2028 Child and Adult Core Sets Annual Review:
Meeting to Review Measures for the 2028 Core Sets, Day 1 Transcript
February 3, 2026, 11:00 AM – 4:15 PM ET

Denesha Lafontant:

Hi, everyone. My name is Denesha Lafontant, and I'm pleased to welcome you to the 2028 Child and Adult Core Sets Annual Review Meeting to Review Measures for the 2028 Core Sets, Day 1.

Patricia Rowan:

Thank you, Denesha. Hi, everyone. My name is Tricia Rowan. I am a Principal Researcher here at Mathematica. It is my pleasure this morning to welcome you to the 2028 review of the Child and Adult Core Sets. Thank you so much to our Workgroup members, our federal colleagues, and members of the public for joining us for today's virtual meeting. Next slide.

I would like to take a moment here at the top to acknowledge my colleagues at Mathematica who have been instrumental in preparing to host this meeting today. It has truly been a team effort to prepare for the meeting, both in terms of content and logistics; and I thank you for all of the hard work the team has put in. Next slide.

We have a full agenda for today and tomorrow's meeting and several important objectives to accomplish in these two days together. The four meeting objectives are listed here on the slide.

First, the Workgroup will discuss the measures that were suggested for removal and the six measures that were suggested for addition to the Child and Adult Core Sets.

Second, the Workgroup will vote on the measures suggested for removal or addition and make recommendations for updates to the 2028 Core Sets.

Third, the Workgroup will discuss gap areas in the Core Sets which will help inform the 2029 public Call for Measures. This discussion will take place on the second day of the meeting, tomorrow; and before we wrap up today, I will preview our plan for this discussion.

Finally, we'll provide multiple opportunities for public comment over to the next two days to inform the Workgroup's discussion.

I do want to pause for a minute here and note that we are committed to a robust, rigorous, and transparent meeting using this virtual format. That said, we acknowledge that attendees may experience challenges with the platform or other technical difficulties; and we hope everyone will be patient as we do our best to adhere to the agenda and fulfill these meeting objectives.

Some of you may be wondering why we don't use video for these meetings. As we have mentioned in some previous years, we have found that some individuals in locations did not have sufficient Internet or Wi-Fi bandwidth to support all 100-plus members of this meeting using their video. So, to ensure full participation by Workgroup members and the public and to mitigate any technical difficulties that sometimes arise with using video, we're just having our videos off today.

We also want to remind Workgroup members of a few ground rules for participation today. First, we acknowledge that everyone brings a point of view based on your individual or organizational perspectives. As a Workgroup collectively, however, you are charged with recommending Core

Set updates as stewards of the Medicaid and CHIP programs as a whole and not from your own individual or organizational perspectives. So please do keep that in mind during discussion and voting.

Second, today's meeting is focused on discussing the measures that are suggested for addition to or removal from the Core Sets. CMS will not be able to respond to questions about CMS policy or decisions; and after providing brief welcome remarks, they will be joining us today in a listening-only mode.

In addition, we know that spending several hours a day in a virtual meeting can be challenging; and we ask that you be punctual in returning from breaks so we can have everyone present for the discussion and voting. And related to that, we will make sure that all Workgroup members who wish to speak may do so. So as Denesha mentioned earlier, please raise your hand if you'd like to speak or contact us through the Slido Q&A if you're having any technical difficulties; and our producers, Fiona and Brice, will be in touch to make sure that we can handle those and you have a chance to speak before we move on.

Finally, we want to remind public attendees that we will have designated opportunities for public comment and ask that you save your comments until we reach those public comment periods. Please note that we will not be accepting public comment through the Q&A feature. So if you submit a comment or question through the Q&A, we will ask you to state that publicly during a public comment period. Next slide.

Now I would like to turn to our Co-Chairs, Kim Elliott and Rachel La Croix, to offer their welcoming remarks. Kim, I believe you're up first.

Kim Elliott:

Thank you. I'd also like to extend my welcome to everyone listening to and participating in the Workgroup meeting today. It is an honor to co-chair this Workgroup with Rachel. I'm happy to continue our work with all of you reviewing and discussing the measures proposed for removal and addition to the 2028 Child and Adult Core Sets measures.

As I prepared for this week's meeting, I certainly appreciated the hard work and great materials developed by Mathematica. I'm sure you did as well.

So thank you for the great work you do, Mathematica. We really do appreciate it. It makes our job so much easier.

I recognize and appreciate the expertise and knowledge that each of the Workgroup members brings from their professional life, all of their unique and diverse quality and performance measure experience that add so much value to our discussion. I also want to acknowledge the time and work everyone has put in preparing for our discussions this week. This preparation of work results in the best recommendations for strengthening the Core Sets and addressing gaps.

The results from this Workgroup have a significant impact on states and the resources that are needed at multiple levels in Medicaid including at the state level, health plan, and provider level. This work provides the data and information needed to measure or evaluate the quality of care, access to care, and timeliness of care for Medicaid beneficiaries. It is the primary driver for the work that we do no matter what our individual roles are related to Medicaid.

The results of our work have an impact on measuring the improvement in quality and outcomes of the Medicaid and CHIP programs. Each measure considered for or included in the Adult or Child Core Sets provides the opportunity to measure quality or outcomes in the specific focus

areas or domains and, when considered together, also provides an opportunity to measure system quality and outcomes.

We've all done a lot of work preparing for this meeting, including applying the information data provided by Mathematica or other sources that we use. We should also consider some other things such as strategic priorities for Medicaid; whether there is room for improvement in quality or outcomes of the measures, if it is actionable; if we really could make an improvement in the care and outcomes based on implementing the measure; is there available data source that supports measure reporting; and does it move this Core Set reporting in the direction of measuring outcomes versus processes.

So again, I just want to thank everybody for your time, effort, energy, thoughtfulness, and all the brain power that you're applying to this work and to this meeting. I look forward to continuing to work with all of you. I'll turn it over to Rachel.

Rachel LaCroix:

Thank you, Kim. And welcome, everyone. I echo the welcome and all of the comments that Kim made thanking Mathematica for helping prepare all of us with all of the comprehensive review materials and thanking the Workgroup members for the work that you've done before the meeting to prepare for a good, robust discussion of the measures proposed for addition and removal.

I'd also like to thank the folks that did submit measure recommendations and for providing the context and important elements for us to consider as to why you believe these measures are good to add to the Core Sets. That really is helpful to be able to review those aspects as we prepare for our discussions for these meetings. So, thank you to everybody for all of that work that you put in prior to this meeting.

Kim did such a good job of covering a lot of the elements of what we need to discuss over the next couple days that I'd like to just keep my comments brief and just say thank you again. I'm really looking forward to our conversation over the next couple of days.

Patricia Rowan:

Wonderful, thank you so much, Kim and Rachel, for your willingness to serve as our co-chairs. Next slide.

So now we are going to do an introduction of Workgroup members and any disclosures of interest. So, we'll go to the next slide.

To ensure the integrity of our review process, we asked all Workgroup members to submit a form that discloses any interests, relationships, or circumstances over the past four years that could give rise to a potential conflict of interest or the appearance of a conflict related to the current Child and Adult Core Set measures or the new measures that will be discussed by the Workgroup. Members deemed to have an interest in a measure suggested for removal or addition will be recused from voting on that measure. So, during the introduction, Workgroup members will be asked to disclose any interests related to the existing or new measures that will be discussed by the Workgroup this week. Next slide.

All right, we are going to do a roll call of our Workgroup members now. When I call your name during the roll call, please unmute yourself, say hello, share any disclosures you have or indicate whether you have nothing to disclose. When you are done, you should be able to

unmute yourself in the platform. So if you're having any trouble getting off mute, just use that "raise hand" feature and we will be sure to help you out. Next slide.

On these next few slides, we have Workgroup members listed in alphabetical order by their last names. When I call your name, please unmute yourself; say hello. If you're muted locally on your headset or phone, please remember to unmute locally as well just in case you are double-muted. If you have any technical issues, like I said, just please use that "raise hand" feature and our team will help you out. I'll start with Kim.

Kim Elliott:

Good morning. I have nothing to disclose.

Patricia Rowan:

Thank you, Kim. Rachel?

Rachel LaCroix:

Good morning. I have nothing to disclose.

Patricia Rowan:

Wonderful. Let's go next to Dawn Alley.

Dawn Alley:

Good morning. I have nothing to disclose.

Patricia Rowan:

Thank you, Dawn.

Erin Alston?

Erin Alston:

Hi, I'm Erin Alston. Nothing to disclose.

Patricia Rowan:

Thank you, Erin.

Stacey Bartell?

Stacey Bartell:

Hi, Stacey Bartell on behalf of American Academy of Family Physicians, and I have nothing to disclose.

Patricia Rowan:

Thank you, Stacey.

Lee Beers?

Lee Beers:

Good morning. This is Lee Beers on behalf of American Academy of Pediatrics, and I have nothing to disclose.

Patricia Rowan:

Thank you, Lee.

Laura?

Laura Boutwell:

Good morning. This is Laura Boutwell, and I have nothing to disclose.

Patricia Rowan:

Thank you, Laura.

Matt?

Matt Brannon:

Good morning. I have nothing to disclose either.

Patricia Rowan:

Thank you, Matt.

Joanne Bush – Joanne, do we have you on the line?

Joanne Bush:

Good morning. Joanne Bush with the Iowa Department of Health and Human Services. I have nothing to disclose. Thank you.

Patricia Rowan:

Thank you.

Angela?

Angela Filzen:

Good morning, everyone. Angela Filzen with G.A. Carmichael Family Health Center on behalf of the America Dental Association. I have nothing to disclose. Thank you.

Patricia Rowan:

Thank you, Angela. We'll go to the next slide.

Jessica Harley?

Jessica Harley:

Good morning. This is Jessica Harley on behalf of Community Health Choice and ACAP, and I have nothing to disclose.

Patricia Rowan:

Thank you, Jessica.

Richard?

Richard Holaday:

Hi, good morning. This is Richard Holaday. I am representing the National Association of Medicaid Directors, and I have nothing to disclose. Thank you.

Patricia Rowan:

Thank you, Richard.

We'll go now to Jeff.

Jeff Huebner:

Hi, everyone. I'm Jeff Huebner. I'm a family doctor in Madison, Wisconsin, nominated by National Association of Medicaid Directors. I work at Wisconsin Department of Health Services-Medicaid. No disclosures.

Patricia Rowan:

Thank you so much for being here.

David Kelley?

David Kelley:

Hi, good morning. I'm David Kelley, Chief Medical Officer at Pennsylvania Medicaid. I'm a general internist. The only thing I have to disclose is I'm a member of NCQA's CPM. Thanks.

Patricia Rowan:

Can you define what CPM is? Do you mind?

David Kelley:

It's Committee for Performance Measurement.

Patricia Rowan:

Wonderful, thank you, Dr. Kelley.

David Kelley:

Thanks.

Patricia Rowan:

Next, we'll go to David Kroll.

David Kroll:

Hi, everyone. David Kroll. I'm a psychiatrist. I'm in Boston, and I was nominated by the American Psychiatric Association. I have nothing to disclose with respect to measures specifically except that the company that I work for, IncludedHealth, as a healthcare organization that markets telehealth services directly to consumers. But I don't think there's any relationship between those activities and any of the measures being discussed today.

Patricia Rowan:

Thank you, David.

Next we'll go to Chimene. Do we have Chimene? I do not see Chimene, so we'll move on to Djinge. I hope I got your pronunciation right, Dr. Lindsay.

Djinge Lindsay:

That was excellent. Good morning. Djinge Lindsay, a family physician and Chief Medical Officer with the Maryland Department of Health, Health Care Financing, and Medicaid. No disclosures. Thank you.

Patricia Rowan:

Thank you so much.

Next, we have Paloma.

Paloma Luisi:

Hi, can you hear me okay?

Patricia Rowan:

We can.

Paloma Luisi:

Oh, good. This is Paloma Luisi. I'm from the New York State Department of Health. I'm the Director of the Bureau of Quality Measurement and Evaluation. I have no disclosures.

Patricia Rowan:

Thank you.

Next, we have Christina.

Christina Marea:

Hi, this is Christina Marea. I sit as an excellent panelist on two NCQA panels, one for congenital syphilis and the other the Birth Equity Accountability Through Measurement panel. I don't think either of those are for today.

Patricia Rowan:

Wonderful, thank you so much.

Angela Parker?

Angela Parker:

Good morning. I'm Angie Parker. I'm with the Kentucky Department for Medicaid Services, and I have no disclosures.

Patricia Rowan:

Thank you, Angie.

Next, we have Nicole Pratt. Do we have Nicole?

Nicole Pratt:

Yes. Hi, Nicole Pratt from the Parent Center, New Jersey, SPAN Parent Advocacy Network. I was nominated by the National Center for Children's Vision and Eye Health. I have nothing to disclose.

Patricia Rowan:

Excellent, thank you so much for being here. Next go to the next slide.

Next, we have Sural Shah. Dr. Shah?

Sural Shah:

Hi, I'm Sural Shah. I'm a general internist and pediatrician working in Los Angeles County. I'm here on behalf of the California Department of Health Care Services. I'm also a Chair of the Council of Immigrant Child and Family Health for the American Academy of Pediatrics, but I do not believe that pertains to the measures we're discussing today. I have no other disclosures.

Patricia Rowan:

Wonderful, thank you so much for being here. Bonnie Silva has let us know she will not be able to join today because of a family emergency, so we are sending our well wishes to Bonnie.

Sarah Tomlinson?

Sarah Tomlinson:

Good morning. Sarah Tomlinson here, and I have nothing to disclose. Thank you.

Patricia Rowan:

Wonderful, thank you, Dr. Tomlinson.

Next, we have Sara Toomey.

Sara Toomey:

This is Sara Toomey. I am a pediatrician and Sr. Vice President, Chief Safety and Quality Officer at Boston's Children's Hospital. Nothing to disclose.

Patricia Rowan:

Thank you so much for being here. Do we have Ann Zerr? I don't see Ann Zerr. Ann, if you're here, please raise hand and we'll elevate you to a panelist. Do we have Bonnie Zima?

All right, Bonnie, we are going to get our producers in touch with you to work on your sound because I cannot hear you. I see that you're unmuted, but I can't hear you.

Then finally, we have David Zona.

David Zona:

Good morning, everyone. This is Dave Zona from IPRO. The only disclosure I have is that the organization that I work for, IPRO, we provide analytics/services in support of Core Set reporting to our external quality review clients.

Patricia Rowan:

Fine, thank you, David.

I believe that Chimene has joined us. Chimene, if you're here, can you raise your hand so we can unmute you?

Chimene Liburd:

Good morning. It's Dr. Chimene Liburd, and I missed the intro. I guess I'm supposed to say where I'm from with no conflicts of interest at DC Medicaid.

Patricia Rowan:

Wonderful, thank you so much for being here, Dr. Liburd. All right, let's try one more time for Bonnie Zima. Bonnie, I'm showing that you're unmuted. I just can't hear you if you're trying to speak.

All right, we will continue troubleshooting. I also just saw Ann Zerr dial in. Dr. Zerr, do you want to unmute and introduce yourself and share any disclosures?

Try again. I'm hearing some feedback from you, Ann. All right, in the interest of time we're going to move on and we'll continue to troubleshoot on audio in the background. In the Slido, you can just enter a Q&A and our producers will help everybody out.

Let's go to the next slide. All right, so the Core Set review process is also supported by federal liaisons who are non-voting members of Workgroup. So I will read the names of the agencies represented here but will not do an individual roll call. We have:

The Agency for Healthcare Research and Quality, the Center for Clinical Standards and Quality at CMS, the Centers for Disease Control and Prevention, the Health Resources and Services Administration, the Office of the Assistant Secretary for Planning and Evaluation, the Office of Disease Prevention and Health Promotion, the Substance Abuse and Mental Health Services Administration, and the United States Department of Veteran Affairs.

Note that some of the federal liaisons are unable to join us today due to the partial government shutdown. However, they will be meeting with CMS in the future to provide their input on measures recommended for addition to or removal from the Core Sets. So for federal liaisons who are on the call today if you have any questions or comments during the Workgroup discussion, please raise your hand and we will unmute you.

Finally, before I move on, I'd like to take the opportunity to thank members of the Division of Quality and Health Outcomes at the Centers for Medicare and Medicaid Services who are joining us today to listen to the discussion, as well as measure stewards who are attending and are available to answer any technical questions about their measures. Next slide.

Now I'm pleased to hand it over to Deirdra Stockmann, the Director of the Division of Quality and Health Outcomes at the Centers for Medicare and Medicaid Services to provide us with some welcoming remarks. Deirdra?

Deirdra Stockmann:

Good morning, everybody. It's so nice to be here with you all today in this virtual room. I am very happy to join Mathematica and the Workgroup co-chairs in welcoming everyone to the 2028 Core Set Review Meeting.

