2026 Child and Adult Core Sets Annual Review: Meeting to Review Measures for the 2026 Core Sets, Day 2 Transcript

February 7, 2024, 11:00 AM – 2:30 PM ET

Talia Parker:

Good morning, everyone. My name is Talia Parker, and I am pleased to welcome you to the 2026 Child and Adult Core Sets Annual Review Meeting to Review Measures for the 2026 Core Sets, Day 2. Before we get started today, we wanted to cover a few technical instructions. If you have any technical issues during today's meeting, please send a message through the Slido Q&A function located in the Slido panel in the bottom right corner of your screen. If you are having issues speaking during Workgroup or public comments, please make sure you are not also muted on your headset or phone. Connecting to audio using computer audio or the "Call Me" feature in Webex are the most reliable options. Please note that call-in only users cannot make comments. If you wish to make comments, please make sure that your audio is associated with your name in the platform. All attendees have entered the meeting muted. There will be opportunities during the meeting for Workgroup members and the public to make comments. To make a comment, please use the raise hand feature in the lower right corner of the participant panel. A hand icon will appear next to your name in the attendee list. You will hear a tone when you have been unmuted. Please wait for your cue to speak, and remember to mute your line when you are done speaking. Also, please lower your hand when you have finished speaking by following the same process you used to raise your hand. Note that the chat is disabled for this meeting. Please use the Slido Q&A feature if you need support. When you send us a question via the Slido Q&A feature, the question will say Waiting for Review. Please click the word Replies under your question to see our response. Closed captioning is available in the Webex platform. To enable closed captioning, click on the CC icon in the lower left corner of your screen. You can also click Ctrl-Shift-A on your keyboard to enable closed captioning. Finally, Workgroup members, please try to log into the Slido voting platform ahead of time to prepare for a vote later today. You will log into Slido the same way you did yesterday and will receive a new authentication code to your email. Let us know via Q&A or email if you are experiencing any difficulties. And with that I will hand it over to Margo to get us started.

Margo Rosenbach:

Thank you, Talia. Welcome back to Day 2 of the Meeting to Review Measures for the 2026 Child and Adult Core Sets. I hope everyone had a nice evening.

We had a very productive and engaging day yesterday with a robust discussion of three measures. The Workgroup recommended removal of the Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD) measure. The Workgroup did not recommend removal of the Initiation and Engagement of Substance Use Disorder Treatment (IET-AD) measure. And the Workgroup recommended addition of the Prenatal Depression Screening and Follow-Up measure. We are looking forward to discussing the final measure suggested for addition to the 2026 Core Sets and getting input from the Workgroup on next year's public call for measures.

Before we begin, let's turn to Kim Elliott and Rachel LaCroix, our two co-chairs for brief welcome remarks.

Kim, would you like to go first?

Kim Elliott:

Welcome everybody back to Day 2 of the Workgroup. I am extremely excited about today's discussions. I think it is going to be a really interesting and fact-filled day.

Yesterday we did have some robust discussions, as Margo mentioned, regarding the measures that were recommended by Workgroup members for removal or addition to the 2026 Core Sets. And I also really appreciate that Workgroup members were really engaged and provided some insight and perspectives for the Workgroup during the discussions that really led, I think, to even more discussion and possibly some changes in people's thoughts on voting on the measures.

I am excited about today's agenda, particularly the social determinants of health. And we know that social determinants of health are having big impacts on our members in Medicaid and their ability to really utilize their health benefits. But I'm looking forward to a really robust discussion to see where we are at with that. And I am also really excited and looking forward to the gap discussion. I really love the new format that Mathematica proposed, and I hope you all will, too, as well. So, I will turn it over to you, Rachel.

Rachel LaCroix:

I would just like to echo Kim's welcoming comments. I am definitely looking forward to our discussion today as well, particularly around the measures suggested for addition regarding social needs. I know we have talked about these kind of metrics in the past and how that has been a gap area that has consistently been identified for a number of years. I am really looking forward to everybody's perspectives and inputs related to that. As well as discussing additional priority gap areas and thinking about criteria to include for the Public Call for Measures. I know that the Public Call for Measures in the future will be a new aspect, and that is kind of exciting as well to think about different folks from different stakeholder groups contributing to some of the measures that we consider in the future, but also wanting to make sure that we have criteria in place to make that as productive as possible and still thinking about things like feasibility and room for improvement and those kinds of things for those metrics.

So, just really looking forward to having another robust conversation with all of you today.

Margo Rosenbach:

Thanks Kim and Rachel and for framing the charge for the day. Next slide, please.

Now we will conduct a roll call of the Workgroup members. Next slide.

We ask that Workgroup members raise their hand when their name is called. We will unmute you and you can say hello. And please ensure that you are not also muted on your headset or phone. After you are done, please mute yourself in the platform and lower your hand. When you would like to speak later during the meeting, raise your hand and we will unmute you again.

So, next slide.

Well, we have already heard from Kim and Rachel. Ben Anderson?

Ben Anderson:

Great to be here again and looking forward to the conversation.

Margo Rosenbach:

Great. Thanks, Ben. Rich Antonelli?

Richard Antonelli:

Can you hear me, Margo?

Margo Rosenbach:

Now I can.

Richard Antonelli:

Okay, yep, I'm here.

Margo Rosenbach:

Great. Okay. Stacey Bartell?

Stacey Bartell:

Good morning. Did you hear me?

Margo Rosenbach:

Yes, now we can. Thank you.

Stacey Bartell:

Thank you.

Margo Rosenbach:

All right. Tricia Brooks. Tricia, you – you look like you are muted again. Tricia, are you able to speak? All right. Tricia, can you unmute yourself?

Tricia Brooks:

There. Okay. Yeah, I forgot to before. I'm here. Good morning.

Margo Rosenbach:

Okay, good. Want you to be able to speak. Okay. Emily Brown?

Emily Brown:

Look forward to the conversation today.

Margo Rosenbach:

Okay. Emily, you are a little bit faint, so if you can get closer to a mic or increase your volume, we want to be able to hear you.

Emily Brown:

Hi. Good morning. Can you – can you hear me now?

Margo Rosenbach:

So much better. Thank you.

Emily Brown:

Okay. Thank you.

Margo Rosenbach:

All right. Joy Burkhard.

Joy Burkhard:

I didn’t hear my name, but this is Joy Burkhard, and good morning from rainy Los Angeles.

Margo Rosenbach:

Okay. Glad to have you. Sorry you couldn’t hear me. Stacey Carpenter?

Stacey Carpenter:

Hi everyone.

Margo Rosenbach:

Thank you. Roshanda Clemons? Is Roshanda here? I see you on – there you go. Roshanda, can you hear me?

Roshanda Clemons:

Good morning.

Margo Rosenbach:

Good morning. Okay. Thank you. Lindsay Cogan? Lindsay, are you there?

Lindsay Cogan:

I am, Margo. Can you hear me?

Margo Rosenbach:

Now I can. Thank you. Jim Crall? Jim, are you there?

Jim Crall:

Yes, I am.

Margo Rosenbach:

Okay. Good. All right. Erica –

Jim Crall:

Margo, could I take the opportunity just to ask someone to post the instructions for getting on the voting website on – maybe on Slido or somewhere?

Margo Rosenbach:

Yes. Someone will be in touch with you. Thank you.

Jim Crall:

Great. Um hmm.

Margo Rosenbach:

Okay. Sure. Thanks for asking. Erica David Park is joining but a little bit late today. Next up, Anne Edwards.

Anne?

Anne Edwards:

Can you hear me?

Margo Rosenbach:

Now I can.

Anne Edwards:

Okay. Good morning, everyone.

Margo Rosenbach:

Great. Thank you. Clara Filice?

Clara Filice:

Hi, it’s Clara Filice.

Margo Rosenbach:

Great. Welcome. Angela Filzen? Angela?

Angela Filzen:

Can you hear me?

Margo Rosenbach:

Now we can.

Angela Filzen:

Good morning, everyone.

Margo Rosenbach:

Morning. Sara Hackbart?

Sara Hackbart:

Good morning. This is Sara Hackbart looking forward to our discussion today.

Margo Rosenbach:

Great. Richard Holaday?

Richard Holaday:

(Inaudible.)

Margo Rosenbach:

Great. Richard, we hear you. Okay. Jeff Huebner? Jeff, you are unmuted. Can you say something? Now you are – there you go.

Jeff Huebner:

Hi, again. Good morning.

Margo Rosenbach:

Good morning. All right. Sarah Johnson is out again today. David Kelley? David? David, you are muted again. There you go.

David Kelley:

Hi. Good morning. Thanks. I'm here.

Margo Rosenbach:

Great. Glad to have you. David Kroll.

David Kroll:

I'm here.

Margo Rosenbach:

Good morning. Jakenna Lebsock? Jakenna? Jakenna?

Jakenna Lebsock:

Good morning. Can you hear me?

Margo Rosenbach:

Now I can. Thank you.

Jakenna Lebsock:

Okay.

Margo Rosenbach:

All right. Good. Hannah Lee-Brown? Hannah, can you say something?

Hannah Lee-Brown:

Hello? Can you hear me? There we are.

Margo Rosenbach:

Now we can.

Hannah Lee-Brown:

Sorry. Hi.

Margo Rosenbach:

Hi. Kathy Leyba? Kathy, you should be unmuted. Kathy, can you say something? Kathy, you might be double muted. Now you are muted. Try again.

All right, she said here in the Q&A. Okay. Lisa Patton?

Lisa Patton:

I'm here.

Margo Rosenbach:

Hi, Lisa. Laura Pennington? Laura?

Laura Pennington:

Hello?

Margo Rosenbach:

Hi. Now we can hear you.

Laura Pennington:

Okay, great. Thank you.

Margo Rosenbach:

Grant Rich?

Grant Rich:

Hear me?

Margo Rosenbach:

Now we can. Yes. Okay. Lisa Satterfield?

Lisa Satterfield:

Hi.

Margo Rosenbach:

Hi, Lisa. Linette Scott? Linette?

Linette Scott:

Can you hear me okay?

Margo Rosenbach:

Now we can.

Linette Scott:

Okay.

Margo Rosenbach:

All right. And next, Bonnie Silva is joining late. Kai Tao?

Kai Tao:

I just want to say the few times you've said you've heard somebody, I haven't heard anyone. So, I don't know if that is my audio?

Margo Rosenbach:

Well, I hear you.

Kai Tao:

Okay. Great. I don't know if that happened to anyone else.

If not, I don't know what's going on–

Margo Rosenbach:

Sounds like there is a little bit of a lag.

Kai Tao:

All right. Thank you.

Margo Rosenbach:

Well, thank you. And if there is an issue, please do let us know again during the – in the Q&A. Ann Zerr? Ann, I don't see a microphone next to your name. I see your hand raised. Can you say something? Ann says, "I cannot hear you but I am present." Ooh. All right. Oh, there you go. Ann, now can you speak?

Ann Zerr:

I can. Thank you. This is Ann Zerr.

Margo Rosenbach:

Okay. Great. And Bonnie Zima? Bonnie, you should be unmuted.

Bonnie Zima:

Yeah, it was a delay. Bonnie Zima, UCLA. Good morning.

Margo Rosenbach:

Good morning. Well, I do think that there is a lag this morning, so we will have to just be a little bit patient as we are going through the discussion of the measure because we want to make sure everybody who wants to be heard can be heard. So, thank you, everyone, for your patience during this – this roll call.

All right. So, next slide, please.

All right. So, here you can see the federal liaisons. We are joined by them. They are non-voting members. Federal liaisons, if you have questions or contributions during the Workgroup discussions, please raise your hand and we will unmute you.

I would also like to acknowledge our colleagues in the Division of Quality and Health Outcomes in the Center for Medicaid and CHIP Services. We heard from Deirdra Stockmann and Gigi Raney yesterday. Thank you for your remarks. And then also the measure stewards who are available to answer questions about their measures.

So, next slide. Let's get started. I would like to turn it over to Chrissy Fiorentini who will present the second measure suggested for addition. Chrissy?

Chrissy Fiorentini:

Thanks, Margo. Next slide.

The final measure suggested for addition is Social Need Screening and Intervention. This measure is defined as the percentage of members who are screened using prespecified instruments at least once during the measurement period for unmet food, housing, and transportation needs and who received a corresponding intervention if they screened positive. Six rates are reported.

The Food Screening rate measures the percentage of members who are screened for food insecurity. The Food Intervention rate measures the percentage of members who received a corresponding intervention within 30 days of screening positive for food insecurity.

The Housing Screening rate measures the percentage of members who are screened for housing instability, homelessness, or housing inadequacy. The Housing Intervention rate measures the percentage of members who received a corresponding intervention within 30 days of screening positive for housing instability, homelessness, or housing inadequacy.

The Transportation Screening rate measures the percentage of members who are screened for transportation insecurity. And the Transportation Intervention rate measures the percentage of members who received a corresponding intervention within 30 days of screening positive for transportation insecurity.

NCQA is the measure steward in the measure specified at the health plan level.

Next slide.

The data collection method is HEDIS Electronic Clinical Data Systems or ECDS. As we discussed yesterday, ECDS includes data from administrative claims, EHRs, case management systems, health information exchanges, and clinical registries. The denominator for each of the screening rates includes members of any age enrolled at the start of the measurement period who also meet criteria for participation. Participation includes both allocation and continuous enrollment criteria which are shown in the next slide.

The denominator for each of the three intervention rates includes members with a positive screen finding in the respective domain between January 1 and December 1 of the measurement year.

Next slide.

And here you can see the allocation and continuous enrollment criteria for inclusion in the screening rate denominators. The allocation criteria are that the member was enrolled with the medical benefit throughout the measurement period, which is January 1 through December 31st, and was enrolled on the last day of the measurement period. The continuous enrollment criteria are that there can be no more than one gap in enrollment of up to 45 days during the measurement period. For Medicaid members where enrollment is verified monthly, a member may not have a gap of more than 30 days.

This slide also shows the numerator definitions for five of the six measure rates.

Next slide.

The numerator definitions continue on this slide. We want to note a few things about the numerator requirements.

First, screening numerators count only screenings completed using one of the instruments included in the measure specification. We have provided the list of eligible screening instruments in the Measure Information Sheet. And only screenings documented using the LOINC codes in the measure specification count towards the measure screening numerators.

