2027 Child and Adult Core Sets Annual Review:
Meeting to Review Measures for the 2027 Core Sets, Day 1 Transcript
February 4, 2025, 11:00 AM – 4:30 PM ET

Talia Parker:

Good morning, everyone. My name is Talia Parker, and I am pleased to welcome you to the 2027 Child and Adult Core Sets Annual Review Meeting to Review Measures for the 2027 Core Sets, Day 1. Before we get started today, we wanted to cover a few technical instructions. Next slide, please.

If you have any technical issues during today's meeting, please send a message through the Slido Q&A function located in the Slido panel on the bottom-right corner of your screen. If you are having issues speaking during Workgroup or public comments, please make sure you are also not muted on your headset or phone. Connecting to audio using computer audio or the "call me" feature in WebEx are the most reliable options. Please note that call-in only users cannot make comments. If you wish to make a comment, please make sure that your audio is associated with your name in the platform. Next slide.

All attendees have entered the meeting muted. There will be opportunities during the meeting for Workgroup members and the public to make comments. To make a comment, please use the "raise hand" feature in the lower right corner of the participant panel. A hand icon will appear next to your name in the attendee list. You will hear a tone when you have been unmuted. Please wait for your cue to speak and remember to mute your line when you are done speaking. Also, please lower your hand when you have finished speaking by following the same process you used to raise your hand. Note that the chat is disabled for this meeting. Please use the Slido Q&A feature if you need support. When you send us a question via the Slido Q&A feature, your question will say, "waiting for review." Our response will appear under your question.

Closed captioning is available in the WebEx platform. To enable closed captioning, click on the CC icon in the lower left corner of your screen. You can also click Ctrl-Shift-A on your keyboard to enable closed captioning. Next slide, please.

And with that, I will hand it over to Tricia to get us started.

Patricia Rowan:

Thanks, Talia. Hi, everyone. My name is Tricia Rowan, and I am a Principal Researcher here at Mathematica. It is my pleasure to welcome you today to the 2027 review of the Child and Adult Core Sets. Thank you to our Workgroup members, federal colleagues, and members of the public for joining us for today's virtual meeting. Next slide.

I do want to take a moment to acknowledge my colleagues here at Mathematica who have been instrumental in preparing to host this meeting today. It has truly been a team effort to prepare for this meeting, both in terms of content and logistics. I also want to acknowledge our colleagues at Aurrera Health Group who will be helping writing the report summarizing today's Workgroup discussions and recommendations. Thank you to the team. Next slide.

We have a full agenda and important objectives to accomplish over the next two days. Our four meeting objectives are listed here on the slide. First, the Workgroup will discuss two measures that were suggested for removal and six measures that were suggested for addition to the Child and Adult Core Sets. Second, the Workgroup will vote on the measures that were suggested for

removal or addition and make recommendations for updates to the 2027 Core Sets. Third, the Workgroup will discuss gap areas in the Core Sets which will inform the 2028 Public Call for Measures. This discussion will take place on the second day of the meeting tomorrow. And before we wrap up today, I will preview our plan for this gap discussion. Finally, we will provide multiple opportunities for public comment over the next two days which will inform the Workgroup discussion.

I would like to pause here for a moment and note that our team is committed to a robust, rigorous, and transparent meeting process even using this virtual format. That said, we acknowledge that attendees may experience challenges, and we hope everyone will be patient as we do our best to adhere to the agenda and fulfill the objectives of the meeting. Some of you may be wondering why we are not using video for this meeting. We have mentioned this over the last few years, but we found that some individuals in some locations do not have sufficient internet or Wi-Fi bandwidth to support video. And so, to ensure full participation by Workgroup members and the public, we want to mitigate those technical difficulties that sometimes arise with using video.

I also want to remind the Workgroup members of a few ground rules for participation today.

First, we acknowledge that everyone brings a point of view based on their individual or organizational perspective. As a Workgroup, however, you are charged with recommending Core Set updates as stewards of the Medicaid and CHIP program as a whole and not from your own individual or organizational perspectives. Please keep this in mind during the discussion and voting. Second, the meeting today is focused on discussing the measures suggested for addition to or removal from the Core Sets. We will not be discussing CMCS policies, and CMCS is joining us today in listening mode. Additionally, we know that spending several hours a day in a virtual meeting can be challenging for all of us. We ask that you be punctual in returning from breaks so we can have everyone present for the discussion and voting. And related to that, we want to make sure that all Workgroup members who wish to speak may do so. This platform will not enable you to mute and unmute yourself when you want to make a comment or ask a question, so, as Talia mentioned earlier, please use the “raise hand” feature in WebEx if you would like to speak or contact us through the Q&A – Slido Q&A feature if you are having technical difficulties and we will make sure we have a chance for you to speak before we move on. Finally, we want to remind public attendees that we will have opportunities – designated opportunities – for public comment throughout the day, and we ask that you save your comments until we reach those periods. Also, please note that we will not be accepting public comment through the Q&A feature.