This meeting is a highlight of our year and a major milestone in the annual process to review and update the Medicaid and CHIP Child and Adult Core Sets. The Child and Adult Core Sets are essential tools in the Medicaid and CHIP quality toolbox. Quality measures help us understand the quality of care delivered to beneficiaries. Quality measure data point us to bright spots where states, plans, and providers are excelling at giving the right and best care to people where and when they need it, and quality measures guide us to where change is needed to realize the highest standard of care to improve health outcomes.

It feels like just the other day we were all anxiously anticipating the advent of mandatory Core Set reporting. And here, at the beginning of 2026, we know that states cleared that new -- relatively new hurdle with flying colors. Now with two years of mandatory reporting under our belts, we continue to be able to report more quality data on more measures from more states each year.

In the last year, we also made huge strides bringing Core Set data to more people in a more transparent, accessible, and dynamic way through the Core Set Data Dashboard. Since launching the Data Dashboard on Medicaid.gov in January of 2025, we have added another year of Core Set data, the 2024 Core Set data this past September; and the team is hard at work to add some earlier years of data to the dashboard for release quite soon, along with some new features that will continue to enhance the useability of the data.

We do use those data. States and their quality improvement partners are always at work digging into the data, identifying opportunities for improvement, and working to close gaps in care. I am thrilled to say that today 20 states are currently engaged in one or more of our Medicaid and CHIP Quality Improvement affinity groups. Underway now are groups focused on maternal health, children's oral health, and early childhood preventive care. States that participate in these affinity groups receive quality improvement coaching and technical assistance to design and implement their own quality improvement activities. States bring together teams of partners all dedicated to making our programs work better, more effectively, and efficiently for Medicaid and CHIP beneficiaries.

So, the Core Sets are the foundation for a whole lot of valuable and impactful work underway at CMS, in states, across health plans, and with communities to advance quality and improve health. This annual engagement with a broad range of individuals and groups is built into the Core Set statute because we at CMS cannot realize the purpose and vision for quality measurement and improvement in Medicaid and CHIP without your input. Input from states, healthcare providers, professional associations, measurement experts, beneficiary and family advocates, and the public, as well as the federal liaisons, are critical to ensuring that the Core Sets continue to paint a meaningful, robust picture of quality of care in Medicaid and CHIP programs and to undergird ongoing efforts to improve care and outcomes.

To your being here today shows your dedication to this mission. Thank you again to the Workgroup members, federal liaisons, members of the public, as well as the CMCS and Mathematica teams for your time and commitment to the Medicaid and CHIP programs. We are deeply grateful. I will hand the floor back, and looking forward to listening to the meeting today and tomorrow.

Patricia Rowan:

Thank you so much, Deirdra. We appreciate you being here. Next slide.

Now I am going to hand it to my colleague Alli Steiner from Mathematica to provide an overview of the Child and Adult Core Sets. Alli, over to you.

Alli Steiner:

Thanks, Tricia. So now I'll share information about the Core Sets to provide high-level context to the measure discussions occurring today and tomorrow. Next slide.

I wanted to start by providing an overview of the Core Set reporting years relevant to this review cycle as CMS and states are working on multiple years of Core Set reporting simultaneously. So, the most recent, publicly available, state performance data are the 2024 Child and Adult Core Sets, which was also the first year of mandatory reporting. For most measures these data reflect services provided in calendar year 2023. The state reporting deadline was December 31, 2024; and CMS started releasing the data publicly in the fall of 2025.

Over the next few slides, I'll provide some highlights from the publicly available 2024 Core Set data. State reporting of the 2025 Core Sets was due on December 31, 2025. CMS is reviewing these data and aims to start sharing the results in the fall of 2026. States are now preparing to report data for the 2026 Core Sets. The 2026 reporting period will open in the fall and close on December 31st of this year. CMS recently released the measure list for the 2027 Child and Adult Core Sets. I'll give a brief overview of the measure changes for 2026 and 2027 a little later in the presentation. State reporting of the 2027 Core Set data will begin in the fall of 2027.

Lastly, the focus of this current review cycle is 2028 Core Sets. CMS will use the recommendations of this Workgroup in combination with other input to make updates for the 2028 Core Sets, and state reporting of the 2028 Core Sets data will then occur in the fall of 2028. Next slide.

Now I'll provide a brief overview of Core Sets mandatory requirements. States must report all Child Core Set measures in the behavioral health measures on the Adult Core Set.

When reporting mandatory measures, states must adhere to the data reporting guidance in the Core Set resource manuals and the technical assistance briefs issued by CMS.

States must include all measure-eligible Medicaid and CHIP beneficiaries for mandatory measures. However, the following populations will continue to be exempt for mandatory reporting for 2026 and 2027. This includes beneficiaries who have other insurance coverage as a primary payor before Medicaid or CHIP, including individuals dually eligible for Medicare and Medicaid and individuals whose Medicaid or CHIP coverage is limited to the payment of liable third-party coverage premiums and/or cost sharing.

Beginning with 2025 Core Sets reporting, states must stratify a subset of mandatory measures by race and ethnicity, sex, and geography. Next slide, please.

Okay, so this slide shows some high-level results from state reporting of the 2024 Child and Adult Core Sets. For 2024 Core Sets, states reported a median of 27 out of 27 measures for the Child Core Set and 30 out of 33 measures for the Adult Core Set. All measures on the Child Core Set and almost all measures on the Adult Core Set met the criteria for public reporting, meaning that they were reported by at least 25 states and met CMS standards for data quality. Reporting was robust with 52 states and territories reporting Core Set measures, and the majority of states either reporting more measures for 2024 than for 2023 or reporting all measures in both years. Next slide, please.

Two measures on both the Child and Adult Core Sets were publicly reported for the first time. This includes the Prenatal and Postpartum Care: Under Age 21 and Prenatal and Postpartum Care: Age 21 and Older measures; and the Screening for Depression and Follow-Up Plan: Ages 12 to 17 and Screening for Depression and Follow-Up Plan Ages 18 and Older.

CMS also publicly reported several performance rates for the first time, including:

Age group stratifications for Metabolic Monitoring for Children and Adolescents on Antipsychotics and Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics, seven indicators from the Child Medicaid CAHPS Survey for children with chronic conditions, medication rates for Use of Pharmacotherapy for Opioid Use Disorder, and a coordination of care indicator from the Adult Medicaid CAHPS Survey. Next slide.

This slide shows the number of states reporting each of the 2024 Child Core Set measures. The red and teal "x's" indicate which measures either have been removed from or modified for the 2025, 2026, or 2027 Core Sets. As you can see, most Core Sets measures were reported by all 52 states and territories that participated in 2024 reporting, and CMS publicly reported information on performance for all measures. Next slide.

This slide shows the number of states reporting each of the 2024 Adult Core Set measures. The six measures at the top of the slide that were reported by 52 states are all behavioral health measures. The voluntary Adult Core Set measures shown on the slides were reported by between 6 and 47 states. All voluntary measures were publicly reported by CMS except for the two shown at the bottom of the slide – HIV Viral Load Suppression and Long-Term Services and Supports Comprehensive Care Plan and Update.

Note that starting with the 2026 Core Sets, the Long-term services and Supports measure is transitioning from the Adult Core Set to the Home and Community-Based Quality Measure Set.

This slide closes out our high-level overview of the results of 2024 Core Sets reporting. If you're interested in seeing more detail, there are a wealth of resources available on Medicaid.gov, as Deirdra mentioned, including a new interactive data dashboard. Next slide, please.

So, in a recent State Health Official letter, or SHO, CMS announced the following updates to the 2026 Child and Adult Core Sets. CMS removed four measures related to pediatric and prenatal

immunization status from the 2026 Child and Adult Core Sets. Although no longer part of the Core Sets, states may voluntarily report on the results of these four utilization measures to allow CMS to maintain a longitudinal dataset on immunization rates. In the SHO, CMS noted that they will explore options to facilitate the development of new vaccine measures and that they plan to engage with stakeholders to learn how the new measures could capture person and family-preferences related to vaccines.

During tomorrow's priority gap discussion, Workgroup members will have the opportunity to provide targeted feedback on opportunities for developing potential alternative vaccine measures that incorporate patient and family preferences.

Next slide. I'll now briefly describe the changes to the 2027 Child and Adult Core Sets. CMS added two measures to the 2027 Core Set – sorry, to the 2027 Adult Core Set. That includes Evaluation of Hepatitis B and C and Adults with Database – Oral Evaluation.

Two measures currently on the Child and Adult Core Sets are being retired by the measure steward and will be removed from the Core Sets. This includes Asthma Medication Ratio and Medical Assistance with Smoking and Tobacco-Related Cessation.

In the SHO, CMS announced that the Prenatal Depression Screening and Follow-Up measure and the Postpartum Depression Screening and Follow-Up measure will remain provisional voluntary measures for 2027. The Postpartum Depression Screening and Follow-Up measure was added as provisional for 2025 Core Set reporting, which just recently concluded; and the Prenatal Depression Screening and Follow-Up measure was included as provisional for the 2026 Core Set, for which reporting will occur in the fall of 2026. So, because of this timing, CMS is still gathering information on whether these measures are feasible to report by all states and produce valid performance results.

More information about the updates to the 2026 and 2027 Core Sets is available at the link on the slide.

Next slide. The Workgroup should consider the composition of the 2027 Core Sets when assessing measures to recommend for addition to or removal from the 2028 Core Sets. The 2027 Child Core Set includes 24 measures, and the Adult Core Set includes 33 measures. For 2027, there are also two provisional measures and three utilization Child measures that are voluntary for state reporting; and there are two provisional measures and one utilization Adult measure. The provisional and utilization measures are not considered part of the 2027 Core Sets and are therefore not included in the figure on the slide.

Note that when a measure is added to the Core Sets, CMS decides whether to add it as a mandatory or provisional measure on a case-by-case basis.

The figure shows the distribution of the Core Set measures by domain. The Child Core Set is more weighted towards measures of primary care and preventive care and behavioral health care, while the Adult Core Set is more heavily weighted towards measures of care of acute and chronic conditions and behavioral health care. The other Core Set domains include Maternal and Perinatal Health with five Child and four Adult measures, Dental and Oral Health Services, with four Child and three Adult measures, and Experience of Care with one Child and one Adult measure.

Please keep in mind that CMS will assign the domains when updating the 2028 Core Sets, so we will not focus on domain assignments during this meeting.

We also wanted to note that some measures cut across the Child and Adult Core Sets, and CMS decides which Core Set to assign the measures to. As we've mentioned in the past, CMS does not have a target number of Core Set measures, either minimum or maximum. Next slide.

So now I'd like to open it up for questions or comments from the Workgroup members. If you have a question related to 2024 Core Sets reporting, mandatory reporting requirements, or the 2027 Core Set measures, please raise your hand to join the queue; and I will call on you.

I'm not seeing any hands yet, so I'll just give it another moment. All right, well, we will have plenty of opportunities for comments and discussion over the next couple of days; so we can continue on. Next slide, please.

All right, so thanks, everyone. We're going to start the measure discussion shortly; but first we'll describe the approach to measure review and do some practice voting. I'll turn it over to Caitlyn Newhard to present next.

Caitlyn Newhard:

Thank you, Alli. Next slide.

We wanted to share some thoughts about the Workgroup's role in strengthening the 2028 Child and Adult Core Sets. The 2028 Core Sets Annual Review Workgroup is charged with assessing the existing Core Sets and recommending measures for removal or addition to strengthen and improve the Core Sets for Medicaid and CHIP. The Workgroup must first determine whether a measure is feasible for state reporting and, if so, also consider the different facets of desirability and viability of adding the measure to the Core Sets. While there are many good measures, we need to keep in mind that to be included on the Core Sets the measure must be feasible and viable for state-level use in Medicaid and CHIP. Next slide.

Another element to consider is multilevel alignment. This graphic shows how alignment can help drive quality improvement in Medicaid and CHIP. At the bottom, we have measures at the clinician or practice level which feed into measures at the program, health plan, health system, or community level. As an example, the Health Home Core Set measures and the HCBS Quality Measure Set are at the program level because they are for distinct subpopulations within a state's Medicaid program. The Child and Adult Core Set measures are state-level measures because they are intended to include all Medicaid and CHIP beneficiaries at the state.

State-level measures can then be aggregated to the national level for monitoring the Medicaid and CHIP program as a whole. The alignment of quality measures across programs and levels can help drive quality improvement by assessing each level of care so that improvement at one level may lead to improvement at other levels. Additionally, alignment is intended to streamline data collection and reporting burden. We asked the Workgroup to consider how the measures under discussion may help facilitate quality improvement both within and across levels. Next slide.

We also wanted to note that measure stewards typically update various aspects of the measure specifications each year. Measures can reflect a variety – or changes can reflect a variety of factors such as new clinical guidance, coding updates, new data sources, and technical corrections identified by users. Many of the measures being reviewed are in the process of being updated or were recently updated. This reflects the evolving nature of quality measurement in healthcare. We have done our best to reflect the most accurate and up to date information about each measure.

Additionally, CMS continues to explore the use of alternate data sources to support calculation and public reporting of current Core Set measures. Alternate data sources can reduce state burden and improve the completeness, consistency, and transparency of measures. Core Set measures are currently calculated on behalf of states using data from CDC WONDER, the NCI-IDD Survey, and the AHRQ CAHPS database. T-MSIS is another data source under consideration for the future.

Last, there is an increasing emphasis within the quality measurement landscape on the use of digital measures and supplemental data sources. Next slide.

In each meeting, we come back to our criteria for assessing measures. We know many of you have seen these slides several times before; however, we have some new Workgroup members and public attendees, and the criteria are foundational to the discussions over the next two days.

In terms of the measures suggested for addition, the first category is our minimum technical feasibility and appropriateness requirements. All suggested measures must meet these requirements. So, the measures we'll discuss today and tomorrow have passed through Mathematica's initial screen based on these criteria.

First, a measure must be fully developed and have detailed specifications that enable production of the measure at the state level. It must have been tested in state Medicaid or CHIP programs or currently being in use by one or more Medicaid or CHIP programs according to measure specifications. There must be an available data source that contains all the elements needed to calculate the measure, including an identifier for Medicaid and CHIP beneficiaries. Specifications and data sources should allow states to calculate the measure consistently. The measure should also align with current clinical guidelines; and the measure must include technical specifications, including code sets that are provided free of charge for state use in the Core Sets.

These criteria were developed to help ensure that if a measure is placed on the Core Sets, states are able to produce consistent state-level results for their Medicaid and CHIP populations. The Mathematica team has assessed the suggested measures for adherence to these minimum criteria. Next slide.

Next, we have criteria for assessing measures suggested for addition in terms of their actionability. Measures that are recommended for addition to the Core Sets should either fill a priority gap in the Core Sets or add value to the existing measures on the Core Sets. In addition, consider whether they can be used to assess state progress in improving healthcare delivery and outcomes and whether they can be stratified by the required stratification categories included in the Annual Core Sets guidance.

Finally, a few other criteria to consider:

- Is the prevalence of the condition or outcome sufficient to produce reliable and meaningful state-level results?
- Is the measure aligned with those used in other CMS programs?
- Would adding the measure to the Core Sets result in no or minimal additional data collection burden for providers and beneficiaries?
- Will all states be able to produce the measure within two years of the measure being added to the Core Sets?
- Are the code sets and codes specified in the measure currently in use by or readily available to Medicaid and CHIP programs?

Next slide.

When Workgroup members are considering measures for removal, we ask them to consider whether the measure no longer meets the criteria for addition. So for example, we ask the Workgroup to consider:

- Are the specifications and data source leading to inconsistent calculations across states?
- Does the measure no longer align with the current clinical guidance?
- Is measure performance for all populations so high that meaningful distinctions in improvement or performance can no longer be made?
- Has another measure been recommended for replacement that is more broadly applicable for the topic, more proximal in time to desired outcomes, or more strongly associated with desired outcomes?

Of course this is not a comprehensive list of reasons for removal but a few key considerations. Next slide.

Now with those criteria in mind, I'll provide an overview of the voting process. Voting will take place by measure after Workgroup discussion and public comment and will be for Workgroup members only. Federal liaisons and other attendees of today's meeting are not eligible to vote on measures. Workgroup members should let us know through the Slido Q&A function in Webex if they will be absent for a portion of the voting. Each measure will be voted on as it's currently specified. If a measure is being considered for removal, a "Yes" vote means "I recommend removing this measure from the Child or Adult Core Set." If the measure is being considered for addition, a "Yes" vote means "I recommend adding this measure to the Core Sets." For the paired antibiotics measures, Workgroup members will first vote on the measures suggested for addition and then on the measures suggested for removal. Measures will be recommended for removal or addition if two-thirds of eligible Workgroup members vote "Yes." Next slide.

