now. And I think that that's good. We took off the childhood BMI. Obesity is a huge issue, but a bad measure. Not a replacement for a gap.

And then the second thing I think is that I think we're more careful now than we were before about whether these measures are actionable at the state level. And so when we started we wanted a measure of hospital performance in CLAB – in central line infection is what we had, but that's not really an actionable measure for – for a state program. So I think that we're getting – we're – we're honing in. and I think that we – and so it's nice to see a decade later that we're making progress.

Rich, go ahead.

It's always nice to follow an old person who speaks wisely.

Yeah, he's not extinct.

I actually would like to – at the risk of stating the obvious but recognizing that we're segmenting the conversation, so I'd like to propose the taxonomic change for the Child Core Set as I did for the adult. And really, to honor what Jim just called out about the measures that currently are in the dental and oral health services as preventive measures. So if – if the group's agreeable to call the first domain access and preventive care, I strongly recommend that we move those dental measures up in there to send a clarion signal to the country access to immunizations is as important as to access to dental screening and sealants. It's all about primary prevention and access to those services. And I just think that that – not that it would lose its spot on the Core Set, but I actually –

(Inaudible.)

Well, I was going to say, we would – we would want to make sure CMS messages this correctly, but from my perspective, there is such evidence for this, especially for Medicaid populations, that why not move it into an access and preventive care space as opposed to sort of being a stand-alone.

Perfect. Thank you. Sally, did you have something?

First, also, I am just so amazed at all the great work and where we came as a group. Amazing to be a part of it. Learned so much. Oh. Amazing to be a part of this and learned so much these past two-and-a-half days.

I just wanted to put out there that as we think about child health measurement, and we think about where a lot of the resources go for commercial and state Medicaid with children with medical complexities, that one of the challenges that we'll continue to have is, you know, that we don't have these large populations. It's – they are rare diseases or rare conditions often compared to what we see on adult health measure developers I know are grappling with this and how to think how to maintain some actionability. And so I just, you know, it's something to keep in mind as we mature in measurement that it may start to look a little bit different than what we see on the adult side as we try and focus on where the quality of care issues are in – in child health.

Terrific. Thank you. I'm going to move us along. One other thing we promised you was to look at the paired – I'm going to use paired in like think globally relatively related to one another, not paired. Pair – for the recap, we, again, sort of made a commitment that we would do this when we had one of our pre-planning calls because I think people were struggling. This slide is a little dense, so I'll walk us through it.

The – the first line around flu vaccinations, there was one suggested for removal with some additions. We took no action on that, so the pairing was not really relevant after the action was taken. We left the flu vaccinations for adults ages 18 to 64.

As it relates to the primary care access, there was a discussion about how those might not be exactly the same. We did vote to remove the child and adolescent access to primary care practitioners. But the three well childs, though, do remain, again across that age band.

Adult BMI we've discussed today. Again, the feedback being we may prefer to have a gap than – I think as Jeff said – have a gap than a bad measure. And so, important we did not choose to add the preventive care and screening which was potentially an alternative.

As it relates to the diabetes, we've already talked about that. We removed an early indicator of that, and chose to recommend removal of that because there was one that could capture it and a little bit more information.

HIV viral load suppression we voted not to change even though there are only a number of – a couple of states, but we heard from some states in the room that states are close, Oklahoma, Florida, and we did not propose the addition of the – of the proposed care, if you will.

Labor and delivery room we made no changes to, and we also did not change the two contraceptive care. We made no change to medical assistance with smoking and tobacco cessation, we made no change to.

And then similar to the diabetic control, we made a shift to perhaps a more meaningful measure as it relates to that.

So, I just wanted to give everybody that picture. Bailey put this slide together, or the team did, and we felt like we had promised you that and we just wanted to see that. It didn't give any of us pause when we reviewed it last night, but everyone's nodding in the room, so that feels good. Okay. Terrific.

So, at this point in time, we were anticipating doing a prioritization process to look at the five that we recommended for addition. We were going to try and use our handy-dandy clickers all the way down to E. Not just A and B, but all the way down to E. But I also heard some hesitance in the room when we started this conversation about that – this proposed exercise. So, let's maybe open it up and discuss there are five. They are not necessarily overlapping. Each is done on its merits. Want to prioritize, or do we just say for the group, this is – this is our best thinking and CMS has heard our debate. We will have a comprehensive report. What we got?

Yeah there is – the five that are – this – if we were to move to a voting process, we did give you a worksheet so that we could help ourselves be successful at that exercise. So, if you want to see what the five are in a stand-alone structure, they're on the worksheet. But let's have the discussion about whether or not the exercise is even something we want to do.

And, again, I don't think we need to have a prolonged discussion. We can quickly move through and do a quick vote, instead of having – Because I don't think anybody really wants to rehash what we already discussed. So, I think our – our theme was here, let's get the clickers out, do a real quick prioritization, and move on.

But the question on the table now is do we do that, and, Marissa, you, I think had the first – there's a lot of tents up, so Marissa, I think you were first out of the box.

First, I just want to say I'm perfectly good with the let's just move on. But two things. One, just wanted to make sure that everyone – everyone around the table understands that these are recommendations to CMS, they may or may not take them. So I know sometimes we've said we've added these five. There might only be one of those five that get added. So I just wanted to make sure that everyone understands that.

And then I guess the question, and I don't know if you guys want to answer, but is – is really for – like what's more useful to the CMS staff because I don't think to us it really – I mean, it's what – if it's more useful to them that we prioritize it, then we should prioritize it, and if it's not, then we shouldn't. That's my thought.

Okay. That's a great – I'll let CMS decide if it wants to answer that question. They have wanted us to sort of operate independently, so they can decide though because I think that is a reasonable question. We're not asking them to weigh in on a measure, but is it useful to get a prioritized product or a product with five recommendations? So, but –

To Marissa's point also, just because we voted things off, doesn't mean that CMS is going to accept that. So, it works both ways.

We've been humbled in our real power around here.

(Inaudible.)

So let's let the workgroup talk first, and then we can get that perspective.

So – so I have a real problem with prioritizing. There are only five. And I'm going to say I'm biased because I do – am a subject matter expert. You're voting on three different domains. One of them which is a new domain, two measurements in that domain, and it comprises 30% - 32% - of all Medicaid expenditures. To say that – that there be a vote on that, like that, that really gives me pause. Not just as an expert in long-term services but as an expert in Medicaid in general that – that we have only put five additions on. Those are our priorities. We didn't put like ten, 15 extra ones in. We only said there were five additions. And so I would have a lot of pause to actually – actually to prioritize.

Terrific. Thank you for your perspective.

Yeah, Lisa Patton. I'm very comfortable with not prioritizing this year, but I think, you know, as one of the fellow dinosaurs on the group, you know, we – yeah, that's right – we have a little bit of a, you know, this is I think the first year we've ever voted to remove seven. So, it gives us – so it gives us more comfort that there is, you know, wiggle room. So, that's it.

Terrific. Thank you. Rich?

As a clinician, before I ever order a test, blood test, x-ray, I always say, what am I going to do with that information. And I'm really stuck with how – what are the criteria by which we would prioritize? I'm actually concerned, especially at – Lowell, I don't think I could have said it any better than – than you just did. What are the criteria? If CMS said you've only got one spot on the Core Set, then – then I've got a criteria. But when you consider it's a multidimensional cognitive matrix that we used to move measures forward, I could almost make the counter-argument that we should have a prioritization for the measures that got voted to remove, because that might send a message to CMS that says you know, maybe you shouldn't remove the XYZ measure. So, in sum, I actually think there's nothing but hazard to prioritize five measures when so much rigor went into them. And they truly aren't comparable on their face.

Okay. Jill, and then I'm going to ask for us to decide what to do with this.

So, I'm in agreement with that. I don't know how I would prioritize these. They're not related. They're not one's a better measure than the other. And I think we had a really rigorous process. I'm not sure how meaningful it would be to prioritize.

Okay. So I'm going to shift the question, with courage, is there anyone who absolutely is desperate to prioritize these five? Okay. So, seeing none, I – we can take a vote. We have the clickers, we could take a vote and make sure everybody feels like their voice is heard. We could also have, after two long days of being together, the trust that the will of the group has been articulated and that our – we are not – even if CMS wanted us to, we are not comfortable prioritizing these five measures. Yes? Terrific. Then I think we come to consensus on that and don't have to use the technology, despite the fact the team worked really hard on creating these, so we give - .

Yes.

Yes. So I think then the – the part of the conversation we wanted to move to next, I'm sorry, I'm catching myself up, is the Close Measure discussion. Yes.

So we have – we are a little ahead of schedule. I know that there are a couple of people, myself included, who have pretty tight turnarounds. Amy, I think, has to be at the airport at one-ish or so, 1:15, so if we end a half-an-hour early, I don't think anyone is going to protest.

So, our goal was to have this conversation until the break. We had allotted about 30 minutes for the conversation about the Close measures. Not to rehash the vote, but really to begin to ask the question of, you know, what – as we were selectively making these decisions, is there something that we would articulate for the good of the report and the good of the ears in the room around why these votes were as close as they were. So, I think we have 30 minutes to do that so we could get ourselves to a little bit after 10:00, take a little bit of an earlier break, and then come back and have that all-important discussion about gaps, which you've already started to sort of (inaudible). Does that work for everybody? Okay.

