2028 Child and Adult Core Sets Annual Review:
Meeting to Review Measures for the 2028 Core Sets, Day 2 Transcript
February 4, 2026, 11:00 AM – 3:00 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 2. And with that, I'll hand it over to Tricia to get us started.

Patricia Rowan:

Excellent. Thank you so much, Denesha. Welcome back, everybody, to Day 2 of the Meeting to Review Measures for the 2028 Child and Adult Core Sets. I hope everyone had a nice evening yesterday.

We had a very productive conversation and a very robust discussion of five measures during yesterday's meeting. To recap the summary of the Workgroup's recommendations yesterday, the Workgroup did not recommend removing the *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis* measures from the Adult and Child Core Sets. And the Workgroup also voted to recommend three measures for addition to the Child and Adult Core Sets. Those were the *Follow-up After Acute and Urgent Care Visits for Asthma*, the *Tobacco Use Screening and Cessation Intervention* measure, and the *Social Need Screening and Intervention* measure.

The Workgroup also voted on adding the *Antibiotic Utilization for Respiratory Conditions*, but that did not reach our threshold for recommendations. So, the Workgroup does not recommend adding that measure. We are looking forward to today's discussion of the final two measures that were suggested for addition to the 2028 Core Sets and getting input from the Workgroup that will inform next year's public Call for Measures. Before we begin today's discussion, I want to give Kim Elliott and Rachel La Croix, our two co-chairs, an opportunity to make brief welcome remarks.

So Kim, would you like to go first?

Kim Elliott:

I'm happy to. So welcome to Day 2. I'm really excited to get started with today's discussion. We had a very productive day yesterday, which resulted in some really good recommendations, as was just mentioned. And I do want to thank all the Workgroup members because your active participation in the measure discussion is really invaluable, and I think it was very helpful, particularly with the measures that we were discussing yesterday and those that we'll be discussing today.

The discussion yesterday was really good because we heard a lot about the clinical aspects of the measures, the provider impact to implement the care and services necessary to do or conduct the measures. And we also heard about the impact of states, the health plans. We talked a lot about data sources and the resources needed at all levels of the health care system, including at the state level, to successfully implement the measures. And I think that will continue through today's discussions as well. We gave a lot of consideration on how implementing the measure may result in improved outcomes for the Medicaid beneficiaries, which is really important that we keep that member as our primary focus on why we're working on these measures at all. And throughout the discussions, I heard little glimmers of potential

gaps that were briefly mentioned, and I'm really looking for that more robust discussion today on gaps.

It sounds like we're going to have lots of thoughts and ideas coming through, which is fantastic. I'm also looking forward to another successful day as we discuss the two measures, the adults' access to care and the value-function of primary care: continuity of care measures. I think those will be very interesting measures to review. And I'm sure that we have all thought about and are prepared for that gap discussion on today's agenda. The Core Sets, we know, are already really pretty robust. For gaps, it is important to think about the whole person, systems, the population served by Medicaid, and other factors to identify the gaps in the Core Sets where measurement may result in improved quality, access to timely care and services, and, of course, improved outcomes, which is what we all really strive for when we do these measurements. Rachel, I'll turn it over to you.

Rachel La Croix:

Thank you, Kim. Good morning, everyone. And I echo Kim's comments. I'm definitely looking forward to a good, robust conversation with you all again regarding the two additional measures we'll be talking about today. And I look forward to hearing everyone's thoughts on the pros and cons of these measures and how they can supplement and add to the Core Sets, as well as hearing about folks' experience with some of these measures if folks do have that information to share.

Also looking forward to our gaps discussion later today and the ideas we can take from that to help improve future years of Workgroup discussions and consideration for measures. So looking forward to some good conversations today and, again, also just want to thank Mathematica for all of the preparation they put into the materials we had to prepare for this meeting and for keeping us on track and coordinating our discussion of these measures during the meeting yesterday and today. Thank you.

Patricia Rowan:

Thank you, Kim and Rachel. Next slide. So now we will do a roll call of Workgroup members.

Next slide. Similar to yesterday, I will call on each Workgroup member in the order that is listed on the slide. When I call your name, please just raise your hand and unmute yourself to say hello and make sure that your audio works. Please ensure you're not double-muted on your headset or phone. And if you have any technical issues, please use the Slido Q&A function for assistance and our producers will be in touch. Please also remember to lower your hand and re-mute yourself after you're done speaking.

Next slide. We've already heard from Kim and Rachel and know their audio works. So I will start with Dawn Alley.

Dawn Alley:

Good morning.

Patricia Rowan:

Good morning, Dawn.

Erin Alston.

Erin Alston:

Good morning.

Patricia Rowan:

Good morning.

Stacey Bartell.

Stacey Bartell:

Hello.

Patricia Rowan:

Good morning.

Lee Beers, I believe, is not able to join us.

All right. Laura Boutwell. Go ahead, Laura. You should be able to unmute yourself.

Laura Boutwell:

Good morning.

Patricia Rowan:

Good morning.

Matt Brannon.

Matt Brannon:

Good morning.

Patricia Rowan:

Good morning.

Joanne Bush.

Joanne Bush:

Good morning.

Patricia Rowan:

Good morning.

Angela Filzen.

Angela Filzen:

Good morning.

Patricia Rowan:

Good morning.

Next slide. Jessica Harley.

Jessica Harley:

Good morning.

Patricia Rowan:

Good morning.

Jeff Huebner?

Jeff Huebner:

Hi, everyone.

Patricia Rowan:

Hi, Jeff.

David Kelley.

David Kelley:

Good morning.

Patricia Rowan:

Good morning.

David Kroll. Oh, David Kroll will be late. Thank you, team.

Chimene Liburd?

Chimene Liburd:

Chimene is here. Good morning.

Patricia Rowan:

Chimene, thank you.

Djinge Lindsay.

Djinge Lindsay:

Good morning.

Patricia Rowan:

Good morning.

We have Paloma Luisi.

Paloma Luisi:

Good morning.

Patricia Rowan:

Good morning.

Christina Marea.

Christina Marea:

Here, Marea.

Patricia Rowan:

Marea, thank you.

Angie Parker.

Angela Parker:

Good morning.

Patricia Rowan:

Good morning.

Nicole Pratt.

Nicole Pratt:

Good morning. It's Nicole.

Patricia Rowan:

Nicole. Thank you.

Next slide. Do we have Sural Shah?

Sural Shah:

Good morning.

Patricia Rowan:

Good morning.

Do we have Bonnie Silva?

Bonnie Silva:

Good morning.

Patricia Rowan:

Good morning, Bonnie.

Do we have Sarah Tomlinson?

Sarah Tomlinson:

Good morning.

Patricia Rowan:

Good morning.

Sara Toomey?

Sara Toomey:

Good morning.

Patricia Rowan:

Good morning.

Ann Zerr?

Ann Zerr:

Good morning.

Patricia Rowan:

Good morning.

Bonnie Zima

Bonnie Zima:

Good morning.

Patricia Rowan:

Good morning. Good to hear your voice. Glad we got your audio fixed.

David Zona?

David Zona:

Good morning.

Patricia Rowan:

Wonderful. Good morning.

Thanks, everybody, so much for being here, spending your day with us.

Next slide. As I mentioned yesterday, the Core Set review process is also supported by federal liaisons who are non-voting members of the Workgroup. And for those 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. I would also, again, like to acknowledge our colleagues at the Center for Medicaid and CHIP Services and the Division of Quality and Health Outcomes, who will also be listening to today's meeting, as well as measure stewards who are available to answer questions about their measures.

Next slide. All right, and let's get started with the substance of today's meeting. I am going to hand it to Deb, who will present on the next measure that is suggested for addition.

Deb Haimowitz:

Thanks, Tricia. The next measure suggested for addition to the 2028 Core Sets is the *Adults' Access to Preventive/Ambulatory Health Services*. Before we get started on this measure, we wanted to provide some context on the existing related measures on the Core Sets. Our aim is to provide context to help Workgroup members consider whether the suggested measure fills a gap in the Core Sets or adds value to the existing measure set. There are five measures related to primary and preventive care for adults on the 2027 Adult Core Set. *Cervical Cancer Screening*, *Chlamydia Screening: Ages 21 to 24*, *Colorectal Cancer Screening*, *Breast Cancer Screening*, and *Adult Immunization Status*.

The measure suggested for addition is *Adults' Access to Preventive/Ambulatory Health Services*. This measure is defined as the percentage of persons ages 20 and older who had an ambulatory or preventive care visit during the measurement period. The National Committee for Quality Assurance, or NCQA, is the measure steward, and the measure is specified at the health plan level. It is a process measure and it was not suggested to replace an existing measure. The data collection method is administrative. The denominator for this measure includes persons 20 years of age and older as of December 31 of the measurement period. The numerator for this measure is one or more ambulatory or preventive visits during the measurement period.

NCQA noted that the measure is currently stratified by age group only. NCQA has not assessed the measure for its ability to capture additional stratifications. The individual who suggested the measure indicated that 21 states included the measure in the performance measure validation in their external quality review, EQR, technical reports for 2023 to 2024. NCQA confirmed that they are aware of six states that are currently using this measure for Medicaid or CHIP, which are New Hampshire, South Carolina, Tennessee, Texas, Virginia, and Washington. The individual who suggested the measure highlighted that preventive services and ambulatory health services are essential to promoting individual and community health, noting that this measure reinforces the responsibility of health plans to ensure access to care for all members. The individual also highlighted that people who do not receive preventive health care are at greater risk of developing advanced or preventable disease, often resulting in higher personal and financial costs.

They cited studies that found that clinical preventive services in the ambulatory setting have substantial benefits in preventing death and illness episodes. Additionally, primary care visits increased the likelihood that patients receive preventive interventions, such as vaccinations and cancer screenings. The individual who suggested… the individual who suggested the measure indicated that there is room for improvement within Medicaid. They cited data showing that in HEDIS Measurement Year 2023, the average performance rate for Medicaid health plans was 74%, 20 percentage points lower than the average rate for commercial and Medicare plans,

each 94%. Although, note that the specifications for commercial plans require a visit every three years, whereas Medicaid and Medicare specifications call for annual visits. The individual who suggested the measure also argued that the broadness of the measure may be helpful for state reporting, contrasting it with condition-specific Adult Core Set measures like the ones listed in the previous slide. With that, I will pass it to Caitlyn to facilitate the Workgroup discussion.

Caitlyn Newhard:

Thanks, Deb. We will now invite discussion about the *Adults' Access to Preventive/Ambulatory Health Services* measure from Workgroup members. First, let's hear from any Workgroup members who have experience using the measure in Medicaid or CHIP. You may raise your hand if you wish to speak. We will call your name and you may unmute yourself. Please remember to say your name before making your comment. So again, this is Workgroup members who have experience using the measure in Medicaid or CHIP. All right. Let's see. We have Sural.

Sural Shah:

Hi. I'm from California Department of Health Care Services, and we do utilize this measure. We've had it as part of our accountability set that we use for our managed care plans for measurement year 2022 to 2025. We did remove it from the accountability set, but that was not because of any feasibility or reporting burden issues. Sorry, any feasibility issues. It was because of reporting burden. We were just trying to reduce the number of measures on our accountability set. We are still monitoring it through other means and have had no challenges with it.

Caitlyn Newhard:

Thanks. That's helpful insight. Any other Workgroup members who have experience using the measure? Let's go ahead with Rachel La Croix.

Rachel La Croix:

Good morning. In Florida, we have required this measure for our Medicaid managed care plans for quite a while. We really feel like this is a helpful measure for a number of the reasons that the individual who recommended this measure did, in terms of trying to capture an adult version or close to it regarding the equivalent of well-child visits, but really trying to get an idea of how many adults are accessing primary care or ambulatory care services. The measure is administrative, so it doesn't have the burden that might be associated with hybrid or some other types of measures. And since 2020, the rates have definitely gone up and down a little bit, indicating that there is definitely some room for improvement in this area as well.

Caitlyn Newhard:

Thanks, Rachel. David Kelley.

David Kelley:

Hi. Good morning. This is Dave Kelley, PA Medicaid. Hopefully you can hear me.

Caitlyn Newhard:

Yes, we can hear you.

David Kelley:

So we do report this measure publicly. Our MCOs gathered the information, and our last three-year trend showed a little bit of improvement. I think we're somewhere around 78% for all age bands. So we do find this to be useful. I think it's also useful, actually, in conjunction with looking at emergency room visits as well. So as a standalone, it's helpful. It's more helpful when you look at it with emergency room visits as well.

The other question that I have, I'm not sure if NCQA, I think is the measure steward, if they are retiring this measure. I thought there was something, at least when I looked it up on the web, that they were considering or they were going to retire the measure. So I don't know if the measure steward could comment on that. I may be wrong, but just wanted to raise that as an issue.

Caitlyn Newhard:

Yeah, that's a good question. Is there anyone from NCQA who might be able to comment on that? Adrianna?

Adrianna Nava:

Yeah, we don't have any upcoming plan or proposed changes or retirement for this measure. So there's no concern there if this was to get voted in.

Caitlyn Newhard:

Great. Thanks for that insight.

David Kelley:

Okay, good to know. I just looked it up on the web and there was some mention there. Again, obviously, who knows what you see on the web. But anyway, I wanted to make sure that wasn't a concern.

Caitlyn Newhard:

Thanks, David. All right. Are there any other Workgroup members who have experience using the measure in Medicaid and CHIP that would like to comment? Oh, Paloma.

Paloma Luisi:

Yes. So we do use this in New York. You know, our results are high for this measure because it's pretty expansive of what is included in the numerator. So while it is used in the quality strategy, I would hesitate to use this in a quality incentive just because, like, the actionable types of interventions from an MCO perspective, I think, are limited when our results are pretty high in New York. So I have some concerns about the leverage that this measure brings, though I do think it is useful for population health review. And for certain populations, like we have the essential plan in New York. So again, not a Medicaid and CHIP plan, but, you know, for example, looking at other types of plans, it can be useful to compare to lower utilizing populations. So it's of interest to me. I do have some concerns about the utility of it from a performance improvement standpoint.

Caitlyn Newhard:

Thank you, Paloma.

Laura Boutwell.