For the intervention numerators, the intervention provided must correspond to the type of need identified. And interventions may include any of the following categories: assistance, assessment, counseling, coordination, education, evaluation of eligibility, provision, or referral. The HEDIS Measurement Year 2024 specifications include stratifications by age group for the Medicaid product line. NCQA noted that they considered other stratification categories during measure testing but determined that was not feasible either because the denominators were too small to stratify or the test data did not include the necessary data elements. NCQA has also indicated that they are working to update the measure to add utility insecurity as a fourth domain. They expect this update to go into effect for Measurement Year 2026, which corresponds to the 2027 Child and Adult Core Sets. But as a reminder, the Workgroup should vote on the measure as currently specified, that is without the utility insecurity domain. The Workgroup member who suggested this measure for addition acknowledged the data collection will be challenging but emphasized the measure’s actionability and strategic priority for Medicaid and CHIP. They noted that health-related social needs (HRSNs) are associated with higher chronic disease prevalence and health care utilization. They indicated that understanding whether enrollees identified at risk of HRSNs are getting connected to needed services can help put other Core Set measure results into context.

The Workgroup member also commented that Medicaid and CHIP populations may be at increased risk for HRSNs as compared with the general population. They cited one study that found that 44.6 percent of HRSN screenings completed within a Medicaid accountable care organization were positive for at least one social risk factor. The Workgroup member also indicated that this would be a new area of measurement and as such there would be a lot of room for improvement and work needed to develop the pathways to report the measure.

Next slide.

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

Margo Rosenbach:

Thank you, Chrissy.

So, Workgroup members, please raise your hand if you would like to make a comment. First I would like to call on Lindsay Cogan to provide an update on New York's experience using this measure. As we mentioned in the Measure Information Sheet, New York Medicaid is using the measure with their managed care plan for HEDIS Measurement Year 2023. Lindsay, you have the floor if you are – there you go.

Lindsay Cogan:

Great. Thank you, Margo. Okay.

Margo Rosenbach:

Lindsay, if you are speaking, you are breaking up.

Lindsay Cogan:

How is that, Margo, any better?

Margo Rosenbach:

Much better. Thank you.

Lindsay Cogan:

Okay. Great.

Thank you for the opportunity to speak about this measure. This is the first year we are collecting this information from our managed care plans. And what we had done is my wonderful staff has reached out to all of our managed care organizations to gather a little bit of additional information. What attracted us to this particular measure is that it allows the opportunity for the type of screening and engagement with a member to happen outside of a traditional medical visit, right. So, you will see other screening and collection measures rely on a medical visit and that happening at that time. We wanted to build out processes in which this information could be collected at any point – any contact point with the member. So, as far as data collection, there are several different streams of how this information could come in to calculate the measure results. There is obviously the passive data screen. So, any electronic health record or insurance claim data that would be collecting this information, you could gather that through either supplemental data feeds or electronic claims data, right? That is heavily reliant on the provider. What we have heard from plans is that electronic health records may have one or two of the questions, but that information is not standardized per the Gravity standards which is what this measure is built off of. So that is an area where we're hoping that the industry really looks to focus and hone and align with data standards that are out there.

Additionally, on top of sort of what you can get from those – those feeds, what we have also seen is our managed care organizations begin to actively collect and screen members either through text, email, calling, traditional care management avenues, using opportunities during onboarding or enrollment, recertification, or any time that member calls Member Services using that as a kick-off point at which to have that conversation. So, data collection, obviously, unlike other ECDS measures that we discussed yesterday, you know, collecting this information using their medical record review or other, we feel at this point it's not – there's not a – a basis of which we are under capturing – we don't feel – we feel like that these are brand new pathways just being built. And so, this type of information is just starting to sort of be filtered through and integrated into – into sort of the types of processes around population health management of the member. Additionally, we like how it points towards standardized tools. Again, we all want to move sort of towards these national standards.

The other points of interest that we have heard back from health plans are the intervention. So, there are different facets to the intervention in this particular measure. Again, it's about if someone screened positive, did something happen? This is not a closed-loop referral measure. This is, you know, did a referral happen? Did you have – it could include things like a passive intervention. Letters. Resource information. It could include actively engaging with the members. It could include walking through resources on a platform. There are many types of platforms available. It could be sharing data with partners and providers. And then what we are hoping to see more of at the health plan level is really monitoring. Tracking and sharing this type of information. Communicating. Understanding which members they have reached, which members they haven't reached yet. And, again, the ultimate goal to really be able to have the outcome of that referral. Did something – in addition to sort of getting that person to the right place, did they get what they need? But that is going to be more, I think, down the line.

Some of the challenges that we have heard, again, that – low response rate from the members. It is something that we are hearing. And I think we all understand that, right. Some members view this data as being too sensitive or private and they are afraid of the response that it may have, so that is something that – the sensitivity – the nature and the sensitivity of asking this type of information is important to really meet that member where they are at.

Providers. We heard back from providers that SDH screening is not yet a part of their regular operations. Oftentimes providers are not wanting to screen if they don't have a clear pathway or a clear what to do next if the member is found to have a need. So, we are working actively on that with our new 1115 waiver.

I think those are the important points. I am trying to go through my notes here. Like anything else, lack of data standardization. That – that definitely comes through. SDH screening tools, that type of data. Getting that into structured, standardized fields, that is going to be the challenge as we move forward.

Strategically, though, it aligns with our 1115. It aligns with where CMS and other – other areas are going. And we're most excited about being able to use this information to stratify additional measures. We feel like that is where this could also be of importance.

So, I think that is all I have to kind of highlight as far as experiences. And I don't know if other states are also using similar measures and have seen something along the same lines.

Margo Rosenbach:

Lindsay, thank you so much for those comments. Very helpful.

I do have a question for you in terms of thinking about this measure being added to the Core Sets. So, it sounds like you are doing a lot of testing, a lot of learning as you go. And I am curious, if this measure were added to the 2026 Core Sets, which is why we are here, would you be able to report this measure for all populations in Medicaid and CHIP that meet the measure eligibility criteria within two years, which is one of our criteria for addition? So, thinking about how you would implement this beyond the 1115, thinking about it, you know, beyond the managed care plans and thinking about it for fee-for-service, just what is the pathway to full implementation of this measure in New York?

Lindsay Cogan:

It – yes, we would be able to report that. So, our 1115 is spanning even fee-for-service members at this point. So, we are not limited to just managed care, so we are pushing this across all populations. So we would be able to report this within two years. It’s not going to look great. It is going to be low to start, but, you know, you have to start somewhere with these measures. But, yes, we would be able to report across all populations within two years.

Margo Rosenbach:

Fabulous. I see Jim Crall, you’re next. Thanks, Lindsay.

Jim, do you have a comment?

Well, why don’t we go to Laura Pennington next.

Laura Pennington:

Thank you, Margo. So, I have a question first and then a response. My question is I noticed that CMS has not determined what domain this would be part of, so would this be required reporting in 2026?

Margo Rosenbach:

Laura, that is a great question. So, I don’t think we can say definitively. Not only is there not a domain assignment, but there is also not a Core Set assignment. But I think looking at the pathway in the past, this measure does include children, or adolescents, and so you can assume that that part of the measure would go into the Child Core Set and then, you know, older individuals, 21 and older, would presumably go into the Adult Core Set. And so, to the extent that history prevails, this measure would be subject to mandatory reporting in the Child Core Set. But not necessarily in 2026. Like I said, our criterion is for a two-year onramp. It is an ECDS measure. CMS is still working on obtaining kind of the pathway for ECDS or digital measures. So, a few ifs here, but, again, like we talked about with the Prenatal Depression Screening measure yesterday, I think voting on the merits of this measure is the way to consider the vote. And as it is currently specified, we are not talking about any changes to the specifications, but knowing that there would be presumably opportunities for technical assistance, for learning, for working with CMS and the TA Team to implement the measure. So, again, I would encourage thinking about this on the merits of the measure and then working out some of those other details later on. Does that answer your question?

Laura Pennington:

Yes, very much so. Thank you.

So, I would just add that, you know, in Washington State we really appreciate the intent of this measure and know that this is where we need to go. We do currently require, and I put air quotes around require, our managed care plans to report this measure. That has occurred to some varying degrees of success. So, to the woman from New York's point, it is going to be slow. I can't guarantee that we will have the data source and be ready to start reporting in 2026, but appreciate the potential to have a kind of a ramp up or phased-in approach. So, I think there is still a lot that we need to learn around the data sources to get ready for this. But, yeah, appreciate the intent but recognize it will be a bit difficult. So, some kind of phased approach would be great. Thank you.

Margo Rosenbach:

Yeah. And as we talked about yesterday at the end of the day, we will have an opportunity to talk about technical assistance needs later on today, so I encourage you to come back and revisit that potentially around technical assistance needs for this kind of measure and other measures as well.

So, with that, David Kelley.

David Kelley:

Hi. Good morning. Can you hear me?

Margo Rosenbach:

Yes.

David Kelley:

Thanks so much. Here in Pennsylvania we have asked our MCOs to do this ECDS measure for calendar 2023, so we will have some – perhaps some preliminary results – so we'll have some results, you know, by the middle of this year. I guess my concern, again, is with which – several concerns. Is this going to be in the pediatric Core Set, and if it is, then would it be mandatory? Obviously, it probably would fall into both adult and pediatric, and to know that would be, I think, helpful.

Secondly, I have, you know, in Pennsylvania we are operationalizing a statewide resource and referral tool through our health information exchange organizations. And many of our MCOs use that same vendor to find help, and it is a resource and referral tool. What we are finding is difficulty in even within health information organizations to take what is coming in from electronic medical records and other resources and actually linking that to these numerators and denominators. They are using, I think, LOINC and SNOMED codes, and guess what? Most providers don't use either one of those codes. We required our patient-centered medical home program to use Z codes to – in identifying health-related social needs on everyone that comes into the practice at least once during that year. So, we have been using Z codes since 2019. It's not perfect. Again, there are multiple – there are more domains than what are in this measure. And there is really not – there is some work in mapping those Z codes into these measures, but I don't think that mapping is happening in a realistic way, at least not yet. And it gives a lot of activity.

So, all that being said, is there is a lot of what ifs. And I also would be curious, what state Medicaid program actually has already operationalized this and used this for quality improvement purposes? Which state is that, and it would be nice if they could comment on their experience if – if, indeed, they have already measured and have some results. Thanks.

Margo Rosenbach:

Thanks, David. I see we have Jim Crall next.

Jim Crall:

Hi, Margo. Can you hear me this time?

Margo Rosenbach:

Yes.

Jim Crall:

Okay. Thank you.

Yes, first of all I would comment, you know, that there is a definite need for this in the, you know, in the growing body of research about social determinants. However, my concerns are those that have been already expressed. I think that feasibility of collecting this. It seems to be going to put quite a burden on providers and states to collect data, and we don't have established data input practices yet from what I've heard so far. So, I think the burden for states and providers really needs to be ironed out. You know, I think this is aspirational. Perhaps too aspirational given the whole gamut of things that are – we are trying to capture here. Concerns about whether it is ready for prime time in terms of a Core Set measure. And just also thinking that, you know, given the difficulties of having providers provide this information, why this isn't something that would fall more to state programs to collect as part of enrollment in annual – annual maintenance of membership. So, those are my concerns about this at this time.

Margo Rosenbach:

Thanks, Jim. We have a lot of people lined up to speak here, so next Karen Hacker from CDC.

Karen Hacker:

Can you hear me?

Margo Rosenbach:

Yes, now I can.

Karen Hacker:

Okay, great. Thank you.

All right. So, from CDC, a lot of what you will hear from us is very similar to the prior speakers. So, we definitely recognize the need to actually do a screening and intervention measure. And I am saying intervention because I think that is where the rubber literally meets the road. We know that screening is not ample, and it is not going to determine whether or not people actually get the resources that they need, but we also recognize that there is going to be a lot of challenges with identifying those interventions in particular. I think you have already heard a lot from health care systems about how difficult it is to even get the data out of the electronic health record. I'll now bring in all of the resources that are going to be needed to fill these social needs including the data streams, the interoperability and all those things and being able to actually get that information back in terms of a close-the-loop scenario. So, we absolutely support this, but we also recognize that there are going to be a lot of challenges to doing this. I found it fascinating that some healthcare systems are not even relying on the actual providers to do this but are thinking about other strategies like using the managed care insurers to do this work.

With that, we want to be part of this and are eager to support our colleagues at other state agencies to support the implementation, but I think recognize that this will likely have to be a phased-in approach as we are hearing from the states who already reported out.

Thanks.

Margo Rosenbach:

Thanks, Karen. Next up, Kim Elliott.

Kim Elliott:

I am really excited, actually, about this particular measure because we have a lot of challenges and I don't think that this Workgroup, or states, or really anyone that is a quality improvement person really moves away from challenges because that is how we make our progress and improvement. But with that said, we talked a lot yesterday about maternal health. We talked a lot about infant health. And the challenges in addressing some of those concerns. If we have measures like this that really address some of those underlying issues that prevent people, or maybe don't easily allow people to get access to care, services, and other needs, it has such an opportunity to really impact so many measures. I mean, we hear the stories all the time about a member that goes into an emergency department and, for whatever reason, the reason they are sometimes giving the emergency department is that, well, I don't have access to a food source, or a warm place to stay when it is cold outside on that weekend because some of the services they receive are only a Monday through Friday sort of thing. And these types of measures, if you are addressing those social determinants of health, will have such a broad impact on many of the other measures in the Core Set. But I do recognize data sources are not perfect. But they are definitely improving. As an auditor of performance measures and HEDIS measures, I see how those electronic health records are being grouped into organizations and submitted to health plans. So, I think that is just continuing and growing. Not that it is perfect, and I know there is a lot to be done, but it is a step in the right direction. So, I – I think that this has a lot of potential. Thank you.

Margo Rosenbach:

Thanks, Kim. Rich Antonelli?

Richard Antonelli:

Really wonderful things. One could say, you know, this is the future of healthcare and the future is here. We can't even begin to think about equitable healthcare and the achievement of health and social justice without this information. So, I am extremely excited about that. We – the Gravity Project is an amazing national resource, I'm glad that somebody mentioned that, setting the stage for this work. I would like to hear a little bit more about the implementation experience. And what I am struggling with here is, is there anybody that says no, we shouldn't do this? The question before us is, should we recommend this in the 2026 Core Set? There are lots of opportunities for improvement in the process. I think that is great. There are a lot of other things I think that need to fall in place to make this meaningful.