So, the other handout that you have, which is the discussion of the measures that were close to the two-thirds threshold – do we have a slide on this? No, okay. So we don't have a slide. So I will read them just so that people on the phone and people without the handout can see them.

And so what we chose to highlight were the votes that had 60% or above. The two-thirds was picked as a following of what NQF does as well as a high bar. Given the conversation we just had, we're not messing around with Core Sets, you know, lot, and we wanted a high bar. And we wanted something that really perhaps suggested a consensus in the group beyond just a simple majority. So, recognize, though, that getting close to two-thirds is important.

So there were five – six measures that were close. One was a considered – consideration for removal and that was related to flu vaccines for adults 18 to 64. And then the one that was close in terms of an addition, the first one was prenatal immunization status. Appropriate treatment for upper respiratory infections. Post-partum depression screening and follow up. Long-term services supports the comprehensive care plan update. And then the HCBS CAHPS. So, two in the long-term services and supports arenas, one in the maternal and perinatal health as currently framed, care of acute and chronic conditions, and then primary care acts as a preventive care.

So, I think what we may want to do is just maybe take these at a slightly higher level than the measures themselves, but as people could reflect on during the conversations about vaccinations, there was some discussion about adding vaccinations for the dually-eligible population. There was the prenatal and then the adult immunization. Are there members of the workgroup who would, you know, share globally, again, not your personal vote because I currently don't remember my votes on each of these, but share your perspective on why maybe these measures were either not voted on for removal or not voted on for addition?

Could I just maybe make a procedural suggestion, and I raised this yesterday. These five characteristics were the framework we were supposed to use in preparing and in our discussions. Could we maybe use this framework, and I saw the slide right before this, I think, listed out the characteristics. Can we couch this discussion in terms of these so that it's not just a back-and-forth –

Yes.

But, yeah, and is on the bottom also, right. But I think it would be helpful for us to –

Great suggestion.

Thank you.

Yeah. Absolutely. Great suggestion. So, if you could, in sharing your perspectives, let us know if it was in relation to actionability, alignment, appropriateness for state-level reporting, feasibility, or strategic priority. Thank you for reminding me of that, Carolyn.

Yes, Laura.

And the answer may be no, but I wonder if the discussion around those could happen on the adult immunization as a – so what's not on here is the adult composite measure.

That's because it was not that close in the voting.

But I wondered, is it – can you have this discussion without looking at them as a set. And maybe – maybe you can.

Let's let the group decide.

Yes.

The adult one was at 54%, so 15 members.

So, as it relates to these for the immunizations, actionability, alignment, appropriateness for state-level reporting, feasibility, the reflection, Lindsay.

I think the biggest issue that I take is I don't think that the Core Set is the place to put brand new, untested measures. So, I feel kind of like a broken record, I say this every year, but I – I understand the desire to want attention and focus, but there's just been issues in the past when we move too fast on a measure without fully understanding it. Feasibility is one point, but also actionability and just understanding that you're actually measuring what you want to measure is just – have a completely untested, brand new measure at this level, I just really feel like that triage of it's got to be being used other places first before it makes it to this stage.

Perfect. Thank you for that perspective.

Agree

Yes. If you agree with that – yes, if you agree that that was sort of the main issue, you don't have to repeat it. I think the – the members on the federal liaison can – can understand that. Yes. Jill?

I had a lot of problem with alignment around all of these immunization measures because they're – for pregnant women, this is for people 11 to – or 18 to 64. This is for people 65 and above. And these are all sort of really somewhat artificial boundaries. But we never get the whole picture. And I understand that we shouldn't be – we probably shouldn't be using measures that are just new because we don't know how they're going to perform. But I do think as we think about this, is it useful to be looking at just a really narrow piece of the population, or does it make sense to look in a more global manner. I mean, you could be 60 and be a dual, right? You have a disability, you could be 60 and be a dual. You get measured in the 18-to-64 flu, but you're a dual. So that was part of my issue with kind of knowing what to do with any of the immunization ones.

Okay. So we've heard the concern about implementation, that it hasn't been tested in – in spaces, and then alignment and feasibility and actionability.

Linette.

And this along the lines of the – the feasibility piece. One of the challenges with immunization set, and Jill talked about that very well, is that I think the future is using our immunization registries, but I don't know that across the country we're ready to do so. And so – and also, just in terms of the adult versus the immunizations that were proposed, I think I might have put both forward, and the idea was the immunization would replace the CAHPS, but it's part of the adult, so if we did the adult, we wouldn't need the immunizations. But, you know, so it – it's one of those, again, to the extent that there's multiples, how do you pick which one?

But what I would hope is that part of what comes out of the conversation for CMS to think about, and they've done this in other areas, is maybe this is an area for an affinity group, for a grant opportunity, for something that helps drive the coordination in a way, and if there's some money behind it, it always gets more attention, that drives the coordination between Medicaid and the public health and registries so that in the future we're able to say yes.

And – and, sorry, the one other things in terms of, again, the feasibility piece, we did move two other measures into the long-term care, the other two that are close here, so those are two different sets of surveys. So from a feasibility perspective, introducing two different sets of surveys which may both be new to some states would not be very feasible.

Sally, did you have a comment?

It's along the lines of feasibility. I am kind of struggling through when something it seems like a really a high priority for the population and feasibility challenges especially with a measure that has some experience but not sufficient, and mainly around those that were coming through the NCQA pipeline. And I supported the measures that I felt met that, like prenatal immunization. My hope and my charge being that CMS would work closely with the states to figure it out. And this will relate to the gap discussion later in – in how to communicate that and make sure that the developers and the community at large, as well as the states, understand that there are feasibility challenges but likely coming soon and – and to help spark the resources and funding to help prepare the states.

So, it's similar, but my vote, then, was to put it on CMS to work to get that done.

Terrific. Thanks.

Beyond the immunization conversation, you know, I think some of the themes we've heard, similarly when the, you know, the postpartum depression screening and follow up, I think everyone acknowledged critical opportunity, the vote reflected the importance of that issue. But perhaps in the same area, it is an electronic clinical data system. That one felt a little different to me just because the – the current measure is bad. We don't have the right documentation in the right chart for the right person. And, you know, there was maybe hope that pushing this one onto the Core Set would help that. But it may need a year or two, tested, and incubated, and decide – and hopefully move along to the ability for electronic clinical data system to be fully operable. So, I think that some of the things we've talked about also relate to that measure in my mind. Critically important, but yet the sort of fundamental structure of the measure may not have been ready for – NR – NPRTF – whatever. Not ready for prime time. NRPT. Thank you.

So a follow-up comment, again, on feasibility, and I think a lot of the electronic measures, we've invested a lot of money – state programs invested a lot of money. I think California, a billion dollars. We're, I think, at $375 million that we've pushed out to provide eligible providers a hospital health system. That's a lot of money. And I'm still not getting – I don't think I'm getting the value from my providers, or from my hospitals, so how do we – how do we really push the envelope in the future and make true quality measurement work electronic and make it easy? I know it's not easy for the providers. But I think that's really our big challenge. And, perhaps, you know, our federal colleagues at various agencies, if you're going to focus funding, maybe this is the area to really focus on so that we can actually get true meaningful use so that we can collect immunization information in the EHR, goes into a health information exchange, goes from there into the state registry, and at various points it can be extracted. Same thing with the postpartum measure. Whether it's a pediatrician doing the postpartum depression screening, or the obstetrician, we're able to actually capture that, and move it, and – and have – feeling good that we're getting accurate information, and it's not burdensome to the provider, and it's reliable.

So, I mean, that's really the challenge. Most of these measures that we didn't – we got really close but we weren't quite ready to make that leap, I think that's the biggest barrier. If we can really get our federal colleagues to work together from a – a funding standpoint, or just from a philosophy standpoint to really push this whole initiative. The fact that NCQA is pushing this, that is going to push not just Medicaid plans, but other commercial Medicare plans to start to do this. So I think the time is right, but it's not – not quite ready for prime time. But I think that's the big feasibility issue.

Yeah. Rick – or Lowell, go ahead.

Yeah, this is Lowell Arye. So I just did want to talk about the long-term services and supports two that got – that didn't quite make – get that final piece.

First of all, the consumer assessment of the CAHPS HCBS is used by a number of states, Pennsylvania, Florida, a number of other states, so – so it is actionable. There is some alignment in reporting, and it is actually feasible. So – so I wanted to mention that as one thing.

In addition, the other one, which is the comprehensive care plan and update, this is a best practice in MLTSS states. It's set to be that way by the Centers for Health Care Strategies in some of their best practices. This is include included in many quality assurance plans or MLTSS are – are – include this as one of the things. So, certainly I would certainly say that – that they both actually rise to the level. And, you know, I certainly understand the two-thirds high bar, but – but I think that the conversation that we're having (inaudible) is an important piece.

The last piece I wanted to say was if you remember, NASUAD Camille Dobson that was here yesterday, and although they are a steward of the NCI-AD, she specifically said on behalf of NASUAD, that they would like the states to have the option for a variety of different programs and surveys including the CAHPS HCBS. So I think that that should be also thought of when people are thinking about this.

And I would just add my perspective on those two, since that scenario that I had direct oversight over as well, is that the fact that the first one was just related to managed care gave me pause - we have a statutory prohibition in the state of Colorado put in by the nursing facilities a decade ago that we are never going to have MLTSS in Colorado, so I've had sort of the mind that David had around the HIVs that there's a lot for us to get through. And, for us, that – the way that care plan is structured is critically important to the advocates. We have had hundreds of hours of stakeholder feedback as to what that

assessment looks like, and so it gave me pause that there would be some nationally-structured. Although it may align with best practices, I get the difference.