Laura Boutwell:

Hi. Good morning. I just wanted to say that Virginia has used this measure for many years and we track for our quality strategy and for our MCO performance. And I also echo some of the comments about its overarching approach may limit deeper conversation on follow up. But we find the measure to be very helpful when tracking from an overall population perspective for our state.

Caitlyn Newhard:

That's helpful. Thank you, Laura. Chimene.

Chimene Liburd:

So D.C. has been using it since 2022. And, you know, our population is probably smaller than many other of the other big states. And so we're using it, I think, from a managed care perspective. It is helpful, but we sometimes have challenges with network adequacy. And so that sometimes is an issue. But outside of that, I just want to let you know we're using it and continue to use it.

Caitlyn Newhard:

Thanks for those insights. Appreciate that.

All right. Now I want to open up the discussion to include other members of the Workgroup and our federal liaisons. So feel free to raise those hands and provide a comment. Sara Toomey?

Sara Toomey:

Hi, Sara Toomey. So I just think conceptually, this is a really important measure, especially given that we have such a crisis in primary care. And I think given the disparities that were identified looking at multi states, it seems like this really could help drive improvement. Admittedly, there are some limitations, as was acknowledged. But I just want to say I think this is a really important measure. Thank you.

Caitlyn Newhard:

Thanks, Sara. Kim?

Kim Elliott:

Thank you. I like this measure. And one of the reasons I like it, on the adult side of the core measure set, one of the things that I think would be really important is the adult's access, having that preventive care visit with their PCP or whomever the provider is. It does kind of set the stage for a lot of the other preventive and screening sorts of measures such as colorectal cancer, breast cancer, cervical cancer. You get those reminders through those preventive health and overall health meetings with your primary care. So I do like this measure. I think it's a

valuable measure. And I think it really sets the stage for other types of care and services, early identification of health care conditions.

Caitlyn Newhard:

Thank you. Thanks, Kim. All right. How about Stacey?

Stacey Bartell:

Hi, Stacey Bartell on behalf of AAFP. We obviously support this measure working in the primary care space. We understand how important regular primary care visits are and even just access to primary care. In a world where we're seeing many physicians leave to go to other types of care like concierge and DPC, we just want to make sure that the Medicaid population still has access to care.

On a personal note, I can say that I think network advocacy is important to assess everywhere. It sounds like some states may have figured it out. I work in a state where there's a lot of large health care systems, and I'm still surprised that there's still a lack of access. So some of these large health care systems are not taking Medicaid patients, and I find that challenging as a primary care doctor. So I'm hopeful with this measure more of these conversations can be had and more information can be gained and we learn more about the problems.

Caitlyn Newhard:

Thanks, Stacey. Those are useful insights. Jeff Huebner.

Jeff Huebner:

Yeah. Hi, everyone. I think in general, I support this measure, and I'm glad to hear other states' experience with this. And, you know, as a lead medical leader in Wisconsin Medicaid, I wish we had this. So that probably tells you that, yeah, I'm supportive. At the same time, I just would like to keep learning a little bit more about the measure, and I'll finish with a question to the group. But I think, you know, in general, a couple of the concerns I have about it maybe not being ideal is just from the standpoint that hopefully this will drive engagement.

We all know that for our Medicaid population, many of them have trouble getting in to see a doctor or have a regular source of care. And that regular source of care is part of the next measure we'll be discussing, too. So this is, I think, an opportunity to drive hopefully at the health plan and the participating health system’s providers some more drive to get people in, because even though clinical guidelines don't necessarily recommend anymore for everyone to get an annual physical as an adult, we know our Medicaid population has higher prevalence of chronic conditions. And I think in addition to the preventive screening opportunities, that's where some of the power to drive health care improvement and outcomes lies with this measure to really get people hopefully in more and then having a regular source of care for those chronic conditions.

I'm wondering two things. One, has anybody looked at or is there any way to parse out how simple acute care visits might credit access for this measure? And I realize that that actually might still be useful, too, from the standpoint that, you know, you're trying to make sure people have access to care in the ambulatory arena instead of having to go to the ER. And then my other question is really related to, is there a way to also tease out, like, specialty care in this versus primary care as counting toward the measure?

Caitlyn Newhard:

Thanks, Jeff. Are there any Workgroup members with states that have experience with this measure able to help answer Jeff's question? And maybe also NCQA. Adrianna, if you're able to weigh in on this specialty piece.

Adrianna Nava:

Sure. So it's primarily looking for ambulatory or preventive care visits. So pulling out, you know, office visits related to primary care and telehealth visits. There's certain outpatient encounters as well, but it wouldn't tie to a specific specialty like I think is being requested right now.

Caitlyn Newhard:

Great. Thanks for that info. David Kelley.

David Kelley:

I guess to question that even further, and it's been a while since I looked at the details of the spec, but is this any ambulatory visit? So it could be specialty, could be primary care? I know that in Pennsylvania, I believe, like we have provider types like hospital clinics and FQHCs. So I don't know if this measure actually gets to that granularity where you can separate out pure primary care from other specialty visits. And maybe NCQA could clarify that. But I think there is value because it really gives you an idea generally of access to mostly primary care that would occur in multiple types of providers within the Medicaid network. But maybe NCQA could share with us the details of that spec and if there is really a way to parse out. Is it just primary care visits or are there other specialists that would be included in the visits?

Caitlyn Newhard:

Sure. Yeah. Let's ask Adrianna.

Adrianna Nava:

Sure. So you have to go into the value sets. So the visits could be within like an OB/GYN. A cardiology visit could satisfy the measure, but we wouldn't be able at this point to stratify the measure by specialty to have that data. You'd have to look at the actual value set.

David Kelley:

Okay. And with that being said, I mean, there's I still think there's a lot of value to this measure. And MCOs would have and the state would have the ability to do some drill down if they would like. And at least within Pennsylvania, I mean, we have other mechanisms, mapping mechanisms to look at network adequacy. But this is a really nice measure. And again, we have seen some improvement definitely since the pandemic. So it's nice to be able to monitor what's happening there.

Caitlyn Newhard:

Great. Thanks, David. Are there any other members of the Workgroup or federal liaisons that would like to comment before we move on to the public comment? Okay, let's move on.

Next slide, please. I guess we can leave it on this slide, but we'll move on to public comment. Now we'd like to provide an opportunity for public comment. If you would like to make a comment about the adults' access to preventive or ambulatory health 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 are done. We'll let you know when you've been unmuted.

All right. Fiona, can we unmute Madison, please? Madison, you should be unmuted.

Madison Schaefer:

My name is Madison Schaefer, and I manage quality measures for North Carolina Medicaid. We have been using this measure and have, and think it's really important. We use it across a lot of our managed care lines of business as well as overall North Carolina Medicaid. And I think we actually submitted one of the proposals to add this measure as well. We think it's a really great example of what a Core Set measure should look like. It covers a very large portion of the population and kind of aligns with the Child Core Set version that was mentioned of the WCV and W30. This kind of extends that age range by including AAP in the adult set. It would be a nice continuity between the two.

We think this is a really important measure, like I said, as it covers a very large portion of our population. And while I do understand that it is broad, I think it's still an important piece of access to care to include in the adult set and is a nice complement to a lot of the more really specific primary care access and preventative care access measures that are already on there that were mentioned like chlamydia screening and colorectal cancer screening. This provides kind of a nice umbrella measure that captures a lot of those potential utilization events. And so, yes, we support this measure and are very excited that it's a proposal here.

Caitlyn Newhard:

Thanks, Madison.

All right. Others?

All right. I'm not seeing any other hands, but I'll give it another moment here. Great. Thank you, everyone, for those insightful comments. Let's move on to voting.

Next slide, please.

Now let's continue on to voting. Workgroup members, please log into Slido the same way you did yesterday. If you have technical issues, please message our team through the Q&A feature in the Slido panel or send us an email with your vote.

Next slide. Okay. For our vote, should the *Adults' Access to Preventive/Ambulatory Health Services* 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 the question does not appear on your voting page, please refresh your browser. And while we're waiting for votes to come in, we want to remind you that voting results you'll see on the screen today are preliminary. Mathematica will do a careful review of all voting results at the end of the day to make sure that each eligible Workgroup member's vote was included and that no votes were double counted. If any of the voting results change as a result of our review, we'll let you know during the wrap-up at the end of the day.

I see we're at 22 votes right now. We are waiting for 28. 24, we're getting there, just a few more votes. So we'll keep it open for a little bit longer. We are just waiting for a few more votes here. I've seen a total of 24, and we are looking for 28 to make sure that we get all the votes in. All right, we're at 26. Just hang tight with us for a moment or two longer here while we track down the last two votes. Definitely appreciate everyone's patience. All right, we're just waiting on one more vote. Again, thanks for your patience, everyone, as the team's kind of working in the background here to track down that last vote. Perfect.

Okay, we are at 28. So let's go ahead and close the vote.

And the results are 93% of Workgroup members voted “yes.” So that does meet the threshold for recommendation. The *Adults' Access to Preventive/Ambulatory Health Services* measure is recommended by the Workgroup for addition to the 2028 Core Sets. Thank you all for your vote.

Now I will pass it back to Denesha to describe the next measure suggested for addition. Next slide.

Denesha Lafontant:

Sorry, double muted. Thanks, Caitlyn. The next measure suggested for addition that the Workgroup will discuss is *Measuring the Value-Functions of Primary Care: Continuity of Care*. Note that there are no measures on the 2027 Child and Adult Core Sets related to continuity of care. The measure suggested for addition is defined as the percentage of a physician’s patients who have a continuity index score of 0.7 or higher among patients with two or more primary care visits in a year. It is calculated at the physician level but can be aggregated to health plans or states.

This measure uses a validated continuity index to assess how consistently patients see the same provider for their primary care visits. The measure steward is the American Board of Family Medicine and it's specified at the physician level. This is an efficiency and process measure and it's not suggested to replace a current measure on the Core Sets. Data for this measure can be collected using administrative, electronic health records, or clinical registry data. The measure steward noted that these data sources are independent options for measure calculation and do not need to be combined or supplemented with one another. The denominator includes patients who had at least two primary care visits to any primary care provider during the reporting year.

We've included the measure definitions for primary care visit and primary care provider at the bottom of the slide for reference. Note that the provider must be a physician. Each patient that is eligible for the denominator is assigned to a primary care provider and the denominator for each provider is the total number of patients attributed to that provider. Additional logic used to calculate the denominator is provided on the slide. To calculate the numerator, a continuity index score is calculated for each patient using the Bice-Boxerman continuity of care index. This index ranges from 0 to 1. 0 reflects completely disjointed care, meaning the patient saw a different provider for each visit and had no continuity of care. And 1 reflects complete continuity with the same provider for all visits. The numerator for each physician is the number of patients attributed to that physician with a continuity index score at least 0.7. The steps used to calculate the numerator at the physician level and then to roll it up to the state Medicaid, and CHIP level are provided on the slide.

Note that the measure can be rolled up to any level of analysis, such as a physician, group practice, health system, health plan, or state level, as long as the patient can be identified as enrolled at that level of analysis. For example, if patients can be attributed to the Medicaid and

CHIP program, the measure can be rolled up to the state Medicaid, and CHIP level. The measure steward explained that the data source allows for stratification by race, ethnicity, sex, and geography. During measure testing, they stratified the full all-payer data source by sex and geography, but not by race and ethnicity, due to unreliable data in the testing dataset. However, they noted that if the data source being used by states has reliable data, the measure could also be stratified by race and ethnicity.

The measure was tested using 2021 data from the Virginia All-payer Claims Database, which offers a patient sample that is demographically similar to the U.S. across age, gender, and rurality. The dataset included Medicaid data from Medicaid low-income health maintenance organizations and special needs plans for individuals dually eligible for Medicare and Medicaid with results stratified by health plan type. The measure steward was not aware of any state Medicaid or CHIP programs that currently use the measure. However, they noted that the measure has been included in two non-Medicaid California state programs, Covered California 2026-2028 Qualified Health Plan Issuer Contract, and the CalPERS 2026 Health Maintenance Organization Contract for state employees. The individual who suggested the measure noted that continuity of care is a core function of primary care that has been consistently associated with improved health outcomes, reduced costs, and greater patient satisfaction, making it a high-impact measure for Medicaid and CHIP populations. They cited research showing that higher continuity, measured using the Bice-Boxerman index is linked to significantly lower health care expenditures and fewer hospitalizations.

Measure testing also revealed a performance gap where Medicaid beneficiaries experience lower continuity of care compared to Medicare beneficiaries and enrollees in some types of commercial health plans. The individual who suggested the measure indicated that Medicaid and CHIP programs could use the continuity measure to identify differences in measure performance and develop targeted interventions to improve continuity, such as empanelment and continuity-focused scheduling guidelines in areas with the lowest continuity scores, thereby improving measure performance overall.

I will now turn it over to Caitlyn to facilitate the Workgroup discussion of this measure as well as public comment.

Caitlyn Newhard:

Thanks, Denesha. We now invite discussion about *Measuring the Value-Functions of Primary Care: Continuity of Care* measure from Workgroup members. We are not aware of any Medicaid or CHIP programs using this measure, so we'll open the discussion to the full Workgroup and our federal liaisons. Please raise your hand if you wish to speak. We will call your name when it is your turn. Please remember to say your name before making your comment.

Before we get started, I'm going to read a comment from one of our Workgroup members, Dr. Lee Beers, who is unable to attend the discussion today. So again, this is a comment from Dr. Beers.

The intent and basis of the measure are strong, and Dr. Beers agrees that continuity can improve the quality of care and experience for patients. Dr. Beers has some pragmatic and implementation concerns largely related to the focus on continuity with an individual provider rather than with a medical home. Dr. Beers has concerns regarding resource limitations. Clinical settings experiencing staffing shortages may have difficulty meeting this measure. Incentivizing continuity with a single provider, especially in the context of staffing shortages, may delay care.

This can be particularly problematic in the first 18 months of life when well visits are more frequent, happening every two to three months.

Dr. Beers has concerns regarding patient and caregiver preferences. While many patients are willing to wait for continuity, allocation of appointments is sometimes driven by patient preferences of when and where they would like to be seen, especially since some practices have multiple locations of care and/or families may need to accommodate work or school schedules. Dr. Beers also has concerns regarding practice characteristic settings such as teaching institutions and practices that use different access arrangements. For example, practice partner models where multiple providers within an institution are organized to be a care team serving the same panel within a group may be disadvantaged by this measure.