All right, are there any questions from Workgroup members about the criteria or voting logistics before we do the practice vote? Workgroup members, go ahead and raise your hand if you have any questions. We'll give it a moment or two.

All right, just a second longer here. I'm not seeing any hands raised. All right, we'll go ahead and move on to the practice vote. Next slide, great, thanks.

As a reminder for all attendees, voting will be for Workgroup members only. Workgroup members, please navigate to the Slido voting page. You can follow this QR code, use the link listing in the Voting Guide, or go to Slido.com and enter "2028ChildAdultCSR" with no spaces as the event code. You will be prompted to enter your email address and name, after which you will enter the verification code sent to your email. Be sure to use the same email address at which you receive communications from the Mathematica Child and Adult Core Sets Review Team. You can remain on this page for the duration of the meeting, and new voting questions should appear as we make them available. If you don't see the new question, just refresh your page and it should pop up. If you need any help, please refer to the Voting Guide or send us a chat through the Q&A feature in Slido. The third page of the Voting Guide has an FAQ section that answers most common problems.

During voting on measures if for any reason you are unable to submit your vote, please send us your vote through Q&A in Slido or to our email address if you are not able to access Webex. Your votes will be visible only to the Mathematica Team. Once you have emailed or sent your

votes to our team, please stop trying to submit your vote through Slido. Our team will submit the vote on your behalf to avoid double-counting. Please know that Mathematica will do a careful review of all voting results at the end of each day to make sure that each eligible Workgroup member's vote was included and counted only once.

Now let's jump into the practice vote. So, Practice Vote #1, first vote: “What is your favorite way to enjoy coffee?” The options that should appear on your voting page are: “black”, “with milk or cream”, “latte”, “iced coffee”, and “I don't drink coffee”.

Please go ahead, Workgroup members, and place your vote.

All right, I see we have 23 votes. We'll give it a few more minutes. We are expecting another vote or two here. I see 23 votes. We're still expecting a few more Workgroup members to submit a vote. All right, we're up to 25. We're getting there – just looking for two more votes. All right, still seeing 25. We are looking for 27, so I'll give it another few moments here. All right, we're just – oh, we're up to 26. So, we're missing just one vote.

All right, voting is closed; and the results are, drum roll please: all right, so 8% enjoys their coffee black; 50% with milk or cream; 19% in a latte; 15% iced coffee; and 8% don't drink coffee.

All right, the next vote, we'll move on to Practice Vote #2. The next vote is: “Do you prefer movies or TV shows?” The options that should appear on your voting page are “movies”, “TV shows”, or “I don't watch either”. Go ahead and please place your votes, Workgroup members. We'll give it a few more minutes here. We are looking for 27, and it looks like we're at 23. We're getting there. We'll just give it another second or two. Just looking for one more vote. All right, we can go ahead and close the poll and show the results. All right, so in response to, "Do you prefer movies or TV shows," 31% prefer movies; 65% prefer TV shows; and 4% don't watch either. Next slide.

All right, thank you all for testing the vote. It should get easier from here. That first practice vote tends to be the most difficult. So, we'll be taking a break until 12:30 p.m. Eastern Time – again, that's 12:30 p.m., which differs slightly from the agenda but if folks can please plan to be back here by 12:30 p.m.

If Workgroup members were having any trouble voting, if they want to stay on the line we can help troubleshoot here. So, see everyone back at 12:30 p.m. Thank you.

[Break]

Alli Steiner:

Hello, welcome back from the break everyone. As a reminder, the paired antibiotics measures will be discussed together.

We'll first vote on the suggested replacement measure and then on the removal. I'm going to facilitate the Workgroup discussion about the two measures; but first, I'll turn it over to Chrissy Fiorentini to provide a brief overview of the measures suggested for removal and addition.

Chrissy Fiorentini:

Thanks, Alli. Next slide. The measure suggested for removal from both the Child and Adult Core Sets is Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis or AAB-CH and AD. The measure is included in the Care of Acute and Chronic Conditions domain.

On the Child Core Set, the measure is defined as the percentage of episodes for beneficiaries ages 3 months to 17 years with a diagnosis of acute bronchitis or bronchiolitis that did not result in an antibiotic-dispensing event. On the Adult Core Set, the measure is defined as the percentage of episodes for beneficiaries age 18 and older with a diagnosis of acute bronchitis or bronchiolitis that did not result in an antibiotic-dispensing event. Both the Child and Adult measures are reported as an inverted rate, such that a higher rate indicates appropriate treatment. The measure steward is the National Committee for Quality Assurance or NCQA. It's a process measure, and the data collection method is administrative. This slide and the next also include the full denominator definition for reference. The denominator for both the Child and Adult measures includes episodes for beneficiaries who had an outpatient visit, emergency department visit, telephone visit, e-visit, or virtual check-in during the intake period with a diagnosis of acute bronchitis or bronchiolitis. Next slide.

Episodes are removed from the denominator if the episode results in an inpatient stay; the beneficiary had a claim or encounter with any diagnosis for a comorbid condition during the 365 days prior to or on the episode date; a new or refilled prescription for an antibiotics medication was dispensed 30 days prior to the episode date or was active on the episode date; or if the beneficiary had a claim or encounter with a competing diagnosis on or three days after the episode date. Episodes are included in the numerator if the prescription for an antibiotic medication was discussed on or three days after the episode date. Starting with 2026 Core Sets reporting, states will be required to stratify the Child Core Set measure by race and ethnicity, sex, and geography. States currently report the Adult Core Set measure stratified by age group. Reporting for additional stratification categories is encouraged but not required for adults. 52 states reported the Child Core Set, and 46 states reported the Adult Core Set measure for 2024 Core Set reporting. All states reported the measure using Core Set specifications. The measure is not included on the Medicaid or CHIP Scorecard. The individual who suggested the measure for removal suggested a replacement measure which they believe is a better fit for the Core Sets. I'll provide more information about the suggested replacement measure and the submitter's rationale for the proposed substitution over the next two slides. Next slide.

The measure suggested to replace the AAB-CH and AD measure is Antibiotic Utilization for Respiratory Conditions. This measure is defined as the percentage of episodes for persons 3 months of age and older with a diagnosis of a respiratory condition that resulted in an antibiotic-dispensing event. Note that the measure steward does not view higher or lower service counts as indicating better or worse performance. NCQA is the measure steward, and it's specified at the health plan level. it is a process measure, and the data collection method is administrative. The denominator includes episodes for persons 3 months of age or older as of the episode date who had an outpatient visit, emergency department visit, telephone visit, e-visit, or virtual check-in during the intake period with a diagnosis of a respiratory condition. This slide also shows the conditions for exclusions from the denominator, which are similar to the denominator exclusion conditions for AAB. However, please note that the values used to identify competing diagnoses differ between the two measures. Next slide.

Episodes are included in the numerator for this measure if a prescription for an antibiotic medication was dispensed on or three days after the episode date. Note that in the HEDIS measurement year 2026 specifications the antibiotic medications list for this measure includes one additional medication that is not included on the AAB medications list. The measure is currently stratified by age group for the Medicaid product line within HEDIS. NCQA as the measure steward noted that it is also feasible to stratify the measure by sex and geography. They have not assessed the feasibility of stratifying the measure by race and ethnicity but plan to assess this stratification in the future. The measure was tested using the Merative

MarketScan Multi-State Medicaid Database, which contains claims data from multiple state Medicaid agencies. The individual who suggested the measure for addition noted that New York State has required reporting of the measure for Medicaid and commercial managed care plans since 2022. They noted that the measure is also in use by the Medicaid programs in Louisiana and New Hampshire. The individual who suggested the measure for addition to the Core Sets and to replace the AAB-CH and AD measure argued that by including a wider spectrum of acute respiratory conditions, the Antibiotic Utilization for Respiratory Conditions measure reduces reliance on precise diagnostic coding and instead captures overall antibiotic prescribing patterns. They further noted that the broader denominator would make the measure less susceptible to natural random variations, facilitating the identification of prescribing variability and outliers among clinicians. They concluded that the suggested measure could have a greater impact on reducing unnecessary antibiotic use compared to the AAB measure. Since the latter measure targets only antibiotic prescribing for bronchitis and bronchiolitis, individual conditions for antibiotics are rarely appropriate.

In their submission, the individual who suggested the measure also emphasized that improving antibiotic prescribing practices in U.S. outpatient settings is critical to enhancing quality of care for Medicaid and CHIP beneficiaries. They noted that unnecessary antibiotic use is an important driver of increases in antibiotic-resistant bacteria, which cause more than 2.8 million infections and over 35,000 deaths nationwide each year. They argued that by collecting actionable data on antibiotic prescribing, states and health plans could use the suggested measure to design audit and feedback interventions to modify clinician behavior and ultimately improve patient outcomes. Next slide.

I will now turn it over to Alli to facilitate the Workgroup discussion of these two measures. Alli?

Alli Steiner:

Thanks, Chrissy.

So, before we begin the discussion, I'm going to read some remarks about the two measures provided by the federal liaison from CDC who was unable to attend today due to the government shutdown. So, in the prepared remarks, the CDC representative noted that in their opinion replacing the Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis AAB measure with the Antibiotic Utilization for Respiratory Conditions (AXR) measure in the Core Sets reduces reporting burden by consolidating measurement across respiratory diagnosis and age groups, allowing a more comprehensive approach. They also noted that unlike single diagnosis measures, AXR reduces the potential for diagnosis shifting. They noted that AXR captures clinician and practice-level variation in antibiotic prescribing across common respiratory illnesses supporting targeted audit and feedback efforts and quality improvement initiatives.

They also noted that because the denominator includes a broader set of ICD-10 codes for respiratory illness diagnoses, AXR is less susceptible to common cause variation, improving the ability to identify meaningful differences in prescribing variability and detecting true outliers. They noted that broad respiratory measures have been successfully used by multiple health systems to improve antibiotic use.

Lastly, they noted that performance on the existing AAB measure has remained stable for the last several years, suggesting that prescribing for bronchitis is stable and that Medicaid performance on AAB is better than that of commercial plans. They also noted that AXR

measure rates on the other hand had *increased* somewhat from Medicaid, suggesting added value in assessing the overall prescribing for respiratory conditions. That was from NCQA data.

So, thank you so much to the CDC representative for providing those remarks. We'll now invite discussion from Workgroup members and other federal liaisons about the paired measures suggested for removal and addition, so Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis and Antibiotic Utilization for Respiratory Conditions.

Please raise your hand, and we'll call on your name. You can unmute yourself when it's your turn to speak. Please remember to also say your name before making your comments. Also, since we're discussing two measures here, please make sure to clearly state which of the two measures you're speaking about.

Again, we're looking for comments from the Workgroup members or federal liaisons at this time. All right, let's see, it looks like we have a hand from Jeff. Can we unmute Jeff?

Jeff Huebner:

Hi, everyone, can you hear me?

Alli Steiner:

We can.

Jeff Huebner:

Yeah, this is Jeff Huebner from Wisconsin again. Thanks for the presentation on these two, and I'll speak about both of them.

First in regards the measure that's potentially up for removal, Antibiotic Utilization for Acute Bronchitis and Bronchiolitis. I think that measure – I agree with a lot of the CDC contributions on the analysis and also what the submitter had put forth. I think that measure – looking at that measure for several years now in multiple job settings, I think it's a measure that doesn't provide a lot of actionable data for clinicians and health systems. It also does have some significant sort of "diagnosis shifting" as it's called or also gaming with it.

So, I'm really heartened to see the potential new measure for Antibiotic Treatment or Utilization for Respiratory Conditions. I'm very interested and like the fact that it covers multiple conditions. It was a little tricky for me to figure out which conditions were included, and I'm not sure if that was stated in the introduction. So just so people know – and someone can correct me if I'm wrong in my research – but it includes three tiers of conditions.

Tier 1 is pneumonia, which generally would necessitate antibiotics. Tier 2, conditions that sometimes necessitate antibiotics – sinusitis and otitis media; and the third one not generally warranted -- bronchitis, upper respiratory infection, and cough.

So again, the CDC analysis I think is on point there. I do have some concerns about this measure and the ability of reporting it at the state level and how it would be used at the state level. I think it's hard to dive into actionable data for clinicians or even health systems without having more granular data on some of those conditions. But I do think if you're able to take into account your local prescribing patterns, population needs, antibiotic appropriateness, you may be able to work on that at a QI level at your state.

I would be very interested to hear – it's mentioned in the materials that New York's been using this since 2022, Louisiana as well. I'm not sure about any other states at the Medicaid level, but would be interested to hear state experience if anybody has insight into that from the Workgroup. Thanks.

Alli Steiner:

Thanks, Jeff. Let's go to Chimene.

Chimene Liburd:

I didn't put my hand down fast enough. Chimene Liburd from DC. Actually, Jeff kind of was spot on, on the comments that I was going to make. So I am not going to waste time, but I concur with Jeff. Thank you.

Alli Steiner:

Thank you. Let's go to Dawn. I thought I saw Dawn's hand up. Dawn Alley, did you have a comment?

Dawn Alley:

I'm sorry. I didn't fully unmute, thank you.

Alli Steiner:

We can hear you.

Dawn Alley:

I concur with the comments already made. I just had an additional technical question, which is that – this the new measure, Antibiotic Utilization for Respiratory Conditions. It says that it's specified at the plan level, but it doesn't seem to be specified at the provider level. But it seemed like part of the justification for the measure was the ability to look at the provider level. So I was curious for those states using it whether you feel like you can get reliable data to be able to understand that provider-level variation.

Alli Steiner:

Great, thanks for that question. Hopefully we'll hear from some states who are using it and who can address that question.

I see a couple other hands raised. Can we go to David?

David Zona:

Hi, good afternoon. This is Dave Zona from IPRO. Just kind of building on the comments that Jeff had initially made, my initial reaction was related specifically to the fact that the new measure suggested for addition includes conditions where antibiotic prescribing is appropriate or could be appropriate. That's concerning me just for the fact of the matter that you really need to do more of a deep dive and better understand the granular details to know where the true opportunity is if you're putting together quality improvement initiatives. Health plans and provider organizations and health systems are going to have to have that information at their disposal to

put together meaningful interventions to drive improvement forward. It's certainly not to say that can't happen, but the measure in and of itself doesn't provide that information to be able to do those things.

That's my comment, thank you.

Alli Steiner:

Thanks, David. Let's go to Sara next.

Sara Toomey:

Hi, so I just want to build on what's been said. So I think one question I have, and it really would be great if there's anybody from New York or Louisiana who are on who have used this measure if they could give some context. But it seems that this measure would be most useful stratified by these different buckets.

Jeff, your looking into what buckets there were was really very valuable. I worry that it'll be very difficult to make comparisons across states if you're combining all of them. At the end of the day, what we're trying to do is reduce unnecessary antibiotics. I'm afraid that by including conditions for which antibiotics are necessary could really complicate how to interpret the information. Thank you.

Alli Steiner:

Thanks, Sara. Let's go to Stacey next.

Stacey Bartell:

Hi, Stacey Bartell. Thanks for the opportunity.

I agree with the previous callers in the concerns that we know it's a complicated measure. As a practicing physician, when I get the status sometimes, like several months after the episode has occurred, I'm not sure that I take the time to go look up every case and decide if it was appropriate or not because in the moment I feel like as a practicing physician I am doing the appropriate thing for the patient in front of me. I think that's what we find particularly challenging about this measure.

Add it to the fact that people seek care in multiple places right now. So sometimes a patient will go to an easier way to seek care, like a telehealth or a minute clinic or something, because it's easier sometimes to get an antibiotic from there than it is from your primary care provider. So I think that's challenging because that antibiotic dings me from a health plan level; it doesn't necessarily ding the provider who wrote the prescription, and that can be very challenging.

I think that's all I had. Thank you.

Alli Steiner:

Thanks for your comment. I just wanted to echo the questions. If there are any state representatives on the call who have used this for their Medicaid or CHIP programs. if you'd be willing to share any insights I think that would be helpful for the other Workgroup members. I see a hand up from Sarah.

Sarah Tomlinson:

Sarah Tomlinson from North Carolina. We have used this measure from health plans in the past who just retired it. Four out of five of the health plans voted to remove it because they felt that it lacked the tracking quality, and I think that's interesting and might be helpful to decide is this the best measure to replace the one that's being considered for removal.

Alli Steiner:

Thanks, Sarah. We appreciate you offering that state perspective. Are there any other comments from Workgroup members either about the measure that's being considered for removal or the measure that's being considered for replacement? I'm seeing a hand up from Sara Toomey.