Then another couple of just quick observations. One is the – what qualifies as an intervention is a relatively low bar. It is better than nothing, but it is a relatively low bar. I think Lindsay Cogan said it well when she said at the very least we could use this for stratification. And I would totally embrace that.

At a somewhat granular level, I am wondering a little bit about this. It makes sense to have something in the Child Core Set. Makes sense to have something in the Adult Core Set. But if the OB asks the mom and it gets recorded, then when that newborn comes into my clinic, do I also have to ask that mom essentially the same set of questions? So, what would be the survey burden especially if you have got a mandatory requirement in one or both sets? And I think, yeah, so those are – those are my comments. Is there any other source that we can get to hear about additional state experience in order to decide whether this is worthy of going to the Core Sets in 2026? Thank you.

Margo Rosenbach:

Thanks, Rich. Well, next up, Ben Anderson. We'll go through the list. There are lots of states that are queued up to speak, but I am trying to get people in order in which they raised their hands. So, Ben Anderson next.

Benjamin Anderson:

Hi. Thank you. And so appreciate this measure being before the group and really appreciate I think the extremely thoughtful, careful discussion around this. I think folks know that, you know, we're sort of – I am here, you know, lifting up a consumer perspective when it comes to the matters before this working group. And from a consumer perspective, this is probably the most important measure that we could be considering as a workgroup because it is so intrinsically tied to not just healthcare, but to health, as we all know. And being healthy is fundamentally what people want from their healthcare system.

So, I do think that this type of measure, a measure that looks at screening, referral, and intervention for social determinants of health should be at the top of the list of things that this group considers. And that everyone participating in this Workgroup and process from CMS to state governments, health plans, providers, and so forth, this is where all of our work should be focused now and certainly into the future.

That said, I think there are a number of questions that have been raised that are questions that I continue to struggle with and really looking for more information on. So, I do think what is encouraging about New York doing this work is the number of managed care plans doing this. So many of those plans are affiliated with a parent company or counterpart that operates in other states. I think that does speak to feasibility in some respects, but would be interested in hearing more about whether or not that sounds right to others on the call.

I think in sort of responding to some of the questions around who should be collecting the data and what age group should we be looking at, it makes so much sense, of course, for the plans to be collecting this data, but we do need providers, I think, collecting this information, too. Especially when it comes to kids. One of the previous commentors spoke about how this information can show up in the ER context. There are also so many stories about pediatricians having kids show up to their offices who have been losing weight only to find out that it is because of a lack of food at home. We know that the red tape that families encounter and experience not just when accessing medical services but other services related to food and housing are significant. And so this really is something that needs to be screened for and services need to be made available sort of around the clock as much as possible where there is no wrong door ever for people to arrive, and express need, and have those needs met.

So, winding down now, you know, I think the biggest questions for us is, you know, I think how many states could realistically implement this measure. I think it has been spoken to a little bit already, but I think the question about the use of LOINC codes is significant. What kind of barrier does that, you know, truly present, and what would be needed to overcome it? Both, I think, in terms of, you know, financially for the states, but also time wise. And when it comes to the standardized tools to collect the information, are these the right tools? Those are, I think, the top questions in my mind.

Really excited – thank you so much for making the space for this and for allowing this long comment on my part. And I'll stop there.

Margo Rosenbach:

Thank you so much, Ben. Next up, Jakenna. What is happening in Arizona?

Jakenna, if you are speaking, I can't hear you.

Jakenna Lebsock:

Can you hear me now?

Margo Rosenbach:

I can.

Jakenna Lebsock:

Okay. So, Arizona is doing an extensive amount of work in this space, and we are testing many different modalities. We are doing work through our HIE, through our health plans. We are incentivizing our providers. And so, I think the topic is absolutely on point and the future of how healthcare should really be contemplated. And this is the starting point of that ability to really give people the space to engage in other forms of healthcare. If their basic needs are met, then we can move into other complexities of healthcare delivery. And so, I absolutely appreciate this topic. I think it is critical.

What I – what I pause with, though, is you are hearing from states that I think are pretty progressive in the social determinants space. And I am worried about states that may not have the resources or the political part support, or just haven't really engaged yet because they are still trying to figure out that they are going to do. And so I don't want to base a decision on the frontrunners of this space. I think we have to be thoughtful about what the states collectively can do to support their providers, or if they happen to have health plans, or the work themselves. And so, I don't know that the timing is right yet. I think it is a really important discussion, but I just pause a little bit. So, thank you for the opportunity to comment.

Margo Rosenbach:

Thank you. Stacey Bartell.

Stacey Bartell:

Thank you. Can you hear me?

Margo Rosenbach:

Yes, very well.

Stacey Bartell:

Great. So, I am speaking on behalf of the Academy of Family Medicine of Family Physicians. So, we support the health-related social needs screening. We think that it is extremely important. We also know the importance of the ability to refer. But I want to second what the previous speaker just said in that we are probably not ready nationally to talk about an intervention measure. For multiple reasons. So, I personally also practice medicine in the state of Michigan. And I can tell you we have been doing this work in the state of Michigan for a long time. And as a practicing physician, I send referrals out all the time or I work in an area where that – that need is not available. So, when you do a measure about an intervention, I can refer if there is something available, and I can refer – I can't refer if there is something not available for that need. So, that is problem number one with an intervention measure is you are not really sure what you are measuring. Is it that the resource wasn't available or did you not do the referral for an intervention?

Problem number two is I can send as many interventions as I want for these patients, but they may not be able to go, they may not be able to go consistently for food resources. It doesn't fix the overall problem of the food – even the food resources. And so, it would be more helpful if states were looking at this data to how they can boost the needs in populations to support it rather than us continuing to refer patients out to these services. And these community services are great in some areas in our state and not in other areas in our state. And I think this is found and reflected in communities across the United States. It is just challenging right now. So we need to get there. There are probably multiple ways to get there, we're just not sure this measure in particular is the right measure at this time. So, the Academy supports more of a social needs screening measure to start with, with the eventual plan to roll it out into an intervention and a closed-loop-referral measure, which was also mentioned earlier today.

Thank you.

Margo Rosenbach:

Thanks, Stacey. Grant Rich. What is happening in Alaska?

Grant Rich:

Hi. Can you hear me?

Can you hear me?

Margo Rosenbach:

Yes. Yes, very well.

Grant Rich:

I'm a psychologist, so I am definitely excited by the topic. Social determinants matter. This goes back to Maslow's Hierarchy of Need with the basic physiological and housing needs as being very basic. So, I very much want to echo what has been said about the value of this topic. However, I also echo the challenges that have been expressed in terms of feasibility and implementation possibilities for all states. States have different systems. They have different staff and provider capacity. Different types of data collection. I think there would be lots of concerns if this was, you know, required right away. You know, with all respect, I am not quite sure we are 100% ready for prime time here. There has been some discussion about whether these are the right tools and to look to see the reliability and validity of the tools I think would be valuable. And I would also say that I think at least one other person mentioned there is always the possibility that right now states could run these measures or similar measures individually, optionally, to suit their needs and their policy environments rather than maybe immediately enforce that all states so the Core Set. So, maybe that sounds a little bit ambiguous, but those are my thoughts at present. Thank you.

Margo Rosenbach:

Great. Thank you so much. Jeff Huebner?

Jeff, you look like you are muted. There you go.

Jeff Huebner:

Great. Can you hear me now?

Margo Rosenbach: Yes.

Jeff Huebner:

Sorry about that. Thanks so much. Yeah, really privileged to be a part of this conversation, and people have spoken very eloquently about both, I think, the importance of moving forward in this space as well as some of the challenges. And, you know, as a family physician, doing this work and seeing the eventual and continued transformation to moving toward health to moving to integrate medical and social care, especially for the Medicaid population, I think is incredibly important if we truly want to achieve health equity and move from healthcare – just providing healthcare to also improving health.

I will say, you know, from my vantage point, I mean, and this is also, I'll just say, too, like this work is part and parcel of why I am working with Medicaid. I hope and believe that this transformation needs to occur as soon as possible to avoid a lot of the different crises that are happening in our society and our health system, healthcare outcomes, many of which were alluded to yesterday when we were talking in those conversations. So, I think about these challenges which are all being highlighted, and some of you are much more expert in them than I am, but I also applaud New York and other places that are trying to figure them out. And I know here in Wisconsin, both our health plans, and as well as health systems, and certainly community-based organizations are trying to figure this out. And I think it is important to start measuring because if we don't start measuring, we are just going to continue to be kind of mired in a lot of the technical challenges and resource challenges that have been alluded to. So, I am hopeful that we will recommend approval as a Workgroup, but I do understand the current challenges. Thank you.

Margo Rosenbach:

Thank you. Lisa Patton.

Lisa Patton:

Oh, thanks, Margo. Yeah, I just wanted to say I am very grateful for this conversation. I know we have been moving in this direction for a while now, so I appreciate the nomination of this measure and seeing it here before us today. You know, we understand the tremendous impact that housing, and food insecurity, and transportation, and other health-related social needs have on overall health outcomes for this critical population. And so, I – I – regardless of the direction that we vote today, I think this is a great step toward normalizing this conversation and including it as part of the healthcare experience. And I – so I'm just so appreciative that we are here and, you know, and I also wanted to say I found it very encouraging to hear about New York's efforts, you know, while appreciating the challenges that they and other states are going to face in working through this. But we are headed in the right direction with this, and so I think this is going to make a real difference in health outcomes across the board as we get there. So, thank you.

Margo Rosenbach:

Thanks, Lisa. Anne Edwards.

Anne Edwards:

Thanks. Can you hear me?

Margo Rosenbach:

Yes.

Anne Edwards:

Okay. Great. So, I appreciate all this conversation and I will try not to repeat, but this is a long time coming. Having been part of prior discussions around gaps, it is good to see this conversation today. There was some call out around where this might fit on the Core Sets, and noting the reporting in the pediatric Set, I just wanted to highlight that in 2023 in Bright Futures, the Periodicity Schedule for the first time really called out in a footnote on screenings around social determinants of health, racism, poverty, and relational health is key and important to consider in family-centered care. So, certainly this measure would align with the work that is happening at a provider level, work that is longstanding but now is being noted in other spaces as well.

I just want to reflect that I also hear the urgency and the desire to do something in this space and yet the ongoing challenge we have around feasibility and perhaps it is a question of technical support in capacity. And for me, at least, I struggle with, you know, when is this – when is a measure mature enough to meet the urgency of the field to really reflect what families and children and adults need for health.

Thanks.

Margo Rosenbach:

Thank you. Emily Brown.

Emily Brown:

Hi everyone, very much like Ben, my role on this Workgroup is really referencing that patient/consumer voice. And I echo all the comments around this is – this is here now. This is where healthcare is going. And, you know, we really need to have mechanisms to support not only identifying members and patients that have these needs, but really moving toward intervention. Again, I applaud the progress of states like New York who have implemented, or passed their 1115 waivers and have that additional support which we know is critical to address that kind of moral injury of asking someone to screen and then having inadequate resources for referral. So, I, you know, I am listening to all of the discussion around the challenges and barriers of the implementation of and feasibility of this measure. But as a patient and consumer who has navigated and lived through the very real barriers and challenges of not having access to the right food at the right time, I just urge urgency on moving forward so that we can continue to build the evidence to support this work. Thank you.

Margo Rosenbach:

Thank you, Emily. Next, Kai Tao.

Kai Tao:

Hi, all. Yeah, I mean, again, can't underscore it. The importance of recognizing that health is so much more than what happens within the medical, right, clinical field. But I just, you know, want to share our experience here in Illinois. This is not necessarily from Medicaid, we are working on our 1115 to really address health-related social needs, but, you know, we worked a lot – I worked a lot on our birth equity, which is with our statewide perinatal quality collaborative. We are one of the largest ones in the United States. And I am also at a very large FQHC doing a lot of deliveries. When we think about the volume, one of the top ten probably. And it is interesting. We have been screening for social determinants of health, both as FQHC and with our hospitals. We have about 70 birthing hospitals that are part of our birth equity initiative which starts with screening for social determinants of health. And I have to say my concern, again, like everybody else, it is so important, but right now, I mean, I can see a patient chart and see that they were screened, and the results are totally different. I have been doing my own little study from what I am seeing at the hospital when they are in labor, and they are admitted, and they are asked these questions, and what we are doing in the outpatient setting probably, you know, with their initial prenatal. It just really concerns me like what – why was it red here but now it is green? You know, once in a while I get to ask them more about it, and, again, anecdotally it is sort of 50-50. Like, oh, yeah, I thought she meant this from that question. You know, now I'm fine. So, I am just concerned about, you know, that kind of old adage, garbage in, garbage out. Not that we shouldn't start working on it, but I'm just not sure right now we're there yet. So, that's what I want to say.

Margo Rosenbach:

Thank you so much. I still see some hands raised, and anyone who has already spoken, I apologize, I am not going to be able to call on you again. But next, Tricia Brooks and then Roshanda Clemons.

Tricia Brooks:

Okay. Can you hear me now?

Margo Rosenbach:

Yes.

Tricia Brooks:

On and off. I'll try to be really quick here. Very rich discussion, both about the opportunities and the urgency which I really feel. I have been in this space 30 years, as CHIP Director for 15 years, and then doing policy research, and we have been talking about bending the cost curve for decades. And the problem is that we keep filling up the pipeline of adults who have multiple chronic conditions rooted in childhood. We have now a dozen states moving toward multi-year continuous eligibility for our youngest children. Several have already been approved to do that and are implementing as we speak. And this seems like a – just a golden opportunity for us to start going back upstream with kids and making sure that they have the supports that they need in order to thrive in school. And we know that school performance and productivity as adults, what earning power, all of that matters tremendously. And this is the missing link. We can give them healthcare, but if we don't make sure that they are in safe, stable housing, good neighborhoods, and have the food that they need, we are not going to bend the cost curve. So, I appreciate the technical challenges. I don't underestimate them. But it seems like it takes decades for things to get done in Medicaid, and I think at some point we have to put that pin in the wall and say this is a priority, and even though it means a lot of scrambling, because it is not going to be our decision in the end, I still think we need to move forward. So, I appreciate the opportunity to share my thoughts.

Margo Rosenbach:

Thank you, Tricia. And last word from the Workgroup is Roshanda Clemons.