All right, so I will again open this up to Workgroup members and federal liaisons who would like to comment on this measure. Please raise your hand. Let's start with Christina.

Christina Marea:

Hi, thank you. I share some of the concerns noted previously, so I won't reiterate those, but I also am concerned about the limitation to physician providers when we have a large cadre of nurse practitioners, physician assistants who provide primary care, both continuity and otherwise. And so I do wonder about the impact of this measure on institutions like federally qualified health centers that have, you know, family nurse practitioners and what happens when you have a diverse provider group providing primary care. And then similar concerns relative to the balance between preference for continuity with a single provider versus timing of being able to get a timely appointment within a similar practice group. I would love to see a continuity of care measure. I'm not sure this is the right one right now, and I look forward to hearing additional comments.

Caitlyn Newhard:

Thank you, Christina. Let's go with Ann.

Ann Zerr:

Good morning. This is Ann Zerr. I'm a practicing internist and the Medicaid medical director in Indiana. I would just reiterate the comments that have already been made. I actually practice in a residency teaching practice, and we aspire to continuity, and the implementation is very difficult. And again, this is a little bit doctor-focused, a little less patient-focused, and it negates the team-based care, as others have already said. I, too, worry about advanced practice providers in certain environments, not in the ambulatory setting, and I think they can add tremendous continuity for our members. I think the value of primary care is not negotiable anymore. It's been proven over and over again. So I have concerns about this measure, not the goal of having people have a medical home and a regular source of care.

Caitlyn Newhard:

Thanks, Ann. That's helpful. Sara Toomey.

Sara Toomey:

Yeah. Hi. This is Sara Toomey. I'm just going to sort of reiterate very briefly a couple of the key concerns from my perspective, one of which is just that, in particular, with, generally speaking, the healthcare shortage, you know, people are working more and thinking differently about care

models and team-based care. And using APPs, whether it be physician's assistants or NPs, are really critical in the context of providing high-quality primary care. That's not to say that continuity isn't important in some manner, but I would argue that having a medical home and having a place where a team of people know a patient, is probably the more important sort of metric, in particular, given the shifts in workforce. Thank you.

Caitlyn Newhard:

Thank you for that. Stacey.

Stacey Bartell:

Hi. Stacey Bartell on behalf of AAFP. We support this measure. We support this measure for many reasons. We hear what everyone is saying with the complexity of the measure. We don't feel that it drives away from care teams with the goal of being greater than 0.7%. It just says that the majority of the time you should see the same primary care provider. The other 0.3% of the time, the rest of the care team should meet that goal, too. We know that as more physicians have become employed, unfortunately, employers don't value the primary care relationship as much as they value the access. And so there's this constant tug between access and continuity. And so I think this measure intent is to just make sure we're still prioritizing continuity.

On a personal note, or I just also want to share from a residency practice standpoint, my previous role was in a residency practice as a medical director. And as part of CPC+, we did report on continuity every year. We reported at continuity for our residents also. And part of ACGME new goals in the last, I believe, year or two is now to report continuity at residency sites also to drive toward better continuity in resident programs. Because we know even in training, it is important for them to develop that patient relationship. And we want to provide good patient care at all sites. And since we know that the majority of Medicaid population is probably driven more toward residency sites and federally qualified health centers, we want to make sure that that continuity message stays the same. So we're by no means trying to limit the importance of advanced care providers. We also just want to make sure that that relationship is maintained and how important it is. And we feel it can be done. The 0.7, we're not saying it has to be 100 or 1.0. The 0.7 is a very reasonable number to try to attain. Thank you.

Caitlyn Newhard:

That's helpful insight, Stacey. Appreciate it.

I also have a comment here from David Kroll that I'm going to be reading aloud. David says, continuity is great, but it requires patients to be able to make appointments in advance and keep them, which is harder to do for patients on Medicaid. There's a lot of data demonstrating this. One important strategy to engaging the Medicaid population is to increase flexibility for how patients access care. A good example, open walk-in hours. This measure would not incentivize flexibility where it would be valuable.

Are there any other Workgroup members that would like to comment?

Kim Elliott.

Kim Elliott:

A couple of things. I think I'd like this measure more if it had been tested in more Medicaid programs to see how it actually worked when implemented. Some of the things that made me

pause a little bit about it were the measure steward indicated that there are four CMS specialty codes that can be used if healthcare service categorization codes are not available. So that could create a few issues from a comparability or measurement perspective. And then they also referenced in the specifications that there is ongoing maintenance of the measure. And some of the things that they're exploring right now for refinement are alternate continuity indexes, thresholds, and identifiers for primary care physicians and visits. And that those refinements are still in the very early stages. I think it has good potential, but I'm just not sure without real testing that it makes sense right now.

Caitlyn Newhard:

Thanks, Kim. I see the measure steward has their hand up. Poonam, can we unmute Poonam?

Poonam Bal:

Thank you for the opportunity to respond and appreciate the Workgroup's thorough review of the measure. We completely understand the concerns about team-based care, but would want to reassure the Workgroup members that we structure the measure to support team-based care. So the measure, if the patient sees an NP, PA, specialist, really anyone but a primary care physician, that is not going to work against the physician and thus will not work against the ultimate score at the rolled-up level. And so the measure is structured that that team-based care is still there. And then even with, if they do see other primary care physicians, we've structured it where it is flexible.

As AAFP mentioned, the threshold is 0.7 at that patient level. But the two reasons there's more flexibility is the Bice-Boxerman index at the patient level. It is looking at not the percentage of visits with that physician, but how much are concentrated with the same physician versus concentrated with many other physicians. And so as long as you're mostly seeing your physician or the main physician, it will not result in you being dinged. So again, it doesn't have to be 100%, and it's more about focused care. Additionally, the physician-level score is an aggregate. So it is all your patients that hit 0.7 or above. And so if you do have a patient that is fluctuating and seeing multiple physicians all the time, it is not necessarily going to ding you overall. And so we've built in some of these structures into the measure to avoid dinging physicians for normal care that we're seeing today and still really encouraging team-based care.

It's also the physician that will be associated with that patient is the one they saw the most. So you know, we've talked about patient preferences. If the recorded physician is someone else than the person they're seeing the most, or if they are, you know, changing based on that year about who they're seeing the most, there is all that flexibility to really allow patients to see who they want to see and to allow flexibility and not create a detriment to access. It's a very patient-focused measure. We do incorporate telehealth into the measure. So it's not just only physically coming in, but, again, allowing those different ways of access. And I know there were some questions about why physician level versus a higher level.

The research that we're doing is, you know, continuity is really that relationship between that physician and patient. And when it goes beyond that to a practice level or a home level, you do lose a lot of the benefits of that relationship. I mean, that's what, you know, research has showed us. And then in terms of the updates that we're doing to the measure, none of those are final. It's more of a reassurance that we want to constantly evaluate the measure and make sure we are providing the best product for, you know, the measure that's going to be the most useful. So it's more of a we're going to continue to always look and see if there's other options, but those are just some of the things that we're going to consider every single time we consider is

just the right measure for the stakeholders and patients and physicians and larger groups. So hopefully I'm able to respond to some of those concerns that were brought up.

Caitlyn Newhard:

Thank you. That was helpful context.

David Kelley, I see your hand raised.

David Kelley:

Thanks. Dave Kelley, Pennsylvania Medicaid. Just a quick question for the measure steward. I was looking at the spec and it looks like the point of service 10 is not included, which is telemedicine, let's say from the patient's home. I think it does allow for point of service 2, telemedicine in a clinical site. Any reasons why I would say probably the more common mode of telemedicine is not included in the spec? Or maybe I'm misreading the spec. I would appreciate any clarification. Thanks.

Poonam Bal:

Of course. Zach, are you on the line? Could you respond to that concern?

Caitlyn Newhard:

Can we unmute Zach, please?

Zach Morgan:

I'm Zach Morgan. I'm a senior data analyst with ABFM and I was actually the one who ran this analysis. So I can't speak to the specific codes that were used for defining this cohort because the specification predated my work on this project. I will say, and I can't at the moment recall what there is for this work or subsequent work as we're continuing to evaluate the measure spec. But I do know we have talked about including telehealth going forward, and I believe we are. I just can't remember if this particular specification included that or not.

David Kelley:

Okay. Thank you.

Caitlyn Newhard:

Sarah Tomlinson.

Sarah Tomlinson:

Hi. Thank you. North Carolina doesn't like this data set. We feel like it's a bit too complex. And with us just voting in to add the *Adults' Access to Preventive/Ambulatory Health Services*, we feel like it's somewhat redundant and we would not support it at this time.

Caitlyn Newhard:

Thanks, Sarah.

Are there any other Workgroup members who would like to comment? Stacey Bartell.

Stacey Bartell:

Hi. I want to circle back and add that I think for those of us in practice, we sometimes forget how complicated it is to start fresh with a new patient every time you see them. And I think from a Medicaid standpoint, the patient would tell you the same thing, that when they go to see a physician or a provider, they want to make sure they're seeing the same person who already knows their story. And if you start fresh every time you go with a different person, some of that story gets lost and some of that care gets lost. And so you're constantly starting over for care. And at some point, you lose that benefit to the patient.

So this does support primary care physicians the most. But it also, I think, is super important to patients to build that relationship, to know that someone knows their charts, to know that things don't get missed, and to make sure that, you know, that relationship can be built of trust, that you trust the person you're going to see. So I just wanted to emphasize that that's that tug with access we're seeing right now from an employer standpoint. And we just want to reiterate that the relationship is also important. And we just want to make sure that the Medicaid population, who's probably at most risk for not having that benefit of their relationship, is not affected by it. Thanks.

Caitlyn Newhard:

Thanks, Stacey.

Are there any other Workgroup members who would like to comment before we move on to the public comment? Djinge? Djinge Lindsay?

Djinge Lindsay:

I am a family physician, so clearly just biased by specialty, but then also just a lot of – we are doing a lot of value-based or alternative payment models for advanced primary care in Maryland. And some of what I think about in considering this measure is I think it's driving the system towards what we know by research is optimal rather than adjusting our measures or how we assess quality based on what our current system is. And I heard a lot of people just kind of reiterate and emphasize the bevy of research there is around the importance of primary care and the importance of primary care and total cost of care and managing healthcare expenses.

And I personally believe until we have a good, adequate supply of primary care in the way that it has been, you know, researched to show that it's beneficial with that continuity that we're going to keep kind of spinning around as a population in the same circles of just acute care, sick care emphasis, right? And we're never really going to see cost savings nor population-wide measures. At the same time, though, great pause with understanding the significant workforce challenges there are as well as what we're going to start seeing with more churn of our population as some of the new Medicaid requirements go into effect.

Caitlyn Newhard:

Thank you.

Now we'd like to provide an opportunity for public comment. If you would like to make a comment about *Measuring the Value-Functions of Primary Care: Continuity of Care* 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 are done. We'll let you know when you've been unmuted.

Fiona, can we unmute Madison?

Madison Schaefer:

Hi, Madison Schaefer again from North Carolina. I think this is a really important area to measure and is a great step forward. However, I am hesitant to support a non-HEDIS measure that's not widely used by states already. I think it could end up being a fairly large administrative burden for states to calculate this for the Core Set. I know personally, if it's not a HEDIS measure, it doesn't go through our, you know, traditional NC3 HEDIS vendor for measure calculations. It'll have to be a state-calculated measure that we either have to contract with our EQRO to calculate or code internally, which is a big lift for our analytics team. I do think it's an important area, and obviously continuity of care is critical for everyone, but especially for Medicaid beneficiaries. I just wonder if this measure might be a little too new and a little bit too administratively burdensome to add.

Caitlyn Newhard:

Thanks, Madison.

Let's go to Gloria.

Gloria Beecher:

I think this measure is a step in the right direction. I do have maybe three questions, however. It wasn't quite clear to me if we're not including the mid-level providers who work with and alongside the primary care physicians, how the providers would get the credit for a visit. If we could share that again. Also, it's very important, that provider/patient relationship, and I see the value in that. But how do we account for those members who might elect not to have a second visit with the doctor they saw previously? How does that impact the physician?

He wouldn't get credit, and it wouldn't be because of his lack of continuity of care. I am often concerned about us holding physicians responsible for something that's not totally within their scope of control. If someone elects not to see a provider, they don't want to see that provider. And so what allowance is made for that if this measure were to go forward? Or folks move away, or they change plans, and so they might not see the same provider. How do we account for those cases?

Caitlyn Newhard:

Thanks, Gloria.

Poonam, are you able to help respond to any of those questions that Gloria had?

Poonam Bal:

Absolutely. So the first question about kind of other NPs, PAs, other ACPs that could be incorporated. So they would not count in the visit for the physician. So if the patient that is more frequently seeing that physician is seen by an NP, PA, et cetera, the visit just doesn't count in the denominator at all. It would only be if they saw a primary care physician. And then in terms of physician level and if a patient chooses not to see them again, again, it's based off of the physician that they saw most often instead of the recorded physician.

So if they started with one primary care physician and then decided that either it was not a good match or they had to move or, you know, what may come that, and then they switch to someone else, whoever they saw the most frequently. And then if there's a tie between who they see most frequently, it would be the one they saw most frequently and then the most recently. So there are all these safeguards in place to allow for, you know, patient preferences and changing and things that are out of the environment. And then while the measure is at the physician level, we really mean it is that physician-patient relationship and then rolled up to all the other levels. It allows those who have the power, such as health systems, health plans, et cetera, to make major change. They're able to get that physician level data because that's where continuity is most impactful. So not necessarily holding the physician accountable.

Caitlyn Newhard:

Thank you. That's helpful information Poonam.

Any other folks that would like to make a comment? Oh, let's see. Jessica Harley.

Jessica Harley:

Hi. Yes, that was helpful information, but it does give me pause from the MCO perspective, because when we are looking at incentive programs for our providers, we are assigning out a specific panel. So if this measure is looking at the provider that the member is choosing to see most frequently, it kind of goes against the assigned panels that we are giving providers and hoping that providers can work towards those panels throughout the year. So it does give me concern that it's not looking at the assigned provider versus who the member is choosing to see. I know we do put onus on that member to update their provider, but, you know, a lot of times that does not always happen. So it may be hard to implement from an MCO side if it's not based off of, you know, that provider attribution that's assigned.