Sara Toomey:

Yes, Sara Toomey. I guess the other question I would have about the one that we're considering for removal, I agree with Jeff's comment also that I don't think there's been a lot of movement on it recently and that while I think initially it had good effect, potentially we have kind of hit sort of a place for where it might not be as useful. I don't know if there are any states on the line for which they are still finding value in having that measure at the state level. There might not be, but I just would be curious if there were.

Alli Steiner:

Thanks, Sara. I'm not seeing any additional hands go up from states. We can definitely – we'd love to hear from states also during the public comment period which we'll go to next. Sarah Tomlinson, I'm still seeing your hand. Did you have an additional comment?

Sarah Tomlinson:

No, I'm sorry. That's a mistake.

Alli Steiner:

Okay, thank you. I see Kim.

Kim Elliott:

I think that when I looked at the trend rates for the measure recommended for removal, it didn't seem like there was a lot of movement anymore. So that one may be a topped-out measure; and all 52 states and territories were reporting the Child and 45 states reporting the Adult measure, so no real comment other than that.

For the one that was suggest for addition, my only concern is because of the – I don't even know if it's necessarily a concern. But if there isn't as much specificity in how the states or the plans or the providers have really focused on what initiatives or actions could be taken to really move the needle on it, it's not as specific as the measure that's currently on the Core Set. So it might create some challenges in that regard.

Alli Steiner:

Thanks, Kim. All right, do we have any other comments from the Workgroup members?

I'm not seeing any, so why don't we go ahead to the next slide.

All right, so now we'll have an opportunity for public comment about the measure. So, if you'd like to make a comment about the Avoidance of Antibiotic Treatment for Acute Bronchitis or Bronchiolitis or the , Antibiotic Utilization for Respiratory Conditions measures, please use the "raise hand" feature in the bottom-right of your participant panel to join the queue. Please also remember to lower your hand when you're done, and we'll let you know when you've been unmuted.

Again, if there are any participants in the public who represent a state perspective, we'd love to hear from you. So it looks like we have a hand raised from Allan. Fiona, can we unmute Allan, please?

Please introduce yourself and give your affiliation.

Allan Seibert:

Thank you. Good morning, can you hear me okay?

Alli Steiner:

We can.

Allan Seibert:

Excellent. My name is Allan Seibert, and I'm one of the leaders for outpatient stewardship at Paramount Health based in Utah.

Just a quick comment on the Antibiotic Utilization for Respiratory Conditions metric. Really, really appreciate all of the comments so far hitting so many highlights of discussions that we've had in our outpatient stewardship program. We've really come to appreciate that it serves much more as a check engine light than a very granular metric like AAB.

But to comments so far, AAB is particularly granular; and with AXR, it is worth sharing that we did recently complete a study looking at over 500,000 respiratory encounters in our urgent care network across the state – 32 clinics over three years, 303 clinicians. We found that AXR was very strongly correlated with Tier 3 prescribing, pharyngitis treatment despite negative group-based stress test, and a number of other prescribing and even diagnostic behaviors for Tier 2 conditions, like sinusitis and otitis. Interestingly, excluding patients with penicillin allergy, these five AXR clinicians were a lot less likely to prescribe narrow-spectrum antibiotic prescriptions and even shorter-duration prescriptions for all patients with sinusitis and AOM.

I recognize this -- our system/our context, and it's important to recognize that there may be unique characteristics a state or a health system deals with that inform exactly what drives AXR. Thank you.

Alli Steiner:

Thanks so much, Allan. Let's move to Alexandra next, please.

Alexandra Yamschikov:

Hi, good afternoon. My name is Alexandra Yamshchikov. I am an infectious disease physician at the University of Rochester Medical Center; and I work with our Antimicrobial Stewardship program, particularly in the outpatient capacity.

I wanted to share our experience specifically with the AAB measure. As an outpatient steward, I can speak to the idea that this measure is pretty much tapped out in our patient population. We're not really including it in any of our value-based purchasing contracts or our patient settings because there's really with diagnostic shifting and sort of the education that we've maximized for our providers, there's really no movement that we can demonstrate in this measure.

In terms of the proposed measure, I wanted to share our experience working with one of the AHRQ programs recently within the past year. They had a safety program for specifically telemedicine practices that adopted a very similar framework to what this measure proposes – so evaluating prescribing for Tier 3, Tier 2, and Tier 1 conditions. Our providers actually found it to be very useful, and our practices found it very useful feedback that was granular enough to be practice changing.

A Core Set doesn't speak to how useful this would be at the plan level, but I wanted to suggest that I appreciate the concerns about including Tier 2 conditions where antibiotics may or may not be necessary. I wanted to share that the way that the AHRQ program approached this issue is by basically honing in more specifically on the antibiotics (inaudible) conditions and really giving – structuring the data gathering in such a way that it gave people grace for the Tier 2 conditions and really focused more on the Tier 3 conditions where antibiotics should really *not* be prescribed.

Increasing the breadth of diagnoses that are included in that category when you compare that to the bronchitis measure really does help with some of that sort of diagnosis shifting and kind of gaming the system practices just because you're looking at a broader scope of prescribing opportunities – or missed opportunities as I should say. So it's just basically a vote in support of the framework, the data framework that's proposed for this measure in that it is possible to code the reports and have the value sets reflect kind of a more granular collection of data that can be actually useful for providers and then practice groups.

Alli Steiner:

Great, thank you for your comments and the context about how you're using the measures. Let's move on to Ryan next, please.

Ryan:

My name is Ryan. I'm a pharmacist at Mayo Clinic in Rochester, Minnesota; and I co-chair our enterprise's Outpatient Antimicrobial Stewardship and Ambulatory Antimicrobial Stewardship program. I recognize this is a complex problem to solve, and so I appreciate the bandwidth that's going into evaluating it.

A couple of things that we focus primarily on Tier 3 syndromes, and prescribing in Tier 3 syndromes has been our focus over many years when it comes to respiratory infections. We have had less luck intervening on Tier 2 syndromes, specifically like sinusitis and antibacterial sinusitis processes. So I guess my concern with the AXR is potentially twofold.

One, I think David mentioned this during the Workgroup discussion, which is just that it is really – it may reveal underlying problems, but it is difficult to intervene specifically on the AXR. It does require the more granular data. Allan also mentioned this with regards to it being sort of a check engine light of a more global prescribing process. But when you're doing the actual quality improvement, it's difficult to intervene at that level.

The other piece is just that it appears to me that a large amount of this data has been done within a single specialty; so for example, evaluations of AXR application in urgent care networks. We have a large outpatient practice with lots of different specialties involved, so I have some concerns about how acuity and ICD-10 code utilization might impact the ability to compare provider to provider or specialty to specialty in this context and may add a layer of complexity when people are trying to essentially benchmark within their institution even across multiple specialties. Thank you.

Alli Steiner:

Thanks so much, Ryan. Let's hear from Adam next, please.

Adam Hersh:

Hi, my name is Adam Hersh. I'm a pediatric infectious diseases physician at the University of Utah. I have really appreciated hearing all the comments, both in favor and some of the challenges associated with this metric; i.e., the outpatient stewardship activities at the University of Utah Health System. This is a metric – or a version of this metric is something that we've put a lot of time and energy into and have experienced – have direct experience with both some of the advantages and strengths of using this metric to do outpatient stewardship along with some of the challenges.

Like other people have pointed out, we have found this to be a very useful metric for tracking. We've found it to be a very useful screening tool to sort of get a sense of maybe where some improvements could occur. But completely want to emphasize that the metric in and of itself is not obviously – does not obviously demonstrate where and how one can intervene. It requires further decomposition.

One of the things that a previous commentor mentioned is exactly what we do. We start with an AXR; and whether we're comparing between clinics, between setting types, or between clinicians, we then decompose the AXR value into the three tiers that were mentioned. We look at the distribution of the frequency with which tiers are assigned within a given (inaudible) value. We look at the frequency with which antibiotics are prescribed within those tiers. It's a little bit of a process, but I think ultimately what we've found is that there's an inherent trade-off between a very granular metric, such as AAB, and a not-so-granular screening metric like the AXR. At least at the system level, we've found it as a very useful starting point. Thank you.

Alli Steiner:

Thanks, Adam. It's helpful to hear how you've used the measure as well. Are there any other public comments? At this time, I'm not seeing any hands. Oh, we have one more comment. Can we unmute Danielle, please?

Danielle Rainis:

Yeah, this is Danielle Rainis from NCQA. I really appreciate all of the discussion around both measures. I think you bring up really good points. It reminds me of when we were developing

this measure and discussing with our antibiotic experts about what would be more useful in the space at the time and I think still right now. They really liked the AXR measure, particularly when it comes to kind of the ability to do QA with this measure. I think one of the benefits of AXR is even though there are both conditions where antibiotics are appropriate and conditions where they are not appropriate, still overall there should be kind of a low level of prescribing for respiratory conditions because most of them are ones in which you should *not* prescribe antibiotics.

I think one thing we heard was that the benefit of using this measure for sort of more kind of longitudinal analysis – so year over year tracking the changes over time – and how that can be a really good signal to a plan or organization to do some of those additional drill-down analyses. It gives you kind of an overall snapshot of what the prescribing is for respiratory conditions overall instead of just honing in on one particular condition.

So I just wanted to add that and also say thank you for considering this for the Core Sets.

Alli Steiner:

Thank you so much, Danielle. All right, let's move on to Dan. I think I saw a hand from Dan. Dan Livorsi, if you would like to make a comment, please feel free to raise your hand again. But in the meantime, let's move on to Nicole, please.

Nicole

[Break in audio]...and I direct our Outpatient Surgery program at Children's Hospital Colorado down in the Denver and Aurora area.

My comment is just to highlight about the AXR, and thank you for all of – it's been really helpful to hear everybody's commentary. We've used the AXR in primarily our urgent care and ED settings along with our primary care settings in our Children's Hospital network for a few years now. We transitioned to using AXR because we found that some of the other HEDIS measures – the other measures were not really showing us – not really highlighting where we knew there was the most overprescribing in the pediatric world. That was primarily for patients with acute otitis media.

My comment here is about using acute otitis media as an example in the pediatric world that I think parallels something like sinusitis in the adult world, where the AXR measure really does capture these Tier 2 diagnoses that we know are one of the primary diagnoses that are overprescribed. So we use the measure to really understand how that paralleled our AOM prescribing and found it to be almost kind of the exact curve, which showed us that the AXR measure that was easier for us to measure really reflected what we had prophesized to be our most overused diagnosis, which was AOM.

So I use this as a very specific example on where we have targeted some of our improvement methods over the last year-and-a-half to show where we used AXR as a way to get the data easier on some of our more challenging clinics to get data from. Then we're able to really hone in on how it reflected some more specific targets for improvement, and we focused on acute otitis media specifically in our institution, which I think actually could be a benefit that you could choose whatever respiratory illness you found to be the most impactful in different institutions, which I think was a highlight of AXR – that you could kind of make that decision as your data reflected versus being very, very granular with bronchiolitis and viral illness measures that we no longer use.

So just as another example of one of our bigger institutions kind of across the Denver Metro area that we have used. Thank you so much.

Alli Steiner:

Thanks so much, Nicole. Are there any other public comments?

All right, well, not seeing any, I think let's move on to the next slide, please. We will move on to our next vote. All right, everyone, so for the first vote: Should the Antibiotic Utilization for Respiratory Conditions measure be added to the Core Sets? The options are: yes, I recommend this measure be added to the Core Sets, and no, I do not recommend adding this measure to the Core Sets. Voting is now open. If the questions don't appear on your page, please refresh your browser. While we're waiting for the results to come in, we just wanted to let you know that the voting results you'll see on screen are preliminary. Mathematica will do a careful review of all voting results at the end of each day to make sure each eligible Workgroup member's vote was counted. If any of the voting results change, we'll let you know during the wrap-up for that day.

All right, thanks for all your votes. We're just expecting one more vote to come in. It looks like we reached the 27 votes, so let's move on.

Okay, so for the results, we have 56% of Workgroup members voted yes. That does not meet the threshold for recommendation, so the Antibiotic Utilization for Respiratory Conditions measure is not recommended by the Workgroup for addition to the 2028 Core Sets.

Let's move on the next vote. Next slide, please.

So for our second vote: Should the Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis Ages 3 Months to 17 Years measure be removed from the Child Core Set? The options are: yes, I recommend removing the measure from the Child Core Set, and no, I do not recommend removing this measure from the Child Core Set.

Please note that we'll separately vote on the measure's removal for the Adult Core Set next, so this is just for the Child Core Set. Voting is now open; and if the question does not appear, please refresh your browser.

Great, we have reached the expected number of votes. That was so quick; thanks, everyone. So let's close the vote.

Okay, so for the results, 59% of Workgroup members voted yes. Again, that does not meet the threshold. So the Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis Ages 3 Months to 17 Years (AAB-CH) measure is not recommended by the Workgroup for removal from the 2028 Child Core Set.

All right, next vote, please. For the third vote: Should the Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis Age 18 and Older measure be removed from the Adult Core Set? The options are: yes, I recommend removing the measure from the Child Core Set, and no, I do not recommend removing this measure from the Child Core Set.

Voting is now open. All right, that reaches the expected number of votes; so we can close the vote.

Another close one – so for the results, 52% of Workgroup members voted yes. That does not meet the threshold for recommendation. The Avoidance of Antibiotic Treatment for Acute

Bronchitis/Bronchiolitis Age 18 and Older measure is not recommended for removal from the 2028 Adult Core Set.

Thank you, everyone, for your participation in the voting process. To recap from the preliminary votes, the Antibiotic Utilization for Respiratory Conditions measure was not recommended for addition; and the existing Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis measures were not recommended for removal. Since they were such close votes and we have a little bit of time, so we wanted to just open it up to the Workgroup members if anyone had an additional comment about what kind of led them to their votes or any additional context about these measures that you'd like to add before we move on.

If there's anything you'd like to share, please raise your hand. Let's hear from Jeff, please.

Jeff Huebner:

I think it was really great to hear all the discussion and information, especially from – really appreciate the clinical experts and leaders from their health systems who contributed to this conversation. It's very helpful, and I think the question still in my mind in regard to adding the new measure was about the usefulness at a state-population level and/or health plan level. I think it would take definitely concerted efforts by clinical health systems and clinical leaders to continue to do this work, which I applaud. For us at a more population level, I think it's a more challenging measure.

That said, I do think antibiotic overuse is a *very* important issue that we do need to pay attention to; so I hope this conversation comes forward again, perhaps with a revision of the measure or a new measure.

Alli Steiner:

Thanks, Jeff, that was helpful. Do any other Workgroup members want to provide any additional insight? Sara?

Sara Toomey:

I just would echo what Jeff said and probably others in the Workgroup agree. I think it really has to do less about how it's being used at the local level, which there were some amazing examples given, but more about how a state is going to use it and even a health plan to drive change. Thank you.

Alli Steiner:

Thanks, Sara. Jessica?

Jessica Harley:

Hi, this is Jessica Harley from Community Health Choice at the health plan level. I will say for the state of Texas, this is a measure that we do actually include in our state reporting, even though it's not in the Core Set. We do report out on it. But it's not one that we have been incentivized by the state in the past, but it is one that we do try to really encourage our providers to track trends because at the health plan level and at a state level we are tracking and trending it.

Alli Steiner:

Thanks for adding that, Jessica.

All right, I'm not seeing any other hands from Workgroup members at this time. We did have one person who raised their hand during the public comment that we were not able to hear from. I just want to give them one more chance to speak. Dan, if you're there and if you still want to make your comment, could you raise your hand?

Dan Livorsi:

I'm an infectious disease physician, and I have a focus in antibiotic stewardship. I work at University of Iowa Health Care System.

We recently did a project with the CDC with our nine urgent care clinics, where we randomized urgent care providers to either getting feedback on the AXR metric or not getting feedback on the AXR metric. The trial went on for 18 months. We found that providers who got the feedback on the AXR metric prescribed fewer antibiotics for respiratory visits. Their use of antibiotics went down by about 10% to 15%, and this was a safe decrease in antibiotic used based on outcomes like return visits and ED visits and hospitalizations.

We also interviewed providers about the metric; and we found that the providers found the metric acceptable, that they thought it was valid and fair, and they felt like it was less prone to gaming than a prior metric that really just focused on the Tier 3 conditions. So I just wanted to share our experience, which was overall a positive one with the AXR. Thank you.

Alli Steiner:

Thank you, Dan. All right, well with that, we will continue on. So let's move to Slide 51, please.

So now I'll pass it over to Deb Haimowitz to describe our next measure suggested for addition to the 2028 Core Sets. Deb?

Deb Haimowitz:

Thanks, Alli. We will now discuss the next measure suggested for addition to the 2028 Core Sets: Follow-Up After Acute and Urgent Care Visits for Asthma. Next slide, please.