Roshanda Clemons:

Morning everyone. I, too, appreciate this really impressive discussion that we are having, and I think – I don't want to be redundant, either, but as a pediatrician, I feel like, and Tricia, I think you have me beat. I'm at 25 years, you got – you got three decades. But I certainly understand the importance of looking at the entire patient. And I think as a pediatrician, anyone knows who – when you are seeing adolescents, that is really time consuming and we essentially have to do all kinds of screenings. And although it is extremely important, I – I think I am just struggling in trying to recognize how it is actually going to be done. Considering that when I am in the office seeing patients, you know, you can be double booked, triple booked, and to add an additional screen, I am wondering when do you get a chance to actually see the patient? So, I mean, that is just a reality of pediatricians. And maybe all providers, but that has just been our history.

And the other portion that I wanted to comment on, just in terms of the state of Nevada, we are looking at a shortage of most of our primary care providers across the board. And in addition to our shortage, I am thinking about just the burnout rate for – for physicians. And so, if we are looking at a shortage, and we are looking at a burnout, and we add an additional measure that may be time consuming, I just don't – I don't see that it is not important, I just see more of it just who is going to do it? So, to one of my colleagues that actually mentioned that perhaps this should be done during the enrollment process for Medicaid where we can actually get the information that we all need in order to provide comprehensive care. But just struggling with imagining how it is actually going to be feasible for the physicians to take on just one more measure that might be more time consuming. That is just my concern. Not that it is not important, but just struggling with how can we do it. So, I can appreciate the introduction of the – and the addition of this measure, but just wondering if we need to just do a little bit more fine tuning. Thank you.

Margo Rosenbach:

Thank you for those comments. And what an engaging, insightful, thoughtful conversation we have had. And the struggle that I can hear everyone over desirability, feasibility, viability. And how do we optimize that. So, this has just been absolutely incredible. We are now at the point where we will open it up for public comment. If you have a public comment, please do raise your hand and I will call on you.

And also, just a reminder to people on the Workgroup who will be voting, please log in to the Slido site now so that we can get ready for the vote. Do we have anybody who wants to make a public comment or should we proceed to the vote? Last call.

All right. Well, that was such a robust conversation, so thank you. Let's move on at this point then for the vote. Alli and Talia.

Alli Steiner:

All right. Thanks, Margo. Okay. So our vote today is, should the social needs screening and intervention measure be added to the Core Sets? And the options are: Yes, I recommend adding the measure to the Core Set. And no, I do not recommend adding this measure to the Core Set. Voting is now open. And just as a reminder, please refresh your browser if the vote does not appear on your screen.

We are still waiting for a couple of votes to come in, so thanks for your patience. And just a reminder, make sure you have submitted your vote. We will take a look at who is missing. All right. We are still missing a couple of votes, so thanks for your patience. We are just trying to check who we are missing. Thanks. It looks like we are missing Jeff and Angela, so if you can make sure you have submitted your votes, please. Oh, we see we got a comment from Angela in the chat. So, thank you, Angela. I think we are still missing Jeff. So, Jeff, is you can try to make sure you have submitted your vote. If not, if you could. So I think it looks like – if you could send your vote in the Q&A.

Margo Rosenbach:

Jeff, you have your hand raised. Did you want to ask a question?

Jeff Huebner:

Thank you. Yeah, I guess I am having internet trouble. I mean I've – I've tried it twice, and it says sent on my end. But I can type it in or just tell you now.

Margo Rosenbach:

Well, we prefer to have it stay confidential, individual votes.

Jeff Huebner:

Okay.

Margo Rosenbach:

Can we give you a – do you have a cell phone, you could text your vote?

Jeff Huebner:

Yep.

Margo Rosenbach:

All right. We are going to check again, but otherwise we will send you – oh, can you see the Q&A?

Jeff Huebner:

I can’t actually. I just have chat available on mine.

Margo Rosenbach:

Okay. We will figure something out. Oh, can you email our – well, can you email our mailbox? Or text is the best way?

Jeff Huebner:

Yep. I can do that.

Margo Rosenbach:

That would be great. Thank you. We will take the vote any way we can get it.

Jeff Huebner:

MACCoreSetReview@mathematica?

Margo Rosenbach:

That’s right.

Jeff Huebner:

Okay, I just sent it through. Hopefully it’s coming. Thank you for the help. Sorry to the group. My home internet is letting me down, apparently.

Margo Rosenbach:

Thanks, everyone, for your patience. I know the suspense is really hard to take at the moment.

Alli Steiner:

Thanks for your patience, everyone. We are just wanting to make sure we have everyone’s votes in. Okay, it looks like we are missing Clara. Clara, are you able to submit your vote or perhaps add it to the Q&A. Clara, I think we are still missing your vote. If you could either submit it to the Q&A or email the Core Set Review email address, we are still waiting for your vote. Okay. We are going to close the vote. Thanks, everyone.

Okay. So, looking at the results, we had 42% of Workgroup members voted yes, so that does not meet the threshold for recommendation. So, Social Need Screening and Intervention Measure is not recommended for – by the Workgroup for addition to the 2026 Core Sets.

We are going to go into a 15-minute break now, so we will see everyone back here at 12:40 Eastern Time. Thanks so much, everyone.

Margo Rosenbach:

Break is over. We are going to get started with the next phase of our conversation. Next slide, please.

So, I think this is actually a very good segue from the previous vote that we just had, which I know was very suspenseful, and thank you everyone for bearing with us while we tallied up the votes. And, you know, talking about priority gap areas and criteria for the Public Call for Measures for the 2027 Child and Adult Core Sets.

Next slide, please.

So, I think as most people know, each year the Workgroup discusses measure gaps on the Child and Adult Core Sets. And the gaps conversation from the prior Workgroup discussion informs the Call for Measures for the subsequent Annual Review. But we are changing it up, as we have mentioned a couple times before. Beginning with the 2027 Child and Adult Core Sets Annual Review cycle, Mathematica will be conducting a Public Call for Measures. And to inform that, we would like to engage the Workgroup in a discussion of priority gap areas that could inform the 2027 Public Call for Measures. And also we will be discussing the criteria for measure submission for the Public Call for Measures. And at the end of this conversation we will also provide an opportunity for public comment if there is anyone in the public that wants to make a comment.

Next slide.

So, how are we going to do this? So, we want all Workgroup members to be thinking about the priority gap areas in the current Child and Adult Core Sets that could be addressed by the Public Call for Measures to strengthen and improve the Core Sets. I know over the years we have had lots of conversations and some questions about what measures are out there related to particular topics. So, we think that the Public Call for Measures will really help to broaden the capture of potential measures for the Core Sets. But we want to keep in mind the purposes and uses of the Core Sets: to estimate and understand the overall national quality of healthcare provided in Medicaid and CHIP, assess access to and quality of healthcare provided to Medicaid and CHIP beneficiaries, identify and improve understanding of the disparities experienced by Medicaid and CHIP beneficiaries, and also use Core Set data to develop targeted quality improvement efforts to advance health equity.

So, the approach that we thought of is to do a lightning round with Workgroup members. And I’m not sure we are going to have time to include federal liaisons today. If we do, we will. If not, there will be other ways for federal liaisons to contribute. And we will use the order of the roster for the roll call. And ask each Workgroup member to mention one priority gap area or plus one a gap area mentioned by another Workgroup member. I know that is going to be really hard, but please be succinct. Please be concrete. And we will do this lightning round and capture all this information to inform the Public Call for Measures.

So, with that, let’s start with the lightning round by hearing from our two co-chairs. So, first Kim Elliott. One gap area. Set a good model here and be succinct and concrete.

Kim Elliott:

I will be succinct and concrete. Gap area that I think affects access, quality, disparities would be in the domain or the area of maternal mortality.

Margo Rosenbach:

Thank you. Rachel LaCroix.

Rachel LaCroix:

Mine is actually related to Kim's somewhat, but part of it would be focusing on stratification by different important special populations like pregnant women, members with serious mental illness, people with developmental disabilities, things in that area.

Margo Rosenbach:

Thank you. Ben Anderson.

Benjamin Anderson:

Yes. Hi. For my priority area I would like to call out consumer experience, particularly when it comes to measuring patient respect or respect of patients, rather. Outside of, of course, what already the CAHPS survey covers. Thank you.

Margo Rosenbach:

Thank you. Rich Antonelli.

Richard Antonelli:

Yes. Thank you. Interesting call for measures. I – one gap area, as I said yesterday, Margo, and I have been holding onto it today, is even with existing measures, could we please come up with a set of a standardized approach to defining disability. In particular, children, and because I have been in conversations before where the adult disability standards are just naturally extended into childhood. And I would like to be able to look at even Core Set measures by disability status. Thank you.

Margo Rosenbach:

Thank you. Stacey Bartell.

Stacey Bartell:

Yes. I would suggest a patient-reported outcome measure or a patient engagement measure would be something I think we are missing.

Margo Rosenbach:

Do you have anything more specific in terms of a patient-reported outcome? Is there something particular in mind? If not, that's okay.

Stacey Bartell:

Oh, sorry, I was muted there. I believe there are some that have been developed by ABFM that are being looked at in some of the quality programs. I can be more specific with it, but there are some out there that are being rolled into other quality programs right now.

Margo Rosenbach:

Great. Thank you. Tricia Brooks.

Tricia Brooks:

I’m glad I am early in the list before my other pediatric supporters chime in here. Adverse childhood experiences.

Margo Rosenbach:

Thank you. Emily Brown.

Emily Brown:

Hi. Thank you. I would like to – I think there is a gap, again, around consumer/patient experience related to social health needs. I know we didn’t pass the screening one, but I feel like we really need to start looking at quality in interventions.

Margo Rosenbach:

Thank you. Joy Burkhard.

Joy Burkhard:

Related and not as I discussed yesterday, looking at outcomes, particularly with screening measures like the HEDIS measures, of course we care about screening and follow up but using the lens of measurement-based care. Are people actually getting better? That’s what really matters, and I would like to see more outcomes measures.

Margo Rosenbach:

Thank you. Stacey Carpenter.

Stacey Carpenter:

There are two that I agree with that were already mentioned, maternal mortality and the adverse childhood experiences.

Margo Rosenbach:

Thank you. Roshanda Clemons.

Roshanda Clemons:

I would like to piggyback on the maternal mortality measures. And then also a priority one that I would suggest is if we can come up with a measure that would somehow correlate the use of social media and internet with depression and suicide rates for adolescents.

Margo Rosenbach:

Thank you. Lindsay Cogan.

Lindsay, you are unmuted, but we can’t hear you. Lindsay? Could you be double muted? Lindsay, I see that you are unmuted but can’t hear you.

Why don’t we move on to Jim Crall, and we can come back to Lindsay.

Jim Crall:

Yes, thanks, Margo. I would like to cast a vote or a plus for the patient-reported outcome measure. Specifically related to oral health. There is a measure called the Oral Health Impact Profile that has been developed and tested rather extensively and is – captures things like chewing or functionality, pain, appearance, social – psychological impact. And the Dental Quality Alliance has currently issued an RFP to do some testing of this beyond the – that that has been done by the measure developers to see if it can be used as a – for a quality or performance measure. So I think this is pretty minimal burden, five items, and could get us outcomes – outcome measures for outcomes themselves or even to help adjust for differences across programs or plans. Even providers, I guess, ultimately, if the testing bears out.

Margo Rosenbach:

Great. Thanks, Jim.

Lindsay Cogan, are you able to speak? I still can't hear you. All right. Well, we will keep going.

Anne Edwards.

Anne Edwards:

Thank you. I guess this is – lots of great ideas. A plus one really around social drivers. I would frame the ACEs as how do we approach that from a strength-base, so looking at social drivers as well as relational health, racism, and poverty and the impacts particularly in the childhood space.

Margo Rosenbach:

Great. Thank you. And thanks for mentioning Bright Futures. That was also helpful earlier.

Clara Filice. Clara -

Clara Filice:

Sorry, I was muted there. I would echo the social drivers across the lifespan. Social drivers of chronic disease and other disease states. I think there are some real gap areas in health equity measurement especially related to barriers to access such as poor quality language access services, disability – the identification of accommodation that I would – that I would also like to add to the list.

Margo Rosenbach:

Thank you. Angela Filzen.

Angela Filzen:

I would also echo a lot of great ideas, but two that stand out. And one was Jim as far as the patient quality measures with the lens of the oral health integration. We've seen a lot of work throughout the state and nation around interdisciplinary collaborative practice, and so measures as such would really lift up the value, you know, for health and utilizing providers across spectrums to help bring about better outcomes. And then the other one would be social drivers, as well. I think that lens is needed to better assist barriers and improve equity across access and utilization of services. Thank you.

Margo Rosenbach:

Thank you. Sara Hackbart.

Sara Hackbart:

Yes, good morning. Thank you so much for this opportunity to comment. I do think we have quite a gap area when it comes to caregivers and especially with the LTSS population and really understanding their – their needs – the caregivers' skills, their needs, their roles. And particularly when it comes to transitions and what – what that looks like, what support can be there, that experience of care that the LTSS population has along with caregivers in that space. I think just in general there is a gap when it comes to our home and community-based service – services and supports when it comes to that quality piece. I think the access rule has done a lot to really bring that HCBS measure set to the forefront. That hasn't been finalized yet, so still some work to do there. But when we really look at the research out there and looking across states, we see that gap. A lot of times we are looking at nursing facility or Medicare type quality performance measures just because we don't have a lot in the HCBS space. So, looking forward to putting that out there and really being able to have some succinct measures across states when it comes to HCBS and LTSS. Thank you.

Margo Rosenbach:

Thanks, Sara. Richard Holaday.

Richard Holaday:

Thank you. So, I just wanted to reiterate maternal morbidity. But also maternal SUD.

Margo Rosenbach:

Thank you. Great. And Lindsay Cogan, are you able to speak?

Not hearing you. I will keep coming back.

Jeff Huebner.

Jeff Huebner:

Thanks. I would just plus one the idea of patient-reported outcome measures and especially patient engagement. I think Stacey Bartell was probably referring to the person-centered primary care measure as a great example of this. The PAM, the Patient Activation Measure, is another example. Thank you.

Margo Rosenbach:

Thank you. David Kelley. David, we can't hear you if you are speaking.

David Kelley:

I – yes, I am speaking.

Margo Rosenbach:

Okay, now I can hear you.