Caitlyn Newhard:

Thanks, Jessica.

Stacey?

Stacey Bartell:

I think that's what we're inherently saying is that the way that we're assigning patients right now is not probably beneficial to the patient or the physician. And so if ultimately, in the end, what we're measuring is the person, how many times is the patient seeing the physician they want to see? We feel that that provides better care. It also provides better satisfaction for the primary care provider. So in terms of improving workforce problems, a lot of what you're seeing in primary care right now in the burnout is from, you know, the loss of the churn, right?

So you're being assigned patients you never see and held accountable for patients you don't see. And so we want to make sure that the patients you see are the ones you're held being accountable for. So actually, we think it fixes some of those problems that we don't believe in assigned panels. We want to actually see patient, you know, gets to choose their primary care provider and who they have. The relationship is important. The other thing I think with regard to reporting, and I think the steward measure could comment on this, is I think this is being reported through MIPS right now. I believe this is an option to report on this measure, and I could be wrong on that, but the steward measure may want to comment on that.

Caitlyn Newhard:

Poonam?

Poonam Bal:

Thank you. Yes, that is correct. This is a QCDR measure. That is an optional measure for MIPS.

Caitlyn Newhard:

Would anyone else like to make a comment, either members of the public or Workgroup members, anyone at this point, before we move on to voting? All right. I'm not seeing any hands, so let's move on to voting.

Next slide, please. Perfect.

Next slide. Okay. For our vote, should *Measuring the Value-Functions of Primary Care: Continuity of Care*, 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 the question does not appear on your voting page, please refresh your browser. All right. 26. We're getting there. 27. Just waiting for one more vote here. Thanks for your patience. Oh, there we go. I see we are at 28 votes. Thank you all. We can go ahead and close the vote and display the results here.

All right. So for the results, 79% of Workgroup members voted “no.” So the measure does not meet the threshold for recommendation. Thank you all for your vote.

I do want to take a few moments here and do a quick debrief just to get folks' take on how folks landed on their vote or if they want to provide any background to what went into their decision-making process. So I want to open that up to Workgroup members.

Is there anyone who would like to share some additional context? Chimene?

Chimene Liburd:

Yeah, thank you. Just listening to the comments from those physicians that are in practice helped me make sense of, you know, it looked like it could be an extra burdensome with having a similar measure, potentially duplicative. And so I think it's important that we, you know, keep in mind the potential burdens by adding measures like this. And I think to Dr. Lindsay's comment about, you know, in terms of changing the system as well as assigning patients and treating patients, we have to change the way we do things. And I think once we get there, then maybe we can look at something like this. But that was really kind of what helped me make my decision to say no.

Caitlyn Newhard:

Thanks, Chimene. That's helpful.

Dawn?

Dawn Alley:

I appreciate the evidence base around the importance of that relationship and the continuity with, you know, a given person. I, though, am concerned from, you know, work with Medicaid beneficiaries that where we are right now is that access is just so important and the role that NPs and PAs play is so critical for some people. Those really are their primary practitioner and they have an ongoing relationship with those folks. So I think there is just a real challenge in the context of where we are with workforce and shortage of, you know, excluding those from this measurement.

Caitlyn Newhard:

Thank you, Dawn.

Paloma?

Paloma Luisi:

Yes, I will echo those sentiments. The lack of mid-level types of data captured and what is included and excluded in the denominator raised some concerns for me. I would like to see this measure mapped out and applied to other states before considering voting on this again. I'm not sure how this would be captured, especially in some of New York's more rural areas. I have some concerns. So the evidence base and the need for this is high. I just need to see it applied in several other settings and claims data sets before voting yes on it. Thank you.

Caitlyn Newhard:

Thank you for your comment.

Laura?

Laura Boutwell:

Hi, good morning. This is Laura from Virginia Medicaid. I just wanted to echo Paloma's comments and circling back. I think what struck me, obviously incredibly important to talk about PCPs and the importance of continuity of care. And I believe it was Kim who brought up the importance of seeing this tested in Medicaid states and I know Paloma just made that reference as well. And I think that would be something that would be incredibly valuable because I do also appreciate the comments of where we are. I agree that access is really where a lot of Medicaid states are looking. I also agree with the idea of looking prospectively at where we want to be. So I think there's a lot of potential with this measure, but I would really like to see how it performs in Medicaid states and where it might move for the future for reconsideration.

Caitlyn Newhard:

Thank you, Laura.

Anyone else?

Well, thank you all for a great discussion this morning. With that, we're going to take a little bit of a break here and we are going to return at 1 p.m. Eastern time. So please be back at 1 p.m. Eastern time.

Thank you.

[Break]

Patricia Rowan:

Wonderful. Thanks so much, everybody, for joining us again. And welcome back from our break. We are now going to turn to this afternoon's discussion of the gap areas for the public Call for Measures for the 2029 Child and Adult Core Sets. Let's go to the next slide.

So each year, the Workgroup discusses measure gaps in the Child and Adult Core Sets to inform the Call for Measures for the subsequent annual review. Today, we will start with a targeted discussion related to immunization measures. As I mentioned yesterday, 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 as part of CMS's plan to engage with stakeholders to learn how new measures could capture person and family preferences related to vaccines.

After this discussion, Child and Adult Core Sets Workgroup will discuss other priority areas in the Child and Adult Core Sets following a round robin format with the Child and Adult Core Set Workgroup Members in the order listed on the roster. Lastly, we'll provide an opportunity for public comment on gap areas as well. Next slide.

Right. So at this point, I have the pleasure of introducing Caprice Knapp. Dr. Knapp is the Principal Deputy Director for the Center for Medicaid and CHIP Services, where she serves as the Center's senior policy and operational executive overseeing Medicaid and CHIP. She's joining today's meeting to provide opening remarks and kick off our discussion. Dr. Knapp, you have the floor.

Caprice Knapp:

Thank you. Thank you so much. Just by way of introduction, recognizing a lot of names on this call. But again, my name is Caprice Knapp. I'm the Principal Deputy Director at CMCS. Spent almost 10 years working in an EQRO. And so this has been a really great place to work with Deirdra and the team in Mathematica on Core Set. And as a state Medicaid director in North Dakota, I was always, of course, interested in the measures that were coming out and thinking through how we would use those, both in our contract work and what we were trying to do on the fee-for-service side. Really appreciate the conversation today. Again, a targeted discussion.

And as I'm listening, what I'm hoping to learn and what we're hoping to learn is thinking about when a child and when a family comes into that encounter with either their pediatrician, their family physician, in an FQ, what happens in that encounter? What kind of information is shared? Is it anticipatory guidance? Is it specific? What information is shared around vaccines? What data is collected? Are there things that go in the clinical record that people are collecting? And if so, what do those look like? And then finally, as we think through this, you know, what would it look like if we wanted to try to create measures and develop measures that would capture what happens in that encounter? So really appreciate the opportunity to listen in today. And if there are specific questions that you have for me or for the center, the center director, please let the team know and we'll take those back. But thank you.

Patricia Rowan:

Thank you so much, Dr. Knapp. We'll go to the next slide. So now we are going to begin our discussion by opening it up to both the Child and Adult and the Health Home Workgroup members. Workgroup members following up on that context that was provided by Dr. Knapp,

please share your perspectives and experiences on some of the targeted questions that I raised at the end of yesterday's meeting, and I'll repeat those now.

So we're looking for whether Workgroup members are aware of or using any metrics on person and family preferences or patient education related to vaccines, whether any states are already collecting information on this topic, and what considerations may be related to collecting and reporting information on person and family preferences and/or patient education consistently and reliably. So we're going to start our discussion today by hearing from Workgroup members who have experience with these topics in the context of state Medicaid and CHIP programs.

Please raise your hand if you wish to speak and we'll call on your name in turn. Child and Adult Workgroup members, you should be able to unmute and mute yourself. Health Home Workgroup members, raise your hand and we will elevate you to a panelist role so that you can unmute your line. Because we do have a number of new folks joining and CMS is here listening to the discussion, I would also just ask that you say your name and affiliation before making your comment so it's clear for those who are listening into this discussion. So again, we're going to start with hearing from Workgroup members from state Medicaid and CHIP agencies on both the Child, Adult and Health Home Workgroups.

I see a hand from Ann Zerr. Ann, go ahead.

Ann Zerr:

This is Ann Zerr. I'm an internist from Indiana and I am Medicaid Medical Director for Indiana. So I think that shared decision-making and consent is sort of implicit in these discussions. I think that people choose their providers based on some of their personal views. And as I think about administratively how we could do this in a way that wouldn't require chart audits or other things, I think that it is messy to think about how this information could be collected. But I do think that physicians, be they interns, pediatricians, family physicians, and advanced practice people, we really don't do things to people without discussing them with the parent, the guardian, and/or the person.

Patricia Rowan:

Thank you for that comment, Ann. David Kelley.

David Kelley:

Good afternoon, Dave Kelley, Pennsylvania Medicaid. One thing that we may want to think about is leveraging the CAHPS surveys. There's the ability to generate supplemental questions for both children and adults. And so that might be a standardized, if there's a standardized set of questions, supplemental questions, whether they're one or two questions, they would be done in a standardized way. You'd probably want to test them for validity. But that may be a way that you could gather that type of information. It would be, again, self-reported survey, but we use the CAHPS surveys.

Most states, not all states, but most states, but also most MCOs leverage the CAHPS surveys. So this might fit into – I know in Pennsylvania we do several supplemental questions, and there's always that ability to add maybe one or two questions. So this might be a mechanism to get that done without placing a burden on practices or trying to figure out, you know, new coding schemes.

Patricia Rowan:

Thank you, Dr. Kelley.

Rachel.

Rachel La Croix:

Hi. So I know, and I agree with Dr. Kelley's suggestions around potentially looking at ways we could leverage the CAHPS survey to ask some of those questions and get parent feedback related to shared decision-making and what kind of information they've been provided related to vaccines for consideration and that kind of thing. When I was thinking about that area as well, I was thinking self-report probably would be the best area for that, which would mean a survey, unless there's another way to capture that. But that might require either medical record review or access to electronic health records just to find confirmation of what physicians discussed with families, if there was any kind of signature requirement for families related to having received information related to vaccines and those kinds of things.

One area, I was looking at what our Florida Department of Health has out there, and they actually, this doesn't provide information specifically about the shared decision-making, although it does describe the types of information that are required to be provided to parents or recipients, adults who are receiving vaccines or considering getting vaccines. That does talk about that kind of information. But there are some data out on the website regarding immunization exemptions. And if I recall correctly, I think one of the gap areas related to vaccines that was mentioned in the State Health Official letter was looking a little more at folks asking for religious or medical exemptions. And it looks like those things are documented on forms that are submitted. So to the extent that those data are captured and might be available to be able to see what some of those rates are, those would be another potential data source for looking at family choices and decisions related to vaccines as well.

Patricia Rowan:

Thank you for that, Rachel.

I'm going to go to Jessica Harley next. And just as a reminder, folks, please do introduce yourself and your affiliation before making your comment.

Jessica Harley:

Jessica Harley with the Community Health Choice, Texas. I also previously worked with Texas Children's Health Plan here in Texas as well. And I've had a lot of experience with specifically the childhood immunization measure on the MCO side and the medical record review in which we would dig through medical records to find that evidence of immunization. And we often found with Texas Children's, one of the practices that they had in place was that signature to either receive or for refusal of vaccinations on there. And that was standard in every member's chart that went through and got immunizations from there.

So you know, I think to Rachel's point, I think it is something that is being done, but in its current state, it is more of a manual process that might be an administrative burden to review. It may be worth considering looking at if there is a way to capture it via LOINC codes or some type of coding mechanism that we are able to track more readily, especially with EHRs and transition to digital.

Patricia Rowan:

Thank you, Jessica. Just as a quick reminder, we're going to start. I see Dr. Beers, you have your hand up. We'll go to you. We're just going to first take comments from folks who are working directly with, for state and Medicaid and CHIP agencies. Any other Workgroup members, either from the Adult, Child or Health Home Workgroups, who would like to make a comment that work directly with state Medicaid and CHIP reporting? Not seeing any other Workgroup members, we did also want to provide an opportunity for other states. Oh, Dr. Kelley, I see your hand if you wanted to speak. Go ahead.

David Kelley:

I just wanted to make another comment. I think during the pandemic, there was actually a G code that was introduced. And I can't remember, I was trying to see if there was a state health officer letter that described its use, but I think it's G0312. And this is immunization counseling by a physician or other qualified health care professional when the vaccine is not administered on that same date of service. And I think in Pennsylvania, I think we pay $10 for that code. So that could be a way to, I'm trying to think of ways to do this where we're not burdening practitioners.

And I think earlier comments that physicians and their practices are most likely already doing this and they're having the discussion. But that code is specifically when there was a discussion and the individual caregiver, family, the patient decided that they did not want that immunization. So again, just wanted to bring that up that that has been out there and has been available. And I think that applies. It was brought up during the pandemic, but I think it applies broadly to immunizations in general.

Patricia Rowan:

That's very helpful. Thank you for sharing that, Dr. Kelley.

I also see – I saw a hand from Jeff.

Jeff Huebner:

Yeah, this is Jeff Huebner from Wisconsin Medicaid. I don't think we have any current initiatives in this space in Wisconsin. But just building on the discussion, I agree about the vaccine counseling code. That could be an option. I know in regards to CAHPS, I think it's a good idea from the standpoint that that's hearing directly from patients or members about what their experience is with their health providers. And I think there are some – I'm not sure if any states are using this, but I believe there are some questions currently about providers engaging in discussions about medications and whether they're the right choice for a patient.

I just want to also put out a caution, and I'm not saying that this conversation has framed it this way, but I am hearing it in some places that this sort of conflation with the idea of patient empowerment, education, choice, and the term “shared decision-making.” And the term “shared decision-making” in the health services literature as well as a lot of initiatives that health systems and clinicians are doing around the country really relates to a different type of decision that is about multiple options that might be equally good for the patient. Whereas in the case of a vaccination, I don't think we want to conflate that recommendation necessarily when there's generally strong evidence in most, if not all cases, for the patient and member and family to receive the vaccination. Of course, it's still their choice and of course clinicians are still providing vaccines in that way, but I just want to be cautious about that specific term and anything that would emerge.