So that – those were – that was sort of my reasoning of concern on that. And then I think the notion of the HCBS CAHPS, a little concerning when CMS said they were still building the database to receive data. That sort of went to Lindsay. I went to Lindsay, it was like, ooh, not – not – not – not ready for that, but really do – we use the NCID – NCI and NCI-AD so I had more comfort for those. But to me, those were the issues related to (inaudible) my (inaudible.)

Jill, did you have something?

I actually just wanted to sort of echo what you just said. I think we really need a comprehensive care plan measure. We need to have it in a way that – that is palatable to not just states and providers, but to advocates and to the people receiving services. And I think it – all of this stuff actually is – is – is what people are already doing. It just needs to be put into the language that they use, and it needs to be socialized, and that's a long process. So – so from the vantage point of is this ready now, I don't think this is ready now to really be usable.

My concern about the – the HCBS CAHPS is, again, sort of alignment. NCI has been around for a long time, but, you know, it – it's nice to have lots of variety. It's also nice to have let's look at these issues, and let's look at them in a – in a similar manner. So – so I'm a little torn between, you know, do you just pick one, or do you use multiples. And when you use multiples, is there a way to compare that data.

Thank you. Laura.

So a couple just general comments. So I would say that just one kind of procedural thing that I think might help in the future is I think when people put in their individual recommendations, they make certain parallels to measures that are on the existing Core Set or measures that they, themselves, are recommending to the existing Core Set. But then once you kind of put it all together, as we saw there are areas like immunization where I think more of a discussion is needed about how all the different things that were suggested fit together with the things that are already on the Core Set. And I think in some cases, between the measure stewards and this room, we kind of got there to connect the dots. But in other places it might have been helpful to have a chart that would show kind of overlaps, and numerators, and denominators between different measures, or, you know, where there maybe are two similar measures but the measure collection methodology is different, right. So just – so that people just have a better sense of kind of how to compare and contrast the different measures.

As I said, I think we did get there in some cases, but I think in other cases people still may have struggled to kind of connect their dots – the dots if they are in areas where the person doesn't have that like comfort of subject matter expertise.

And then, I guess just to weigh in one last time on the LTSS piece, I would say ditto to what Lowell has said. I think the three survey measures really not only are used in different states, but they're also more effective for different segments of the LTSS population. And so, I do actually think there is a really valid case to be made that states should really be able to choose among the three different tools because there isn't really a perfect tool that cuts across all segments of the LTSS program at this time. Obviously some are more kind of weathered and tested than others. But I do think that that's an area where kind of giving states a little bit of flexibility would be very wise to make sure that they are able to monitor it in some capacity (inaudible).

Thank you. Real quick, and then we'll (inaudible).

Yeah. I just – I just wanted to get to the point about – about the advocates and the consumers with regards to the – the comprehensive plan. I don't know – states that have done MLTSS well have had a very thorough, well-thought-out stakeholder review. In New Jersey it took us two years to go through the planning of it with the stakeholders. And this was one of the assessment piece and making sure were some of the things that they wanted to make sure was in the – in the quality plan. And I know I'm going to say this, that CMS is – I've said it before when I was a public official, we did not get the support and technical assistance we needed from CMS to actually create these things, and we had to look upon the stakeholders and say what is it you wanted. This was one of the ones they wanted.

So, to answer your question, they are the ones who told us they wanted to ensure that there was proper transition between – between moving from fee-for-service to MLTSS. One of their – one of their criteria was specifically the comprehensive plan updates and the like. So – so – it – it – that's why – why states who have done this right feel this is a best practice.

Thank you. Rich, and then Carolyn, and then Sally, and, again, Carolyn's request I think it's still good to capture to the extent actionability, alignment, etc., just to give measure stewards and others a sense of our decision making.

Thank you. So, in the context of talking about these close measures, I'd like to maybe encourage us to take a step back and think strategically. What I've really enjoyed about the last three days is the evolution of a process that – that's got some structure and accountability, both internally and with external stakeholders. But what I'm wondering is, is it reasonable for this group, if not in this moment then between the meetings, to come up with a set of criteria by which measures would come to this group for consideration for the Core Set. Some of the measures that we saw are ready for prime time. Others are incredibly important but are in no – nowhere close to prime time. And others like, where did that measure come from? And I don't want to be specific. But, you know, so – so to the degree that CMS wants to do the spaghetti against the wall, I'm volunteering my time because you give – you play the tune and I'll dance to it. But I'd love to have some criteria, because, you know, to be honest with you, the criteria on the wall behind you guys are okay, but there's so much flexibility there. And, again, I can't remember in my whole life where I've ever disagreed with Lindsay. I'd like to be able to send a clear message about can we please have some experience in the field and not just an N of one or two. That will allow us to honor measures for ongoing testing, come back next year, here's what we're looking for. I think that will move us into a much more efficient process of pruning instead of macheting our way through this jungle.

Perfect. Thank you. Carolyn.

Thank you. So I want to follow up on a comment that David Kelley made, but it really touches on – and I won't repeat what Rich just said because I agree in terms of issues around feasibility. You know, the one thing I will add is – and maybe this is an appeal to our federal partners as David was doing earlier – but I – I totally agree with Jill and Lowell that we need something like a shared care plan. The challenge is that whether you're talking about EMR systems, or care management platforms, and many community-based organizations also have their own database, it's very challenging to operationalize these in the systems as they exist today. They are not built in. Oftentimes you – you have to pay extra money to customize these systems, or to buy an add-on module. And then even when you do have these functionalities, then they're – oftentimes they are no – not reportable fields. And so maybe that's just a plug to our federal partners to work with the vendors to ensure that in order for these measures to become more feasible,

these are functionalities that are routinely built in to the off-the-shelf products, not things that have to be customized.

Sally, and then Elliott, and then Tricia.

This really is along the lines of the criteria in which – and – and information that we have when we're reviewing measures.

First, I know how much work it is for staff to get ready for a meeting like this. It – it's mammoth. But one of the things that was often missing, not completely, was performance information about the measures themselves. And that would include emerging measures as well. And it left us either having to have too much faith in an NQF endorsement rationale, which are not always consistent across committees. Some committees set higher bars than – than others. Or – or the fact that it wasn't endorsed because we were relying on that somewhat. Not to rehash statistical validity, etc., but a little bit more information about the measure. I had to do a little bit of Googling on my own, but certainly couldn't do it for all the measures at all.

The other thing is, I agree with what Rich said about, you know, setting up some criteria about which measures make it to the review. I do want to add, though, I don't want to block those measures from emerging into a discussion, and maybe this is related to how do we treat gaps. So, if – and – and – that some measures that don't have experience actually have a heck of a lot more experience than others, and it would be really difficult, I think, as a committee for us to navigate through that without more information about them. But a way to allow the committee to know that there is a measure coming but perhaps not suitable for vote today because that signal that comes out of this committee and what is said I think is pretty important, and it – and it tells folks a lot of information where to start focusing resources.

So, I just want to add that it's not that they disappear because then by the time they get here, maybe they aren't what we – aren't what is needed and they had been given signals that maybe they were. So I just want to put that on the table.

Okay. We are going to move toward wrapping up this conversation, but Tricia Elliott, Tricia Brooks, and then Diana.

This is Tricia Elliott. I just wanted to offer this perspective in terms of going through the process the past few days. (Inaudible – audio breaks)

So I appreciate what Rich had to say about (inaudible) kind of a process to make sure that measures that are coming forward are ready for prime time. But then I think we need more time to talk about gaps because the way to get the conversation on the table is to recommend something that may not be ready for prime time but allows the conversation (inaudible). And probably being the least technically-oriented person at the table, you know, I really represent the child health community who wants to advocate for better and more measures that generally look at how do we change the trajectory of children's health and not just focus on where the high costs are. So, I would just say that if we're going to change the process and only consider those measures that are absolutely ready for prime time, there has to be more (inaudible).

That's a very important point of the conversation, and for those on the phone, there's a lot of nodding around the room to Tricia Brooks' comment.

And I'm going to give you the last word in this sort of – oh, yes, Kim. Thank you. Right in front of me, I missed you. Kim and then Diana.

Yeah, I think my tent must be hidden or something.

Sorry. I apologize.

I just wanted to say that I think that it's really important to really think about the value, and I think that's been discussed by David a little bit. But for Medicaid it's maternal health, it's children, that's the traditional population. Now we have a big population of men with the expansion of Medicaid. And we really need to focus on where we can bring value and where we're really going to make a difference in improving the health and outcomes. So a real focus on outcomes for those populations. So when we talk about like the prenatal immunizations, and that affects not only the moms, but it also impacts the children, it's a really big bang for the buck. So I like us focusing on things like that because we have such a limited real estate on the Core Measure sets.

That point may be a little point in which in the conversation where we just simply (inaudible) level-set the current Medicaid enrollment population and – and what we know about their lived experiences. Have that data. But that may have helped us stay focused on that population (inaudible).

I just wanted to make a comment about our close vote on the maternal and perinatal health postpartum depression screening follow-up measure. And I just want to say a few things.

This is a highly clinically-relevant measure. We have the worst maternal health outcomes in all developed nations. We have rising maternal mortality and a persistent and widening racial disparity gap. Sixty percent of maternal mortality is preventable. According to a comparison of the Bureau of Labor Statistics, with our morality rates, being an African-American childbearing woman is the fifth most deadliest job in the United States today.