Now I would like to turn it to our Workgroup co-chairs Kim Elliott and Rachel La Croix to offer their welcome remarks. I think Kim, you are up first.

Kim Elliott:

Thank you. I would also like to welcome you to the Orientation meeting. I am very happy to join all of you and happy to co-chair this Workgroup with Rachel. I would like to welcome the Workgroup members, federal partners and liaisons, stakeholders, and the public. Thank you for carving out the time in your busy schedules to focus on strengthening the CMS core measure sets. I am looking forward to a very robust discussion of each of the measure recommendations that we made for removal or addition to the Sets. As we prepare for this meeting, our unique experience, expertise, and knowledge will be an asset to these discussions. invited and welcomed members of the public to suggest measures to add or remove from the Core Sets,

and I believe very strongly that this diverse perspective from all of the people that participated in the process will result in very thoughtful and meaningful recommendations for the Core Sets. The results from the Workgroup have a significant impact on states, particularly for mandatory reporting and the resources that are needed. Our thoughtful approach to our work over the next two days will consider the value of the measures in indicating or estimating the quality of care for services provided to Medicaid members, the prevalence of the measure conditions which results in reliable and meaningful results across strengths. The strengths' accessibility, accuracy, and completeness of data needed to calculate the measures. And the actionability of making improvements in care and outcomes. Thank you for your commitment to our work over the next two days. And now I would like to turn it over to Rachel for her remarks.

Rachel La Croix:

Thank you, Kim. I echo Kim's and Mathematica's welcome to everyone attending and participating in this Core Set Review Workgroup. I am really looking forward to our conversation over the next couple of days, and I appreciate all of the thoughtfulness that went into the recommendations for removal and additions that were submitted for us to review during this Workgroup meeting over the next couple of days. Again, as the Mathematica team put together all of the resources for us to prepare for this meeting, again this year I would just like to thank them for all the work that went into that. All of the materials were very helpful in preparing for the meeting and being ready to have a robust discussion of the measures, so that, as always, is invaluable. And I really look forward to our conversation over the next couple of days. So, welcome, everyone.

Patricia Rowan:

Thank you, Kim and Rachel, we appreciate your remarks. Next slide.

Now we will introduce the Workgroup members and any disclosures of interest. Next slide.

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

When we go through the roll call, we ask that each Workgroup member raises their hand in WebEx when their name is called. You should hear a tone when you have been unmuted by the event producer. Please ensure that you are not also muted on your headset or phone. When we unmute you, you can say hello, share any disclosures you have or indicate that you have nothing to disclose. And when you are done, you can mute yourself in the platform and lower your hand. And when you would like to speak later during the meeting, just use that "raise hand" feature again and we will unmute you then. Next slide.

All right. On the next four slides we have listed the Workgroup members in alphabetical order by their last name. When I call your name, please use that "raise hand" feature so we can unmute you. If you have also muted yourself on your headset or phone, please remember to unmute your own line so that you are not double muted. And if you have any technical issues, please

use the Slido Q&A function for assistance and we will – we will get back to you if you are able to come off mute. So, Kim, starting with you, we will have you come off mute and indicate whether you have anything to disclose.

Kim Elliott:

Hi. I have nothing to disclose. Thank you.

Patricia Rowan:

Thank you. Rachel? Go ahead, Rachel.

Rachel La Croix:

Okay. I have nothing to disclose.

Patricia Rowan:

Great. Thank you. Benjamin. Ben Anderson? Go ahead, Ben, you should be able to -

Benjamin Anderson:

Families USA. Nothing to disclose.

Patricia Rowan:

Thank you. Next, we have Richard Antonelli. Richard. Derek, can we unmute Richard? Go ahead.

Richard Antonelli:

[Rich] Antonelli. No disclosures.

Patricia Rowan:

Next, we have Palav Babaria. I don't know if Palav is here today. Do not see Palav.

Okay. Stacey Bartell. I know Stacey is having some audio connection issues, so we might – we will come back to Stacey.