I was trying to look and see, and I don't think there are in our Core Sets that's currently for Medicaid and not sure about other payers, if there are any other measures around shared decision-making. In the realm of preventive care, I know there's been consideration and maybe there is an NCQA measure that hasn't been adopted for the Core Set regarding lung cancer screening. But I'll say as a practicing clinician as well, the lung cancer screening shared decision-making tools and requirements that providers have to receive payment for a lung cancer screening that the patient elects to proceed with are pretty onerous. So again, and I appreciate CMS has always been increasingly paying attention to provider burden with these sorts of measures, so I think that's important too.

Patricia Rowan:

Thank you, Dr. Huebner.

Richard Holaday.

Richard Holaday:

Hi, good afternoon. Richard Holaday from Delaware Medicaid. So from Delaware's perspective, one challenge we're encountering as we work with Core Sets is how performance is presented and interpreted over time. And one of the biggest issues isn't just with which measures are included in the Core Sets, but how they're presented and used.

When measures are shown as isolated single year snapshots, it becomes difficult to distinguish true performance change from normal variation, particularly for measures with smaller denominators, et cetera. So as Delaware begins drafting its 2026 quality strategy, we found that longitudinal trending, specifically relating to the Medicaid dashboard that was created two years ago, we request that showing performance over multiple years in a single view would provide a much clearer and more actionable quality signal for states.

Patricia Rowan:

Thank you for that comment, Richard. We appreciate it.

Kim Elliott.

Kim Elliott:

Thanks. I really like David's idea, Dr. Kelley's idea about the use of the code and the potential that might have to really get to what we're trying to accomplish through this discussion. CAHPS is also a good idea, however, I do worry about the response rate that continues to be relatively low in most cases. So I think it's a good idea, but I think we'd have to look at ways to really try to get a better response rate on the CAHPS survey. Otherwise, I don't have any other really great suggestions right now.

Patricia Rowan:

Thank you, Kim.

I want to go next to Sural Shah, Dr. Shah from California.

Sural Shah:

Hi, thank you. So I'm from California Medicaid. I'm also a practicing internist and pediatrician, a primary care provider. I just wanted to look at, I really agree with the comments that Jeff made earlier. I do want to make sure we're careful about what our goal is with this and how it is framed and perceived. I do agree with the other discussions about what might be alternative ways if we do want to get at this. But I think one of the things that is occurring to me is that I'm interested in understanding more about why people are declining, you know, when we know what is recommended in terms of vaccine schedules and what is best from a health perspective. So just thinking through if there is a way to get at that question, either in addition to or separate from this question.

Patricia Rowan:

Thank you, Dr. Shah.

All right. We want to also provide an opportunity for representatives from state Medicaid and CHIP agencies who may be listening in as members of the public to weigh in on this conversation. And then we will go to broad Workgroup discussion. So if you are somebody from a state Medicaid or CHIP agency and you would like to weigh in, please raise your hand.

I see Laura Pennington has a hand up. Go ahead. Okay, Laura. We should be able to hear you now.

Laura Pennington:

This is Laura. Can you hear me?

Patricia Rowan:

We can. Please introduce yourself and state your affiliation.

Laura Pennington:

This is Laura Pennington from the Washington State Medicaid agency. I'm the quality measurement and improvement manager here. Wanted to follow up on Dr. Huebner's comment about cautioning the Workgroup. I really appreciate that. In Washington State, we have a shared decision-making program and we've worked with national and international experts to build that. And shared decision-making is really intended for preference-sensitive conditions when there's more than one viable option. So I did like David's suggestion about potentially using a counseling LOINC code. So I appreciate this conversation and, again, agree with Dr. Huebner and the other speaker that I would urge you to think about taking shared decision-making, that term out of your conversation related to vaccines. Thank you.

Patricia Rowan:

Thank you, Laura. If there are other representatives from state Medicaid and CHIP agencies who are attending this meeting as a member of the public or members of the Health Home Workgroup who would like to share, please raise your hand. All right. I am not seeing any other hands raised. So at this point, I am going to open this discussion up to the broader Workgroups, Workgroup members for both Adult/Child and Health Home. We will also have another opportunity for public comment.

Dr. Beers, Lee Beers, go ahead.

Lee Beers:

Wonderful. Thank you so much. I appreciate the opportunity. This is Lee Beers from the American Academy of Pediatrics. I think, you know, just a couple things to add. You know, one, I do agree with some of the prior Workgroup members' comments. I think Dr. Kelley mentioned the counseling code. That is definitely something that I think could be very useful here. And it is, you know, speaking sort of on behalf of what we're doing as an organization, it is something that we educate our members on pretty regularly. And so I do think that could be a feasible mechanism.

There are also some additional ICD-9 codes that could be useful in understanding sort of parents' reasons if they are declining vaccines for declining those vaccines. So I think those things could be helpful. You know, I think one thing that I would raise, though, is that I think this information is going to be most valuable in the context of really understanding sort of what the immunization rates are. You know, understanding those immunization rates helps us to understand, you know, where, you know, where there are decreases in vaccine uptake. You know, and really understanding that across states. Right? If it's a voluntary measure, you know, we won't necessarily know that across states, we'll get an incomplete picture.

And so what I might suggest is perhaps a hybrid measure where we are retaining the immunization core measures sort of monitoring, you know, vaccination rates, but also including pathways to document reasons for exclusions and reasons for exclusion and why children may not have been vaccinated. And I think doing some sort of hybrid type measure like that would really give us some very robust information and really help us to get to the goals that we're trying to achieve here.

I think the last thing I'll add is just, you know, obviously, you know, we and our members have a lot of experience. Dr. Knapp, you mentioned just really wanting to understand what happens in the context of the pediatric visit. And I think we'd be very happy to talk more offline about that. You know, I agree with one of the previous Workgroup members that that talking about vaccines and really participating in conversation with a family around sort of their goals and questions is a very routine part of our visits. And so I'd be happy to talk in more detail about that at another time if that's helpful.

Patricia Rowan:

Thank you so much, Dr. Beers. Other comments on this topic from Workgroup members.

Stacey Bartell, go ahead. And please, again, folks, just introduce yourself and state your affiliation, if you don't mind.

Stacey Bartell:

Hi, Dr. Bartell on behalf of the American Academy of Family Physicians. Thanks for the opportunity. The only thing I could add, and I also secondary everything Dr. Beers said, is that we do also give the VIS information sheets if you're asking about where we give education from. And we do document that those are given with regard to safety information that's given for all of the vaccines. And that's just standard of care, I believe, for most practices.

Also, in my prior role as a medical director, I did also participate in the VFC program. And that has a lot of data that they collect right now. And I'm not sure if that might be looking at where

some of that data comes from. But that data is collected right now by the states, I believe, in terms of safety monitoring of vaccines and getting vaccines and informed consent of getting vaccines. I do know that in my state, religious exemptions are only given at the county department level. They're not given at the individual physician level, which I do think takes a lot of, again, administrative burden off of the individual doctor to have to give that religious exemption. And I just think that that's been tremendously helpful for us in terms of giving vaccines to the right kids that need them.

The other thing is that the G 0312 code seems like a plausible way to monitor it. The only thing I would caution against is I know I've been in practice for more than 20 years, and I would say that we used to be able to document vaccine refusals in our EMR. But what it then did is it took it off of the quality list as something we should be addressing, which means the following year when the child came for their well-child visit, it wasn't even on the list to just discuss vaccinations. And that was problematic for us because we all know that we need to have that conversation every year with regard to vaccines. If the patient isn't ready in that moment today to have the vaccine, it doesn't mean they won't be next year. And that discussion probably needs to be had again. And even over time and even within months, parents will change their minds and bring children back in for vaccines.

So I think it was a good thing that that refusal was removed as a reason to opt out of the quality measure. I do think that, you know, it's just important to keep that in mind if we think about going forward. But I do think right now our process for all vaccines is always involving informed consent about the vaccines and always giving the vaccine information sheet to parents. And there used to be good CDC information that we could also give to parents on vaccines, which was super helpful. Understanding the scheduling of vaccines, how vaccines were given and what each individual vaccine was used for. And I found that helpful to support us in doing this work. Thank you.

Patricia Rowan:

Thank you so much for that comment, Dr. Bartell.

I'm going to go next to Dawn Alley.

Dawn Alley:

Thank you. Good afternoon, Dawn Alley. I'm Chief Strategy Officer, or excuse me, Chief Scale Officer at Impact Care. I participate in the Workgroup in my personal capacity as a former Medicaid beneficiary, family caregiver of a Medicaid beneficiary and health services researcher. I echo the earlier concerns related to applying a shared decision-making framework where it is not relevant based on the evidence.

I really like Dr. Kelley's idea of leveraging CAHPS. I did want to flag one concern related to the idea of using vaccine counseling codes. I certainly agree that providers should be compensated for their time related to that counseling. I am just a little bit concerned about any situation in which, you know, we're only billing or only, you know, where we're paying specifically for circumstances in which a vaccine is not delivered. And in an ideal world, you know, would want to see that vaccine counseling paid for regardless of the particular outcome of whether the individual receives the vaccine or not.

Patricia Rowan:

Thank you, Dawn.

Other comments from the Workgroup on this topic? Dr. Kelley.

David Kelley:

I did put in Slido. There are, as was mentioned, there are some CPT codes that could be used to compensate physicians and other providers for counseling based on the time that they spent. And then there is a CPT code if the vaccine is administered. And then I mentioned the G code that's more specific for Medicaid when it's not administered. So using some of these existing frameworks, there could be the construction of a quality measure again to at least capture a counseling component.

Patricia Rowan:

Thank you, Dr. Kelley. We've also taken note of the specific codes you shared in Slido, and we can include them in our draft report. So those are captured as well.

Dr. Zerr.

Ann Zerr:

I don't think in Indiana we pay for those counseling codes. And so a significant amount of fiscal would have to convince people to do that. And we know even for things as simple as pediatric developmental screening, we look at the chart and the physician clearly did it, but the code is not billed. So I do worry about data capture with using codes, and I don't know how many states actually reimburse for vaccine counseling. We include it as part of the preventive visit that the child gets. So not saying it's right or wrong. It's how we do it.

Patricia Rowan:

Super helpful. Thank you for that. All right. I'm not seeing any other hands raised. I do want to give maybe one more opportunity to members of the public from state Medicaid and CHIP agencies to part to make a comment on this topic.

I see a hand from Janelle White. Brice, could we unmute Janelle? And Janelle, please introduce yourself. It sounds like Janelle, maybe you are a member of the Health Home Workgroup. So thank you for being here.

Janelle White:

Yes, I am. Good afternoon. Thank you. And apologies. I think I missed my turn but had to join this meeting late due to a conflict. So just wanted to co-sign, double click on what some of my colleagues mentioned about the vaccine counseling code. In North Carolina, we realize a success using the vaccine counseling code that that has been mentioned a few times. And then also, I believe it was just shared before me that there are other codes that can be utilized. And it's not just if the individual chooses to not have the vaccine, it is the time spent. So again, just wanted to co-sign and share our experience in North Carolina using that vaccination code. Thank you. And then also being mindful of the administrative and documentation burden. Thank you.

Patricia Rowan:

Yes, thank you. Thank you for being here. Great. I am not seeing any other hands raised on this topic. And I want to thank everyone for being here and for engaging in the discussion. I want to

also again extend our gratitude to Dr. Knapp from CMS for joining us and kicking off the discussion. And at this point, we will turn to our broader discussion of priority gap areas in the Child and Adult Core Sets. And then after that, we will have an opportunity for public comment more broadly on any of these gap areas.

So let's go to the next slide.

So to facilitate our conversation about other priority gap areas, we are going to use a round robin approach and ask each Workgroup member to mention one gap area that they think should be a priority to address through next year's public Call for Measures. Workgroup members can also add support to a gap area that is mentioned by another Workgroup member. And as I mentioned yesterday, I'd also encourage the Workgroup to keep in mind MAHA priorities related to nutrition coaching, fitness and quality measures that support children's health outcomes.

We also know that there is always a lot of interest in gap areas related to maternal health outcomes, including maternal mortality. And for the purposes of this conversation, we really encourage Workgroup members to keep in mind one of the criteria for addition to the Core Sets, which is the prevalence of the condition or outcome being measured must be sufficient to produce reliable and meaningful state level results, taking into account Medicaid and CHIP population sizes and demographics. So think about just potential measures or measure concepts that would measure some of the intermediate outcomes related to maternal morbid… morbidity and mortality.

So let's get started. I'm going to have my team go back to the roster slide so I can keep track of who we're talking to. Thank you, team. We'll, as I mentioned, go in the order of the roster used for the roll call. So we'll hear first from our two co-chairs. Kim, why don't you go first?

Kim Elliott:

Thank you. I talk a lot with the different states that I work with as an EQRO, and maternal mortality in the Medicaid population continues to be a priority area for several of the states that we work with, particularly in the weeks immediately following delivery. We have an impact, perhaps measures supported by ACOG recommendations, of course, that are focused on perhaps earlier postpartum visits, follow-up visits within seven days of delivery for high-risk pregnancies, or maternity provider follow-up contact within three weeks of delivery. It's something that could maybe shorten how quickly you're able to follow-up on these high-risk pregnancies and maybe impact or reduce the mortality in the maternal space.

Patricia Rowan:

Thank you, Kim.

Rachel?

Rachel La Croix:

So looking at the priority gap areas that were identified last year, and I actually was going to mention maternal mortality as well. So I'll give a second vote for that one. And also just some additional maternal health outcome measures and thinking generally about that area, and the potential for some measures possibly around interbirth intervals or things that could impact the health of subsequent pregnancies for Medicaid women and infants. And so thinking about some of those types of measures and whether those might be available to look at using the CDC

WONDER data, like the other perinatal related measures that are already being used. The other area that I wanted to mention was really around behavioral health and looking at things like the screening for anxiety or for loneliness and isolation and thinking about how some of those things relate to other health outcomes, not just mental and behavioral health related, that may have impact on physical health outcomes as well.

Patricia Rowan:

Thank you, Rachel.