If you extend the postpartum period to the first year of life, suicide is the number one cause of maternal mortality in the United States. So this is highly clinically relevant. It's actionable. As David said, while screening rates can, right, go high when you look at claims data on follow up of depressed people, it's abysmal. So it's important to have a measure where we're screening and accounting for follow up.

It's aligned. It's appropriate for state-level action. As to whether it's feasible to measure, that's the challenge, but it is actionable.

And that's my comment.

Thank you very much.

Follow up on that.

Yes.

Again, I presented data. We, in Pennsylvania, have actually been doing this via chart review. It is actionable. And we've seen a considerable amount of improvement. And I'm going to say that those that actually get into treatment, either by pharm – you know, pharmacy claims, behavioral health claims, it is like 70%-plus. And it took a long time to get there. So this is actionable. It is doable. The measure that we

were looking at (inaudible) electronic measure (inaudible). So, it is doable. It's actionable. It is feasible. But the electronic part makes it (inaudible).

So is it appropriate to call for a re-vote?

I don't think so.

Okay.

Thanks for asking.

I – I don't think we want to go there, but I think, again, to the point that I think Marissa reminded us, this is a set of recommendations to our federal partners. They will have other criteria. Their relationship with other members of the – other components of the federal government, our conversation and dialogue, and then there are a number of CMMI-related priorities, the moms and the (inaudible), that relate to maternal and child health, so a growing area of focus from the Innovation Center as well. So, with that I think there may be other opportunities and we're just simply recommending.

So, Alice, did you have something to say?

Yeah, really quickly, three points. One to address Jill's– to provide clarification comments. Thank you, Jill. So the – all the adults and prenatal immunization status measures are ACIP recommendations, so essentially there's no age band for adults 19 and up. And for prenatal is specific for flu and Tdap.

And then for Jeff, we'd love to seek your thoughts about what constituted that measure because I think the flu based on the CAHPS measure has been performing consistently at 39% of the state average for the four years. How does that measure drive performance, that's something I would love to seek your insight on.

And then in regarding to ECDS, it does include IIS immunization registry, and in every state there is – there is an IIS immunization registry. I understand data availability and quality may be an issue, and that's where we can work with our federal partners promoting the interoperability initiative led by CMS.

Thank you.

So I think Linette mentioned the goal would be the immunization registry, and so I think that, to me, the conversation here was that we're just not there yet. It's just not – we're not there, and technical assistance (inaudible) greatly appreciated to help make that immunization. If I recall the conversation directly as well, that there is a difference between childhood immunization and adult immunization participation in that registry.

Yeah.

So, I think that that is in part your answer to that question.

Yeah. I think if you've seen one state immunization registry, you've seen one. There's a lot of variation. Some are extremely robust. Others still need a lot of work. And we would look to our federal partners to help those states really, you know, develop a better immunization registry. We were at a meeting last week with our medical directors, and there were quite a few in the room that were really saying that it's a huge challenge. I mean, immunization registries, many states are really not operating the way they really

should be. It's a challenge, but it's a great opportunity. I really see driving both the immunization registry and health information exchange. We should be able to capture the information efficiently without having to do chart review and without having to (inaudible).

Okay. So with that, I'm going to ask that we take our break from 10:15 to 10:30. We'll come back at 10:30 and make that transition that we've been so interested in to talk about gaps.

[chime]

[crowd chatter]

[music – with audio breaks]

Okay. I'm going to suggest we get started.

Okay. A number of people came up to me at the break and have some pretty tight timelines to get out, so we may bump up our goal of an 11:30 conclusion time just to give people the breadth of time they need to make those flights home. We've been here, some of us, since Monday given the travel time, so I know that's of importance to get back to families and to work.

We have started this gap conversation sort of throughout the – the time, and I think people are very excited about this, so I don't also want to feel like we're going to give the conversation short shrift. But there have been points in time where the Mathematica staff has gathered or noted the places where we've said that there are gaps.

So, I do want to move us into the – the gap areas and areas for measure development. And just – there is a slide that really walks us through the framework for long-term planning on the Child and Adult Core Sets. And so – oh, good, the Venn diagram is behind me. So, you know, we have used a set of criteria today around alignment, and actionability, and strategic priorities, but there is also this sort of similar but slightly different frame as it relates to long-term planning. So not – you know, we've been eyes down. Now we're going to lift eyes up and look across to the horizon. And as we do, the sort of guideposts that we're using in this conversation remain around feasibility. I think that that has been something that, really, Tricia, I appreciated you saying that the realities of what this looks like not on paper. I mean, our providers do that and put stuff in contracts all the time, and they come back to us and they're like, have you ever been in a clinic? And sometimes the answer is no, which is why we didn't get it right.

So, I think this notion of feasibility from a state Medicaid perspective and CHIPS administration perspective is critical. And I think, as Jeff mentioned at the break, there has been some interesting conversation about what's the difference between sort of public health surveillance, managed care, quality assurance activities, and contract requirement value-based purchasing, etc., and then the Core Set. And the desire to have a federally-comparable perspective on performance of a critical program like Medicaid and CHIP.

So, feasibility has not only that technological component, but also is it feasible for the specific task of the Core Sets and the measures.

That also, I think, gets us to the issue of desirability, and then long-term viability.

So, there's a couple of ways I could imagine we could start this conversation about gaps. We could do it from a life stage perspective. Small people and pregnant women. Middle-aged children, you now, child and adolescents. Young adulthood. You know, we could do it from a life stage perspective. That's one framework.

We could do it from an area of – not domain because we've already had some conversations that maybe the current context of the domains is a little off. But we could do it from a, you know, prevention, primary care intervention, long-term services and supports. We've not talked about end-of-life care which is critically important for the Medicaid program as well.

So, is there a group perspective of how the best way to get into the gaps conversation? Diana?

I think of cross-cutting issues and concepts of over use, under use, misuse. Which every time we put in the baskets like you're describing, it doesn't hit on that.

Okay.

I don't have a proposal. I don't think that's a proper structure, over use, under use, misuse, but overutilization in Medicaid is such a driver of poor quality and high cost and poor patient experience. So, somehow we're not hitting it in this context and structure.

Okay. And – and by overutilization, you mean overutilization of services, or what – what do you mean by that conceptually?

Services, medicines, high use of technology, under use of social support services, interprofessional teams. Maybe I just jumped into a gap. I don't know.

Yeah, that's where I went.

Prior to agreeing – okay.

Yeah. So there – there may be a gap of mechanism for us to understand the appropriateness of care, in some ways. And that overutilization and underutilization, perhaps that's an area.

Jeff?

I'm thinking of this from the population health point of view, and gaps in things like – things that are – are injuring or killing folks, so mental health, chemical dependency, immunizations, infectious diseases (inaudible) that those are a little agnostic (inaudible).

Others? Yeah, Kim.

I think about it, also from the vulnerable populations, and that would be our aging, our elderly, our disabled, and the small children. The most vulnerable in our population to make sure we have measures that really fill those gaps.

Tricia?

So, I mean I really think focusing on how do we stop filing up the pipeline with adults who have multiple chronic conditions that we end up cycling through all these other things that we do to reduce costs for them. And we have got to start with early childhood.

So, maybe what we could do, I'm not sure the framework is emerging, but we're – we're going to muddle through. But maybe – maybe we take Jeff's perspective a little, and maybe each of us, to the extent that you have something to contribute to this conversation, could reflect on the – on the Core Set and/or Medicaid measurement at large. Because this is a gap in aspirations so we can untether ourselves a bit from the actual Core Set in some ways, but that's our anchor. And think about where are there areas that you have the greatest concern about either quality of care or missing the appropriate focus in the Medicaid program given the needs of the population. So where is it that, you know, Tricia, I think you just – I'll start with you because you and I talked about it on our way over here, so I happened to know you were going to say that. So, but, this notion of a gap by perceived (inaudible) you articulated we're not focused enough on the opportunities that Medicaid presents to help known vulnerable children start off on the right trajectory and become maximized – maximize their health as young people and adults. So, that – there's a gap there of the areas of focus of the Medicaid program, and that's reflected in the Core Set. Is that accurate?

Um, yes. I mean, I think that covers developmental screening, and follow up, and referrals, and social determinants and ACES and all of those buckets that will affect children's coverage. While I have the mic, I just have to say that I disagree with the concept that continuity of coverage is not a quality measure, because if we're not keeping these kids continuously enrolled, there are delays in care, there's a lack of preventive care. We have got to start looking if there are other ways that we can get at the data, but we have performance measures that CMS put out in 2013 that they aren't fully reporting on including the reasons that kids lose coverage. We're down 920,000 kids in 39 states this year, and there is no evidence these kids are (inaudible) PSI or private insurance in any way. This is – this is a problem. And you're just – you're going to be dealing in the healthcare system with these kids' mental health issues in adolescence. Their multiple chronic conditions in (inaudible.)

Perfect. Thank you. How about others in that frame of an area of vulnerability or concern that Medicaid maybe doesn't have enough focus or energy on that. Lowell.

So I do want to talk about people with disabilities in general, not just specifically long-term services and supports, both individuals at all stages of life, from early childhood literally through – through adulthood and – and -and aging of people with disabilities. This is actually the first age cohort of people with developmental disabilities who are aging at – at the same rate as the so-called general population. And the impact that we have on that.