Before we go over the details for this measure, I'd like to highlight the other measures on the 2027 Core Sets related to the management of asthma. PQI 05: Chronic Obstructive Pulmonary Disease, or COPD, or Asthma in Older Adults Administration Rate; and PQI 15: Asthma in Younger Adults Administration Rate. Both measures are on the Adult Core Set. There are no measures on the 2027 Child Core Set related to the management of asthma. Note that the asthma medication ratio, or AMR, measure was included on the Child Core Set for ages 15 to 18 and the Adult Core Set for ages 19 to 64 through the 2026 Core Sets but was retired by the measure steward and removed for the 2027 Core Sets. The measure that we'll be discussing today was suggested as a replacement for the AMR measure. Next slide, please.

The measure suggested for addition is Follow-Up After Acute and Urgent Care Visits for Asthma. This measure is defined as the percentage of persons ages 5 to 64 with an urgent care visit, acute inpatient discharge, observation stay discharge, or emergency department visit with a diagnosis of asthma that had a corresponding outpatient follow-up visit with a diagnosis of asthma within 30 days. NCQA is the measure steward, and the measure is specified at the health plan level. It is a process measure. The measure was suggested to replace the Asthma

Medication Ratio Ages 5 to 18 measure on the Child Core Set and the Asthma Medication Ratio Ages 19 to 64 measure on the Adult Core Set. As I mentioned earlier, both measures were retired for the 2027 Core Sets.

The data collection method is HEDIS Electronic Clinical Data Systems or ECDS. ECDS includes data from administrative claims, EHRs, case management systems, health information exchanges, and clinical registries. The denominator includes acute visits for asthma on or between January 1st and December 1st of the measurement period for persons ages 5 to 64 as of the episode date. Acute visits include urgent care visits, ED visits, acute inpatient discharges, and observation stay discharges. This slide also shows the conditions under which ED and urgent care visits are excluded from the denominator. Finally, the slide identifies the specified rates for the measure in HEDIS reporting, including age group and COPD diagnosis status. Next slide, please.

This slide shows the numerator. The numerator of this measure is an outpatient visit, telephone visit, e-visit, or virtual check-in with a diagnosis of asthma within 30 days after the asthma episode. The slide also shows the conditions for exclusions from the numerator. NCQA, the measure steward, explains that the data source allows for stratification by race, ethnicity, sex, and geography. The measure was tested using the Merative MarketSkan Multistate Medicaid Database, which includes claims data from multiple state Medicaid agencies. NCQA noted that the measure is not currently in use by any states since it was only recently released in August of 2025.

The individual who suggested the measure indicated that it would address an existing gap area in the Core Sets related to the care for asthma due to the retirement of the AMR measure. They emphasized that asthma is a serious chronic lung disease that led to over 90 hospitalizations and nearly one million ED visits among U.S. children and adults in 2020. The individual also noted that research underscores the importance of care continuity and the effectiveness of timely outpatient visits in preventing exacerbations for individuals with asthma. The individual explained that the Follow-Up After Acute and Urgent Care Visits for Asthma measure is intended to incentivize plans to ensure their patients receive an outpatient visit after an acute asthma exacerbation. By understanding follow-up rates after acute care utilization for asthma, plans can identify and address factors that inhibit care continuity following asthma exacerbations. Next slide, please.

In addition to introducing the Follow-Up After Acute and Urgent Care Visits for Asthma measure, we would like to provide a brief comparison between the measure and the Asthma Medication Ratio measure that was retired from the Child and Adult Core Sets. While the Workgroup will not be voting on whether to remove AMR from the Core Sets, it may be helpful for the Workgroup to be aware of these key differences. To start, the Asthma Medication Ratio measure's data collection method is administrative. The Follow-Up After Acute and Urgent Care Visits for Asthma measure's data collection method is ECDS. The Asthma Medication Ratio measure's denominator includes beneficiaries with persistent asthma ages 5 to 64. In contrast, the Follow-Up After Acute and Urgent Care Visits for Asthma measure's denominator includes asthma episodes for persons ages 5 to 64.

This slide also shows some of the key conditions for exclusions from both denominators. While the Asthma Medication Ratio measure is not stratified by a specific diagnosis, the Follow-Up After Acute and Urgent Care Visits for Asthma measure reports separate rates for persons with and without COPD. The measures also assess two different outcomes. The Asthma Medication Ratio measure calculates a ratio of controller medications to total asthma medications of greater than or equal to 0.50 during the measurement year. The Follow-Up After Acute and Urgent Care

Visits for Asthma measure assesses outpatient follow-up visits with a diagnosis of asthma within 30 days after the asthma episode. Next slide, please.

I will now pass it back to Alli to facilitate the Workgroup discussion of this measure as well as public comment.

Alli Steiner:

Thank you, Deb.

So we'll now invite discussion of the Follow-Up After Acute and Urgent Care Visits for Asthma measure from Workgroup members. As Deb mentioned, this is a first-year HEDIS measure, so we don't believe any states are using it just yet. But if you do have any experience using this measure in Medicaid and CHIP and would like to make a comment, we'd love to hear from you. So please raise your hand; and we will call on you, and you can unmute your cell phone when it's your turn.

Again, we're hoping to first hear if there's anyone using this measure in Medicaid or CHIP. Well, if you are using it and we welcome you to – oops, it looks like we have a hand raised from Sural.

Can we unmute Sural, please?

Sural Shah:

We of course are not using it yet, but we have added it to our managed care monitoring set for MY 2026.

Alli Steiner:

Very helpful, thank you.

So not seeing any other hands, we'll open up the discussion to include other members of the Workgroup and federal liaisons. Please raise your hand if you wish to speak, and we'll call on you.

Kim Elliott:

I don't like silence, so I'll start the discussion.

Alli Steiner:

Thank you.

Kim Elliott:

The penetration rate for Medicaid was asthma. Diagnosis of asthma has been relatively high. According to the information I looked at, it was like 12% or something like that for children. I also looked at the information that was provided regarding the follow up that's been measured when NCQA did their testing using Medicaid data, and it looks like there's quite a bit of room for improvement across all of the different age groups, from a low of 29.9% all the way up to 47%. Follow up is something that is actionable by both plans or through state requirements of plans, through outreach, and even working with providers to conduct outreach.

So I think this one does show promise from an actionability standpoint and based on the number of enrollees in Medicaid that are diagnosed with asthma or similar conditions. So I just wanted to point that out. I think that there's an opportunity here that makes sense for Medicaid.

Alli Steiner:

Thank you, Kim. Any other Workgroup members have comments on this measure?

Jeff Huebner:

Thanks, Kim, for going first. I agree. I think one of the pieces of data that strikes me always with this population – it is a highly prevalent chronic disease, especially for children in Medicaid. Right now with retirement of the AMR measure, there's not going to be a quality measure for asthma for children. So I think this measure meets most if not all the criteria that we have for potentially including it.

I'm not the biggest fan always of process measures, and this is very much a process measure; but I think it can drive improvement in care, hopefully that will lead to better asthma control and reduced ED visits and complications leading to hospitalizations.

For children, I think asthma is the number one reason for missed school time of any chronic disease, so I'm leaning toward supporting this.

Alli Steiner:

Thanks, Jeff. Let's hear from Djinge.

Djinge Lindsay:

I will concur with all of Jeff's statements, and just add that in Maryland we are looking forward to adding this to our MCO Performance Incentive plans and the alignment opportunities that we'll have in future years to add this to our Advanced Primary Care Program quality measures.

We have a high burden of asthma. We haven't seen a lot of good – and no real improvements in the ED and acute care utilization. So hoping that this can help foster some additional collaboration between our providers and our MCOs in the best interests of our pediatric members and our adult members with asthma. Thank you.

Alli Steiner:

Thank you, Djinge. Let's hear from Stacey, please.

Stacey Bartell:

Hi, Stacey Bartell. I'm speaking for the AAFP.

We appreciate the importance of asthma follow up after acute care visits. Speaking as a practicing provider, I can note though that we have had – we participated in CCP Plus in the state of Michigan where I practice. We do two weeks for follow up for any inpatient discharges. So I think this measure is a little bit confusing from the 30-day standpoint. We don't often get data again for follow up for urgent cares and telehealth visits. So it would be hard for us to know where that measure starts as a practicing physician and how to do better on that metric.

Also of note is I pulled an AAP article from early 2025 which talked about how do you improve asthma flares. The first one was viruses, so therefore vaccinations. Exposure to dust mites, cockroach bites, and pet dander – which again is keeping our schools safe and clean and our housing safe and clean for kids – and outdoor pollutants and tobacco use.

So from all of those standpoints, a follow up visit isn't going to make a difference for some of those things. We understand how important just access to primary care is; and we just want to note that, yes, it's important measure. We need to do better on asthma, but I'm not sure the follow-up measure is the best way to do that. Thank you.

Alli Steiner:

Thanks, Stacey. Let's go to Lee next, please.

Lee Beers:

Wonderful, well thank you. Thank you, Stacey, for referencing the AAP article.

I'm speaking on behalf of AAP. I do just want to echo that asthma is a really significant condition in childhood and really does deserve quality monitoring. I will admit I have a little bit of pause in that we don't have quite as much experience with this metric as perhaps some others. I think, like others, I am probably swayed by the importance of the need to be doing quality monitoring in this space.

Alli Steiner:

Thanks for that comment, Lee. Are there any other comments from Workgroup members about this measure? David Kelley.

David Kelley:

Hi, good afternoon. For Pennsylvania Medicaid, I believe we're going to be adding this as a HEDIS measure; so our plans will be measuring this, and we'll look at what those results show us.

I think that asthma – when you look at the reasons for adding something to the Core Sets, I think this measure checks most of the boxes if not all of them. It is feasible. It's an ECDS measure; but it's almost, I would say, exclusively driven by claims-based data. I think it will be actionable; and perhaps NCQA later on can share some of their preliminary results when they – we're running the data to put this measure together, that might be helpful.

I think the fact that we're looking at urgent care as kind of a separate follow-up bucket may make quality improvement efforts interesting because, again, that is a big opportunity where I think a previous commentor say that it's hard to know when somebody has come from urgent care. Well, the MCO will know; and if they see that referral pattern, that somebody's been seen in urgent care and there's no good follow up, then that's an intervention that could be done, let's say, at a health plan or MCO level.

So, I am supportive. I think it is important to get those follow-up visits. Obviously, there are a lot of things outside of the medical care that's delivered in an office visit that affect asthma. But getting that office visit and assuring that the patients are on the right medications, they know how to take the medications appropriately, they're not confused with previous meds that maybe

they were on – I think that's really, really important. So I'm very supportive of this measure. Thanks.

Alli Steiner:

Thanks so much, David. All right, any last comments? Any additional comments from the Workgroup members?

All right, so not seeing any hands, let's go to the next slide, please.

Okay, and now we'll have the opportunity for public comment. If you'd like to make a comment about the Follow-Up After Acute and Urgent Care Visits for Asthma measure, please used the "raise hand" feature in the bottom right-hand of the participant panel to join the queue; and please lower your hand when you're finished speaking. When we call on you, please introduce yourself and give your affiliation.

Can we unmute Jacqueline, please?

Jacqueline Link:

Hi, are you able to hear me?

Alli Steiner:

Yes, we can.

Jacqueline Link:

Great, thank you. Hi, I'm Jacqueline Link. I'm a health policy manager with the American Lung Association. Thank you for the opportunity to provide input today on the proposed asthma quality measure. I'm here to urge you to vote for the addition of the Follow-Up After Acute Care and Urgent Care Visits for Asthma in the Adult and Child Core Sets.

Quality measures are important for tracking asthma management and understanding treatment effectiveness. Asthma affects more than 26 million people in the U.S., including 4.5 million children; and poorly-managed asthma leads to nearly two million emergency department visits each year in the U.S. and accounted for over 94,000 hospitalizations in 2020.

The American Lung Association supports the proposed Follow-Up After Acute Care Visits for Asthma added to the Adult and Child Core Sets. This measure will encourage a stronger role for primary care in asthma management and provide a greater incentive for health plans to ensure that patients are receiving follow-up care from a medical home.

The emergence of single maintenance and reliever therapy, or SMART therapy, has posed challenges to calculating the asthma medication ratio or AMR. We are disappointed that the retirement of the AMR in 2027 Core Sets means that there will be a gap in tracking asthma management. It is critical that this new measure be implemented in 2028. This is especially important for Medicaid programs, as the burden of asthma disproportionately affects people enrolled in Medicaid as the rates are consistently higher among those enrolled in Medicaid, at 12.4%, than those in private insurance at 7.4%; and 43% of all Medicaid enrollees are children.

The Lung Association strongly encourages the committee to vote to add this asthma measure to the Child and Adult Core Sets. Thank you for your time today.

Alli Steiner:

Thank you, Jacqueline. Are there any other public comments about this measure? Okay, I'm not seeing any public comments. Why don't we move on to the vote, please. So we'll go to the next slide; and we'll open up our next vote, please.

For the next vote, the question is: Should the Follow-Up After Acute and Urgent Care Visits for Asthma be added to the Core Sets? The options are: yes, I recommend this measure be added to the Core Sets, and no, I do not recommend adding this measure to the Core Sets. Voting is now open. If you are not seeing the vote, please refresh your browser. All right, there we are. It looks like we already had 26 votes come in, so we're still waiting on one final vote. All right, we are waiting on one more vote; so just give us a minute to try to determine whose vote we're missing.

We were missing Chimene's vote – if you wouldn't mind trying to submit your vote, Chimene. Chimene, are you – if you're on the call, if you could try submitting your vote through the Q&A Slido. We're not seeing it in the poll yet. We'll just give it another minute and then we'll move forward. All right, Chimene may have stepped away; so why don't we go ahead and close the vote.

Okay, so we have for the results 92% of Workgroup members voted yes, and that does meet the threshold for recommendation. The Follow-Up After Acute and Urgent Care Visits for Asthma measure is recommended by the Workgroup for addition to the 2028 Core Sets.

All right, thank you so much. We will move on to the next slide, please.

Well, thank you so much to everyone for the great discussion and the voting on that measure. We're now scheduled to take another short break. We're going to – actually, we're a little bit ahead of schedule so we are going to take a little bit of a longer break this time to allow us to catch up a little bit closer to the agenda. So let's plan to be back here at 2:30 p.m. So again, we will come back here at 2:30 p.m., where Chrissy will present our next measure for discretion.

Thanks so much, everyone.

[Break]

Chrissy Fiorentini:

Hi, everyone. Welcome back from the break. We're now going to discuss the next measure suggested for addition, Tobacco Use Screening and Cessation Intervention. Next slide.

Before we jump into the details of the suggested measure, I'd like to note that there are no measures in the 2027 Core Sets related to tobacco use. The Medical Assistance with Smoking and Tobacco Use Cessation, or MSC-AD measure, was included on the Adult Core Set through the 2026 Core Set. This measure was retired by the measure steward and removed from the 2027 Adult Core Set. MSC-AD assessed different facets of providing medical assistance to smoking and tobacco use cessation:

- The Advising Smokers and Tobacco Users to Quit rate measured the percentage of beneficiaries aged 18 or older who were current users smokers or tobacco users and who had received advice to quit during the measurement year.

- The Discussing Cessation Medications rate measured the percentage of beneficiaries age 18 and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year.
- The Discussing Cessation Strategies rate measured the percentage of beneficiaries age 18 and older who were current smokers or tobacco users and who discussed or were provided cessation methods or strategies during the measurement year.

I'll highlight some key differences between MSC-AD and the new tobacco measure suggested for addition in a couple of slides. Next slide.

Tobacco Use Screening and Cessation Intervention was suggested for addition to the Core Sets to replace the retired MSC-AD measure. It measures the percentage of persons age 12 and older who were screened for commercial tobacco product use at least once during the measurement period and who received tobacco cessation intervention if they were identified as a tobacco user. Two rates are reported. The Tobacco Use Screening rate measures the percentage who were screened for tobacco rates, and the Cessation Intervention rate measures the percentage who were identified as a tobacco user and who received tobacco cessation intervention. The measure steward is NCQA, and it is specified at the health plan level. It's a process measure, and the data collection method is HEDIS Electronic Clinical Data Systems.

The denominator for the Tobacco Use Screening rate includes persons 12 years of age and older at the start of the measurement period who meet continuous enrollment criteria and do not meet exclusion criteria. The denominator for the Cessation Intervention rate includes persons from the Tobacco Use Screening numerator who were identified as a positive tobacco user between January 1 and December 1 of the measurement period. The numerator for the Tobacco Use Screening rate includes persons who were screened for tobacco use and identified as either a positive or a negative tobacco user during the measurement period. Note that persons are identified as either positive or negative tobacco users through LOINC codes and that tobacco use includes all commercial tobacco and nicotine products. Next slide.