We'll go next to Dawn.

Dawn Alley:

Thank you. I would like to see development of measures that relate to duration of coverage or continuity of coverage as we enter a period where there may be greater instability in coverage. In general, I think that's important for us to be able to monitor. And also, given that the denominator is some of the other measures in the Core Set is related to, you know, are related to access or diagnosis or, you know, 12 months of coverage or those sorts of things, I'm just concerned about who may be out of the denominator and having some visibility into kind of who we're not capturing in some of those other measures.

So that would be the first area that I would mention. And then I would also like to mention an emphasis on person-centered goal attainment measures. I know NCQA has been doing a lot of work in this area initially coming out of the long-term services and supports arena and the idea that beneficiaries may have goals specifically related to physical function or independence, but those measures have now been tested also in behavioral health populations and a variety of populations. And I think they could apply really nicely to the emphasis on things like physical activity and nutrition and wellness where individuals may have, you know, a goal that is specific to them.

And those areas may not be as amenable to kind of one size fits all measures around things like physical activity and nutrition. But, you know, if someone can say, here is my physical activity goal or my weight loss goal, that there are a variety of ways of supporting folks in achieving those goals and capturing that information in a person-centered way. And I'll also note that the availability of those person-centered goal attainment measures would help with some of the issues that we were also talking about yesterday related to, you know, things like screening and referral and making sure that people are actually achieving, you know, their goals or having their needs addressed rather than, you know, simply getting a referral.

Patricia Rowan:

Thank you, Dawn.

Next, we have Erin Alston.

Erin Alston:

Yeah, I'm Erin Alston. I am the Workgroup member for the American College of Obstetricians and Gynecologists. And I guess I would first want to kind of point out the perspective that we currently have on maternal mortality measurement is that obviously it's an incredibly important topic that should be a primary focus in measurement in the future. But at current practice, it's incredibly difficult to do in a way that's feasible and meaningful to our members. And especially

with the CPT, the AMA CPT deleting the current maternity global codes, we'll see a very large upending of how maternity services are built and coded in the future. And I would be remiss if I didn't use that as a reason as to why we should maybe put pause on interest on other maternal related health outcome measures.

I think, again, that this is something that we can prioritize for focus and gap closing as these changes in how we've delivered care will be changing from the past 40 years to what we're doing now, kind of seeing where we land on the uptake for that, recognizing that a lot of Medicaid states have already done an unbundling process, but not all. So there will be a bit of a learning curve and an adjustment period in which a lot of states will be kind of understanding how the unbundling will function. But I do believe that from our organization's perspective in terms of wanting to give focus and priority to more gynecologic conditions, I think that there is a pronounced gap in measurement that is associated with menopause, either vasomotor symptoms or even something like osteoporosis, urinary incontinence, something that more so focuses on gynecologic conditions that are experienced in older women and people experiencing those types of conditions. And it would be a great gap to fill in the Adult Core Set in particular. Thank you.

Patricia Rowan:

Thank you, Erin.

I will go next to Stacey Bartell, Dr. Bartell.

Stacey Bartell:

Hi, Stacey Bartell on behalf of American Academy of Family Physicians. So I like the things that have been presented so far. We obviously always champion maternal mortality, so a three-month postpartum measurement. Anything in that to make sure we're getting patients in for visits. Sometimes family practice also does postpartum visits, not only for patients we see, but sometimes patients who can't get back to an OB/GYN because of the distance to care. So we're also very involved in that.

The person-centered goal attainment is a great one. There's a lot of those different types of measures out there being developed. Currently, right now, we have in the measure set that aligns with the healthier children goal is the one about education at each well-child visit, where we give education for exercise and education about healthy eating. So I think we are currently doing those goals right now, and I think those are being measured right now. I think the part that concerns me the most, again, as a practicing physician is, you know, the challenge of the people who are really outside the range on BMI. So what do we have to offer them, and what are we giving them, and what does that look like?

So again, that's more of, like, availability of services than measurement. But I feel like we can counsel, but if we aren't putting things in place to support those patients, like some of the newer medications, that group is being lost. And so the more we can do to impact patients in terms of self-management goals and meeting those goals, I think we would do the most good. So even things like giving people home blood pressure cuffs or CGMs or things like access to care, I find would probably be the most good for our patients in this population. So anything we can do to help that population would probably be the best.

Patricia Rowan:

Thank you, Dr. Bartell.

Do we still have Dr. Beers on the line? We may not.

Lee Beers:

Yes.

Patricia Rowan:

Go ahead.

Lee Beers:

I have just a little bit more time, but I'm glad that my last name is early in the alphabet. So thank you. Yeah, I mean, a couple things, gosh. I mean, even just a few people in, I think, really most of the things that I would raise have been raised. I'm very much in agreement with the focus on maternal health. And I think just to point out that, you know, infant and child and adolescent health is very deeply intertwined with maternal and family health. So this is an issue that is important to us at the American Academy of Pediatrics as well. I do also appreciate the focus on sort of person-centered goal setting and thinking about sort of how we measure and address that.

And then I really would also, the additional point I was going to raise, which actually Dr. Bartell just raised for me, is around counseling regarding nutrition and physical activity. You know, that is very much a part of the pediatric well visit and recommended through Bright Futures. And so that is absolutely a best practice. And I think, you know, the barriers really do come in resource availability within communities and the availability of fresh, healthy foods in places that are accessible and affordable to families. And so, you know, I think we'd be willing to sort of think more about additional measures to sort of help tease that out.

Though I would caution, again, as a practicing physician, you know, we want to make sure those measures are practical and feasible across all practice settings. But, you know, just do want to emphasize that that's a priority that we share and would be happy to continue to explore that. Thanks.

Patricia Rowan:

Thank you, Dr. Beers.

I'm going to jump around a little bit from the beginning and to the end of the alphabet because Bonnie Zima, I believe, has to leave early. Bonnie, are you able to unmute yourself and share your comments?

Bonnie Zima:

Can you hear me through the call-in feature?

Patricia Rowan:

We can, yes.

Bonnie Zima:

Oh, yay. Okay. So I'm on the old-fashioned telephone. Okay. You had mentioned earlier the MAHA report. And so I think that some areas that we could focus on is really around child

mental health safety. Again, continue, you know, identifying a gap in suicide risk. Also, seclusions and restraints on the inpatient unit, use of off-label use of psychotropic medication for aggression, and general safety monitoring for psychotropic medications. And even in the evidence, we really don't know, you know, how long to keep, for example, a child on an SSRI. So I think that those are potential visionary statements.

And I think in addition to gaps, I've really liked the way in our discussion there's been a lot of forward thinking about digital measures. And I think in that I'd like to take an opportunity to really comment on the potential to leverage advances in research informatics and EHR data science to address some of the limitations of approach to measuring adherence to national quality measures. And we hear them in the discussion over and over each year. And I really appreciate the perseverance of our Medicaid state directors and holding the vision. And, you know, no surprise to this group. You know, we hear a lot about burden on providers and agencies to collect data, concerns about variable data quality, the use of aggregated data over measurement years that's not really aligned to the individual's episode of care.

There's also been a lot of progress in thinking about stratification, but it's really only by social demographics. The level of analysis continues to be at the health plan. And, again, I think we're all in the same boat as far as acknowledging the need to have better clinical validity for our measures. And sort of thinking forward, and I understand this might sound a little futuristic, but an innovative solution could be, which is potentially scalable, is to develop vendor-neutral common data model automated search queries using structured EHR data to identify adherence to recommended care processes.

And there's actually advances in statistics now to use observational data to emulate randomized clinical trials to assess clinical validity. And I think with that forward thinking, it would take a lot of money. And so I think, you know, the more we can also do to really strengthen the partnership between CMS and NIH to give CMS the data they need to improve quality, which would be great. And I think that in this visionary statement, you know, the end product would be something that's nonproprietary, potentially scalable for providers, healthcare systems, health plans, and Medicaid state agencies. And I really appreciate your patience. Thank you.

Patricia Rowan:

Thank you, Bonnie.

All right. We'll go next to Laura Boutwell.

Laura Boutwell:

Hi. Good afternoon. This is Laura Boutwell from the Virginia Department of Medical Assistance Services and Medicaid agency here in the state. And I do want to first just co-sign Virginia has high priority on maternal health, maternal mortality and behavioral health measures. So I do appreciate those Workgroup members who have brought those issues forward. So in an effort to also bring a couple of additional measures, opportunities, I've been thinking a lot about a post-COVID world where we are focused on chronic condition management.

And while we have many measures in the, in the Core Sets that have focus on certain areas, there are a couple areas that I believe might have some opportunities. One would be allergy and allergy management, as well as look—especially in childhood, but also in adult populations—as well as potentially looking at arthritis or other chronic pain conditions that impact some of our older adults, and looking at overall holistic management of those long-term conditions. Thank you for the opportunity.

Patricia Rowan:

Thank you.

We'll go next to Matt Brannon.

Matt Brannon:

Good afternoon. Can you hear me?

Patricia Rowan:

Yes, we can.

Matt Brannon:

Okay. Great. I'm actually just going to throw out a plus one on two of these great ideas that have actually been presented. So you know, Kim and Rachel presented maternal mortality, and I'd like to give a plus one on that. And then the emphasis on person-centered goals, I'd also like to give a plus one on that one as well.

Patricia Rowan:

Thank you, Matt.

We'll go next to Joanne Bush.

Joanne Bush:

Hello. Good afternoon. I'm Joanne Bush with the Iowa Department of Health and Human Services. We do support maternity mortality and behavioral health measures, but we'd like to add one additional consideration for social determinants of health. Here in Iowa, we have started doing some work and working very closely with our managed care organizations on social determinants of health and see how that impacts, for example, unstable housing on the well-being of the children. How they manage chronic conditions and also food insecurities in adults and how that ends up into diabetic symptoms or hypertension. And so we would like to propose social determinants of health outcomes. Thank you.

Patricia Rowan:

Thank you.

I'll go next to Angela Filzen.

Angela Filzen:

Good afternoon, everyone, and thanks so much for this opportunity to share. I wanted to echo the sentiments of a few of those that have already been shared, specifically maternal mortality in the state of Mississippi. Currently, I'm in the capacity as a general dentist with one of the FQHCs in the state, but I previously served as a state dental director for Mississippi. And so this is a big issue in our state around maternal mortality.

But in addition to that, I also want to champion some of the other things that were mentioned around diet and nutrition, chronic disease management, because all of these really allow us to

work across disciplines. And it's very important, specifically with oral health and holistic care, because they impede that. So again, maternal mortality, something around nutrition and diet, because we do, as well as many other states, have a lot of issues around diabetes and management thereof, and also preventing that in, you know, children and adolescents, and then chronic disease management. Thank you.

Patricia Rowan:

Thank you, Dr. Filzen.

Let's go to the next slide, team.

And go next to Jessica Harley.

Jessica Harley:

Hello. Yes, I want to echo a few sentiments as well. First, for Dr. Alley's measure that she mentioned on the impact of continuity of coverage, I think this is going to be a very important one that we need to put some efforts into watching, and I know ACAP has done a lot of work around making sure there is continuous coverage for our children. But I think that's definitely something that needs to be added to the watch list.

And then also to echo Joanne's points on SDOH, I think there's opportunity, not with the SNS-E screening measure, but with the interventions measure, potentially looking at, you know, closed-loop process or potentially interval screening for members who've screened positive. So that way there's actual follow-up of, were the interventions put in place? Did they make an impact to meeting the identified needs? And then also in alignment with what Dr. Bartell and Dr. Beers shared with the nutrition and physical activity screening, I do think that is a widely standardized practice. However, in agreement, the follow-up of an abnormal BMI is an area of opportunity that might need to be explored further.

Patricia Rowan:

Thank you, Jessica.

We'll go next to Richard Holaday.

Richard Holaday:

So one thing we're thinking about in Delaware is how the Core Sets can better support understanding and change over time to help inform state quality priorities, especially as we begin using them more strategically. Many of the current Core Set measures are process-based, as we all know, which are often easier to specify and report, but they don't always indicate whether care actually led to better health outcomes. And over time, there may be opportunities to incorporate more outcome-oriented measures, particularly where ECDS-based measures or other linked data sets could support feasible and stable reporting across the state. Thank you.

Patricia Rowan:

Thank you. Now I couldn't get off mute.

All right. We'll go next to Dr. Huebner.

Jeff Huebner:

Yeah. Hi, everyone. I'm going to plus one chronic pain. It's such a huge prevalence in the Medicaid adult population, and there really is a paucity of good quality measurement out there. And I think especially the attention to patient-centered outcomes has been mentioned here a few times for different areas, and that's one where it probably would be well applied.

And I also want to mention that in regards to the current HHS priority around childhood obesity and outcomes, I think the current Core Set measure around weight assessment and counseling is, I'm guessing, maybe similar to the conversation we had around antibiotic avoidance for bronchitis yesterday. I'm not sure. I'm curious if other states are finding it helpful at this point, but I think it's subject to gaming. And what's really much more important is around what are those interventions available that are evidence-based to help kids and families hopefully achieve better health outcomes in that space.

Patricia Rowan:

Thank you, Dr. Huebner, and we'll go next to Dr. David Kelley.

David Kelley:

Thanks, and good afternoon. I'll plus one again for maternal mortality, but I'd actually like to expand that to maternal morbidity as well. I think there's, from a quality improvement standpoint, when you start to look at the number of individuals that actually experience morbidity, it's fairly high. And so I think that's something that we should even more broadly look at and try to think in terms of interventions. And along that note, I would think in terms of getting more granularity to current measures like prenatal care and postpartum care. What actually happens within those visits? Is there depression screening and follow-up? Is there tobacco screening and intervention? Are health-related social needs screened and referred for follow-up? Are there immunizations offered?

So I'd like to actually see more granularity within those prenatal visits. And then, obviously, same thing with postpartum visits. Obviously, immunization is not an issue there. But I think with the unbundling of some of the OB codes, this may actually be an opportunity to gather even more information. I think we should also look at medication-assisted treatment for individuals that are pregnant. We know that there's very good evidence that this is a standard of care for individuals with opioid use disorder during pregnancy. So, I think that is something, at least in Pennsylvania, that is, unfortunately, a huge driver of both mortality and morbidity. I also think within postpartum especially, but some prenatal, that we need to leverage remote monitoring technology, such as blood pressure monitoring. And especially, again, in those folks with known hypertension or preeclampsia, who are very high risk, who can have blood pressure monitoring. And not just, you know, who gets monitored, but what are some of those outcomes.