Laura Boutwell. Go ahead.

Laura Boutwell:

Can you hear me? I'm sorry.

Patricia Rowan:

Yes, we can hear you now.

Laura Boutwell:

Right. Thank you. I have nothing to disclose.

Patricia Rowan:

Great. Thank you. Next, we have Matt Brannon. Go ahead Matt.

Matt Brannon:

I have nothing to disclose either. Sorry.

Patricia Rowan:

That's okay. Next, we have Emily Brown. Go ahead Emily.

Emily Brown:

Hi. I have nothing to disclose.

Patricia Rowan:

Great. Thank you. Next, we have Joanne Bush. Do we have Joanne? All right, we can come back to Joanne.

Do we have Stacey Carpenter?

Remember to use the "raise hand" feature.

Oh, there is Stacey. Can we unmute Stacey?

Stacey Carpenter:

Nothing to disclose. Thank you.

Patricia Rowan:

Great. We will go to the next slide. Next, we have Roshanda Clemons. Okay, go ahead. Roshanda, can you hear us?

Roshanda Clemons:

I can hear you. Can you not hear me?

Patricia Rowan:

Now we can hear you. Yes, go ahead.

Roshanda Clemons:

Good morning. I have no disclosures.

Patricia Rowan:

Wonderful. Thank you for being here.

Next up we have Lindsay Cogan. Do we have – oh, yep, I do see Lindsay. Can we unmute Lindsay, Derek? Go ahead Lindsay.

Lindsay Cogan:

Good morning. I have no conflicts.

Patricia Rowan:

I also see Erica David-Park. Can we unmute Erica? Go ahead. Go ahead, Erica. Let's try to unmute Erica again. Go ahead, Erica. Let's try to unmute Erica again. Erica?

Erica David-Park:

Good morning. Can you hear me?

Patricia Rowan:

Yes, we can.

Erica David-Park:

Oh, good. Sorry, I was having audio issues there. I have nothing to disclose.

Patricia Rowan:

Great. Next up we have Anne Edwards. Can we unmute Anne? Go ahead, Anne.

Anne Edwards:

Good morning. Anne Edwards. Nothing to disclose.

Patricia Rowan:

Great. Next, we have Clara Filice. I apologize if I am saying your last name wrong, Clara.

I also see Stacey Bartell has her hand up. Derek, can we unmute Stacey? Go ahead Stacey.

Stacey Bartell:

So, I apologize for being late. And yes, I have nothing to disclose.

Patricia Rowan:

Wonderful. Thank you. And Clara. I see Clara's hand up. Can we unmute Clara? Go ahead, Clara.

Clara Filice:

Good morning. It's Clara Filice. I have nothing to disclose.

Patricia Rowan:

Wonderful. Thank you for being here. Next, we have Angela Filzen. Can we unmute Angela? Try to unmute her again. There we go. Go ahead, Angela.

Angela Filzen:

Good morning. I have nothing to disclose. Can you hear me okay?

Patricia Rowan:

We can. Yes. Thank you for being here.

Angela Filzen:

Thank you.

Patricia Rowan:

Next, we have Sara Hackbart. Do we have Sara?

Let's move on to Richard Holaday. Do we have Richard? Go ahead. Oh, Richard, can you try that again? We lost your audio at the end there.

Richard Holaday:

Sorry about that. I have nothing to disclose.

Patricia Rowan:

Wonderful. Thanks so much. Thanks for being here.

Next, we have Jeff Huebner. And apologies again. If I am mispronouncing your name, please correct me, everybody. Can we unmute Jeff? Go ahead, Jeff.

Jeff Huebner:

Morning, everybody. Yeah, this is Jeff Huebner from Wisconsin. And I have nothing to disclose.

Patricia Rowan:

Wonderful. Thank you for being here. David Kelley. Can we unmute David? Go ahead, David.

David Kelley:

Morning. Hopefully you can hear me.

Patricia Rowan:

Yep.

David Kelley:

Dave Kelley, Pennsylvania Medicaid. I am a member of NCQA's Committee for Performance Measurement. I also am a member of an organization called MODRN, the Medicaid Outcomes Distributed Research Network, that is a set of Medicaid states and state academic partners that really work on combing through multistate Medicaid data to do quality improvement. And I receive no money or funding from either. Thanks.