There's nothing in the Core Sets that I've seen, and tell me if I'm wrong, that actually looks at some of these issues of access to services and – and – and needs for these individuals. And – and kind of how Medicaid actually provides those kinds of supports. Not just long – and I'm not talking about long-term services and supports. I'm talking about actual health care. Physical therapies and the like that actually assists them over the long term to maintain their – their ability to actually live and participate within the community. And these are not just long term services and supports. So there's those aspects of it as well. And this is also, as I said, for children, both very young, from birth to the young age of three and four, and then childhood adolescents.

So if I could just pile onto that, again, I think it is vitally important. Shifting over to dental, one of the things that may need to be looked at is access to dental care for those individuals with special needs.

And then piling on to Tricia's comment, I think really a vital area is really looking at adverse childhood events. Looking at this growing body of literature, that assessing that early on really gives us an idea of what's going to happen to that child and are there things that we can actually do to intervene to – to change that trajectory.

(Inaudible)

Um, yes, Lisa Patton. I just wanted to mention the importance of workforce, and, you know, sort of the cross-cutting issue, and this gets back to Diana's point, sort of how do we extend care, how do we make care more accessible, and really equip other staff and other health workers, other peers and so forth, with the necessary tools to be able to address a lot of health issues. And that also ties into social determinants of health and who provides that, who assesses for it. Some of the conversations we've been having in our SDOH data integration group is around the burden on the providers of where do these assessments occur, how do the screenings happen, and also so that they're not overly burdensome to consumers. With changing social determinants of health needs, that can heavily influence health outcomes.

That's – that's very important, the workforce issues. Complex. Is it to some extent – I'm just trying to make the connection to the federal Medicaid program – is it down – are you suggesting down to the level of we'd be able to inform federal Medicaid structural policy that doesn't prohibit the right workforce from participating, or where – where does your head go with that?

Well, we've talked about it a lot in terms of care coordination, care integration, who are the right – what's the right multidisciplinaries to have at the table. You know, we hear a lot from primary care docs and other medical professionals that they're, you know, feeling quite overwhelmed with the demands of screening and referral and having the right networks in place. And so I think, you know, perhaps the AHC model is going to offer some lessons around the expansion of that. You know, there are other models in place that are – that are addressing that. You know, we also talk about it in the context of parity, of parity implementation, and one of the tremendous barriers to the real implementation of parity is the available workforce. So, you know, I think there are a lot of different levers that we have on the large scale.

Okay. I'm going to shift to the left side of the table. Bonnie, and then go down the line.

So, I think one gap that I think is pretty apparent is there's not anything related to suicide. And – and I understand that there's a lot of challenges in measuring that, but – so I'm just going to leave it sort of a broad domain, so suicide. You know, but – but let's think about it. So, is it early detection, screening? Is it a quality measure about suicide prevention? Right. Because that cuts across age, gender, or postpartum, or SUD.

Yeah, I think Dr. Seeff had an addition to that.

So this, I'm just, again, channeling broad CDC, but we have very robust discussion on ACES measure and suicide prevention, and there is a measure around adult suicide prevention. It doesn't have USPSTF recommendation because of any issue many of you raised that there's concern about you screen and then providers don't know what to do. But enormously important and prevalence going up at all ages. So, a way to, you know, hurry up and get to something that could be used would be great. But it's a major gap that we'd identified, too.

I'm reminded that there was an e-measure for suicide risk assessment in the pediatric population that actually was removed from the Core Set, so, again, it goes back to….I will tell you that, yes, there's feasibility issues, but at Children's Hospital in Philadelphia we actually did re-operationalize this and that yeah, there was this concern, yes, they're in an academic health center. Once you train, and you educate, and you give those PCPs and their support staff the right resources, you know, in a court – I've always said, in a court of law, how could you stand up and defend that you didn't know what to do? You're a healthcare professional. You need to figure that out.

And actually, once that – once they felt comfortable that they could do this, the barriers went down and the uptake went up. So, point well taken. So noted that it was on the Core – Pediatric Core Set and it was removed.

Terrific, David.

First, thank you, Bonnie. I think what I would say actually expands upon that a bit in the same theme. I'm heartened that there's a lot of attention to behavioral health needs in this population. One of the areas where really quality measures don't exist yet is around the management of behavioral health condition problems in youth medical settings. And the reason is that the evidence around is fairly new relative to some of the areas. But, there is mounting robust evidence that attention to behavioral health problems in institutions, in medical settings primarily, at least among adults, is associated with better health outcomes, lower costs, often lowers the length of stay.

Some of the target conditions around this where the most common studies might be less applicable to the Medicaid population, that being delirium, which is probably more relevant to the Medicare population. But some of the other target conditions are relevant to the Medicaid population including depression, substance use disorder, endocarditis is a big one and one where comprehensive addiction care has been shown (inaudible) AMA discharges and improve completion of antibiotics treatment.

So I bring this up here not because I expect there to be measures for this group to be voting on anytime in the next one to two years, but I'm hoping that the people in this room who are responsible for developing and testing measures hear this and recognize this as an important (inaudible).

Diana, is yours up from earlier? Okay. Jeff.

So, I – I have to say that I think we still have a lot more work to do in the issues around child health, and I've been starting to keep track of how many people are saying social determinants of health because (inaudible) down the line (inaudible) frequent. But I want to focus just for a minute on something else, and that's that we don't spend – and it came up earlier just for a minute – but we don't spend very much time talking about men's health. And I think we do our communities a disservice by focusing just on maternal/child health. I at one time suggested to Michael (inaudible) that we name parental/child health. Because I think that we know, you know, functional families have, well, I want to be (inaudible) LGBT folks, too, but functional families always have two (inaudible). And so I feel like – so I feel like that's a really important thing that we need to get at because when we talk about social determinants and those things, we miss that.

The other thing I want to say, which may be a little more technical, is I think because of some regulations around minimal necessary data for enrollment, we don't get race, ethnicity, and culture any more. And that's a huge deal because it's sort of like running our programs with blinders on. So I think that addressing where the disparities are, where there have been long histories of institutional racism and

inequity, we need to make sure that we don't create a measurement system that perpetuates that because we failed to look. And (inaudible).

OK. Jennifer.

Hi. Jennifer Tracey. So, a little bit more building on what Tricia said. I feel like, you know, there's just an absence in general of birth-to-five measures that really capture the importance of infant and early childhood mental health for infants and toddlers. And even up through age five. And so I was struck by even when I was trying to find measures that I could suggest for this effort, even something as simple as social/emotional screening that's been endorsed and put out there, the AAP is still sort of pulling together it's formal statement on, you know, social/emotional screening and it's coming. But it just struck me as very odd that we have developmental screening, but social/emotional screening has been seen to be such a key predictor in kindergarten readiness, success in later life, and we also know that it's most important in birth-to-three. So that seemed like a huge opportunity area.

And I'm struck with this feasibility versus how do we help spur measures to be developed. And so I'm glad we're talking about the gaps. Because we talk about ACES, and we talk about SDOH, I do think trauma-informed care is a huge piece of this, and it goes to the workforce development piece Lisa, that you mentioned. Because, you know, we're going to expect our primary care physicians and others to sort of open up that Pandora box. It's – even just talking about that, actually families have reported it – it helps. Even if you don't know where to refer them or know what to do, just having acknowledgment that, wow, that was really difficult what you went through. That helps families. But giving physicians more resources around what to do around trauma-informed care would be huge.

And then I'll just finally mention, too, I think a greater focus on dyadic services and really the family dyad because we can't separate the child from the parent. And, of course, since we know Medicaid is responsible for so many births, and of course in certain states that's close to 70% of coverage for births, what happens on the parent side is so critical and what happens to the child in the early years and the future on further on into life. And, of course, a lot of those children may be on Medicaid long term. So it really is imperative, I think, that we focus (inaudible).

And the last little piece, foster care. That seems like one area that we could focus on in the future. And, of course, for infants and toddlers, they are the largest proportion of children in foster care in this country, infants especially. So I just wanted to put a plug in for that.

I'll just jump in very quickly on that. I really appreciate, Jeff, your referencing the racial and ethnic data. When I administered the program in Colorado, I did feel like I was driving with blinders on as it related to understanding the experiences of different racial and ethnic groups within the population. Similarly, we can't pair moms and babies in the Colorado Medicaid program. And when I talk to most of my Medicaid friends, they can't either. I don't understand how we comprehensively move a – a dyadic frame or the family frame forward without the ability to see them in a constellation of a family within our claims data and other things. So, if there are technical assistance opportunities to help states get the systems so we can see families and we can understand with confidence the racial and ethnic makeup of our programs, that would be a super important thing.

And, again, I'll pile onto that comment. Again, there are states – we're fairly confident in our information. It's not perfect, but we actually use that to really drive a lot of quality improvement. Make all of our plans over sample. I think it's up to 20 measures. And we look at that, and we have them look at it, and we

really – wherever there are defined disparities, that's really the opportunity for plans to really make an impact. So, it is vitally important in terms of in the future to really – in terms of not just doing these measures, but stratifying them by race and ethnicity. And, again, hopefully, do that through electronic means. This was supposed to get fixed with Meaningful Use that at the provider level there were ways of better identifying race and ethnicity. So I think there – there's a great opportunity here to make the data even better, but even though it's not perfect, still look at it and think in terms of quality improvement that's focused on those issues.