So I think there's some really good opportunities within maternal care that we can really take things to the next level. Some of this can be done with billing, coding, but obviously in the new digital age, I think there's even more opportunities to capture these types of data elements within maternal care. I'm going to turn to pediatrics. And again, I'm a general internist, so I'm, you know, I'm not a maternal expert. I'm certainly not a pediatric expert. So I'll be redundant somewhat. I think weight management, not just counseling, but weight management programs are something that we need to think in terms of.

In Pennsylvania Medicaid, we turned on some counseling and some codes for both behavioral health and for primary care physicians around weight management and counseling back in

2007. We continue to provide for those services. So I think it's an opportunity to not just screen and identify children that are at risk or overweight or obese, but to actually, what are some of the interventions that could be done and could be captured. I think also, you know, the social needs screening that we voted on yesterday to add, it would be interesting to look at food insecurity in the pediatric population. And again, think in terms of how can we get them food, but how can we get them healthy food? And then at least in Pennsylvania Medicaid, we do pay for nutritionists, dietitians to provide counseling.

And again, I think that's really important to be able to think in terms of what are some of the ways that we can work with our children to have them think and their parents to think in terms of healthier food choices. And then the last thing that – and this has been, I think I've stated this multiple years in a row. When it comes to ACEs, I think that there is an opportunity to look at adverse childhood experiences. There are codes that are now – and again, I know billing codes are not always the way to go, but there are codes. There are validated screening tools. There are G codes that can be used for folks that score over four.

And then not just, you know, did they get screened, did they have over four experiences, but is there follow up? So I think this is a really huge area, at least within pediatrics. Certainly, it could be you did that also and applied it to adults as well. In the Medicaid population, I think you'd see a lot of folks with scores over four. So I'll stop there and sorry for being redundant, but I've talked about ACEs for probably at least last year and probably the last two years. Thanks.

Patricia Rowan:

Thank you.

We'll go next to Dr. David Kroll.

David Kroll:

Hi, everyone. I also, you know, echo and agree with everything that's been said already. The one area that actually I want to just bring up a little bit is I think that we should just anticipate that a lot of what we take for granted about what access to care looks like, what health care delivery looks like and what value-based care looks like may be changing a lot over the next three to five years in the setting of AI. And I know that measures are sometimes, you know, can easily go out of date when the world is progressing really quickly.

And I would just urge measure developers and this group to keep an eye out for, you know, recognizing things are likely to change and look out for the ways that AI is likely to change care. I think where we're going to see some early changes is what access to care looks like in certain kinds of care. I wouldn't say care being replaced by AI, but certain kinds of clinical interactions and peri-clinical interactions being replaced by AI, as well as opportunities for AI to potentially gather and generate a lot more high-quality data.

And as these changes start to come about, I think that quality measures just anticipate that we may need to become in a position of thinking about, like, how do we measure the quality of that and particularly how do we measure the safety of those kinds of interactions and how do we use our quality measures to ensure that AI is not being used as a substitute for quality care where we need quality care. And just, again, I don't think we're in a position where we can really very clearly predict every way it's going to affect the way that we deliver care and measure care. But I think we should just be mindful of and anticipate that a lot's going to change pretty quickly and we should just try to be ahead of that as much as we can.

Patricia Rowan:

That's helpful. Thank you, Dr. Kroll.

Next, we'll go to Dr. Liburd Dr. Liburd, if you're still with us, you are muted. All right. We'll come back to Dr. Liburd. She may have stepped away for a moment. We'll go to Dr. Lindsay. Djinge Lindsay.

Djinge Lindsay:

Thank you. I will concur on the continuity of coverage. I think that will be very important as we move forward in assessing the trends and other quality measures as well. A gap area that I don't think we have a ready measure for, but I would just want to highlight, and some of this is driven by personal experience as a parent of third graders. But I'm very interested in how the health community will be able to help mitigate or prevent some of the impacts we're seeing on youth mental health due to screen time and screen addiction.

So just I think that definitely by the time we get to 2029, we'll have like more data about the impacts of these different video game systems and devices that have been in the hands of children for some years now. But I think that the early data that we're starting to see in the last year or so is very concerning. And, you know, those addictive behaviors and some of the changes in cognition are definitely going to impact other health outcomes as we move forward as a population. So I'll leave that there. Thank you.

Patricia Rowan:

Thank you. We'll go next to Paloma.

Paloma Luisi:

Hello. I concur with many of my colleagues' recommendations and thank them for their passionate ideas. We in New York have largely moved away from using *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*—it's a Core Set measure on the children's Core Set—as a pay-for-performance measure. It is included in pay-for-reporting type entities, but that measure is very high. The numerator is high because, and speaking with the clinicians and my colleagues in the New York State Department of Health, we found that that measure is easy to mark as completed.

So I believe an appropriate place for growth and development of a measure is in investigating how we can measure the current recommendations for physical health and then especially with related to childhood obesity, looking especially at the recommendations from the AAP. And then, again, looking forward to, you know, that we are looking very much in the future, we should be investigating how GLP-1-related and any other appropriate medications are also used for children. And again, I am not recommending any clinical guidelines for that measure. But just saying that we should look much more carefully at utilizing those recommendations into an appropriate measure that looks for interventions into childhood obesity. I also concur that we should be looking at ACEs and that we should be investigating how we can capture interventions like the HOPE intervention as recently described in peer-reviewed publications and even in the New York Times for children so that overall the health of children in America can improve. Thanks so much.

Patricia Rowan:

Thank you, Paloma.

We'll go next to Christina.

Christina Marea:

Hi, Christina Marea from American College of Nurse Midwives. Thank you. And I want to endorse a lot of what my colleagues have emphasized, particularly Dr. Kelley, several of the points that came up there. With a focus on maternal mortality and identifying and measuring some of the upstream causes, contributors or protective factors, particularly a continuity of care measure in the perinatal spectrum with inclusion from pregnancy through postpartum, early visits for postpartum and then some additional areas that I think are in development potentially for some measures, including specialist access.

So being able to, you know, people with risk factors for preeclampsia, eclampsia, are they able to access cardiology, endocrinology? Similarly, behavioral health screening and referral with some of that closed loop. And then we've talked and we voted on our measure today for social determinants of health. But I think for a lot of these, it's really important to have a linked measure, including case management, particularly in the perinatal spectrum for people who have elevated either medical risk, social determinant of health, or behavioral risk factors, that they are linked to a case management.

In addition to continuity, the NTSV rate, looking at C-section trends nationally. And then overall, as we're thinking of social determinants of health, and I apologize if I'm missing some of it, but the financial strain in health care, including difficulty getting to, paying for, scheduling visits. And then I just wanted to echo what a number of others have said, that the continuity of coverage is going to be really critical, given some upcoming changes in particularly both perinatal and non, menopause and GYN related conditions, substance use disorder and medication management, both for the general population, but for the perinatal population, screening for ACEs.

And then also just a note with some of the nutrition and other health promotion related measures that measuring those without an SDOH measure has a lot of problematic aspects to it, you know, promoting health and nutrition and physical activity if you are unable to buy food, access healthy outdoor spaces, have clean air. So ensuring that we're taking a perspective that brings in the financial and economic circumstances of the families to whom we are making these recommendations, because we know that unintended harms around health and nutrition counseling, including screening for disordered eating and some of that economic exclusion, can have profound impacts. Thank you.

Patricia Rowan:

Thank you. Do we still have Angela Parker on the line? Angela may have needed to drop. I'll go to Nicole Pratt.

Nicole Pratt:

So I'm not a medical professional. I'm a parent, but I, you know, work with a lot of families and I definitely want to echo the sentiments around maternal health. I know in New Jersey, we, over the last eight years, maybe 10 years, we've done a lot of work in improving maternal health, but there is definitely still a lot of work that needs to be done, especially around ensuring that especially women have access to good mental health services. That is definitely, I know it's

probably a struggle in many states, especially when it comes to Medicaid insurance and finding appropriate mental health care.

It's a struggle with private insurance, definitely a struggle with Medicaid, and especially around, I also want to add individuals with disabilities, whether it's children or young adults, and accessing appropriate mental health services for individuals with disabilities, and definitely echoing the sentiments around looking at measures on the social determinants of health. And as we've seen over the last many years, and I think someone mentioned, you know, since COVID, you know, it's definitely been a shift with the social determinants of health and, you know, with so many things changing so rapidly and people having access to those supports and services, and when going to the doctors, you know, the doctors really look at that as the whole family. Even if they're just going say for the child, but they're looking at the whole family and the type of supports those families may need and making sure that the insurance is able to help manage those cases appropriately and looking at the measures and how that's working.

Caitlyn Newhard:

Thank you. I am going to go now to Sara Toomey, who I believe you have to step away, so go ahead, Dr. Toomey.

Sara Toomey:

Yeah. Thank you. I appreciate it. I just want to thank all of the colleagues for their really thoughtful responses, and I echo many of what has been said. I think I'm going to call out specifically expanding maternal mortality to include sort of a more thoughtful conversation around morbidity, I think was a really important point, as was the need to rethink the weight control measure in particular in children as the screening and counseling really has not been adequate to drive the needed change. I also wanted to call out the importance of screening for ACEs, and I would also second including that. Another one that I wanted to call out is CGM. You know, while diabetes type 1 is not as common in pediatrics populations, we do find that there are many disparities in the rates of actually having children and adolescents on CGMs in regards to not only racial/ethnic disparities but also socioeconomic.

So I think that would be a very interesting measure. And then lastly, I wanted to just go back to our earlier conversation about vaccines. I really think that we need to double down that vaccines are extraordinarily important to care for our children. And I think at least speaking for pediatricians, I think the current climate and being able to figure out a way to better appreciate that these conversations are occurring and that while we're not penalizing our clinicians when patients are not getting the needed vaccines, I think it's going to be very important.

And then the last comment I'll just make is around Bonnie's comment around digital measures. I think the more that we can leverage using EHR-based measures, the better off we're going to be moving forward, that we will be able to get higher quality measures that will allow us to think more critically about the care that we're providing and outcomes for our patients and members. Thank you.

Patricia Rowan:

Thank you, Dr. Toomey.

Before we move on to the next slide, I wanted to see if Dr. Liburd is here and would like to share.

All right. Next slide. And now we will go to Dr. Shah from California.

Sural Shah:

Thank you for the opportunity to comment. I agree with a lot of what has already been said. I definitely want to lift up just the importance of vaccines and making sure that we are clear in our commitment to promoting evidence-based medicine. I also wanted to lift up the continuity of coverage issue. I agree that that is a major focus area and will be an area that impacts our ability to provide high-quality care across the board. I also agree on the nutrition counseling and physical activity counseling, in my experience, also a very easy measure to game. And so I agree with thinking through shifting that focus.

For the SDOH-related issues, I really appreciated our discussion on that during this meeting and agree we should be moving towards thinking through something that actually focuses on connection to resources. And even if that means narrowing the scope to focusing on specific services, you know, the suggestion around food insecurity I think might be helpful, but thinking through how to narrow that so that we can actually measure that appropriately and effectively would be, I think, a good start to making sure we're thinking through that issue. And then agree with the conversations around maternal mortality and morbidity.

I did want to add one other suggestion related to conversations from this meeting, and that was around how adults utilize primary care services. I think we all in this meeting had a good discussion about ways that we might want to think through that, how important having access to primary care is, in particular when we think about primary care access as it later relates to acute care utilization. And so I think just thinking through that would be really important. In the discussion we had today, I think one of the things that came up was, well, the continuity, right, having that percentage of visits with the same provider, that may be difficult. But what I still heard from everyone is this understanding that it is important for people to have access, not just to any ambulatory outpatient provider, but to their primary care provider. And so I just wanted to lift that up as something that I think warrants further discussion and consideration. Thank you.

Patricia Rowan:

Thank you. I'll go next to Bonnie Silva. Bonnie, you're still muted if you're trying to speak. All right. Let's go to Sarah Tomlinson.

Sarah Tomlinson:

Okay. Thank you. Great discussion. I just want to offer two votes for measures that have already been mentioned. Continuity of coverage, I think that's very important. And that would show quality health care. And chronic pain, which hadn't been mentioned much, but I think it deserves inclusion. Thank you.

Patricia Rowan:

Thank you. Let's go to Dr. Zerr.

Ann Zerr:

Hello. Well, I'm old, so I get to talk. So in 2004, Kurt Kroenke wrote this article called The Many C's of Primary Care. And what he found was that the average person had 15 actionable risk factors and 24 recommendations based just on the U.S. Preventive Services Task Force. So what that says to me is that the doctor in their office or the PA, NP is totally overwhelmed the

minute they walk into the office. And that was in 2004. And health care has gotten more complex. So I think we need some fundamental health care reforms.

And everybody on this call already knew that. But I think there's some really clever things. And I am actually very excited about what AI can do. And patients who are low-income, we know a lot of things that don't work. Right? And we also know that the group of people that we're discussing are more likely to be overrepresented by lots and lots of chronic conditions, be they physical health, mental health, et cetera. And so this group has to be better than any of us who are presumably middle class who go with reasonable health literacy, a car that starts and some people who love us. So this is really, really hard work.

And so I am really excited about the idea of value-based purchasing, covered lives, where this person needs 10 minutes, that person needs two hours, a little bit of the FQHC philosophy. But it has to be done in a way that meets the patient's needs. And most of what we've talked about are a little bit checkbox-y. And unfortunately, there are certain conditions in primary care that are very responsive to counseling. Weight, however, is not one of them. There's lots of data about programs. And, you know, even Weight Watchers now has a way to get to GLP-1s. So I think that it is just sort of everything everybody has said is accurate. It's my experience. And it's based on both my academic world as well as my practical world.