The numerator for the Cessation Intervention rate includes persons who received tobacco cessation intervention during the measurement period or 180 days prior to the measurement period. Allowable cessation interventions differ based on age. Persons ages 12 through 17 must receive tobacco cessation counseling to qualify for the numerator. Persons age 18 and older may receive either tobacco cessation counseling or a dispensed pharmacotherapy intervention. Allowable pharmacotherapy interventions are indicated on the slide.

The HEDIS measure specifications include stratifications by age group for the Medicaid product line, and the measure steward confirmed that it is also feasible to stratify the measure by race and ethnicity, sex, and geography.

The measure steward provided testing results showing that they tested the measure using data from two health plans in four health systems in different states. One of the health plans was in California, served a majority Latino population, and provided testing data for over 900,000 members age 12 and older with either Medicaid or commercial insurance. This health plan provided Medicaid-specific testing results, which we summarized in the Measure Information Sheet available on our website.

The measure is new for HEDIS measurement year 2026, so adoption is still emerging. Neither Mathematica nor the measure steward is aware of any state Medicaid or CHIP programs that are currently using the measure.

Two individuals suggested this measure for addition to the Core Sets as a replacement for the MSC-AD measure. Both individuals who suggested the measures noted that tobacco use is a leading cause of preventable morbidity and mortality in the United States, and they cited data showing higher prevalence of tobacco use among adults covered by Medicaid as compared to adults who had private coverage, Medicare coverage only, or some other type of public coverage. They indicated that adding this measure to the Core Sets would support universal screening for tobacco use and referral to cessation intervention.

Both individuals suggested that the measure could be used by state Medicaid and CHIP programs to charter their quality improvement efforts. For example, the measure Tobacco Use Screening rate could be used to identify populations not receiving tobacco screening or providers or programs not administering tobacco screening. The Tobacco Cessation intervention rate could be used to identify gaps in care, such as lack of referrals to cessation counseling or prescription of pharmacotherapy. Both submitters argued that adoption of the measure could lead to increases in receiving evidence-based smoking cessation methods. Next slide.

Before we turn to the Workgroup discussion of the Tobacco Use Screening and Cessation Intervention measure, I'm also going to briefly summarize the key differences between this measure, abbreviated as TSC-E, and the retired Adult Core Set measure that would replace MSC-AD. As a reminder, CMS has already removed MSC-AD from the 2027 Adult Core Set; so the Workgroup will not be voting on whether to remove MSC-AD or whether TSC-E is a better measure than MSC-AD. Instead, the Workgroup should consider whether TSC-E is a good fit for the Core Sets given the existing measurement gap related to tobacco use screening and cessation. However, it might be helpful for the Workgroup to be aware of the following key differences between the retired tobacco measure and the measure suggested for addition.

First, TSC-E includes both adolescents and adults age 12 and older, while MSC-AD includes only adults age 18 and older. Next is the difference in data collection methods. TSC-E uses the HEDIS Electronic Clinical Data Systems method while MSC-AD uses CAHPS survey data. The measure denominators also differ. TSC-E's tobacco use screening rate includes all beneficiaries regardless of tobacco use status, while it's cessation intervention rate is limited to beneficiaries who were identified as positive tobacco users. In contrast, the denominator for all three of MSC-AD's rate includes only beneficiaries who self-identify as current smokers or tobacco users. So TSC-E is more of a population-based measure in terms of the screening rate. Lastly, the measures differ in the amount of details they provide about the types of tobacco cessation interventions received. TSC-E's Cessation Intervention rate indicates only whether the beneficiary received any type of tobacco cessation intervention and does not identify the type of intervention. Although note for adolescents, the technical specifications only allow for one type of cessation intervention. In contrast, MSC-AD provides additional detail about the types of interventions that are provided to adult beneficiaries.

Next slide. I will now turn it over to Alli to lead Workgroup discussion and public comment about this measure.

Alli Steiner:

Thank you, Chrissy. So, we'll now invite discussion about the Tobacco Use Screening and Cessation Intervention measure from Workgroup members. As Chrissy mentioned, this is a first-year HEDIS measure; so we don't expect anyone to have performance data just yet. However, we have heard that a few states are or will *be* using this measure with their managed care plans moving forward. So if you have experience using this measure in Medicaid and CHIP, managed

care, or you're planning to and you would like to make a comment first, please raise your hand and we'll call on you.

Again, we're hoping to start by hearing from anyone who has started using it or is planning to use it in their Medicaid and CHIP.

Do we have anyone from the Workgroup who like to speak about – oh, it looks like we have a hand raised from David. Can we unmute David?

David Zona:

Good afternoon. This is David Zona from IPRO. My feedback on this measure is specific to the data that's required to calculate it reliably and accurately; and specifically, with respect to the fact that the measure relies on the presence of LOINC codes.

Those of you who are close to the calculation processes and the data collection are probably aware that the LOINC codes are not typically provided as a function of claims payment, which is typically how many states – at least the states that I've been working closely with in my scope of work – are receiving their encounter data and then storing it in their MMIS systems, many of which then use that data to calculate these measures for Core Set purposes. So of course without that LOINC data, you're not going to get an accurate, reliable rate or much of a rate at all.

I can say that in the work that my organization is doing, we are currently calculating on behalf of some of our clients' Core Set rates for their support of their fulfillment of their Core Set reporting requirements to CMS. We work directly then with the health plans in those states to secure that data. So certainly it's possible. You can certainly get around that; but obviously not without additional administrative details of having to query the plans, work with the plans, get the data from the plans, clean the data. So you can see where I'm going with that. It's a lot more work and more of a challenge to get the information to then calculate an accurate and reliable rate.

Those are my comments. Thank you.

Alli Steiner:

Thanks, David, that's very helpful. Let's hear from Chimene next, please.

Chimene Liburd:

I'm curious in thinking about some of the things that young people are using and whether or not this will capture all of those things. What comes to mind is the vaping. I don't know if adults are using it as well. I'm just thinking more from the children aspect. So it's more of a question. I'm just posing it as to will this really capture everything? Will we be missing things? What is it that potentially may need to be thought about more in this measure? That's all, thank you.

Alli Steiner:

Thanks, Chimene. Yes, my understanding is it does include vaping. It includes all commercial tobacco and nicotine use. Okay, thanks for that comment and question. Let's go to Jessica next.

Jessica Harley:

Hi, yes, this is Jessica from Community Health Choice. I just want to echo David's sentiment with the LOINC codes. From the payer perspective, it is extremely difficult to capture the LOINC

codes because they are not coming across on claims forms. So it's requiring extensive mapping with each provider's EHR; and for one MCO, they may have multiple different provider groups on many different EHRs. So it is a very extensive process to go through mapping each of those in order to get that supplemental data that's required for ECDS. I do, however, though think that this is a very valuable measure. But we may need to look at the feasibility of how MCOs are able to actually get that data.

Alli Steiner:

Thank you, Jessica. All right, we can open it up to all other Workgroup members and federal liaisons at this time. So please feel free to raise your hand if you'd like to speak about this measure, and we'll call on you in turn. Ann Zerr?

Ann Zerr:

I would just ask could you put the slide up again to compare the two measures so my brain works better as they're talking?

Alli Steiner:

Yes, let's go back one slide, thank you.

Sara Toomey:

Thank you so much. That's really all I need right now.

Alli Steiner:

David Zona, I see your hand is up. Did you have an additional comment?

David Zona:

Oh, no, I'm sorry about that. I forgot to take my hand down. Thank you for the reminder.

Alli Steiner:

Okay, sure. Let's hear from Kim, please.

Kim Elliott:

I'm also concerned about the feasibility just from the coding aspects of it. I think over time mapping and things will improve, and the ability to capture some of the data will improve. But I'm not 100% confident that we're there right now, so I think the accuracy and validity of the rates may be questionable, particularly across states. Some states have better ability to capture data, have better data sources than other states.

But I do think it's a very important thing to be measuring; so if we can get back to a measure that actually is reportable, has good data sources, is feasible for states and plans to report, I think it would put it in a better place for the Core Measure Set since it is something that is really important for the Medicaid population.

Alli Steiner:

Thanks, Kim. Stacey?

Stacey Bartell:

Hi, thanks. I just wanted to advocate that this is a really important measure going forward to make sure we're screening all levels. I would say in the last six months clinically I've seen crazy stories of young kids overusing and abusing tobacco products – not cigarettes but other forms of nicotine. All that we can do to measure this and stay on top of this is going to be important.

With regard to the measurement, I would argue that shifting to this new way of measuring the ECQMs takes the burden off of physicians and providers who are trying to nonstop drop codes when we're billing the claim. So I get it that it's difficult, but I think the whole point in moving to these new versions of ECQMs is why we're doing this – so providers aren't taking the stress. We're just trying to do the work in our office, not trying to code it correctly to get the credit.

Alli Steiner:

Thank you for that comment. Are there any other comments from Workgroup members about this measure? David Kelley?

David Kelley:

Thanks, I was wondering if there was any way that the measure steward could share in their testing their capabilities to translate the LOINC codes into something that's captured electronically.

Then I guess the other question is if this is ECDS, I think we need to stop thinking of, well, everything's got to be dropped into the claim; and are there other ways to capture. So if you're a managed care plan, I'd like to think our plans are asking just about everybody that's new to the plan or has a chronic condition or just about anybody whether or not they use tobacco. They should be gathering that information and placing it into a care management or a health risk assessment database which, to my understanding I think and maybe NCQA could clarify, that could be used for this measure.

But I don't know, it would be nice if the measure steward could elucidate how those LOINC codes get translated and then how do they actually get captured from the provider to either being dropped in claims or captured by a managed care plan in the care management system.

Alli Steiner:

Yeah, thanks for that question, David. Do we have Jules from NCQA on the line? If so, could you please raise your hand? Great, we have Jules. Let's unmute Jules, please. Thank you.

Jules Reich:

Thank you for unmuting me; and thank you for your question, David. In testing, we did do some pretty intensive exploration of codes other than the LOINC codes. However, we decided that LOINC codes were the best option here to clinically capture different types of tobacco use and to be able to capture that broader array of products. We did have successful results in our testing with everyone we tested with being able to report strong results.

I know this is a larger issue with NCQA's overall strategy with ECDS, and I will definitely take your feedback back to the team.

David Kelley:

Thank you.

Alli Steiner:

Thank you, David. Thank you, Jules. David Zona?

David Zona:

Yeah, hi, it's David again from IPRO. I just wanted to further clarify my earlier comments, just based on the responses from some of the other participants. I'm not suggesting that the LOINC codes aren't the right way to capture the information, only that my knowledge of current state for potentially how many of the states are able to capture and report data currently, there would have to be some work done to be able to accurately and reliably report the rate.

To Dr. Kelley's point. With the transition to ECDS and all the digital measure strategy unfolding with NCQA and HEDIS reporting, I mean certainly the industry is going in that direction; and the pace is only going to continue to pick up. But 2028 will be here before we know it, right? So I just wanted to point out the fact that there's definitely some work to be done if we want to get reliably reported rates on the table when 2028 rolls around. Thank you.

Alli Steiner:

Thank you, David. Let's go to Jeff next.

Jeff Huebner:

Yeah, this is a question. I mean, I'm glad to hear the discussion around the technical side of this because it is complex; and I'm glad for the opportunity to see this hopefully moving the burden off of providers themselves as much as possible in relationship to documentation and coding so they can actually focus on the work of the screening and intervention.

Can someone specifically answer – so in reading about the testing that was done in the materials that were provided, I was astounded at how low the screening rates were. I just feel like this is routinely done by providers in health systems, and I believe for the retired measure rates were much higher. So I guess I'm wondering if – and maybe this has already been answered in the discussion – but I'm wondering if that's a direct relationship of this challenge with the coding and the LOINC codes and if that means this ready for prime time as important of a measure as it is. I agree with everybody that we need to be doing this screening. There's a lot of work that needs to be done given the explosion of use of other forms of nicotine.

Alli Steiner:

Yeah, thanks for that question, Jeff.

Let's see, Jules, are you able to respond to that question about the measure testing and whether the performance rates – if there are any concerns about the performance rates there?

Jules Reich:

Yeah, I can respond to that. I cannot reveal too much about measure testing because we do have an anonymity agreement with the organizations that partner and test with us. Our sites when we did our qualitative inquiries with them after the testing process, they did let us know

that they felt that some of the screening was under reported. But they also pointed to some issues within their systems about perhaps not reinforcing the need for screening with some populations and particularly – like in some key populations as well that might have contributed to the lower rate.

We did try several methods of testing with them and different ways of reporting. So I do appreciate the concerns about this not being ready for prime time but also appreciating how this has been – discussion of LOINC codes and moving to ECDS measures has been a topic of discussion maybe throughout the industry for some years. So we're really trying to encourage people to think ahead as much as possible and not delay updates. Thank you.

Alli Steiner:

Thank you for that. Jessica?

Jessica Harley:

Hi, again. I just wanted to add to my previous comments earlier. While the LOINC coding and supplemental data capture for ECDS is very challenging from a health plan perspective, unless it is put of importance – like on the Core Set or something like that – it gives very little leverage to the quality teams within these MCOs to be able to put that dedicated, extra time it takes into doing the additional mapping and coding that's required for it.

So while it's not the same measure, Social Needs Screening was a good example of my previous MCO Texas Children's Health Plan where when that was identified as something that was important for our state, we could leverage the fact that we don't have any LOINC coding on it. But it's something incentivized by the state, and we have to put our resources into doing all the additional steps of going through every single EHR and mapping out every question that can map back to social needs screening.

So while this is something that probably is screened and under reported, until the health plans have enough reasoning to put in the resources to do that very manual process of looking through all of their providers' EHRs and creating the supplemental feeds that will pull that into the back end and apply the applicable LOINC codes, it's not going to move as quickly as we'd like it to because we're having to pull and put resources into other ECDS measures that are getting that support from incentive programs.

So I do think it is something that is really important, and it's going to take a while for health plans to get to that stage where it can be well reported. But unless we have that incentive pushing us in that direction, they're going to prioritize other ECDS measures that are needing to be transitioned beforehand.

Alli Steiner:

Thank you for that comment. Are there any other comments from the Workgroup members? Ann Zerr?

Ann Zerr:

I see this as fairly useful for states to understand pockets of heavy use and collaboration with smoking cessation programs across the state to put – so that the numerator and denominator make sense on a population basis as well as an MCO kind of basis.

Alli Steiner:

Yeah, thank you, Ann. Last call for any Workgroup member comments. Why don't we move to the next slide, please – or actually, two slides to the public comment.

So now we'll provide an opportunity for public comment. If you'd like to make a comment about the Tobacco Use Screening and Cessation Intervention measure, please use the "raise hand" feature in the bottom-right of the participant panel to join the queue; and lower your hand when you're done. We'll let you know when you've been unmuted, and please remember to state your name and affiliation. First we'll hear from Ben.

Ben Hamlin:

Ben Hamlin, and I'm director of digital health at IPRO. A couple comments with regard to this measure in general and also the use of LOINC. So, this measure is actually a digital quality measure, which by 2028 will be more the norm than the exception. By 2030, it will be absolutely the norm. For any assessments, measurements, and vital signs reporting, LOINC is the preferred technology for all clinical data exchange for all of those categories. So as you see more measures moving from CAHPS survey questions to actual digital quality measures, you're going to essentially see LOINC as the foundation for that kind of data capture.

That also holds true – we heard about social needs screening. That holds true for depression screening, for unhealthy alcohol use, and so on and so on and so forth – vital signs, everything. So essentially, it's a necessary terminology to be able to support; and the time – the clock is ticking in terms of MCOs to be able to support that.

To Dr. Kelley's point, absolutely a registry or a care management dataset that is capturing this information for either employees through the employer-sponsored health plan or from the MCO for other reasons, that is an absolutely acceptable ECDS data source. Hopefully that dataset will be captured using the standard terminologies and the essential metadata around that so that these can be easily reported and captured by both the clinical quality measure but also perhaps the care managers who are doing outreach to help those folks get healthier by quitting smoking. I think I'll leave it there. Thank you.

Alli Steiner:

Okay, thank you, Ben. Next we'll hear from Elisa.

Elisa Tong:

Hello, I don't know if I need to start over.

Alli Steiner:

Sorry, yeah, we missed the very beginning of what you said if you wouldn't mind stating your name and where you're calling from. Thank you.

Elisa Tong:

Sure, yes, my name is Elisa Tong. I'm a general medicine physician and health services researcher at University of California Davis; and I lead California Quits, a project funded by our state to advance tobacco quality and pop health with our state Medicaid program. I also served

on the NCQA Technical Expert Panel Committee for this metric. Just full disclosure, I'm happy to say that we beta tested it, so have direct experience.

So I agree with what folks were saying, and it's a little surprising to me about it only being the LOINC codes that when we work with our health plans, we know that they need this measure to say why they need to put resources in to prioritize tobacco as a population-based measure. Also without that mandate, it's a lot harder for the teams to prioritize this.