Jill. So, both you and Jennifer - Jill Arnold. Both you and Jennifer talk about the dyad and the challenges around the dyad especially in the perinatal period. I mean, they're obviously connected while pregnant, you know, pregnant, but then it separates. And so keeping, you know, being able to look at that through at least a year – postpartum is so important. And a lot of the other points (inaudible) have been brought up. But one of the things I want to point out, too, is, see I would say that the perinatal period is actually underrepresented here. I don't think it's robust enough. But I – I'm very biased in this, of course. And looking at pregnant women and adding it to the list of vulnerable populations, when I didn't hear it listed, like people were listing them, and I'm like, and, you know, and pregnant people.

And the other thing, too, I want to point out is if you need more – I mean, there are ample subject matter experts in this area that can come because I noticed that the only topic of conversation yesterday where people were bringing up their own personal experiences, they're not necessarily reflective of the population that we're dealing with. I don't want to be presumptuous about, you know, everyone's insurance status in the room, but like I just question the appropriateness of making decisions based on personal experiences and not really looking at the data and maybe bringing in some other lived experiences, and so subject matter experts and some actual, you know, patient experience in that. So, yeah.

Thank you, Jill.

Jill.

So as a pediatrician I'm not going to talk about kids, but I ditto everything that everybody said. I think that we have a population of people who have multiple disease conditions, multiple comorbidities. We measure single – the common single ones. What we don't look at is how well things are put together for those individuals that have multiple chronic conditions. I'm not going to say care coordination because I think care coordination gets – gets touted and talked about, but I just don't – I'll be honest. I've read about it. I'm not sure what it is. I'm not sure people know how to do it. I think the people that are intuitive with it do it and everybody else sort of – it – it's not clear to me that that's the answer. And I don't know what the answer is in terms of how to measure that. But it seems like we should have some way to measure sort of people having multiple conditions, and are they accessing care, and are they getting the care that they need around those multiple conditions, and not just the sort of – not just the chronic common ones. But is there a way to measure it that's kind of disease condition agnostic so that you could measure that you're getting care, that it's coordinated, and not necessarily, you know, that you had a hemoglobin A1c or an eye exam or whatever.

Okay. Thank you. Laura?

So I'll say ditto to what was said before around the population of people who are aging and people of all ages with disabilities. One sort of twist on that that I'd like to put on the table is really thinking about

Medicaid's role in improving outcomes for people who are dually eligible. And I think, you know, that's a big topic. It may feel like an overwhelming scope for the Medicaid program to kind of weigh in on that, however, there are a lot of levers that states can pull to try to incentivize kind of coordinated care across both Medicaid and Medicare. And we've alluded to, I think, a couple of those in the discussions we've had over the last couple of days. There's also, obviously, a massive investment happening on the Medicaid side in terms of care management programs and LTSS services and other benefits for people who are in that population. So I would just say, you know, I think there's something to be said. I don't know if it – how it gets framed on the Core Set, but around sort of those integrated and aligned programs.

Perfect. David has a comment and then (inaudible).

To pile onto that again, I think that our federal partners have done a great job recently in really pushing the Medicare data to – to the states including Part D. We're still left in that Medicare Advantage gap. We have the fee-for-service. There's some Medicare Advantage claims. But I think that's really helpful for state programs to really start to develop quality metrics that go across those programs. And I know that there are challenges sometimes with the NCQA accreditation process where you're trying to go across these various programs or various MCOs.

So, while we're talking about LTSS again, I think rebalancing. We did have one measure that was not – was voted down. But I think rebalancing is a key issue. It needs to be handled judiciously with a focus that when folks move out of a nursing facility back into the community, they do so safely and they have all of the appropriate wraparound services. I think that is an area that should be a focus, not just from an economic standpoint, but for what the consumer really wants – where they want to be and why they want to be there.

Lindsay.

As I look at the Core Set, and I think I mentioned earlier, it's very medical heavy. So, we just can't continue to push everything down to a PCP. It's not realistic. And so to the degree that we can look at more of these cross sectors, opportunities, or ways to infuse cross-sector measurement. I mean, some of it is in here. I would say the developmental screen is probably the closest, right? That's definitely one that we're – we're – and it's going to be a hurdle to figure out how to bring the sectors together. But as a Medicaid program where we offer so many wraparound services and do so much more than just medical, that it feels like we're kind of – we're kind of disregarding that.

And then, you know, I agree with the child care dyad is struggle, but also what is a huge struggle for many Medicaid programs is identifying when women are pregnant. So we're often operating with blinders on, and so the opportunity to intervene early is very difficult. And so often we're working retrospectively. There was a live birth. It happened. Okay. Well, it would have been good to intervene much, much earlier. So I think any – any opportunity or effort to help improve early identification of pregnancy, even in – even in, you know, the earliest stages would be incredibly important to think about.

And then and feasibility. So I was talking to someone about this in the – in the break, and I'm going to say it here so it will be written down for you. But, in the feasibility realm, I'd encourage our federal partners and as people walk away from here, not thinking about feasibility on a measure-by-measure basis. But instead think about feasibility as the core data elements, or core data flows, that need to happen, and that could span across multiple measures. So, as a state, New York, we focused first on something like vital signs, right? Our next – our next phase is screening. Did a screen happen? What was it for? And was

there follow up? And, you know, if you figure that out at a feasibility side, that opens the door for screening for depression, suicide, prenatal, postpartum. You name it, right? So, when you think about feasibility, don't limit yourself to just one measure. Take a step back and say, if I can fix this problem, look at how many areas would be open to us to be able to explore. So I think that's (inaudible).

Yeah, I appreciated Jill's reflection on that on the high intensity substitutes for treatment and the follow up for seven to 30 days. A sort of reminder that we do a lot of things at seven and 30 days, this would just be another measure to add to that framework, so I – I think you're saying the same thing, let's think about the frameworks of the way we want to capture information, and then we can look at that feasibility and have a cascade of things that move more quickly if we work on the fundamental structure of the collection. Thank you.

Rich.

I think an example of that, really, would be to take the developmental screening, and then couple that with both the childhood and early intervention (inaudible) follow-up treatment. Perfect example, and, you know, as an agency we have claims for both so we kind of do that, but, again, it's a feasibility issue, but it's not just about screening. What happens to those kids that screen positive that may need additional services. And they to early intervention. And you can test (inaudible) apply that to a whole host of screening measures. Screening is great, but what happens then.

Thank you. Rich.

Yeah. So now I have the wonderful challenge within two minutes of trying not to repeat anything, but I'm going to make a series of points and I'll try to punctuate each one.

So first of all, I want to make sure that my suggestion of having some structure to the way measures get considered here. I completely endorse what Tricia said. What we're doing right now is a robust conversation about gaps. This is in some sense even more important than the voting on the measures, and I sort of think of this group and the SIM – its analog over at the NQF – this is like the fed's open-market committee. It sends a signal to stakeholders, it sends a signal to measure developers, it sends a signal to Medicaid programs, and this, for me, is the meat of the meeting.

Second, Lindsay, I would add that in addition to the developmental measure, the behavioral health measures give us the opportunity to explicitly measure integration across settings, sectors, disciplines, etc. And that brings up my – my next issue. So there are different kinds of gaps. One is a conceptual gap. We need to measure something, okay, we need to measure for that. But then the other is the implementation gap. I think many really good measure concepts that we heard in the last couple of days are great, but where the gap is, how do we get the data flows, and do we need a piece of technology, etc., etc. There's no question that – that bringing in the social determinants screen, measuring the fact that the referral was made and the services were received. There's an awful lot of implementation gap that has to be filled in. And I would argue we need to be parsimonious about what those measures are so that when states have to, or CMS has to, invest probably literally tens, if not hundreds, of millions of dollars, you're doing the right thing directionally.

The voice of the beneficiaries. I think – I'll just take a guess – one of the Jills in that corner – that increases the chances that I just got that right – I couldn't agree more. I was on a panel with the other dinosaur last year at Academy Health. And we were asked to do a panel on ACES. And I thought I knew all of this great information. And then somebody from Family Voices came in and said we're really

disturbed about having ACES be about us. Tell me more about that. Said, we already are going in, you know, we're housing insecure, we may not have a stable relationship, but then I get a clinician telling me, okay, your kid now has five ACES. And I just want to call that out. And it totally reframed how I think about ACES from a screening perspective. I would argue, and we have the data to support this, but ACES, yes, they can be done at the level of an individual encounter, but they're probably more reflective of the zip code and /or the census track, and you can even stratify that on the basis of socioeconomic and racial and cultural strata as well.

So, I'm calling that out not because we should take our foot off the gas about ACES. There's no question about that. But I'd love to make sure that these meetings are sufficiently infused with more than anecdotes and with actually data that represents the voice of the beneficiaries.

And then finally I want to talk about transition. So for those of you around the table that aren't pediatricians and/or family medicine, I don't want you to answer this. But if I say, what's a transition, you think about acute care facility to a SNF, don't you? Or a cardiac ICU unit to the regular floor, etc. But for those of us in the maternal and child health work, transition is somehow getting from the pediatric side to the adult side. Every time I see a measure that is based on chronological age, 18 plus, they often are designed around the age of majority, and that's fine. But for those of us that actually take care of – of youth and young adults with complex needs. If I've got a 22-year-old patient who has hypertension at Boston Children's Hospital, chances are really good they're a frequent flyer in our congenital cardiac program.

So I just want to call this notion out, recognizing that most of the – most of the discussion in Washington is on the adult side. But a lot of these measures that simply start at the age of majority are actually discriminating against youth and young adults with special health care needs.