David Kelley:

Okay. Very good. So, I would think in terms of for the Adult Core Set adding the adult immunization measure. We have pediatric, we have child and adolescent immunization measures on the pediatric Core Set. I think not having adult immunization measures really sends a message that that is not a priority within our population, and obviously this is one of the most effective healthcare interventions that we have in the twentieth and twenty-first centuries. So. The other one that I would advocate for is looking at Hepatitis C. The screening, treating, and then does it test positive, to actually look at those that initiate into treatment. Thanks.

Margo Rosenbach:

Thanks, David. David Kroll.

David, if you are speaking, we can't hear you.

David, could you be double muted?

Margo Rosenbach:

I think we might - David?

Okay. Well, let's keep going. Jakenna Lebsock.

Jakenna Lebsock:

Can you hear me?

Margo Rosenbach:

Now I can.

Jakenna Lebsock:

Okay. I would like to echo support for a maternal mortality metric. I think that is really important and an area we need to focus on. And then would also echo continued focus and work in the social needs space and really figuring out a metric that would work. I think that is going to be critically important as well.

Margo Rosenbach:

A quick question or comment. The maternal – when you say maternal mortality, those rates are pretty low at the state level, fortunately. Obviously still a very major concern and issue worthy of attention but low from the standpoint of a state-level rate for the Core Set. Are you – and I did already hear somebody mention morbidity. So, are you thinking maybe severe maternal mortality as – or morbidity as well? Not to put words in your mouth, but just to keep in mind this also is meant for state-level reporting.

Jakenna Lebsock:

Yeah, I think it is more probably in the mortality space, at least what we are focusing on is more of an equity-based measure and what those outcomes really look like for different stratifications. And granted it is low, but I think there is a lot of underlying factors that we still need to work on to truly be at a place where, at least in Arizona, we would be comfortable with what we are seeing. So –

Margo Rosenbach:

That's a helpful clarification. Thank you so much.

Jakenna Lebsock:

Sure.

Margo Rosenbach:

All right. Hannah Lee-Brown.

Hannah Lee-Brown:

Yes, hi. Thank you. I would like to call out opioid utilization. Especially since we voted to remove the one measure, I think there might be a little bit of a gap here. And it would be great to see something that is a little bit more focused on something farther upstream in the prescribing process. Perhaps something around initiation of therapy. Maybe something kind of akin to what has been proposed in the Part D program. It would be great to see some alignment between programs there.

If I might also add kind of a plus one to support the comments much, much earlier around disability-related measures. I think that is so important and so often overlooked, so I would just kind of like to lend support there.

Margo Rosenbach:

Great. Thank you. Kathy Leyba. I'm not sure I see Kathy on right – oh, there you go. Okay. If you are speaking, we can't hear you.

Kathy, are you possibly double muted? Kathy, are you able to speak?

Katherine Leyba:

Hear us now?

Margo Rosenbach:

Yes.

Katherine Leyba:

Oh, great. Thank you. I have been trying to get this unmuted for a while. So, focus on maternal mortality, SUD specifically. We would really like to see something that supports that. In our state we, you know, that is one of our target populations.

Also, I don't know if this is the right space for this but network adequacy. Our – our state is like struggling with specialty providers and even HCBS. I know a colleague mentioned that a minute ago. I think that is one of our biggest challenges. And because it aligns with access, I don't know if that is something that we could look at.

Margo Rosenbach:

Great. Thank you. Let me go back and see – Lindsay Cogan, are you able to speak? You look like you are unmuted.

And David Kroll.

David Kroll:

Hi there. Sorry about my muting issues earlier. I appreciate all the comments that have been made. The one additional area I would want to call attention to is that for measures that pertain to depression. You know, right now a lot of the measures we rely on pertain to screening, which is really important, but we know that screening alone does not improve outcomes. Documentation of a follow-up plan probably adds some to that but is somewhat difficult to do. There are depression outcome measures that do exist, and I believe some of them have been approved. I know that some of them have been approved for use in quality payment programs. They don't have quite as much data to support them. The measurement-based care, meaning the use of symptom rating scales to really field those measures is not really in widespread use. That's why I don't think they are quite ready for prime time or inclusion in the Core Set. But over time what I would like to see is if we can get more data on the use of these outcomes measures for depression, I would love to see these ultimately replace screening measures. Thanks.

Margo Rosenbach:

Great. Thank you. All right, Lisa Patton.

Lisa Patton:

Thanks, Margo. Yeah, there are too many good ones. I will be a plus one for social drivers, of course. And then also just in terms of the opioid measures, now that we – now with the evolution of the measurement process and also the epidemic itself, it would be great to see some more nuanced opioid measures that we could take a look at. Thank you.

Margo Rosenbach:

Thank you. Laura Pennington.

Laura Pennington:

Thanks, Margo. So I want to plus one the outcomes-based measures. We are very interested in measures that demonstrate the impact of interventions on the actual health outcomes. As an example, and kind of to David's point, the DRR depression, remission, and response measure from NCQA is one that we are particularly interested in and adding to all of our current contracts. So, that would be my vote.

Margo Rosenbach:

Great. Thank you. Grant Rich.

Grant Rich:

Hello. Can you hear me?

Margo Rosenbach:

Yes.

Grant Rich:

Yeah. I am a psychologist, and I have noticed there is a number of opioid, depression, and maternal measures, and that is great. Maybe there could be more and better. But what I did notice is there is not a measure of anxiety disorders. The lifetime prevalence of anxiety disorders including PTSD is about 25 to 30 percent. So it seems smart to have a measure perhaps screening and referral to treatment for anxiety disorders. And I toss in we don't have anything on personality disorders either. The lifetime prevalence, just to pick one, borderline personality disorder which gives elevated suicide, SUD risk, and elevated risk of job and relationship, is about two percent. That is double the lifetime prevalence of schizophrenia. So, I would advise there. And my plus one, I would definitely support an ACEs-like measure, adverse childhood experiences, as well as protective and compensatory experiences, PACEs measures that could look at some social drivers including racism and poverty. Thank you.

Margo Rosenbach:

Thank you. Lisa Satterfield.

Lisa Satterfield:

Hi, everyone. Thanks for this discussion. In terms of the maternal mortality, obviously it is a very important topic for ACOG and for the country. I do think that there are other entities measuring this at this time. You know, the CDC collects this data and updates it annually and they break it down by race and time of delivery and mental health and a whole list of other conditions. So – and to echo what was said earlier, the n per state and per hospital is so low that you run into issues with disclosing information that could be identified as personal health information. So, I'm not exactly sure what the answer is for maternal mortality or measuring maternal morbidity except for that one of the issues we do have is that because of the global OB codes and the way the claims run, we don't have a good idea of how many visits are being done for each – for each patient, and we don't have a good idea even for different conditions they have. So, that might be something we want to think about or maybe this isn't the venue.

But I do have a couple of other ideas. There are a couple of quality-of-life measurement tools out there for menopause and for bleeding disorders. And I think that those are very important to Medicaid and Medicare. Bleeding disorders especially in the child and adolescent population as the start of menses begins much earlier in our society. And then menopause is just – it is finally becoming okay to talk about publicly, so it would be great to see if folks are being asked about their menopause symptoms as well as their bleeding disorders.

And the other thing that we are tooling around with is urinary incontinence. There is a NCQA measure right now for urinary incontinence over the age of 60, but I mean the fact is that it kind of happens at the age of 40 and 50 there is a pretty high prevalence as well. So, while it is great that there is a measure for over 60, it would be good to see if younger patients who maybe are having it not related to age, which it's kind of not related to age anyway, are being asked because I do believe that there are several patients out there that are just kind of dealing with it and think it is normal after having a child, which it is not.

So, those would be my three additions to the list. Thank you.

Margo Rosenbach:

All right. Thanks, Lisa. Linette Scott.

Linette Scott:

Can you hear me okay?

Margo Rosenbach:

A little faint, but yes.

Linette Scott:

Okay. So, being towards the end of the list here, a few plus ones. So, certainly patient consumer experience is something we have talked about a lot over the years and having a better way of doing that would be great. Adult immunizations is another one that was talked about at various times in terms of having it better – better reporting there. The – the other one that I would do a particular plus one on, long-term-support services, home and community-based services. In particular, highlighting that there is reporting that CMS has been working on in that space using our T-MSIS data, and they are planning to start reporting using our T-MSIS data which, of course, is dependent on the data quality issues. But there may be some opportunities given that to look into measures in that space that are feasible and help fill that gap. Thank you.

Margo Rosenbach:

Thank you. Kai Tao.

Kai Tao:

Hi. Okay, I took my assignment very seriously. So, falling under the three domains for both Child and Adult: Primary Care Access and Preventive Health, Maternal and Perinatal Health, and Experience of Care. And also what I am recommending would be extremely helpful and balancing, or complementing the current Child and Adult measures of contraceptive care methods, or CCW, CCP. I would like to recommend a 2020 NQF-endorsed four-question tool to measure patient-reported experience. It is termed a Patient-Centered Contraceptive Counseling, or PCCC for short. We know hearing from the patient voice is the best way to understand the quality of health care. And it is especially relevant where we see wide gaps in health care outcomes stemming from implicit bias, cultural stereotyping, or racism. Whether it is for birth spacing, pregnancy prevention related to coexisting morbidity, or treating many common symptoms and gynecologic conditions, nine out of ten women have used some type of birth control in their lifetime. And the ongoing assault on women’s right to choose continues to boil, therefore, unfettered access to all methods of contraception is critical for bodily autonomy and the wellbeing of our nation. So, specifically for contraception, the best method is the one that the patient voluntarily chooses. Thus, patient experience is particularly important given the personal nature of contraceptive choice with no target for any specific method. Patients want to feel respected and heard. They want enough information to make a decision. And they want support with their decision. This is exactly what the PCCC captures. Many of the providers being evaluated by – if we use the PCCC are also the same frontline providers in providing obstetrical care, which is a further reason to adopt the PCCC. This measurement can transcend into improving the outcomes of birth and postpartum morbidity and mortality that has been brought up here. It is time we address the entire reproductive lifespan which starts with preventative services such as contraceptive care. I can’t think of a better way to identify and improve understanding of the health disparities experienced by Medicaid and CHIP beneficiaries than with the PCCC. Thank you.

Margo Rosenbach:

Thanks, Kai. Ann Zerr.

Ann Zerr:

I think all great ideas. I think, you know, we could figure out the logistics of all of them. I actually would be very interested in some quality metrics around home care. I think it is sort of uncharted territory, and I think that the expectations for what that looks like and how it should be measured are very unclear. And I think it ties into many of the priorities that other people have mentioned with people with disabilities, complex children getting a lot of home services. So, I think figuring out some way to look at some quality around home care services. And outcomes.

Margo Rosenbach:

Great. Thanks, Ann. Bonnie Zima.

Bonnie Zima:

I just have two unique comments. One is to bring forth the issue of the gap around suicide. We have talked about this before. One option is to examine use of evidence-based suicide risk strategies stratified by the socio demographics, consider stratifying by composite index of social vulnerabilities. And I understand it is a big task, but maybe a start is to examine use of evidence-based suicide risk strategies after an ED visit for a suicidal ideation or suicide attempt with time windows of seven and 30 days.

The other thing I would like to mention is our ADHD measure. I would like to consider expanding the maintenance phase to add reporting publicly prescription persistent stimulant medication and engagement in ADHD care at three and six months. And the reason why the three-month time window is important is that this would then comply with Department of Justice limits of 90-day supply of stimulant medication.

Thank you.

Margo Rosenbach:

Thanks, Bonnie. I think we will try to do a quick round robin or lightning round with federal liaisons. I am not sure who exactly is on. I see Stephanie Clark from CMS. Stephanie, do you have any comments? Or one comment?

Stephanie Clark:

I just wanted to plus one the social drivers of health as well as the maternal health. Thank you.

Margo Rosenbach:

Thank you. Abby from CDC. Abby, I see you there. Do you want to raise your hand and we can unmute you?

Oh, Hilary. Okay, I see you now, so you are unmuted.

Hilary Wall:

This is Hilary Wall. Can you hear me?

Margo Rosenbach:

Yes.

Hillary Wallach:

Okay. Great. Thank you. So, I just want to quickly say it has been great to hear so many suggest a measure for maternal mortality, but I am going to make a quick plea for a maternal morbidity measure. The Medicaid Adult Core Set includes controlling high blood pressure, but this measure excludes pregnant persons. And one of the leading causes of maternal mortality is hypertension, and it disproportionately impacts Black and Native American women. So, about a year-and-a-half ago, the American College of Obstetricians and Gynecologists issued a practice advisory urging OB-GYNs to use a lower threshold which was placed at greater than or equal to 140 over 90 milliliters of mercury as that threshold for initiating or titrating antihypertensive medications. For years that threshold had been above 160 over 100, or what is referred to as severe hypertension. So, currently we have a measurement gap to assess hypertension management for pregnant women with what I will generally refer to as pre-severe hypertension, if you will. And so, I think this is a big opportunity for states and the country. Thank you.

Margo Rosenbach:

Thank you. I am not seeing others in the list of attendees from AHRQ, or HRSA, Indian Health Service, ASPE, Office of Disease Prevention and Health Promotion, SAMHSA, or Veteran Affairs. Is there anyone from those agencies that wanted to make a comment before we move on? If so, please raise your hand.

Yes, I see Girma Alemu.

Girma Alemu:

Girma from HRSA.

Margo Rosenbach:

Sorry. Or thank you.

Girma Alemu:

Can you hear me?

Margo Rosenbach:

Yes, I can. Sorry I – I botched up your name, the pronunciation.

Girma Alemu:

Yeah. Girma. It’s – yeah. You know, many of the gaps have been already mentioned, but I would like to see the social screening intervention measure, you know, looked into. You know, there are constant mentions today which CMS needs to look into and bring it back, you know, for the next review. I think this is an important measure. Thank you.

Margo Rosenbach:

Thank you.

All right. With that, thank you everyone for taking that seriously with the lightning round, and let's move on to criteria. We don't have as much time to talk about the criteria, so the next slide, please. And I think we will just do raised hands and give it about ten minutes or so. But thinking about the Call for Measures criteria, you know that we have minimum technical feasibility requirements, actionability and strategic priority, other considerations. And any other criteria that you would suggest for the 2027 Public Call for Measures. So, I am going to turn to the next slide, and you will see the list of criteria that we used for the 2026 Call. As you know, all the minimum technical feasibility requirements must be met for a measure to be considered. We expect that that would also apply to the Public Call for Measures. But then also there would be some other factors, again that ensure that the measures are a good fit for the Core Sets.