So I think that's the next place where measures have to go, which is how did we really help the person? And most of it can, and for now, the way we're set up and the way we're paid essentially is one patient, one visit. And that's been my entire nearly 40-year career. And so if a patient doesn't show up, I can try to call them. They've changed their phone. I can send them a letter. It's not going to be delivered. So it takes a huge team of people to meet the needs of these patients. But we don't do it. That's not how our health system is fundamentally organized. So without some major, major changes, in another 22 years, we'll have this exact same conversation. And so as I said yesterday, I'm all in for social determinants of health, but that cannot be the provider's, the prescriber's job, right? It takes a whole team to try to improve care. So anyway, I think that we're going to – and oh, the other thing about continuity, I rearrange the deck chairs and the schedules all the time to get the residents and faculty to have continuity. And I value it more than anything. But there are some generational differences in continuity.

My kids who are in their 20s, they could care less if they see the same people, but they don't have chronic conditions. So I think it's very different. And I wouldn't have done a good job for Rich Antonelli if I wouldn't have talked about the need for some care and some love wrapped around children, youth, and adults with intellectual and developmental disabilities and significant medical complexity. Because I think those people fall through the cracks, they see a lot of specialists, or they can't see any specialists, and they have a great need for specialists. So that was my huge soapbox about all these things are wonderful. It really is time for a major explosion in healthcare. And AI will help that. But I also think we have to be very respectful of generational changes, lack of technology for many of these people that we've been talking about. So I'm excited about the things, the work that we got done, but there's a whole lot of work left to be done.

Patricia Rowan:

Thank you for your comments, Dr. Zerr. You heard from Dr. Zima. So I think, David Zona, that leaves you. Probably had a lifetime of being last on the alphabet list, huh? David Zona, are you trying to speak? If so, you're still muted. All right, I'm going to go back also to Dr. Liburd. I see you're back with us. Go ahead, Dr. Liburd.

Chimene Liburd:

My apologies. I had to run to the restroom. You know, having been in this world – oh, can you hear me? Can you not hear me? Hello?

Patricia Rowan:

Yeah, we can hear you.

Chimene Liburd:

Oh, sorry.

Patricia Rowan:

We can hear you.

Chimene Liburd:

Having kind of been in this Medicaid space for a couple of years, I'm still fairly new to it. But having been a practicing physician, both in internal medicine and lifestyle medicine, the areas where I think we need to focus on is really on prevention. And so as we move forward, you know, this is more forward thinking and probably not something that will happen soon. But at least, you know, from my perspective, what I'm trying to do is get those things covered that make sense in terms of promoting prevention and allowing providers to get paid for the time that they spend in counseling on weight, tobacco, exercise, et cetera, in addition to promoting healthy lifestyle and eating.

And so from a measure perspective, you know, is it the chicken before the egg? Do we start talking about and mandating specific things? In my mind, that the six tenets of lifestyle medicine have merit. And so how do we, one, get payers like the managed care organizations to start thinking from a value-based perspective and reinforcing that with incentive payments and/or requiring certain things to be done and potentially having some type of, I don't want to say punitive, but requirements to force prevention? We are, you know, continuing around chasing diseases. And with, you know, with the GLP-1s, for example, we need to think about and start talking about and promoting healthy behaviors.

And so does creating certain measures that will force that, is that where the gap is and how do we do that? So that's kind of what I've been thinking about over kind of listening to at least some of the primary care measures that were proposed. I just think we have to start thinking differently and forcing others to do the things that need to be done to really change this health care system that is extremely complex. And it is, for folks that are vulnerable, it's very difficult to navigate. And we have to make it less difficult and seamless in order to promote healthy behaviors and reduce the disease burden we have in this society. So that's my overarching kind of thought process as I've listened to some of the comments today. Thank you.

Patricia Rowan:

Thank you. Let me circle back and see if David Zona is with us and wants to share. All right. David may have needed to step away. So I want to thank everybody for your contributions. This conversation is always so thoughtful and you all come prepared. So thank you so much for participating in this discussion. We'll go to the next slide.

And now we'd like to provide an opportunity for public comment on the gap areas in the Child and Adult Core Sets. This can be both related to the earlier discussion about immunization measures as well as other priority gap areas in the Core Sets. If you'd like to make a comment, please use the raise hand feature in the bottom right section of the participant panel to join the queue and lower your hand when you're done speaking. We will let you know when you've been unmuted. So I will open it up now for public comment.

All right. I see a hand from Gloria Beecher, Fiona. Okay, Gloria, you should be unmuted. Please introduce yourself and state your affiliation.

Gloria Beecher:

Are you hearing me?

Patricia Rowan:

Yes, we can hear you.

Gloria Beecher:

Okay. So I'm endorsing all the suggestions that were made. Too many to call up, but I wanted to particularly mention the suggestion to begin to look at outcome measures. It's very easy to check the box. So the effort to flip the measures, modify them so the outcome, for example, your weight counseling could look at percentage of members reporting a weight loss given in number of pounds. But getting to that level of granularity is going to demand data beyond claims. It's going to need direct contact with medical records.

And I don't know if a survey has been done or if at this point we can speak with any certainty that every provider has electronic medical record with the capability of having data fields from which we can obtain such kind of granular data. So that's something else to consider. Also, I would dare to suggest that probably the Core Set could begin to increase the number of measures that could be used in the inpatient setting. Especially I'm speaking specifically to the effort to determine measures for programs like the hospital direct provider program, the DPP. It's very difficult to use any current Core Set measures for that program. And I'm almost sure CMS would like us to pull from Core Sets. But the measures we have currently are overwhelmingly more indicated for the outpatient settings. So just a bug in the ear of measure development.

I also like the idea of going back to the continuity of care. I think it was Dr. Toomey who brought up that the population we're working with now, population of beneficiaries of Medicaid are not keen on necessarily seeing the same provider every time. They just want to see someone, get it over and done with. They have no loyalty, no commitment. So yes, while the older members might want to see their doctor, quote unquote, I don't know if that's a general statement and should be applied across the generations that we deal with. I like the idea, too, of revisiting the postpartum care measure to close the gap between – I think, the range for follow-up care is too wide. So considering hard data and practice that most of your mortality and morbidity occurs in the earlier weeks post-delivery. And so if we don't change the measure, at least consider modifying the follow-up period that we have based the current measure on. Just thought I would share those two. Thank you.

Patricia Rowan:

Thank you so much. All right. I am not seeing any other hands raised for public comment. And given the time, I am going to move along. So thank you, everyone, for your comments today. And now we have come to the reflections part of the meeting. So we can go to the next slide.

So this slide has a quick agenda for this part of the meeting. So to begin, I'm going to recap the Workgroup's recommendations for updating the Core Sets. The Workgroup discussed seven measures over the last two days, including one measure for removal and six measures for addition. As a reminder, to be recommended for removal or addition, a measure requires a "yes" vote from at least two-thirds of the Workgroup members. Thank you, everyone, for managing with the voting technology in this virtual environment. We appreciate it. I think you all hit a new record for the quickness of the voting. So appreciate everybody sticking with us. To recap the votes, the Workgroup did not recommend removing the *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis* measure from the Child and Adult Core Sets.

And of the six measures that were suggested for addition, the Workgroup recommended adding four measures to the Core Sets. So the measures that are recommended for addition are the *Follow-Up After Acute and Urgent Care Visits for Asthma*, *Tobacco Use Screening and Cessation Intervention*, *Social Need Screening and Intervention*, and *Adults' Access to Preventive/Ambulatory Health Services*. The other two measures that were discussed and voted on were, the *Antibiotic Utilization for Respiratory Conditions*. That measure did not meet our threshold, and so it is not recommended for addition. And finally, the Workgroup discussed the *Measuring the Value-Functions of Primary Care: Continuity of Care* measure. And that measure also did not meet the threshold and is not recommended for addition.

We also had a really robust discussion on gap areas to inform the 2029 public Call for Measures. We will use this input as we plan for next year's public Call for Measures. And now we always want to give an opportunity for the Workgroup to reflect on this year's review process. And in the spirit of continuous quality improvement, we'd like to give folks an opportunity to suggest things that our team could do to improve the review process for next year. These may be suggestions in terms of the meeting, the previous two meetings we held—the orientation meeting and the preparation meeting—the Call for Measures process, the resources provided by Mathematica, or anything else that comes to mind.

So I will open it up for Workgroup discussion on that topic. If you have a comment, please feel free to raise your hand. All right. I am not seeing any hands raised. I am not going to take that as proof that we did everything perfectly. But I will say you all know where to find us. And one of these upcoming slides will include our team's email address to make sure that if you do have any thoughts on ways the process could be improved, we hear that feedback. And actually, I do see Dr. Liburd's hand up. Go ahead, Dr. Liburd.

Chimene Liburd:

You know, you guys do a really good job in terms of the preparation before and during in terms of the flow of the meeting. The voting, I think, if I remember last year, it was different. Maybe I'm just not remembering. And it's a little hard. I was having some difficulty at times trying to use my phone and then have the computer, you know, kind of paying attention on the computer and making sure my phone refreshed. So I'm not sure if there's a way to do voting in the actual WebEx to make things maybe easier. But, I mean, that's, you know, that's minor. I think overall, though, the meeting was well run and you all provided all of the necessary information to be able to vote and provide the feedback accordingly. So thank you.

Patricia Rowan:

Thank you for that feedback. Every year we do assess our voting platform, so we really appreciate the feedback. All right, I don't see any other hands raised. Like I said, I want to thank you, everybody, for your feedback. We really do take your feedback and your suggestions very seriously as we begin the planning process. As you can imagine, a lot goes into each year's review cycle and, you know, probably tomorrow the ink won't even be dry on this meeting and our team will be preparing for next year already. So any other suggestions, please feel free to reach out to us. We will also be sending out a post-meeting evaluation form for you to fill out if you'd like to share any additional feedback anonymously with our team.

Next slide. All right, I do want to provide one last opportunity for public comment on any of the topics that have been discussed over the last two days. So if folks in the members of the public would like to make a comment or ask a question, please again use the raise hand feature in the bottom right corner of the participant panel. All right, I'm not seeing any hands, so we can move on to the next slide. All right, so as I begin to wrap things up here, I do want to, again, thank our Workgroup members for your flexibility and patience in conducting this meeting. We know that sometimes folks have audio issues or technology concerns, and we appreciate everybody's patience as we worked through all of those topics.

Next slide. I'd also like to call on our co-chairs, Kim and Rachel, to provide any final remarks. So we'll start with Rachel.

Rachel La Croix:

Thank you. First off, I'd just like to thank Mathematica for all of the preparation work they did for this meeting, for keeping us on schedule, and really doing a great job facilitating discussion of all of the measures and the gap areas and keeping us moving on making important decisions around the recommendations for changes to the Core Sets. I'd also like to thank all of the Workgroup members, as well as the folks from other states who are not members of the Workgroup, but shared some of their experiences with some of the measures as well. All of that really added to the conversation and items that we were able to consider as we thought about the different measures and potential changes to the Core Sets.

Also, thank you to other folks that shared information during the public comment sections. We really appreciate everyone's participation and interest in these meetings and all of the work going into really trying to make the Core Sets as comprehensive, but also feasible for states to be able to collect and report on these measures and use them for quality improvement activities moving forward. So thank you, everyone, for a great meeting. And I will turn it over to Kim.

Kim Elliott:

Thank you, Rachel. I also want to thank everyone for a very productive Workgroup meeting. All meetings are productive when we get together. I thought this one was particularly productive. Our work has a real impact on measuring the progress of improving the health and well-being of the individuals served by Medicaid and CHIP. Our discussion kind of reflected that. It was a real robust discussion.

What continues to impress me throughout the Core Set Workgroup meeting is the passion that's demonstrated by each participant for the purpose of strengthening the Core Sets. The thoughtful and informed approach to the discussion was really impressive today and yesterday. Each Workgroup member considered multiple factors, including the relevancy, desirability, viability, feasibility of the measures that were being discussed. The discussions also focused on

the ability to report the measures such as and also things like intervention options and whether measuring will improve outcomes for the Medicaid and CHIP populations. The application of subject matter expertise of Workgroup members resulted in informed recommendations. At least, I think they were really good recommendations for CMS's Core Set consideration.

Throughout the discussions we heard about the member, the member's voice, and how a measure may impact the health and well-being of the member and how quality and access to care may be improved by measuring the various aspects of care. I recognize and thank everyone for the commitment that it takes to participate in these meetings. I appreciate the work that everyone takes to prepare for the meeting, to recommend changes to the Core Sets, the thoughtful review process, and consideration of the impacts to members, providers, health plans, and states. I sincerely thank you, all the Workgroup members, Mathematica and the great job that you always do, CMS and other state and federal partners, the public that participated in the Workgroup meeting, and to the state Medicaid agencies and their partners who have the heavy lift resulting from the Workgroup recommendations. So thank you, everyone.

Patricia Rowan:

Thank you, Kim and Rachel. We appreciate all of your support as our co-chairs. Next slide.

So by now, this slide looks probably pretty familiar to you. It lays out the key milestones for the 2028 Core Set Annual Review process. Our journey began back in August 20th of last year when we convened the group for the first time and continued on January 14th with our webinar to prepare for this week's voting meeting. We're really grateful for all the time folks have taken to prepare for this meeting and really that you've spent the better part of two days with us.

Our next step as a team here at Mathematica is to review and synthesize the discussion that occurred over the last two days and prepare a draft report. The draft report will be made available for public comment and Workgroup members will have an opportunity also to review and comment on that report during the public comment period. Our team will then review all the public comments and finalize the report for release. And from there, CMS will review the final report, obtain additional input from interested parties, including other federal agencies and state Medicaid and CHIP quality leaders. Then the 2028 Core Set updates will be released.

Next slide. If you have any questions or feedback for our team about the Child and Adult Core Sets Annual Review process, our email address is here on the slide. It is MAC – M-A-C, as in Medicaid and CHIP, M-A-C – MACCoreSetReview@mathematica-mpr.com. All of us on our team will see those emails and we'll be sure somebody gets back to you quickly.

Next slide. Finally, one last thank you to all of our Workgroup members, our federal liaisons, measure stewards, CMS, and public attendees for your contributions to this meeting. Thank you to everyone who contributed to the process. And again, just a special shout out to our Mathematica team. This meeting would not have been possible without every single one of your time and effort and help. So I wish everybody well. I look forward to seeing folks again for next year's process. And that concludes the 2028 Child and Adult Core Set Review Annual Workgroup meeting. This meeting is now adjourned. And have a good rest of your day, everyone.