And a quality measure for that. Much – many of the quality measures that exist for transitioning pediatric to youth are basically, is the youth ready? Has the family been prepared? And that somehow if I spent – and the policy statement says I start at the thirteenth birthday – that if I work with that – that -that patient and their family, after eight years, they're going to be able to just walk into any internal medicine practice, and that 24-year-old with autism, a G tube, and epilepsy, that internist is going to say, welcome. It ain't happening. And so I want to let you folks know that this is another opportunity for integration.

Lowell, your point about the number of people with developmental disabilities increasing is significant. I can tell you, we have a tsunami of young adults, and adults, with autism. And I can't even figure out how to frame an ask for the adult community. So we're actually testing models now that allow their autism care to stay on the pediatric side and move their adult care into the adult PCP. So, it comes back to that notion of integration.

So I just wanted to make sure that as far as I'm concerned, in the last three days, nobody has thought about transition for the sake of transition. And if we only segmented on patients with neurodevelopmental disabilities, we've got about 50 years of work ahead of us.

Thank you. Amy. And then I'll come to you, Sally.

So, I agree with what you just said. And being a family physician, it helps. My transitions are easier because I transition my babies from – from me to me. So that – that helps.

And kind of piggybacking on what you said and a little bit on what Lowell said, I'm going to give a name to it that I think states need to start looking at for that – for the very reason that you were just talking about – is network adequacy. I think that that's something that needs to get measured within states. So, if we have all of these Medicaid patients that they have a place (inaudible). So when you have a kid that needs to transition to an adult provider, that they have an adult provider that's going to accept their Medicaid and see them. Because that is a huge, huge problem.

Again, this is an antidote. But when I was practicing, I was the only practitioner in probably a hundred-mile area that would take Medicaid babies. We had pediatricians in town. They wouldn't take them. So a third of my practice was pediatrics because I took all the Medicaid babies that were (inaudible). It – it's a big problem, and states need to have a handle on how – what their network adequacy is for Medicaid in their state and then try to figure out how to solve (inaudible) this problem, and it's – I think it's getting bigger.

Perfect. Thank you. Sally.

Building on what Bennie said and in full agreement, I take a step back and I do have to ask, what is the Core Set and why we have the Core Set. And I was thinking about this last night, and it seems to me, where we're talking right now about the measures and their actionability on the Core Set, that the focus is on measures that allow us to compare state performance but are also measures that states can take specifically that measure and hold healthcare providers accountable for. Not saying that Medicaid agencies aren't doing things about it, but that there's a desire that that measure can be used as the accountability levels below that are feeding up. And I just wonder if as the Core Set matures, is that the end purpose of the Core Set, or is it even the current purpose? Do, for example, infant mortality, and not to get into the surveillance versus health issues, but it gets to some of, you know, cross-sector types of measures as well. What about these bigger dot measures? And clearly, what states would need, I would imagine, are – are the measures in which they could then hold others accountable for that would move the dial on infant mortality and that they might be different vertically and horizontally within the ecosystem, health and social providers. So, inpatient hospital may have a different measure that helps support infant mortality from the integrated primary care medical home, etc.

And I – I – every time I come to the Core Set, I am always a little bit uncertain about that tension. Are we, you know, are we looking for measures that the state can then say I'm going to hold the health plan accountable for, and the health plan is going to hold the providers accountable for, because there seems to be, so far, that that's what these measures are. Or are we also trying to identify gaps in the quality of care that we want to compare states and we're holding accountable for, that they may not be able to hold directly, you now, their health providers accountable for. And I think that's a big gap, both in the understanding as well as, you know, the state accountability piece for the Core Set, that we're not quite there yet if that's what we want it to do.

And the other thing I want to add is I do think it would be helpful when we're talking about the gaps to not just conceptually but specifically understand where state-level measures do exist but perhaps not in the Core Set. And it doesn't mean that they need to be in the Core Set, but when we're – as we move forward in talking about gaps, already having a sense of what those are and how much they're used by states would be really helpful, and if they're actionable as they are by states.

Okay. Terrific. Thank you. Jim, you've been waiting patiently, and then Carolyn as well. And then I think we're going to move to - to begin to wrap and create opportunity for our federal partners to speak as well. So, Jim.

Great. Thank you.

This is probably going to sound a bit like Rich's point, last point, but to me it's a different point, which is we've struggled, you know, trying to think about different measures, what ought to be in the Set, when do we have overlap and we not have overlap. And I guess the point I want to raise is that I really think we – if we're talking about core measures, they really ought to be measures that have more of life course sort of potential to them. And particularly I think in the – in the pediatric world, and specifically within the dental world, it really matters not just to have an aggregate measure for kids from zero to 20 years of age. But when you really start looking, you know, year by year, and segmenting that out, you get a very different and – and fuller appreciation about where you're doing relatively well and where you're not doing relatively well. And that applies not just to just different age slices. So, you know, I mean, prenatal, neonatal, first three years of life, you know, preschoolers, adolescents. All of that sort of piece. But – but, really, also can apply to, you know, other segmentation, particularly of analysis. And then I think, you know, strategically in terms of how do we improve this healthcare system, about other segments of the population. Whether it be kids with special healthcare needs, whether it be adolescents, whether it be kids that already have some other source of behavioral issues.

So the point is, I think, you know, if you're really looking at measures, and I there must be an evolution that's happening over this time, to get to better measures. But measures that, yes, some of them actually, you know, really need to have a particular condition focus. But some of them, I think, ought to be looking at these broader processes about, at least in pediatrics, if, you know, if the EPSDT is still the, you know, kind of the framework that we're working with, a better understanding about how well that's working, not just in a broad, sort of global way, but at these critical junctures. If a kid is screened, I mean, are they getting screened? And when they're screened, you know, is there a follow up? And if we can just bring some sort of epidemiology or cost factor or something into those considerations to put some focus on and help support people who get this data, and are working hard to get this data, to really start thinking about the quality improvement aspect of the system beyond that. I – I think that there'll, you know, be more utility and impact from whatever ends up in the Core Set.

Terrific. Thank you.

One of the things, again, I think to follow up on your point is that there – many of these measures do have age specifications, and it might be helpful for CMS in those measures to not just reflect the results, you know, globally across those large age bands, but look at and – and report on sub-age bands because, for instance, dental and for many of the other measures in pediatrics, there are specific ages. You know, that zero-to-three age, and then that adolescent age, that's where the big opportunity for quality improvement is. So it's – it's not just, you know, the broad measure, but there are specific age bands within that measure that folks need to really focus on.

Perfect. Thank you. Carolyn, you'll have the last perspective.

That puts a lot of pressure on. So I'm going to make three what I hope are quick points, and without the risk of repeating what Rich said, I do want to second his plug for developing measures to address these gaps around transition-age youth. These individuals have some of the highest utilization, are among the

highest volume of individuals who end up boarding in the ED. And the only thing I would add to what Rich said is that right here in D.C., Patience White and Peg McManus have been doing some great work around proposing measures around transition-age youth. They're with the Thought Transitions program at the National Alliance to Advance Adolescent Health. So I would highly recommend looking at their work.

Rich mentioned that it's very difficult to transition these kids into adult medicine practices. Part of that is a workforce development issue, which ties into a point I think Lisa was making, or one of the Ls made, about workforce development. And I don't know what the scope of this group is or of Core Sets specifically in – in addressing workforce development issues. But when you think about, in particular, entry-level workers, we're all competing for the same limited pool of entry-level workers. Community health workers, home health care PCAs, day hab workers, group home workers, and so forth. So, again, it's beyond the scope of our discussion today, but I'd love to think about how we address this issue because it really does get to a lot of the things we're trying to achieve with the quality measures, enabling people to access health care, to remain in the community.

And that really leads to my third point which is a topic we haven't really raised but does cut across, as Diana was talking about earlier, cutting across several domains, and that is caregiver support, caregiver wellbeing. And this touches on the disability community, the frail/elderly, those with VHSUD. And we just put in a plug for thinking about how we can incorporate whether it's in patient experience surveys, or care plans, measures around caregiver support and wellbeing because these are the individuals who make up for those gaps in the workforce and to enable vulnerable populations to maximize their health outcomes, to remain in the community, and to be maximally functional. Thank you.

Thank you.

(Inaudible) our fed liaisons had some perspectives to share.

Just quickly. So, I just personally want to thank you all again for inviting us. It's been enormously helpful. And I think it's been helpful to have multiple feds sitting at the table and thinking strategically about how we can be more helpful.

Really appreciated many comments on maybe the place – one of the places the fed's focus is on infrastructure and less on topic, and so we're all talking about that as well.

And lots of learning on what goes in a scorecard. Or what goes in the core versus the general versus the scorecard, which I'm still listening for and learning from my CMS colleagues.

So, but just a couple of – so, all of that notwithstanding, there are some topics that I do think are worth raising as gaps. And some of them do get at men's health and these big ticket, common, costly, preventable conditions that are particularly prevalent in Medicaid populations. And so coming – not ready for prime time, but there is a series or measures that AMA apparently is putting forward around prediabetes. Said they may be ready next year. That would, you know, represent a new measure that you might not want to tackle because it's too new. But, lots of thought, so whether it's BMI or actually around prediabetes, that seems critically important.

There's a series of cancer screening tests that will be coming down the pike. You know, I know colorectal wasn't added. Lung.