Any comments on these criteria, any other criteria that you have in mind that you would suggest we consider?

Ben Anderson?

Benjamin Anderson:

Yes. Thank you. Thank you so much for the question. I think – I think it would be great to see equity added in a larger way. And I don't mean, you know, just in terms of, you know, what – what is able to be stratified, but, you know, considerations around measures, for example, related to pregnancy, women's health, children's health. Maybe particular measures that are particularly useful for certain subgroups within the population. I think that would be a great addition to the criteria. Thank you.

Margo Rosenbach:

Thank you. Rich Antonelli.

Richard Antonelli:

Yeah, thank you. And thank you for this wonderful exercise. Being mindful that in order for the current – the 2026, we – the measure has to be demonstrated with stratification, I think that will get us to equity as well. But I would like to really sort of call this out in the Call for Measures, Margo, that explicitly let them know what the requirements are that were in the State Health Officer letter sort of as a minimum foundation and then moving forward as well. Thank you.

Margo Rosenbach:

Thanks, Rich. That is a great idea. I mean, certainly one of the things we are thinking about is how this process would be revamped in terms of the form that we would be using and requiring complete submission. And I know sometimes, you know, some information might be missing or unknown, but I think for the Public Call for Measures, as I think is done in other parts of CMS, there will be a requirement that complete information be provided about the measure. And that is an excellent suggestion in terms of making sure that it is amenable to stratification. That the data elements are there, that it has been tested, validated, and so on. So, thank you for that suggestion.

Lindsay Cogan, are you able to speak now?

Lindsay Cogan:

I am. Can you hear me?

Margo Rosenbach:

I can. Do you want to go back with any priority gap area? I don't know if you could hear the conversation, if you have something to add there?

Lindsay Cogan:

I could. I had – I had another call that I was on. And I think that the vast majority of the gap areas that I had wanted to bring up were there.

I just wanted to think about the application of the Core Sets I think is an area in which I think maybe we could spend a little bit more time on next year. So, we as a – at the state Medicaid level are being asked to, in all of our work, whether it is through payment arrangements, or evaluation work, or reporting and monitoring requirements, different offices within CMS all point us back to the Core Measure Sets. So, when there are gaps, particularly in strategic priorities are areas that we are all working on, that tends to cause a lot of issues for us at the state level. So, I just wanted to kind of bring that up and maybe make a plea for next year to spend a little bit more time having other areas of CMS talking about how they apply or are using the Core Set measures in different programmatic areas because I think that would drive us toward another dimension of the conversation when we think about gap measure areas. So, that was just the one thing that I don't think was brought up today.

Margo Rosenbach:

Great. Thank you.

Lindsay Cogan:

And then the additional criteria, so I just had one. Just the duplication, right. So, if someone is putting forward a measure that is already represented in the Core Set, I think there needs to be a requirement that that measure be either removed and replaced or we need to be careful about duplication, measuring the same thing in a slightly different way, across our Core Sets. So, I think that there are definitely areas where we can expand and look into different care processes or outcomes. But I just want to be careful, and I think that that should be another criterion that when you are putting forward a measure, if it is already reflected in the current measure, that should be highlighted in the Call for Measures. That that is – we are looking to sort of fill gaps, replace where necessary if there is change in clinical guidance, if there is an outcome measure in replacement of a process measure. But to have multiple process measures that look at the same thing is something I would like to see us really kind of move away from and hone and focus a little bit more.

Margo Rosenbach:

Thanks. Great idea.

Joy Burkhard.

Joy Burkhard:

Just on that comment, I wonder if there is a way that the meetings could be structured slightly different to allow like a motion to adopt a new measure and replace an old one after Workgroup discussion. Margo, it makes it a little more difficult, perhaps, or challenging with your team, but it feels sometimes with discussion so rich that it is hard to, when you are making a nomination, to remove or replace, we really need the full Workgroup's input, I think, on replacement if – I think you are following. Hopefully you are following, Margo.

Margo Rosenbach:

Yeah. I would need to think about how that could work in practice. I think that is really the intent of the Call for Measures that if you are suggesting a measure for addition, but kind of going back to Lindsay's point, where there is a potential for a replacement, that that would be handled in combination and so that the discussion and the vote would deal with both the addition and the removal. But I do understand what you are getting at.

Joy Burkhard:

Yeah. And anyone who has ever been on a board of directors knows how this works. There is some discussion, and then there can be a motion, a vote, to address the measure proposed, and then amended motion to accept the new measure and replace the old. Do you see what I mean? So, I am happy to talk through some of that, the logistics, really Robert's Rules of Order – anchored in Robert's Rules of Order.

Margo Rosenbach:

Yeah. I would say that this is a very different process, but we will certainly take that under advisement of how that might work in reality. There's a lot of considerations. So, thanks for that comment.

David Kelley, you are next.

David Kelley:

Thanks so much. One thing that I think we should think about as new measures come to us is the concept of harmonization. So, if some new measure is proposed, and let's say there are very similar measures that are also out there that meet all of the other requirements, that there is some – some research or homework done to look at which of those two measures is more widely used. So, again, that way we are – if we are going to vote on a measure, it is a measure that is most widely used if there are, let's say, two competing measures out there.

Margo Rosenbach:

Great. Thank you.

Jeff Huebner.

Jeff Huebner:

Thank you. Yeah, it has been wonderful to be a part of this group, and it is my first year so I am learning still how the process works. I appreciate David's comments there around harmonization. I was going to also just talk about alignment. I see that listed in the other considerations out there. I think if there is more context for us in regards to what other federal programs are doing and/or in the commercial environment, that could be really helpful, too, because I know provider burden, Medicaid burden, administrative burden in general, whether it is at the level of state agencies, providers, health systems, that is incredibly challenged in contributing to some of the workforce issues and the burnout issues right now.

I also want to do a quick plus one on the equity and call that out. I had the privilege to be part of an NQF workgroup. I think it was their first health equity advisory group that was brought into the Medicare MUC process, Measures Under Consideration. And it was very explicitly not just about whether the measure can be stratified, but whether the measure itself is going to contribute to more equitable health outcomes looking at especially the population health impacts. And I think looking at the measures in isolation is a challenge for us a group. I think as other people have pointed out in some of the conversations yesterday, there is a finite amount of resources bandwidth, and if we are putting X, Y, or Z resources into certain measures, it makes it harder, for example, to maybe put more effort into the SDOH arena or other important arenas. Thanks.

Margo Rosenbach:

Thank you. Tricia Brooks.

Tricia Brooks:

Yes, thank you. So, you know, when you mentioned yesterday that there will be a call for the public, the first thought that flooded my head was, oh, my god, we are going to be overwhelmed, right. So, I do believe this emphasis on that the completion of the, you know, the recommendation or suggestion really needs to be emphasized. But I am also wondering if there is a way, and you may need to give this more thought so not expecting an answer necessarily, for people to just weigh on the gaps. So, a measure may not be ready for prime time, but I think it would be interesting to sort of take the pulse of people who watch from a quality perspective to hear what they would throw out there as being gaps in priorities that could be addressed in future measure development. Thank you.

Margo Rosenbach:

That is very interesting, Tricia. I think some of us are remembering back to the first year that we did the Core Sets Review meeting, in person, back in 2019, I think it was. David was a co-chair at the time. And we had 50 plus measures and we're pretty terrified about that happening again. And that is where actually the minimum technical feasibility requirements came from. So, I think your comments are good. I think it is something that we are giving a lot of thought to. I think another element here, and I thought about this also when we had the conversation about the Social Need Screening and Intervention measure, is that some measures might not be ready for prime time, but maybe there is further testing of the measure in Medicaid as part of kind of the learning process. As many people said, it's not ready but, you know, we think it is important to make some progress. So, that is another thought, that even if a measure is not ready for prime time, maybe there are other dispositions for, you know, kind of making progress.

Tricia Brooks:

Thank you.

Margo Rosenbach:

Ann Zerr, did you have your hand raised? Ann, did you have a comment?

Ann Zerr:

. Yes, thanks. I was just going to feel some compassion for my primary care colleagues, just some thoughts about who is going to be responsible for carrying out the measures. And because I do think, to follow up on some comments, people really are weary and overwhelmed, and so I think that, you know, the minimum criteria are key. You are working hard to shift it away from the provider doing the one-on-one care with the member, and I think that is going to be key to the quality and success of the measurements.

Margo Rosenbach:

So, to extrapolate from what you said and also some of the things we hard in the last measure discussion, is one of the ways to think about this, where does the data collection responsibility fall? Is it the provider? The plan? The beneficiary? Secondary data from, you know, the state, T-MSIS, TAF…Is that a way to be thinking about this?

Ann Zerr:

Margo, I think that was perfectly articulated. I think you took a huge amount of mess and – and made it really very succinct. And I think that is key that, you know, as I thought about what Kai said, it's just like, oh, my goodness, you know, primary care doctors have to do this. Because you have to do this because they may not touch the midwife or the obstetrician. So, just thinking about, yes, the way you said it is perfect.

Margo Rosenbach:

But going back to that measure, which I am familiar with, the burden is on both the provider and the beneficiary in that particular case. And so, thinking about it from kind of a collection of information perspective, the way OMB does, there is a burden on the provider and a burden on the beneficiary. So, you know, thinking about the word burden, in quotes, but that is the way OMB thinks about it. So, that is a very helpful way of thinking about it.

Another thing that comes to mind as you were talking, and other people, what level was the measure developed for? Plan? Provider? Etc. And has it been used at the state level. So, we – we have, we think it is our third criterion in the first column, is that – well, no, actually it is the second one, is that it must have been tested in state Medicaid and/or CHIP programs or be in use. But I think there is also that element of, you know, the adaptability to state-level reporting. So, very helpful comments. Thank you.

All right. Joy Burkhard. Do you have another comment?

Joy Burkhard:

A quick comment more for CMS, and I think we discussed this just briefly last year. You know, an overall impression from me has been that the measurement development processes can be a bit of the tail wagging the dog, meaning the measures are developed by various entities and then we consider them. And I wonder if there is some sort of broader strategic process that this group or others could be involved in that look at – and I think we are kind of moving in that direction, Margo, but, you know, put out a call for a measure to be developed and then – and say that these are the things that we would like to see within it, and then have it be developed just to move things along more efficiently. We also, with the perinatal depression measures, had to actually fundraise, find philanthropy, to fund the measures being developed by NCQA, which is ludicrous, really. We need to identify the gaps in measures and then have federal funding to develop those. Thank you.

Margo Rosenbach:

Other comments before we move on to public – oh, Roshanda.

Roshanda Clemons:

Thank you so much for this opportunity. I am a newbie, too, here, so this has been – I really appreciate having the chance to even participate in these dynamic discussions and just this forum in general. And so, what I was thinking about just in the couple days of experience I just had listening, is that it would be nice if there was an opportunity to just do like revisions. Because I am thinking about in terms of like how much of a struggle it seems like when people were trying to make the decisions as to whether we should make additions or remove where we were really looking to kind of braiding some of the measures together. Like if we just look at in terms of like the prenatal measure that we just passed and then the postpartum. Like if there would be an opportunity where we can do revisions or even as information is – surfaces and we may see that outcomes show that something is just a little bit outdated. Not that the measure needs to be removed, but it might need to just be tweaked a little bit. So, that would just be helpful if we had an opportunity to do that.

Margo Rosenbach:

Yeah. Thanks for that comment. It is definitely something that we have given some thought to, and we will give some more thought to it as well. Whether there is some kind of a debrief afterwards. I think we had hoped to have more time to even talk about the social needs measure, maybe with that idea in mind about what some next steps might be since there is just a, you know, a very high level of desirability of that measure but other concerns about the challenges. And maybe when we get to this next part of the agenda we can talk a little bit more from that point of view related to technical assistance and next steps with some of the measures that exist but that aren't ready for prime time. So, thank you for raising that.

Richard Holaday.

Richard Holaday:

Yes, thank you. This is also my first year on these Annual Review meetings. I really appreciate the opportunity. As I have been listening in the last couple of years as Director of Quality for DMMA. I would just like to reiterate the harmonization of measures and equity. But also I do have a question and I don't know if this is the place for that, but when measures' technical specifications change, I don't know if that is something that we could – if it is possible to take a look into that. For example, how the IET measure moved from member-based to episode-based.

Margo Rosenbach:

Interesting. David Kelley, you might know the answer to this, but when that changed, whether NCQA put that out for public comment because oftentimes they do put things out for public comment. That is a tough thing for us to do here, I think, in the context of Core Set Review, but it is something that we do make note of when we update the technical specifications. I think it is a really interesting point. Something that we can think about, and think about with CMS as well because even measures that stay on the Core Set, every year it seems like there are some changes. And on March 19, I will put out a plug, we are going to be doing our 2024 webinar, and that is when we will be noting some of the changes that were made to measures for the FFY 2024 reporting period. And there always are changes that we learn about. But I think it is a good question.

Yes, David?

David Kelley:

I think NCQA, they did put that out, I believe, for public comment. And I know that – I don't know at some point maybe they would be willing to share – a lot of times when they do those types of changes, they actually run some preliminary testing on various lines of business. So, which is very, very informative. So, that may be something that you would ask NCQA to do is to really look at whether or not a particular change in a measure has a significant difference in the result. And then how trendable is that. Those are all reasonable questions, and if it is an NCQA measure and they are the ones that have changed the spec, I think they probably would – it would be very informative. And maybe that is something that could be done. You know, maybe not in this forum, but in some of the other TAGs and other quality forums that you guys help to run. So, I think that – that is probably the right forum to address those changes. But it is a great question because you really get into, you know, we use that measure for some our incentive programs with our MCOs. And, obviously, then you get into trending and whether or not you can really trend from one year to the other. And in some instances, we make – make managed care plans do it the old way for at least a year so that there – there is an overlapping year there so that they can really trend incremental improvement.

Margo Rosenbach:

David, that is a great point. And, in fact, we do work with NCQA on trendability, and we put out an annual technical assistance resource or methods resource related to trendability of Core Set measures. Of course, with COVID we haven't been trending for the last couple of years, but expect that to pick up again at some point relatively soon.

So, very good point. That is definitely one of our considerations analytically. But it also just gives some good insights into the implications of changes for continuity.