So just to recap three reasons, and I submitted public comment. But why do we need this new metric now? Well, first the fold metric that was on the original 2024 Medicaid Core Set needs to be continued. It's already been said tobacco is the leading preventable cause of death. Medicaid populations have higher burdens. The Surgeon General has called vaping a youth epidemic. This metric captures not just smoking; it captures, as mentioned, tobacco and commercial nicotine products. So cessation interventions can be brief counseling and/or medications, so it's strong evidence-based.

Second reason, the old metric was based on CAHPS as mentioned earlier. The Consumer Survey of patients usually right for patient satisfaction, but this new metric will finally upgrade tobacco to like all other important health conditions and be population-based.

I know there was some question about data validity. But in California when we looked at our CAHPS survey data, our Medicaid managed care plans have a lot of missing data. Only one of like the 25 plans had 100 smokers surveyed in the CAHPS dataset. So we don't have reliable data. This population metric will actually start prioritizing it.

So third, finally, I think this new metric is feasible, appropriate, actionable – all those things that everyone needs to consider. It aligns with what the CMS eCQI and community clinics are already reporting to the uniform data system, and that measure was updated in 2024 to include ages 12 and up. So we're doing it already in the clinics. In California for our state Medicaid program, we already use this metric in the quality incentive pool. It's like a value-based care program for public hospital clinics, and it's been essential for us in quality improvement to report out the screening and treatment. So even with this age breakout, it will be even better.

Then for our Medicaid managed care plans that we work with in our California Quits Team, some of the trailblazers have already been trying to put together some registries and conducting proactive outreach outside of the clinics, which is again helping us primary care folks and other providers. They're already working with our free state quitline for outreach. But we do kind of need this measure to get things going again on tobacco.

Then so in summary, I strongly recommend approval of this. Some of these other details of how to measure it with Jules and NCQA I'm sure can be refined in time for the 2028 Medicaid Core Sets. If possible, it would be great if it could be retroactively added to the 2027 Medicaid Core Sets to avoid a measurement gap. I believe Deirdra Stockmann said that could be considered. But NCQA already approved this metric for measurement year 2026. Thanks.

Alli Steiner:

Thank you, Elisa; and, yes, that's right. CMS did say that it could be considered for 2027 if it were to be recommended. Thank you. Next we'll move on to Jacqueline.

Jacqueline Link:

Hi, can you hear me?

Alli Steiner:

Yes, we can.

Jacqueline Link:

Hi, I'm Jacqueline Link. Once again, I'm a health policy manager with the American Lung Association. Thank you for the opportunity to speak with you.

I'm here today to ask you to vote to include the Tobacco Use Screening and Cessation Intervention in the Adult and Child Core Sets. The Centers for Medicare and Medicaid Services announced on December 30, 2025, that the Medical Assistance with Smoking and Tobacco Use Cessation was being retired in the 2027 Adult Core Set. While we are very encouraged to see the new measure, Tobacco Use Screening and Cessation Intervention, being considered for 2028 Core Set, we are disappointed that there will not be data on tobacco use and cessation collected from health plans in 2027.

The data will help identify gaps in screening and treatment. Once those gaps are identified, they can be addressed. Tobacco use is the leading cause of preventable death and disease in the United States. The 2020 Surgeon General's Report on smoking cessation found that quitting smoking is beneficial at any age and improves health outcomes. Data show that most people who smoke want to quit, about 67.7%; but only a fraction actually quit, or 8.8%.

Including Tobacco Use Screening and Cessation Intervention in the Core Sets will encourage plans and providers to ask about tobacco use and provide cessation treatment to individuals who use tobacco. This is especially important for Medicaid programs. Medicaid enrollees smoke at very high rates. While the overall smoking rate is 11.5%, nationally Medicaid enrollees smoke at a rate of 21.5%, while some data show that smoking rates in some Medicaid programs are as high as 50%. Not surprisingly, smoking-related illness accounts for approximately $39 billion annually in the Medicaid program.

Helping Medicaid smokers quit makes sense. It will save lives and money. The Tobacco Use Screening and Cessation Intervention measures the percentage of individuals age 12 and up screened for tobacco use and then those who use tobacco, those who receive treatment – of those who use tobacco, those who receive treatment. Because this measure captures information on children 12 and up, the Lung Association believes it should be included in both the Child and Adult Core Sets.

The data collected from Tobacco Use Screening and Cessation Intervention measure is important. The measure encourages smoking cessation and identifies gaps in patients getting screened and getting treatment. The Lung Association strongly encourages the Committee to vote to include this tobacco cessation measure as part of the Child and Adult Core Sets.

Thank you again for the opportunity to provide comments.

Alli Steiner:

Thank you, Jacqueline. We'll hear from Margaret next.

Margaret Hitchcock:

Thank you for the opportunity. My name is Margaret Hitchcock. I'm the President of the California Colorectal Cancer Coalition. It might seem a little bit outside my wheelhouse; but, one, I just want to remind everybody – number one, I encourage this measure to be adopted. I

think that sometimes we lose sight of the fact that tobacco smokers are at increased risk for a vast number of different cancers that impact all of us that work in other cancer spaces.

Also, kind of the whole issue of having the quality measure itself added, we at – C4 is our kind of acronym – we facilitated adoption of the colorectal cancer screening measure for the Medicaid population, and it has resulted in a significant shift in California for Medicaid participant Medicare managed care plans. So the hope is that we'd see something similar in California as it relates to tobacco use.

Then on a personal note because I always throw this in, I had a sister that we estimate started smoking at 15 and I'm guessing earlier; and she died a pretty brutal death by 54. So I love the fact that it's dropping to starting at 12 because I think it's a more realistic approach. So once again, I think we should adopt this measure; and thank you for your time.

Alli Steiner:

Thank you so much, Margaret. Ben, I noticed that you have your hand up. Do you have another comment?

Ben Hamlin:

Yes, I remembered my third point, sorry. Just with regard to the revision provider burden, the ECDS reporting protocol was absolutely designed to focus on minimizing burden to providers who are doing quality reporting. The main tenet for that was connection to other sources like HIEs and HDU's, health information exchanges and health data utilities, in their state which the providers were mostly already connected to instead of having the MCOs contact them directly asking for this.

Where we have found success in that, particularly for measures that require – is a standard question being asked of all patients at a frequency to be determined is in the unhealthy alcohol use screening measure where during the testing of that measure, development of that measure, a very simple natural language process algorithm was used to review clinical notes and other sources of information. The idea confirmed that in fact these questions *were* being asked in a highly standardized fashion, and so they were able to actually map that question and request a LOINC code for that question because LOINC is a preferred terminology.

So again, I am going to take an assumption here that the reason the rates are low is mostly because the data is not being transferred in an (inaudible) and standard format to the right place and the right time; and that can be fixed through some fairly simple improvements at both the provider level and/or at the MCO data level.

So I would encourage, again, this measure to be accepted because it will – it does set the stage. It also helps people get ready for the next phase of CMS reporting, which is coming very, very quickly. If we don't start now, you're never going to get there. Thank you.

Alli Steiner:

Thank you, Ben. Madison?

Madison Shaffer:

Madison Shaffer and I work for North Carolina Medicaid in the quality measuring space. I'm less familiar with the technical details around the potential administrative burden of calculating this

measure. I know at North Carolina we're very excited about this update. I know it's been mentioned already, but we're thrilled about the lowering of the age range as well as the inclusion of all types of tobacco use including vapes and all of that.

So we're very thrilled about this measure. We've added it to a lot of our lines of business measures for our measurement year 2026, and we can calculate it. I agree with the sentiment around there might be some adjustment required to calculate this as an ECDS measure. But it is the change that's coming with a lot of HEDIS measures; and I think even if it might be a little bit difficult for its first measurement year to be calculated this coming year, it's a good shift and an important measure for states to focus on. With the retirement of the MSC measure, I think it's important that we include this and work towards kind of collecting the data in an electronic clinical way. Focusing on this younger age group is important to us as well.

Alli Steiner:

Thanks so much, Madison. I'm not seeing any additional hands. So I think let's move on to the voting on the measure.

David Kelley:

This is David Kelley. Just a real quick comment. I'm supportive of this measure. I know it's somewhat of a stretch measure when it comes to the feasibility. It does somewhat marry up to the measure that's part of the CMS MIPS program for Medicare. Tobacco is one of the leading causes of death, and our Medicaid population partakes at a very high percentage. We actually have measured that through chart review and some of our pregnant individuals.

There's a current huge gap in measurement since the CAHPS question is removed. So we have – this would be for clinical care starting in 2027. So the HIE/HIO folks, EHR vendors need to have pressure put on them to get this done. It is a little bit of a stretch, but I think this is really an important measure; and I strongly advocate that we support this. Thanks.

Alli Steiner:

Thanks, David. I'm sorry I missed your hand. Double-checking, I don't see any other hands. Keep me honest, team.

All right, let's move on to the vote then for this measure. For the vote, the question is: Should the Tobacco Use Screening and Cessation Intervention measure be added to the Core Sets? The options are: yes, I recommend adding this measure to the Core Sets, and no, I do not recommend adding this measure to the Core Sets. Voting is now open. If you don't see the question, please try refreshing your browser. We're waiting for a couple more votes to come in. All right, there we go. We can close the poll.

Okay, for the results: 96% of Workgroup members voted yes, and so that does meet the threshold for recommendation. The Tobacco Use Screening and Cessation Intervention is recommended by the Workgroup for addition to the 2028 Core Sets.

Thanks so much, everyone, for your participation in the voting process. Next slide, please. Okay, now Caitlyn will describe our next measure suggested for addition to the 2028 Core Sets.

Caitlyn Newhard:

Thanks, Alli. As Alli mentioned, we will now discuss the next measure suggested for addition to the 2028 Core Sets, Social Needs Screening and Intervention.

Before we jump into the details of this measure, I'd like to note that there are no measures on the 2027 Core Sets covering a similar topic.

Next slide. The Social Needs Screening and Intervention measure is defined as the percentage of persons who were screened using prespecified instruments or assessed by a provider at least once during the measurement period for unmet food, housing, and transportation needs and who received a corresponding intervention within 30 days of a positive screen or identified meet. Six rates are reported: food screening, food intervention, housing screening, housing intervention, transportation screening, and transportation intervention.

NCQA is the measure steward, and the measure is specified at the health plan level. It's a process measure, and it was not suggested to replace an existing measure. The data collection method is HEDICS Electronic Clinical Data Systems or ECDS. As we've discussed, ECDS includes data from administrative claims, EHRs, case management systems, health information exchanges, and clinical registries. Next slide.

The denominator of each of the screening rates includes each person of any age enrolled at the start of the measurement period who met continuous enrollment criteria. The denominator for each of the three intervention rates includes members with an identified need or positive screen finding in the respective domain between January 1 and December 1 of the measurement period. Note that persons are included in intervention denominators based on the presence of either an ICD-10 Z code indicating an identified need or an LOINC code indicating a positive screen finding. Next slide.

The numerator definitions are on the slide. The numerator for each of the screening rates includes persons with a documented screening result or assessment by a provider in the respective domain between January 1 and December 1 of the measurement period. The numerator for each of the intervention rates includes persons who received an intervention in the respective domain on or up to 30 days after the positive screen occurred or the need was identified. Next slide.

We want to note a few things about the denominator requirements. First, screen 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 code in the measure specification or an ICD-10 Z code indicating an identified need count toward the measure's screening numerators. For the intervention numerators, the intervention provided must correspond to the type of need identified. Interventions may include any of the following categories: direct assistance, counseling, coordination, education, evaluation of eligibility, provision, or referral.

In terms of stratification, the measure steward explained that in the first few years of measure reporting, the measure has not had a large enough sample to generate valid results for race and ethnicity stratification. They expect that with increases in data availability for the measure over time, there may be an opportunity to reassess the validity of race and ethnicity stratification in the coming years. The measure steward has *not* assessed the measure for stratification by sex or geography. Next slide.

The measure steward indicated that pilot testing of the measure was conducted on a national Medicaid sample from one health plan in 2022. The measure is currently in use by state Medicaid and CHIP agencies including in California, Georgia, Kentucky, New Jersey, New York, and Pennsylvania. The individual who suggested this measure argued that the measure encourages systemic identification and timely follow up of unmet food, housing, and transportation needs which directly affect access to care and health outcomes. By requiring interventions within a defined time frame, it promotes action rather than documentation alone and strengthens data tracking and accountability.

They argue that addressing these barriers can improve disease management, reduce avoidable utilization and costs, enhance member satisfaction, and advance health equity. The individual who suggested the measure for addition also noted that they expected that by virtue of the means tested nature of the program, Medicaid beneficiaries typically have greater needs for support and resources compared to individuals with commercial coverage.

They noted that findings from CMS's Accountable Health Communities model showed that health-related social needs are widespread among Medicaid beneficiaries and that beneficiaries are highly interested in receiving support. Nearly one million unique Medicare and Medicaid beneficiaries were screened during the course of the model. The majority, about 70%, were enrolled in Medicaid or were dually eligible for Medicare and Medicaid. Of those screened, 37% had one or more of the five poor social needs; and among those eligible for assistance, 77% chose to participate in navigation support services to help address their identified needs.

As a final note, the measure steward shared that they expect to update the specifications for this measure in March 2026. Key planned updates include removing the provider assessment code, G0136, and its associated G and Z codes. After this update takes effect, instances of social needs screening and positive screens will only be able to be identified through LOINC codes. The other update is updating the intervention procedure value sets for all social needs domains. The value set updates will bring them in alignment with the current Gravity Project code list and remove some SNOMED assessment codes. Lastly, adding guidance to the technical specifications regarding an exception for identifying screening occurrence for food insecurity. Next slide.

I will now turn it over to Alli to lead Workgroup discussion and public comment on this measure.

Alli Steiner:

Thank you, Caitlyn. All right, so now we'll invite discussion about the Social Needs Screening and Intervention measure from Workgroup members. First, let's hear from any Workgroup members who've experienced using the measure in Medicaid or CHIP programs. You may raise your hand if you wish to speak. Jessica?

Jessica Harley:

Hi, Jessica Harley, Community Health Choice. My experience with this was actually with Texas Children's Health Plan. We implemented the Social Needs Screening and mapped out all of the LOINC codes for it. But something that we found in our implementation is that the screening we were able to capture; but the intervention portion, while well-intended, could also capture actions that were not actually going to impact or really drive change for the anticipated gaps there or needs that were identified.

So, a lot of times, we saw providers just adding a blanket education to the end of their after-visit summary; so that could count as education for the intervention, but in reality and in practice it

wasn't often brought up and discussed with the member, or a referral was placed but never followed through.

So, my concern is while this is a very important measure that needs to be addressed, the intervention in the way that it is currently written captures – essentially just checks off items that would be easy to get 100% on that intervention portion.

Alli Steiner:

Thanks, Jessica, helpful context. Let's hear from David Kelley next, please.

David Kelley:

Hi, in Pennsylvania Medicaid we started reporting this in measurement year 2023 and 2024. So this year will be our third year in reporting. Obviously, there's still continue to be some challenges; however, we've seen some progress with our managed care plans. Again, there are various ways that they can collect the data. So again, it sounds like the measure steward is heading more and more towards the use of LOINC codes.

But from our standpoint, it is feasible. Agree that sometimes the interventions are checkboxes. In Pennsylvania we have a program called "PA Navigate" that we have with our health information exchanges have stood up “Find Help”. That that is now available and can be hopefully in the future leveraged to collect data on both referrals and interventions with thousands of CVOs that are signed up to “Find Help”.

So we're excited about this. We think it's a great opportunity. Folks know the literature on health-related social needs and how they can really drive – unfortunately, those unmet gaps can really drive medical costs.

Alli Steiner:

Thank you, David. Are there any other Workgroup members that have a comment? David Zona, did you have a comment?

David Zona:

Oh, no, I'm sorry. I must have forgot to put my hand down.

Alli Steiner:

Okay, why don't we go to Dawn?

Dawn Alley:

Thanks, good afternoon. I have both a comment and a question.

My comment is that I think this is an incredibly important area. I was actually one of the co-creators of the Accountable Health Communities tool, which is one of the screening tools that is part of the screening component of this measure. I do have some concerns about the intervention categories and particularly the inclusion of referral alone as a type of intervention. In the Accountable Health Communities model, that was actually the comparison group received only referrals; and the very positive results coming out of the Accountable Health Communities' work at CMS appear to be driven more and were set up as related to receiving assistance and support.

I am concerned to hear what Jessica shared, which corresponds with my I guess fear about a measure that allows referral only to be part of what's included in intervention. I know a lot of states are already using this measure, and so I know you already called for states to share their experiences. But I'd be really interested. I'm heartened by Dr. Kelley sharing that there's progress happening. I'd be really interested to know from other states what you're seeing in terms of that intervention component and whether you feel that this is really driving resolution and services to address those needs.