And then, again, just really want to reinforce all of the issues around suicide – there are measures available, but suicide, social determinants, ACES, I feel like there was one other topic but I don't – I'm trying to talk.

And then one other thing to think about, you know, so what happens in a clinical setting, what happens around social determinants, but what happens in that bridge in the community. So, I know there's an Affinity group around asthma being stood up. But our asthma folks feel like there's a gap in measuring community delivery of asthma, which I think represents a broad kind of gap.

So I'm going to stop. Did you want to add anything?

Again, this is Alice Tsai with the National Vaccine Program Office. Thank you all for the opportunity to hear your thoughts and we appreciate your recommendations greatly and some of the insights you presented.

And I – I totally echo the life course perspective of the Core Set, and hence it's more – and, again, I would like to emphasize that adult and prenatal immunization status, in conjunction with the childhood and the adolescent immunization status measures is the complete package. And they all align with ACIP recommendations. And so despite that in, you know, the workgroup decided, or has recommended not to be added to the Core Set for the adult and prenatal immunization, I encourage the states to try it out, test it out, you know, help us learn, and then also provide some feedback on those measures, all be really appreciated as we look forward to improving the health for all.

And, also, like our CDC colleague here, with CMS colleagues, we're all trying to, you know, figure out ways to make your lives easier through different tools, mechanisms, etc. Thank you.

So, we will sort of begin to wrap the conversation about gaps. You know, as I was listening, the sort of undercurrent that I heard is appropriately so, the Core Set began with a set of clinical measures that were tried and true and tested and endorsed by HEDIS or NQF or others for sort of the general population.

What I hear us articulating, and I think it's probably shared among CMS and others but worth articulating, is as we evolve, we really want the Core Set to measure the performance of the Medicaid and CHIP programs at meeting the unique needs of Medicaid enrollees beyond just those that are typical and perhaps even public health. So, around pregnancy, early childhood, children with special healthcare needs, those transitional periods, men now for states that have expanded, individuals with disabilities, and then the aging population, oral health, those with multiple chronic conditions, behavioral health. But beyond that to stretch to acknowledge the complexity of the life circumstances of many of the individuals who are served by Medicaid and CHIP. I don't like the word social determinants of health, I like complex life circumstances better because I think those are complex life circumstances that impact one's life overall, their ability to thrive in the community not only impacts the bottom line of the healthcare system.

And then the workforce and the caregiver supports that are needed. And so the – I think what we're asking for is a more holistic view over time of – of the Medicaid program and the role it plays in our nation's health in terms of addressing the unique needs of individuals. And so I think that's a vision that I think is good to put our mind around.

And then we need the infrastructure to be able to deliver on that, right?

And so I think those are the gaps we've talked about, both those conceptual gaps, implementation gaps, and to some extent a request for a philosophical shift. Beyond just things that are easy to measure and that have maybe been included in a traditional healthcare structure but those that really target, given that the word is core – target the unique needs of individuals by Medicaid and CHIP.

So with that we'll conclude the gap conversation and move to – to a public comment opportunity. Just a general public comment opportunity. And then we'll begin to wrap our time together overall with sort of going out of the conceptual and back to the logistics.

So, is there opportunity for public comment? Yes, please.

Hi. Sepheen Byron, NCQA. Measure Developer, as you all know. It's been really enlightening to hear all of this. As you know, NCQA both develops and implements measures, so a lot of the themes here absolutely resonate with me. You know, we really keep an eye on feasibility because we understand and we're going to get all of the feedback from the field if we put out a measure that's not feasible.

I just wanted to make a note about the electronic clinical data systems. You know, we know that there are challenges, and we absolutely hear all of the concerns around that. I think everyone here agrees that that's the way we need to go. It's really the way to give those with boots on the ground who are taking care of patients a fuller picture of that patient. I mean, it's – it's really maddening to know that all of those data are out there and that it cannot inform care in a way that is, you know, connected. And so with the ECDS reporting method that we are trying to push towards, that use of those data, and we're doing it with measures. And to that, and I just wanted to suggest that, you know, I don't know if there is a way with the Core Set, because I think we're thinking about this, and anyone who has a program should think about how we can have a set for innovation and try to relieve burden in some way to free up those resources to be able to take a chance on measures like perinatal depression, right? With ECDS we try to attack the measure areas where we know systems need to work together, like perinatal depression where you have fragmentation of care, but it – it's high impact if you can get that care to work. And so that's why we focus on depression screening and follow up, perinatal depression, adult and perinatal immunizations. You know, registries, lab data. I echo Lindsay's suggestion to go for those data elements that will open up so many measures and get us past measure-by-measure focus, get us away from the claims and medical record crutch. You know, we really want to move towards that. We know we're a long way off. There's a lot of variation out there. But, if there's a way to think about segmenting a group of measures that could be for innovation and free up resources so that you give people credit for something so that they can focus on the new measures of tomorrow. That's what I wanted to say.

Terrific. Thank you.

Thank you.

Anyone else have public comment? Yes, please.

Hi. My name is Dr. Angela Shen. I'm a Captain, retired from the U.S. Public Health Service. I actually came to town just for lunch, but your meeting happened to coincide. So, I'm happy to be here.

Without reiterating kind of the appreciation of the committee, as well as very enlightening to hear kind of this holistic approach to measures, making them full, and how to move forward across a number of (inaudible), I just have three short points.

One is I appreciate, I believe it was Laurie's comments, about how to frame the measures around (inaudible) recognizing the importance of the committee and practitioners (inaudible) sub-cohorts and populations and how that kind of fits into the (inaudible) as well as the continuum of vaccinations (inaudible).

So, I, unfortunately, wasn't here earlier, but appreciate that this is very complicated, even for people in the immunization (inaudible) probably do a better job of packaging that so that not only the committee (inaudible) but as well as practitioners.

My second is – I really thought that you guys would talk about (inaudible) health. But in – in listening (inaudible), I think we're going to have a lot of lessons learned from the first few years of – of newer measures, not only the immunizations but the other ones that have been approved of late, of these HEDIS measures. And one thing that I talked to someone at the break about is, if we want an ideal, then some of that ideal might be five, ten years out. And I'm not sure that that's the – that we want to, as the public health community, to wait that long. But I appreciate that the community and the committee here is really being thoughtful about both the feasibility and actionability. But I would urge us not to – what that's phrase about perfection being the enemy of the good? I'm notorious for butchering those sayings, but I think you got the gist on that.

And my final one is as – as one of the (inaudible) or – or brain child behind designing both the composite measures in my former life, then I think that one thing that really resonated with us, and hundreds of focus groups discussions, is that the composite measures we designed specifically to be a single focal point to promote a shared adherence to the standard of care. And so recognizing that it could be confusing to have these subpopulations, age, they're not restrictions but recommendations. And adhering to the letter of ACIP, we – we hope we were thoughtful in designing the constructs of both composites in the spirit of the childhood composite as well as the adolescent one so that it is our effort to make life easier, not only for the committee, but ultimately for the practitioner so that you have this single point, focal point, where you could somewhat measure or promote more so the adherence measure that we wanted.

Thank you.

Thank you so much for your time.

Any more public comments? Is there anyone on the phone?

We have no hands raised at this time, so just as a last reminder, five star to raise your hand to speak.

And while we wait for that, a committee shout out to Brice, who has also managed [applause] managed our technical capacity, so thank you.

Thank you. I'm blushing.

We only wish you could see – we could see you.

So, with that, I'm going to turn it over to Margo and Bailey to wrap us up.

Great. Thank you so much, Gretchen.

I would just want to spend a couple minutes discussing the next steps for the 2020 annual review process, and then we'll wrap up and send everyone on their way.

So, based on the discussions over the last two-and-a-half days, our team is going to put together a report, a draft report, and this report will be made available for public comment as well as the workgroup's comments in July. And then based on the public comments, we'll finalize the report in August. And CMS will then release the 2020 Core Sets prior to December 31st. So all the work will end with that, and then we'll start again.

[laughter]

And a few thank yous before we head home. So first I'd really like to say a huge thank you to our Chairs, Gretchen, David [applause]. Yeah. You guys did an amazing job and we really appreciate your guidance and your experience. So, thank you again.

And next I'd like to thank the workgroup. You guys discussed and voted on 56 measures. You had a wonderful conversation this morning. And it's very apparent that you all did that homework we gave you, so thank you for that. And you came very well prepared. [applause]

And we really appreciate – oh, I – I'm good at that. So, and we really appreciate the valuable input and time and your contributions. We know that this is quite an ask to take all that time away, and we really appreciate it.

Our team will be sending you a brief evaluation next week about the process on the annual review. And we'd really appreciate it if you took your time to provide your feedback. I have been listening to what you said this morning and taking notes on that as well, but if you could fill out the actual evaluation, we would greatly appreciate that.

And finally I wanted to thank the Mathematica and Harbage and others who have helped put this event on. So thank you, you guys have done a wonderful job.

[applause]

And, finally, you can leave your name tags either on the desk here or drop them in the bucket. And I think we might have one final comment, but I just want to say thank you, have a safe trip home, and we really appreciate it.

Yes, please, Steve.

I haven't been very vocal for the last three days, and that's because you all are so much more expert than I am. I did want to take the opportunity as a Medicaid Director to say how much I have learned (inaudible). I truly believe that this is (inaudible).

[applause]

Terrific. Safe travels home, everyone.

This concludes the webcast for today. Please submit feedback for the presentation team using the survey in your browser window when the event concludes.