All right. Well, I think at this point, if there are no further comments, last call before we open it up for public comment. All right. Any public comment at this point about the Public Call for Measures?

Jeff Schiff. Hello. Jeff, we can't hear you. You are now muted again.

Jeff Schiff:

Can you hear me now?

Margo Rosenbach:

Yes.

Jeff Schiff:

It is wonderful to hear voices of old friends and new – and new ones. I am a little bit of a dinosaur here since I was involved in the 2009 Core Set selection and still involved in the Health Home Core Set.

I wanted to just highlight a few things that I am hoping will be taken into consideration. One, which Joy Burkhard, I think, just hit very nicely, is on figuring out a way to accelerate the process for new measure development. As I work with the Medicaid Medical Director Network, there are measures that are slow to come up and are key public health concerns for the

Medicaid population. And it would be nice for the government to figure out a way to sort of accelerate the prioritization of the development of those measures so it doesn't take as long as it sometimes does.

And around picking measures, I just want to suggest that we think a little bit – we think about this as state reporting so we can see where states are at. But I think we also have to think a little bit, not just about the burden of collection, but around who the accountable entity for change is. So, if measures like low birth weight are accountable across a broad spectrum, and some measures are very specifically accountable for providers, we have to figure out how much energy and then real estate we want to put into accountability at which level. And I wonder if that would be a way to, on the chart that is there, if that is a way to at least classify measures to think about what entity is accountable. And then one specific thing under there, and I think this came up earlier, is around how to make sure we have adequate access for services as part of that accountability equation.

Thank you all for dedicating your time to this, and it is nice to be able to comment.

Margo Rosenbach:

Nice to hear your voice, Jeff. Thank you.

Other public comments? Do we have any other public comments before we move on to the last part of our meeting? All right. Well, why don't we move along. We have one more opportunity for public comment at the end. All right. So now we are at the reflections part of the meeting. Next slide, please.

So, this slide presents an agenda for this part of meeting. To begin, I would like to recap the Workgroup's recommendations for updating the Core Sets. The Workgroup discussed four measures including two measures suggested for removal and two measures suggested for addition. As a reminder, to be recommended for removal or addition, a measure required a yes vote from at least two-thirds of the Workgroup members. And thanks to everyone for managing the new voting technology in this virtual environment.

So, the two measures suggested for removal, the Workgroup voted to recommend the Use of Opioids at High Dosage in Persons Without Cancer, OHD-AD, was recommended for removal. Initiation and Engagement of Substance Use Disorder Treatment was not recommended for removal. And of the two measures suggested for addition, the Workgroup recommended one measure for addition, Prenatal Depression Screening and Follow- Up, but did not recommend Social Need Screening and Intervention for addition.

We also had a very robust discussion about the priority gap areas and criteria for the Public Call for Measures for next year. And thank you everyone for all of your input as we plan for the Call for Measures.

So now we are going to ask the Workgroup to reflect on state reporting of the Child and Adult Core Sets, especially with the implementation this year of mandatory reporting. We would like to hear Workgroup member suggestions for technical assistance to help states with reporting of the Child and Adult Core Sets measures. Are there suggestions on how to build state capacity for calculating and reporting Core Set measures?

So, Workgroup members. Suggestions for technical assistance.

Kim Elliott.

Kim Elliott:

Hi. One of the things that came up quite often during our discussion today was technical assistance related to the ECDS measures and whether that is just for the states or the states and their managed care organizations. Because I think both would benefit from that kind of technical assistance from CMS or their partners.

Margo Rosenbach:

That’s great. And digital measures more generally, I would say, right?

Kim Elliott:

Yes, I would say so.

Margo Rosenbach:

Thank you for that, Kim.

Richard Antonelli.

Richard Antonelli:

Thanks, Margo. And before I make a suggestion, I just need a clarification. Do we anticipate across the states and the territories that mandatory public reporting means the same thing? Will – the question is this: will that data be sufficiently made public so that all relevant persons, so not just providers, not just the agencies, but the beneficiaries, will actually have a chance to look at it and – and make recommendations for improvement. So, in other words, what will we do with that data? So, is – if that is going to be heterogeneous, I would like to make a recommendation that we try to make that as effective as possible. And if it is homogeneous, that’s great and I would love to hear what the proposal is for TA on, quote/unquote, what are we going to do with this data to make things better?

Margo Rosenbach:

Wow. Okay. So, a few things, Rich. So, first of all, data that meet the threshold for public reporting are publicly reported. There is a raw data file. There are measure performance tables. There are chart packs and other products. So, the idea is that those products would continue to be produced. The idea also being that with mandatory reporting, and also I will add voluntary reporting of Adult Core Set measures that are not subject to mandatory reporting, with mandatory reporting the intent is that all states would adhere to technical specifications so that it does move to greater homogeneity. Currently there is a bit more heterogeneity in terms of which populations are included and a variety of other factors, variations from the technical specifications. So, the idea is that we would move toward greater adherence to the technical specifications and greater inclusivity of all populations across all states. So, I’m not sure if that answered your question, but I think the idea is that we would be moving to greater homogeneity.

I think the other part of your question is, well, now what? We have all this data. We have more data for more states, what gets done with it? I think there is a lot of excitement on the part of CMS and lots of others. You know, states use these data to benchmark themselves against other states. Think about quality improvement initiatives. Think about how they can address gaps in disparities with more stratification that’s happening. So, I think if I am understanding your question, we would be moving in the direction to having greater use of the data for the purposes for which it was intended. Understanding nationally what the overall quality of healthcare is. Being able to look across states. Being able to look within states. So, I think that – that is the intent. And you also did mention the territories, and thank you for that because Puerto Rico, Guam, and the Virgin Islands are all subject to mandatory reporting as well. They will take – it will require a lot of technical assistance since they are, you know, a little bit behind where states are in public reporting or in reporting the Core Set measures, so I think that is another element that we are very focused on is what we can do to help the territories to adhere to mandatory reporting requirements.

Did I answer your question?

Richard Antonelli:

I think you just knocked it out of the park, which was why I sort of asked that. And you are exactly right. They are not the same question but you can see how the latter would be impacted by the former. So, during this phase of moving toward homogeneity, I would just want to make sure that technical assistance that is put out is not just, here is how to do that – those measures so that the Medicaid agency feels like we are moving the needle. I hope that they are. But what is the line of sight to other key members of the community? And I have been doing some health justice work lately, so I am not using the term stakeholders, but for all relevant people that have something to say in it. So, if there could be a TA information stream around engaging communities so that they can look at the data collectively and make recommendations for improvement. And we could even honor that there will be a phase, Margo, before everybody is following a uniform playbook, which is absolutely fine, but maybe the engagement approach in New York will be complementary or different from what it is in Montana, etc. So, patients and family and stakeholder engagement. CBO engagement as we start moving more into looking at holistic drivers of health. I would love to see that kind of technical assistance. Thank you.

Margo Rosenbach:

Thanks, Rich. As always, really interesting. The other thing I will say that is up and coming is more efforts toward implementing new quality improvement initiatives with CMCS. You might be aware that we had about seven affinity groups with a focus on some Core Set measures, some were focused on other measures. But we are going to be initiating with CMS additional affinity groups, and I think that is another way to be able to use the data to drive improvement as we have more and better data. And identify where the improvement is needed to kind of lift up all, you know, all communities. So -

Richard Antonelli:

Margo, that is amazing. Thank you. Thanks to the team. Thank you CMCS.

Margo Rosenbach:

Thank you, Rich.

David Kelley.

David Kelley:

Thanks so much. So, as far as technical assistance goes, I would suggest taking a look at those measures where there is low reporting or lower reporting compared to others. And I think in the pediatric set on the one slide there are probably five or six measures that I think less than 30 or

40 states were able to report. So – so maybe focusing on those, since those will be mandatory, focusing on those five or six measures and working with states that perhaps have not been able to report them, finding out why, and then removing any barriers. I mean, some of them are new measures, some of them are CAHPS related. The Screening for Depression and Follow-Up for kids is a relatively – I think only 21 states reported that. So, I just think ongoing technical assistance for those measures, the mandatory measures for pediatrics. And then any of the behavioral health measures for adults, I think those are areas that we want to make sure folks feel that they are getting the full support. So, looking at low reporting, but also looking at – I'll say low results or areas where, across all of the measures, where the performance is not optimal. And, again, we had discussion around Initiation and Engagement measure where I think nationally, I think about only half of folks got initiated. I think it fell off to less than, I don't know, 20% that got engaged. So, looking at those – those low results, and then thinking in terms of how do we continue to support and help states. And then once some of the equity reporting comes in, some of the race and ethnicity reporting comes in, to really look at those areas where there are inequities or there are equity gaps. And there are some states that have been doing this for many years and talking about, again, interventions that perhaps have worked to help close some of those gaps.

So I would also think in terms of behavioral health and physical health integration. Several of the measures in both the pediatric and adult sets really are really pushing towards better integration between behavioral health and physical health services. And I think CMCS has, you know, brought forth, you know – I think this may be one of the affinity groups that may be one of the, you know, this year an opportunity for states to participate in ongoing opportunities to really discuss that and take – programmatically make some changes.

And then I think also within maternity, I think there is a lot of opportunity there, and I think CMCS has an opportunity there for states to participate in – in this next year. But maybe using those forums and other forums to really talk about, what do we do about low results? What do we do about measured inequities? And then how do we really focus on whole-person care, especially with integrating physical and behavioral health and those measures that are pertinent to that.

So, thanks.

Margo Rosenbach:

Thanks, David. And I love how you are bringing together quality measurement and quality improvement because to a large extent in this meeting we focused on the quality measurement side, but I think what you are linking together is the quality improvement side with quality measurement so that we can use the measures to drive improvement and hopefully that is also going to drive improvement in measurement. So, kind of a whole cycle. So, thank you for that.

I see Jim Crall.

Jim Crall:

Yes. Thanks, Margo. Actually David more or less beat me to the punch or the point I was going to make. I noticed that in looking at that chart that was provided, that graph of different states and reporting different measures, happy to see that the oral health measures were reported by a majority of states but they are at the very bottom down there in terms of number of states reporting. And so I would really, given the fact that those are administrative data, claims data largely, to generate those measures would suggest that that is beyond the radar for technical assistance to states to see if we can get those numbers up more in the range of the other states, particularly as we move to mandatory reporting. And although I can't, you know, commit on behalf of the Dental Quality Alliance, I am sure they would be interested in helping with some technical assistance. They have been doing quite a bit of work on looking at the T-MSIS data across all the states and looking at trends there. So, that might be another way to reduce some of the burden on states and to get more uniform reporting.

Margo Rosenbach:

Yeah. Thanks, Jim. I will say, though, that in FFY 22 where you saw the numbers were somewhat lower, maybe, for some of the dental measures, those were first-year measures. So, we were ecstatic that enough states reported in the first year of those measures being on the Child Core Set to be able to publicly report. So, we are optimistic with 2023 and then again into 2024 with mandatory reporting those numbers will go up. But that is a really good point that we certainly will be watching that. And I think as many people know, the deadline for 2023 reporting was at the end of the calendar year, so we are just starting to look at the data. And we will be using it to inform the technical assistance plans for mandatory reporting. And David, to your point, that Depression Screening and Follow-Up measure, CDF, is definitely on a list for outreach to states to figure out what their challenges are and then also states that are successfully reporting it and figure out what their secret sauce is so that we can share some of those practices with other states. So, these are all great suggestions.

Kim Elliott.

Jim Crall:

Thank you very much.

Margo Rosenbach:

Sure. Thank you. Kim, you are next.

Kim Elliott:

Okay, great. Thanks. One other thing that I was thinking about, too, is supplemental data. Managed care organizations have gotten really, really good at using supplemental data sources, and even CMS has gotten really good at using supplemental data if you want to think of data for the low birth weight or very low birth weight measures being supplemental data outside of their immediate system. But maybe some technical assistance on how states can pull in some other data in addition to like HIE data, but other sources such as those the MCOs use to really supplement and provide, I guess, more complete data for their reporting of the measures.

Margo Rosenbach:

Kim, that's a great point, especially the immunization, immunization system – the immunization information system data, IIS, particularly to the extent that AIS might, in the future, be added for Adult Immunization Status and to improve the adolescent measure and Child Immunization Status. So, I think that is something that is on the horizon for technical assistance to the extent that it would help states to be more complete in their reporting, especially when children or adults get their services in, you know, outside of a traditional healthcare system where the claims might not be in the traditional claims encounter data system. So.

Kim Elliott:

Yeah, and with all of the data aggregators out there now collecting stuff from medical records and medical record systems, there are just so many opportunities that perhaps they could take advantage of to make the data more complete.

Margo Rosenbach:

Great. Thank you for that suggestion.

Joy Burkhard.

Joy Burkhard:

My comment is a bit related to that discussion as well, but a bit broader. I think it will be important for CMS to help flag national resources that exist from various agencies at the federal level, for example with the new Perinatal Depression Screening measures. There are – there is a new National Maternal Mental Health Hotline and directory of providers if that is something that could be discussed and shared. Also, HRSA has provided states – some states – grants to create telepsychiatry consult lines for frontline providers that are – that are screening. And those are important resources, for example, to share. And then along the lines of ECDS measures, or electronic measures, and outside data sources, you know it strikes me that one of the sources in the Perinatal Depression measures are case insurer plan case management screens. And so it makes me pause and think, you know, if I am a provider, how do I know that that screen might have occurred, especially if it is a positive, and what does it look like in terms of reporting back to providers? Which some providers might appreciate and some may not, but just the reflecting back that, you know, care is still delivered by providers, not health plans, and so that is an important consideration I think.

And then lastly, national laws that may impact these outcomes and processes, for example with regard to social needs or depression screening with children and families and mothers. The Child Abuse Prevention and Treatment Act, CAPTA, provides framework for state Child Protective Services departments. And we have heard and worked on many cases ourselves where a provider may interpret mandatory reporting laws to require that they report a positive depression screen to Child Protective Services, and horrible things can happen. So I just want to flag that as a really important consideration for technical assistance and coordination with those state agencies.

Margo Rosenbach:

And just to clarify, when you talk about technical assistance, this is not related to quality. Is it – how do you relate that back to quality measurement, like measurement as part of Core Set reporting? I might be missing a little bit of a link there.

Joy Burkhard:

Yeah, well, and it is a great point. Not all this is directly related to the technical aspect of measurement but considerations around implementation.