My other just procedural question is do we have to vote on – like are we voting up or down on all six of these measures at the same time, or do we have any ability to disaggregate them?

Alli Steiner:

Thank you for that question. There will just be one measure vote on the measure in its entirety. Let's go to Ann Zerr next, please.

Ann Zerr:

Thank you. I also am a practicing physician, and I'm a Medicaid medical director in a *very* large system. The nativity of the C-Suite in terms of social determinants of health is relatively frightening to me, and now at least there's a name for it. But I am totally excited about some accountability for very large health systems in terms of providing the right resources. We're super good at providing very expensive medical care. We're not very good at providing what the patient needs. So I'm all in on this measure.

Alli Steiner:

Thank you, Ann. Stacey?

Stacey Bartell:

Thank you. The AAFP supports goals of reducing health inequities; however, we have concerns about it being applied downstream to individual physicians and being used as an accountability measure being tied to payment.

So, my personal experience as a practicing physician in this is I practice in the state of Michigan. We participated in a Medicaid project. I believe it started in 2016, where we started screening. I have both worked for a large health care system, and I both have worked in rural areas and in more urban areas, where I currently work. I would say that the screening part is probably easier than the referral part.

Some communities and what we hear from our physicians is they don't have community organizations to refer to. So, yes, you can check the box by counseling; or you can check a box by recommending something. But sometimes that community organization has already closed, or sometimes that community organization no longer provides that service. Until you have a process in place where those places are being vetted regularly, I did not see my large health care system that I worked for doing that work.

I would like to say that the state hopefully can do that work, and perhaps the plans can do that work; but we fear that being pushed to the individual physicians. Right now, I'm a private doc; and there's no way that I have the ability to stay on top of what is a great community organization to refer to in my Metro Detroit area – especially for my patients who spread all over.

So while transportation to medical appointments is generally covered well, transportation to buy food would not be covered well. We don't have public transportation in the state of Michigan because we're the auto industry. So again, it's very frustrating as physicians. We fully support this needs to be done. It's just to put it on to individual physicians and practices is really, really difficult and challenging.

Alli Steiner:

Thanks, Stacey. I'll just note we welcome comments from all Workgroup members and federal liaisons at this point, but still very interested in hearing if there are additional state perspectives. We'll go to Kim next, please.

Kim Elliott:

I really do think it's critical that we address the social needs if we're going to have progress in the health care needs and other types of needs of the members we're serving in Medicaid. I do worry when there are so many different types of screening tools and to ensure that providers have access to all of those tools. Some of them, of course, it's proprietary and wouldn't be available; but there are a variety within each category that are not proprietary, so that's great.

But then, again, I think the prior person speaking to me referenced the resources needed to address all of those needs and how you keep up on all of those and how providers maintain those lists. I think there's a lot of work and collaboration that will need to occur to really see significant improvement in this measure, but I do think it's a really important measurement tool if we're going to address and really make significant improvement in the health needs of members.

Alli Steiner:

Thanks, Kim. Lee?

Lee Beers:

Thank you very much, and thank you all for the prior comments. I do think this is a really important measure and an important thing for us to be tracking. It does align with AAP policy in terms of what we recommend in pediatric practice.

I think the additional comment that I just would want to make is that I do actually think that while I recognize that of course when we identify needs, we would like to have really robust follow up with families. I think some of the prior Workgroup members have noted that resources available within communities and practices are highly variable. And I do think actually sort of everyone just discussing the needs and providing a referral with families can be an important intervention in and of itself, right?

I do think referral as an intervention is a very reasonable thing. I think that's a reasonable threshold. Thank you.

Alli Steiner:

Thank you. Let's hear from Christina next.

Christina Marea:

Hi, this is Christina Marea from the American College of Nurse Midwives. I just wanted to echo some of the enthusiasm for this measure, particularly from Ann Zerr. I work inversely in a federally qualified health center where we have a high amount of social need, where we do social need screening. As others have mentioned, this is a mechanism for accountability and documentation. While it won't be perfect, we know that social needs are a primary driver for health outcomes.

So this is an excellent place to start, These are strong measures, and I think the potential benefits of moving this forward definitely outweigh some of the limitations.

Alli Steiner:

Thank you, Christina. Jeff?

Jeff Huebner:

Yeah, I don't have a ton of additional I can add from the commentary standpoint; but I do want to voice my strong support for this. I think when it had come up previously a couple of years ago, it was still in its early stages; and there's still opportunity for improvement it sounds like, especially around the intervention aspect of it. But hopefully the measure is going to push health systems/states to provide more of that infrastructure so it doesn't fall on the individual clinicians involved with screening.

I think the best practices out there really support that; and for those states, like mine, that do not have an 1115 waiver or something similar to really boost this work, I think the measure can help push this forward. Thank you.

Alli Steiner:

Thank you. David?

David Zona:

Yeah, hi, David Zona. I changed my mind. I do have a comment on this measure. I just wanted to say that this measure, for those of you who are aware of the codes that are required, much like the smoking measure does require the LOINC codes. But what I didn't preface my comments on the smoking measure with that I wish I had – and I'm glad to see that that measure passed – is that I do agree that this is an important measure, just as is the smoking measure that we passed.

Everybody is well aware of all the social determinant concerns and how important this topic is in general in Medicaid and in populations. I wholeheartedly support that this measure would be relevant and meaningful. Just that I do have concerns that in 2028 there will be work that states will have to do to be able to reliably and accurately report it. My colleague Ben mentioned the transition to digital eventually. All of those challenges, when digital becomes a reality, go away. I'm just not as much of an optimist as he is that we'll be there in 2028.

But I do wholeheartedly agree with this measure and the intent, and I would encourage others to support it as well. Thank you.

Alli Steiner:

Thank you, Dave. Dawn?

Dawn Alley:

Thanks for coming back to me. I wanted to just follow up because I'm hearing a lot of enthusiasm around sort of referral is better than nothing. I think this will probably come to the discussion we have tomorrow. I understand that may be beyond the scope of this immediate measure and more about where do we go from here and what are the gaps. But I just want to emphasize that I do worry that there is a potential for this measure which – I'm so excited that we're taking these issues seriously – but there is a potential for this measure to cause folks to feel like they have addressed social needs when they haven't.

I've been privileged for about the last five years to be on the frontlines of organizations serving Medicaid home and community-based services populations and now working with community health work group programs. I've just seen a lot of last-mile problems, where a health plan has said, "Here is a grocery delivery voucher," for example. But then the person lives in an unsafe area where no vendors will actually deliver or transcription vouchers are theoretically available but can't actually be applied.

I recognize that those are issues that are well beyond the scope of an individual family practice doc, but I do want to make sure that we as a system are thinking about how we actually make sure that those issues get addressed and that people's goals and needs are addressed rather than at the end of the day saying, "Well, I offered them *X*." I recognize that there's a danger there. As you can hear, I'm really concerned about this.

I recognize there's a danger there that we're holding these measures to a higher level than other sorts of expert-like interventions where we do screening and referral. But again, I just worry a little bit about the danger of stopping at referral, and would love to see us thinking about how we make sure that we're really addressing people's needs and goals.

Alli Steiner:

Thank you, Dawn. Paloma, I noticed at one point you may have unmuted. I just wanted to make sure to give you the chance to speak if you were hoping to make a comment on this measure. If so, you can unmute yourself; or try raising your hand, and we can help unmute you.

Are there any other comments from the Workgroup members? Please feel free to raise your hands.

I'm not seeing any hands. So why don't we move on to the next slide, please?

All right, so now we'd like to provide an opportunity for public comment. If you'd like to make a comment about the Social Needs Screening and Intervention measure, please use the "Raise Hand" feature in the bottom-right of the participant panel to join the queue; and please lower your hand when you're finished making your comment. Just a reminder to please introduce yourself and state your affiliation. Madison?

Madison Shaffer:

Yeah, hello, my name is Madison Shaffer again; and I'm with North Carolina Medicaid. I think we're very excited by the prospect of this measure and agree with all the sentiment. This is a really important area for us to innovate around quality measures. Personally, our state has a

state-standardized health-related resource needs screener that we use and mandate for our managed care plans. As it is a kind of homegrown screener that kind of pieces information from a lot of different existing screeners, it would not fall into numerator compliance for this measure; so our rates would probably be pretty low. That's not to say we don't support this measure and think it's valuable and could potentially shift our screening practices to improve performance in this way.

But did want to flag that the list of included screeners is not comprehensive and is difficult for us technically using a state-specific screener, which has its own limitations in its own way. But just wanted to flag that and do express support here. Just wanted to flag that potential difficulty.

Alli Steiner:

Thank you so much, Madison, helpful context. Any other public comment? All right, I'm not seeing public comment; but I see Djinge from the Workgroup with her hand up. Djinge, would you like to make a comment?

Djinge Lindsay:

Yeah, I did just want to share as consideration. I wholeheartedly support Social Needs Screening. I do get wary like – do get wary about the referral based on all the issues that Dawn raised. But taking back also the last comment, we have required our MCOs in Maryland to use a standardized screening; and we've built that off of PREPARE. It is a very real issue for us that we have leveraged a proprietary tool because we saw some proposed priced fluctuations that were going to run the State a lot of money.

So I would just put that out for consideration and looking to – not to say "Yay" or "Nay" against this, but just as a consideration as we are. If this adopted and is rolled out that we can perhaps think about other screening tools. I know there are some included already that will not be an additional cost to implement yet still will help us identify needs for our Medicaid population and the ability to kind of link them into resources that will address those.

Alli Steiner:

Thank you, Djinge. All right, I'm not seeing any other hands. So why don't we move on to the final vote for today?

All right, so for this final vote of the day, the question is: Should the Social Needs Screening and Intervention measure be added to the Core Sets? The options are: “yes, I recommend adding this measure to the Core Sets”, and “no, I do not recommend adding this measure to the Core Sets.” Voting is now open. As a reminder, if you don't see the question you can refresh your page. So we are looking for 26 votes on this measure. One member of the Workgroup is choosing not to vote on this measure. Okay, so in that case we've reached our 26 votes. We can lock the poll and see the results.

Okay, so in terms of the results, 81% of Workgroup members voted "yes," and so that does meet the threshold for recommendation. The Social Needs Screening and Intervention measure is recommended by the Workgroup for addition to the 2028 Core Sets. So thanks so much, everyone, for your participation in this voting process. Next slide, please.

I'll now pass it back to Tricia for a brief wrap-up.

Patricia Rowan:

Thank you so much, Alli.

I just lost my notes here; but thank you, everybody, for sticking with us today. We really appreciate the engaged discussion from all of our Workgroup members, our measure stewards, and the members of the public; I just want to thank everybody for your contributions today.

To recap the measures that were voted on today, the Workgroup considered a paired measure for removal and addition and did not recommend adding the Antibiotic Utilization for Respiratory Conditions and did not recommend removing the Avoidance of Antibiotic Treatment for Acute Bronchitis and Bronchiolitis measures to the Core Sets.

The Workgroup also considered three more measures for addition and did recommend adding all three. So those measures that were recommended for addition include the Follow-Up After Acute and Urgent Care Visits for Asthma measure, the Tobacco Use Screening and Cessation Intervention measure, and the Social Needs Screening and Intervention measure. Let's go to the next slide, and I'll briefly preview the agenda for tomorrow.

So tomorrow we will discuss our last two measures that were suggested for addition. Those measures are the Adult Access to Preventive and Ambulatory Health Services measure and the Measuring the Value-Functions of Primary Care Continuity of Care measure. We will also discuss gap areas to inform the public Call for Measures for the 2029 Child and Adult Core Sets. This will include a targeted discussion related to immunization measures as well as discussion of other priority gap areas. We'll then provide a recap of the meeting and discuss some future directions and discuss next steps in the Core Set Annual Review process and have a final opportunity for public comment. Next slide.

I do want to preview our plan for tomorrow's discussion of gap areas to help inform the 2029 public Call for Measures. As mentioned in the previous slide, we will start with a targeted discussion related to immunization measures. To capture additional expertise and experiences, Mathematica and CMS have also invited the Health Home Core Sets Annual Review Workgroup to participate in this discussion tomorrow as part of CMS's plan to engage broadly with stakeholders to learn how new measures could capture person and family preferences related to vaccines. During this discussion, CMS is particularly interested in learning whether Workgroup members are aware of or are using any metrics on person and family preferences or patient education related to vaccines; whether any states are already collecting this information; and what the considerations might be related to collecting and reporting information on person and family preferences and/or patient education consistently and reliably.

Following that, we'll move into a discussion of other priority gap areas. This discussion will include just the Child and Adult Core Set Review Workgroup. Like we've done in the past, we'll ask each Workgroup member to briefly mention one gap area that they think should be a priority for the Child and Adult Core Sets or to plus one a gap area mentioned by another Workgroup member. Note that we do plan to call on each Workgroup member in the order listed on the roster. So if your name's at the beginning of the alphabet, you'll be first to be called on. For this discussion, we encourage the Workgroup members to keep in mind the HHS MAHA priorities related to nutrition coaching, fitness, and quality measures that support children's health outcomes. There will also be an opportunity for public comment on gap areas after the Workgroup discussion. Next slide.

Before we adjourn, I'd like to give our co-chairs, Kim and Rachel, an opportunity to make final closeout remarks. I think I'm going to start with Rachel first since Kim went first earlier this morning.

Rachel LaCroix:

Thank you, can you hear me okay?

Patricia Rowan:

Yep, you sound great.

Rachel LaCroix:

Okay, great, thank you. Really good conversations today about all of the measures under consideration. I'd like to thank everybody for the really thoughtful comments and thank everybody who shared their experience with some of these measures so that we could all think about those as we were determining voting on adding or potentially removing measures. It's really, really helpful to hear perspectives from the states as well as from other interested parties about some of the pros and cons of these different measures, some of the challenges with some of the data sources and coding for the measures, and all of that. It really just provided a really great comprehensive background and context to make these decisions.

So I really appreciate everybody sharing and the conversation around all of these different measures we discussed today. I felt like we really got through a lot going through the measures that we did and really liked hearing all the different ideas kind of on both sides for all of these measures. So thank you all for that conversation.

I look forward to our finishing up with the last two measures recommended for addition that we'll be discussing tomorrow, and I know I'm really looking forward to our gap areas discussion as well. I feel like every year that really has been a good brainstorming session. It's great to hear about different areas or, in some cases, maybe subareas within the are that we might already be looking at that doesn't seem to be adequately captured with the Core Measure Sets as they currently exist. So definitely looking forward to that discussion tomorrow. Thank you, everybody, for your participation and feedback today.

Patricia Rowan:

Thank you, Rachel. Kim?

Kim Elliott:

It really was a very busy and, I think, very – it was just a very good day. I want to thank everyone for a full and productive day. I'm always impressed and appreciative of the level of preparation and engagement of all of the Workgroup members.

Our work has a real impact on measuring the progress and improving the health and the well-being of individuals enrolled in Medicaid and CHIP, and some of that was evidenced in some of the measures that were suggested for addition today. It's amazing how much progress has also been made in both the number of states reporting the measures, regardless of the mandatory reporting requirements, and the number of measures that are being reported.

Our discussion of measures for removal and addition today was informative and really focused on strengthening the Core Sets. It also focused on the ability to report the measures, the data sources and feasibility, identifying interventions, and whether measuring will improve the outcomes to the Medicaid and CHIP populations. That's what I really appreciate about each of the participants of the Workgroup -- is really lending comments, feedback, and their experience to each of those areas because all of those areas are so important in being able to successfully report the measures.

The subject matter expertise of Workgroup members, both for and against measure recommendations, I think really resulted in informed recommendations for CMS to consider for the Core Sets.

We have two more measures to discuss tomorrow; and based on today's discussion, I'm anticipating a lively discussion. I also noted during the measure discussion that Workgroup members were already starting to consider and identify potential measure gap areas. This puts us in a good place for some of our work tomorrow.

So, thank you, everyone, for your hard work leading up to today's meeting and for a *very* productive day; and tomorrow will be even more successful, I'm confident.

Patricia Rowan:

Thank you, Kim and Rachel.

We'll go to the next slide.

So thank you again, everyone, for being here and participating in Day 1 of the 2028 Child and Adult Core Sets Review Annual Meeting. We will begin promptly tomorrow at 11:00 a.m. Eastern Time again. We ask Workgroup members to dial in a few minutes early just to make sure we don't have any tech concerns.

This concludes Day 1 of our meeting. Enjoy the rest of your day, and we hope you'll join us again tomorrow at 11:00 a.m. Eastern. Thanks, everybody, for being here. This meeting is now adjourned.