Patricia Rowan:

Thank you, David. We appreciate the disclosure. And just for the group, we will share that our team did review David's disclosure and determined that you do not need to recuse yourself from

voting, so we look forward to your participation on the MODRN-stewarded measure which will be discussed. Thank you.

David Kelley:

Thank you.

Patricia Rowan:

Next slide. David Kroll. Go ahead, David.

David Kroll:

[David] Kroll. I have no disclosures. Hi, everyone.

Patricia Rowan:

Thanks for being here.

Next, we have Jakenna Lebsock. Again, please correct me. We have lots of new people this year, so apologies for my pronunciation. Go ahead, Jakenna. Jakenna, can you hear us? Okay. Jakenna, we do not have your audio, and you might have – when you tried to unmute you might have accidentally hung up, which is a mistake I make all the time. So, try dialing back in and raise your hand, and we will get you back on.

Next, we have Hannah Lee-Brown. Can we unmute Hannah? Go ahead. Hannah? We might have also lost your audio. I hope I didn't jinx everybody. Okay, we'll try this again.

Next, we have Katherine Leyba. Lee-ba? Katherine, can we unmute Katherine? Go ahead Katherine. Derek, can we unmute Katherine? Go ahead, Katherine.

Katherine Leyba:

This is Katherine. Nothing to disclose.

Patricia Rowan:

Thank you. Can we unmute Hannah? Go ahead, Hannah. Hannah, go ahead. Can you hear us now? You might be muted locally on your own line, Hannah. Doublecheck that for me. Can you hear us, Hannah? Okay, I am going to keep going and we will come back.

Next, we have Chimene Liburd. Please correct me. Go ahead.

Chimene Liburd:

Chimene Liburd. No disclosures.

Patricia Rowan:

Thank you. Next, we have Angela Parker. Go ahead Angela.

Angela Parker:

Good morning. No disclosures.

Patricia Rowan:

Thanks, Angela. I see Jakenna has her hand up. Can we unmute Jakenna? Go ahead Jakenna.

Jakenna Lebsock:

Good morning. Can you hear me now?

Patricia Rowan:

We can. Yep.

Jakenna Lebsock:

Good morning, everyone. Jakenna Lebsock. Arizona Medicaid. I do serve on the Board of Directors for ADvancing States, but I am not here representing them nor have I had any conversations with them regarding the measure sets.

Patricia Rowan:

Thank you, Jakenna.

Next, we have Lisa Patton. Can we unmute Lisa? Go ahead Lisa. Can we – okay, go ahead, Lisa.

Lisa Patton:

No disclosures.

Patricia Rowan:

Great. Thanks, Lisa.

Next, we have Laura Pennington.

Laura Pennington:

I have nothing to disclose. Thank you.

Patricia Rowan:

Can we try unmuting Hannah again? Go ahead, Hannah. Okay, we are still not hearing Hannah. All right.

Unmute Grant Rich. Go ahead, Grant.

Grant Rich:

This is Grant J. Rich. No disclosures.

Patricia Rowan:

Thank you, Grant.

Hannah, do you want to try again? Okay, we are going to have our producer reach out to you to see – to troubleshoot what is happening.

Lisa Satterfield, I think we said we may not have -- or is Lisa here?

Okay, let's go to the next slide. Bonnie Silva. Let's unmute Bonnie. Go ahead, Bonnie.

Bonnie Silva:

Colorado Medicaid. I also serve on the Board of ADvancing States. I did not put that in my disclosures because I didn't think it met criteria for a conflict. So to that end, I don't have anything to disclose. If you need me to add that additional detail, I am happy to re-send my form.

Patricia Rowan:

I think that's okay, Bonnie. Thank you for offering, though. I appreciate it.

Bonnie Silva:

Thank you.

Patricia Rowan:

Next, we have Kai Tao. Kai? Can we unmute Kai?

Kai Tao:

I have nothing –

Patricia Rowan:

Go ahead.

Kai Tao:

– to declare. This is Kai Tao. Thanks.

Patricia Rowan:

Thank you. Next, we have Sarah Tomlinson. Can we unmute Sarah? Go ahead Sarah.

Let's also try Bonnie Zima.

We are not hearing, Sarah, so I will give her a chance to check her local mute.

Is Bonnie Zima here?

Oh, Sarah, do you want to try again? Go ahead, Sarah.

Sarah Tomlinson:

I'm sorry, I have no conflicts of interest. Thank you.

Patricia Rowan:

Thank you, Sarah.

Hannah Lee-Brown. Can we try Hannah again?

Hannah Lee-Brown:

Hi.