Margo Rosenbach:

Okay. Thank you. Helpful. Any other comments on technical assistance needs to support state reporting?

I think that some that I was expecting to hear related to digital and ECDS we heard. Stratification. Any – anything else before we move on to the last part of this agenda here?

All right. So, in the spirit of continuous quality improvement, we would also like to give Workgroup members an opportunity to suggest ways that we can improve the review process for next year. And I will say that our intention is to be in person next year, after all these years, so I think that is something that we have heard in the past, so I will preempt that, that that is our hope. All things considered and all that, you know, if it all works out. But other feedback?

Rachel. And then Tricia.

Rachel LaCroix:

Can you hear me?

Margo Rosenbach:

Yes.

Rachel LaCroix:

Okay, great. I really liked the way the process worked for this meeting. I really like the way that your team restructured the order in which we did kind of one measure at a time, had all the discussion, the public comment, and the voting before moving on to another measure. I thought that worked really well. One thing, and I don't know if it – it's not necessarily part of the process of the meeting itself, but maybe something to consider for future suggestions of additions to the Core Sets. And I am thinking of this just because there was such a robust discussion around the social needs measure today. And it was pretty close between folks recommending to add it and not recommending at this time, which I think really reflects the rich conversation about how that this is a measure that is important to all of us, but we don't feel like it is quite ready to be something that would be mandatory for states to report at this time. I am wondering – I don't know if we would be able to build into the process in the future for – and I know we are already working on the Core Set a couple of years out from now, and that we are doing those things more in advance, but I am wondering if there could be almost like a kind of pool of, we know this is a measure we want in the future and it really would be determining when it may be ready to be added. And I am just thinking if we would be able to say, you know, it is something we want to come back and consider for the 2028 Core Set, or something along those lines. And that might also help streamline and get us away from people recommending it every year and trying to set up an advance time when we could consider it again. I don't know if that makes sense.

Margo Rosenbach:

It does. And it is actually something that I have been thinking about a little bit. It is like a pipeline, and so, over the next two years we will be checking back with Lindsay in New York, and David in Pennsylvania, and Laura in Washington, and so on, to find out how's it going. And then keeping track of other states. And then at some point making – it's almost like imposing those technical feasibility criteria like on an annual basis to say, well, does it mean technically feasible now, should we bring it back, as opposed to depending on somebody to bring it back. It is a really interesting question to be thinking of it as a pipeline. Is that what you have in mind?

Rachel LaCroix:

Yes. Yeah. Pretty much. And also because do we still have as part of the criteria for adding or removing measures that if it has already been done a certain number of times within previous years, we shouldn't be suggesting a change unless there truly is something significantly different?

Margo Rosenbach:

Yes. Yes.

Rachel LaCroix:

Okay.

Margo Rosenbach:

It had been a rule of three – if it is three times, then it would not be considered again unless there was a change. And some of you might have noticed that the OHD measure was considered this year for the fourth time, and that was because of considerations that there was new information that would be provided this year that – that CMS wanted to share with the Workgroup to have the Workgroup reconsider the measure. So, in general, yes, three times is the rule. You know, things could change over time with changes in clinical guidance, or experience with a measure.

Rachel LaCroix:

And I think that is why I am thinking if we could do the pipeline thing, then we wouldn't have to worry about hitting that three time cap with a measure that we all know we want at some point in the future, if we always kind of had it in holding to consider again.

Margo Rosenbach:

Right. Well, and I think what I was hearing when people were talking about this, and I wish we had more time to have a full debrief on people who did not recommend the measure for addition. It was a relatively close vote, and I think it could have gone either way, but probably ended up, you know, it was reflecting that tension between yes, it is a really desirable measure, but no, it is not ready for prime time. And I think the idea for measures that are not ready for prime time, you are kind of waiting and watching to see how it plays out. Now, it doesn't mean it would necessarily come back by, you know, in two years, if New York, and Washington, and Pennsylvania have determined that, no, there is another measure out there that we like more, or it is still too challenging. But at least it gets it into a pipeline. So, it is a really interesting thing to think about.

Rachel LaCroix:

Thanks.

Margo Rosenbach:

Thank you. All right. Tricia Brooks.

Tricia Brooks:

Thanks, Margo. I – I do – having – this is my fifth, maybe sixth, year. I was definitely at an in-person meeting, maybe two. And have watched the evolution of the process overall. And I have said this before, and at the risk or embarrassing all of you at Mathematica, I just have to say that I am always so impressed with how prepared you are, how organized you are, and how responsive you are. I also have the pleasure of serving as Commissioner on MACPAC, and I have got to say that it is all about the staff work that happens. Both at the commission level and at this level. Because without that kind of competence we would never get as far as we have gotten in this process. So, thank you for that.

I do – I like the concept of pipelines. I have tried to put this forth in MACPAC. We have subcommittees. I think part of the challenge, of course, just recognizing it, is the desire for this kind of dialogue and discussion to be in the public domain and accessible to whomever wants to listen in. And so I think we have to, you know, consider that as we think about changing things up and perhaps finding a path to that pipeline.

But thanks again for a great job. You guys are – are really impressive. Appreciate it.

Margo Rosenbach:

Thank you, Tricia, on behalf of the entire team. We enjoy it, and it is hard work, but it is all worth it when we get to this point.

And I just want to clarify, the pipeline does not mean that the decision would be made without public conversation because we would want to bring it back, but it is a pipeline to say, we are going to keep watching it, we are going to keep looking at it so that we have a better sense based on all the feedback that we heard here, you know, is it getting closer to being ready for public use, or for state use. So, yes, we would never anticipate, and CMS would never allow it, for a measure to be added to the Core Sets without this public discourse. But at least be watching a measure that states and others like yourself are very interested in.

All right. Thank you for your comments.

Ben Anderson.

Benjamin Anderson:

Yes. Hi. Thank you, Margo. And I really do want to echo Tricia's comments on just how great of a job you and the team at Mathematica have done with this process. It's – it's multifaceted. It relates to complex issues. There are so many things that we need to weigh in on, and you have just done an excellent job of making it so streamlined, so easy from the Workgroup member perspective, so really want to thank you again for another fantastic year of meetings.

The only thing I sort of want to raise as a possible area to consider in the future. And it struck me sort of as part of the discussion around the Social Need Screening and Intervention measure. I think what was particularly challenging about that conversation was I think there were a lot of questions raised, but as a Workgroup member, it remained unclear whether or not there were any answers to the questions being raised or if they were sort of unheard or if there was information that people had but didn't share. And I think it might be useful in the future if there is a, you know, a collection of the questions that came up in that conversation in particular, if this measure or a similar measure were to come up again, it might be helpful for Workgroup members to sort of have like a readout on sort of where we are now and what the status of, you know, the answers to some of those questions are in the future.

Margo Rosenbach:

That is a great suggestion. Thank you. Any other Workgroup member comments? Any other reflections?

Joy Burkhard?

Joy Burkhard:

Margo. Just a quick question. Is it – is it still that the Workgroup members will be responsible for nominating measures to be removed and added and not outside partners? I think – I think that is still the case but just wanted to make sure if I understood.

Margo Rosenbach:

So, the purpose of the Public Call for Measures is that the public would have the opportunity to participate in the Call for Measures in addition to the Workgroup.

Joy Burkhard:

Okay. Good. That is helpful. So, my just having completed the application, if you will, for Call for Measures, I think there will need to be some opportunity to make that as easy as possible for outside folks and consider what – what – what the Mathematica team can augment. It's like very technical, as you know, as it should be, but there may or may not be – there may be some ideas that are important to hear that folks who are submitting Call for Measures won't be privy to all the background that the rest of us on the Workgroup might have been privy to. Does that make sense, Margo?

Margo Rosenbach:

It does. And actually it is kind of the opposite. That if you are submitting a measure through a Public Call for Measures, in order to submit we want complete applications. So, if they don't know the measure steward, or they don't know whether the measure has been tested, we would expect them to find that out as part of the Public Call for Measures. So, I think there is an expectation through the Public Call for Measures that those submitting would be very familiar with the measures, be able to speak to the measures, and have complete knowledge. So, I hear what you are saying, that the Workgroup members might not have all that information, but we would fully expect someone who is submitting as part of the Public Call for Measures would have that information.

Joy Burkhard:

Okay. Thank you.

Margo Rosenbach:

All right. David Kelley. One last comment before we move on to public comment.

David Kelley:

So, just to pile onto that thought, I think it would be – maybe giving some technical assistance to the public or outside organizations when it comes to filling out that – that application. Maybe that is something that would be helpful. But also I think if we do get inundated like we did in whatever year that was, 2018 or 19, that there be, I'll say, adequate time to – that those additions and deletions be given to the committee to have maybe a longer period of time to kind of look at and assess what's happening. And then I would also suggest that the timeframe in which you open up for additions and/or deletions, that that maybe is extended and doesn't occur like around the holidays. So, just from a timing standpoint, giving maybe more time and that, you know, when we are submitting additions or deletions to the Core Set. And then once we have our 30 for next year, that maybe there is more time for the committee members to really carefully look at those measures.

So, food for thought. And, again, I always like to commend Mathematica for – the entire staff – for the great job that you guys do in really queuing this up. And also want to thank our federal partners for the opportunity for all of us to really participate in the process.

Margo Rosenbach:

Thanks, David. These are great ideas, and I think will very much help us think through the process.

All right. With that, I think we will move on to the next slide.

And we have our final opportunity for public comment. So, if you are a member of the public and have a comment, please raise your hand and I will call on you. I am not seeing any public comments. Give it one more minute. All right. Well, why don't we move on to the next slide.

All right. So, we are almost ready to wrap up. We would love to thank our Workgroup members for your flexibility and patience in conducting this meeting virtually, especially with the voting, and the muting, the unmuting. Thank you so much for all of your participation. It was wonderful how engaged you all were, how insightful your comments were. So, thank you for that.

And now I would like to call on our co-chairs, Kim and Rachel, for any final remarks you would like to make. Next slide.

And how about if we have Rachel go first.

Rachel LaCroix:

Okay. Can you hear me?

Margo Rosenbach:

Yes.

Rachel LaCroix:

Okay. Thank you everyone for the really good conversations over the past couple of days. I think I mentioned this earlier, but I really felt like the recommendations for changes this year were very thoughtful, and the information provided by the Workgroup members suggesting those changes regarding the reason why really was helpful for all of us in reviewing. And I felt like we had really good, robust conversations around those proposed changes and that the recommendations we have come away with really involved a lot of thought and detail. So I really would like to thank everyone for that.

I would also like to echo everyone thanks to Mathematica for doing such a great job of keeping all of us organized and providing all the different resources to support our conversations over the past couple of days. And just also being very flexible working with folks on the voting and different aspects of the meeting.

And then also for asking for the feedback around what kind of technical assistance can help states with the mandatory reporting this year as well as thinking about how we can improve things in the future.

So, I feel like even though the meetings have been virtual, I feel like there has been a really good level of engagement and conversation and that we really have made some progress during this meeting. So, thank you everyone.

And I'll turn it over to Kim.

Kim Elliott:

Great. Thank you, Rachel, and, you know, I agree with almost everything you said – actually probably everything you said. It was really an excellent meeting, and what continues to impress me throughout all of the Core Set Workgroup meetings is really the passion that everyone demonstrates during the Workgroup discussions, whether it is on the measures themselves that are being considered or whether it is related to gaps. Everybody really thinks through everything and really puts out some really good responses and information. So, I really do appreciate that.

Each Workgroup member really does consider multiple factors, including the relevancy, the desirability, viability, and feasibility for the measures. So, the conversations are really thoughtful and informed. Subject matter expertise of this group is really phenomenal and it really informs the process and the discussion. And sometimes it even makes me think a little bit differently about how I thought I was going to vote on a measure. And I am sure some of you experience that as well. And through all of the considerations, I am consistently hearing about the member, the member's voice, and how a measure may impact the health and wellbeing of the member, which shows that we are really continuing to put the member right in the center of this which is what really needs to happen when we are considering measures that are going to improve their quality or quality of life. I recognize and thank you all for your commitment to this and the commitment it takes to participate in these meetings whether it is the work preparing for the meeting, to recommend changes to the Core Sets, the thoughtful review process before we actually meet for the virtual or in-person meeting. And then, of course, the reconsideration or consideration of the impacts to the members, providers, managed care organizations, the states overall, because that really is critical when we are trying to implement such a large set of performance metrics.

I also appreciate the new format. It really was a good format for this meeting, Mathematica, so thank you for that. Also, the process for the Call for Measures I think is going to continue to be a really good value add for these meetings. And I really enjoyed and appreciated the format change for the lightning round for identifying gaps in the Core Measure Sets. I think we received a lot of really good information through that process.

And a real sincere thank you, also, to Workgroup members, Mathematica, CMS, all the other state and federal partners, the public that participated in this meeting, and to the state Medicaid agencies and their partners who really do have the heavy lift resulting from the Workgroup recommendations. So, thank you.

Margo Rosenbach:

Thanks Kim and Rachel. We appreciate your support throughout this journey.

So, next slide, please.

By now this slide should look very familiar. It lays out the key milestones for the 2026 Core Sets Annual Review process. Our journey began together on September 6th last year, continued with the January 10th webinar to get organized for this week's voting meeting. And we are grateful for all the time you have taken to prepare for this meeting and also that you have spent the better part of two days with us.

Our next step is to review and synthesize the discussions that occurred over the last two days and prepare a draft report. The draft report will be made available for public comment in April. And then, in addition, Workgroup members will have an opportunity to review and comment on the report. Our team will then review all the public comments and will finalize the report, which will be released in June. So from there, CMS will review the final report and obtain additional input from interested parties including other federal agencies and from state Medicaid and CHIP quality leaders. Then CMS will release the 2026 Core Set updates.

Next slide, please.

If you have questions about the Child and Adult Core Sets Annual Review, please email the Mathematica Core Sets Review Team at the address shown on this slide.

Next slide.

And finally, thank you. One last thank you to the Workgroup members, federal liaisons, measure stewards, and public attendees for your contributions. We also want to express our appreciation to staff in the Division of Quality and Health Outcomes at CMCS for your support. And a special shout out to the Mathematica Core Sets Team. This meeting would not have been possible without everyone's help. We wish everyone well.

This concludes the 2026 Child and Adult Core Sets Annual Review Workgroup Meeting. This meeting is now adjourned.