Patricia Rowan:

Hi!

Hannah Lee-Brown:

Are you able to hear me?

Patricia Rowan:

Yes.

Hannah Lee-Brown:

Oh, thank goodness. Thank you for your patience. I am so sorry.

Patricia Rowan:

That's all right.

Hannah Lee-Brown:

I have one disclosure. Just that my current employer is Novo Nordisk, but my views are my own. I have not discussed the Workgroup with my employer, the measures for the Workgroup with them.

Patricia Rowan:

Thank you, Hannah.

Do we have Bonnie Zima? Okay.

And then I know we missed Sara Hackbart and Joanne Bush.

Do we have Sara or Joanne?

Oh, I see Joanne. Can we unmute Joanne? Go ahead.

Joanne Bush:

Hi. This is Joanne Bush. I have nothing to disclose.

Patricia Rowan:

Great. Thank you.

Do we have Bonnie Zima or Sara Hackbart?

Oh, I see Bonnie. Go ahead Bonnie.

Bonnie Zima:

This is Bonnie Zima.

Patricia Rowan:

Do you have any disclosures?

Bonnie Zima:

No. No disclosures.

Patricia Rowan:

Thank you for being here. All right. Is there anyone else that I missed? Any other Workgroup members that were unable to come off of mute or anything like that? All right. Well, thanks, everybody, for hanging with us. This is always the hardest part of the meeting, to be honest, so it's all downhill from here. Let's go to the next slide.

We are also joined today by federal liaisons who are non-voting members of the Workgroup. I will read the name of the agencies here but not do an individual roll call. We have the Agency for Healthcare Research and Quality, the Center for Clinical Standards and Quality at CMS, the Centers for Disease Control and Prevention, the Health Resources and Services Administration, the Office of the Assistant Secretary for Planning and Evaluation, the Office of Disease Prevention and Health Promotion, the Substance Abuse and Mental Health Services Administration, and the United States Department of Veterans Affairs. I do want to make a note that federal liaisons are here today in listen-only mode and are unlikely – unable to contribute to the conversation.

We would also like to take the opportunity to thank members of the Division of Quality and Health Outcomes at the Center for Medicaid and CHIP Services who are joining us today to listen to the discussion. And also, for the measure stewards who are attending and available to answer questions about their measures. Next slide.

Next, my colleague Chrissy Fiorentini, from Mathematica, will provide an overview of the Child and Adult Core Sets. Chrissy?

Chrissy Fiorentini:

Thanks, Tricia. So, I am going to share some information about the Core Sets to provide high-level context for the measure discussions occurring today and tomorrow. I want to start off by providing an overview of the Core Set reporting years relevant to this review cycle, as CMS and states are working on multiple years of Core Set reporting simultaneously.

The most recent publicly available state performance data are for the 2023 Child and Adult Core Sets. For most measures, these data reflect services provided in calendar year 2022. These data were due from states by December 31, 2023, and CMS started releasing the data publicly in the fall of 2024. Over the next few slides, I will provide some highlights from the publicly available 2023 Core Set data. Next, the first year of mandatory reporting was for the 2024 Core Sets. Those data were due to CMS at the end of this past December. CMS is currently reviewing those data and expects to begin making the results publicly available in the fall of

2025. And states are now preparing to report data for the 2025 Core Sets. That data reporting period will open in the fall and close on December 31 of this year.

CMS recently released the measure lists for the 2026 Child and Adult Core Sets. I will give a brief overview of the changes for 2026 a little later in the presentation. State reporting of the 2026 Core Set data will begin in the fall of 2026. And lastly, the focus of this current review cycle is the 2027 Core Sets. CMS will use the recommendations of this Workgroup, in combination with other input, to make updates for the 2027 Core Sets, and then state reporting of those data will occur in the fall of 2027. Next slide.

This slide shows some of the high-level results of voluntary state reporting of the 2023 Child and Adult Core Sets. For the 2023 Core Sets, states reported a median of 25.5 out of 27 measures in the Child Core Set and 28 of the 34 measures on the Adult Core Set. Almost all measures met criteria for public reporting, meaning that they are reported by at least 25 states and met CMS standards for data quality. Reporting was very robust, with the majority of states reporting more measures for 2023 than for 2022. As you might expect, the most frequently reported measures are those that states can calculate accurately using claims and encounter data. Less frequently reported measures include those that require medical record abstraction, electronic health records, and survey data collection. Not surprisingly, it often takes a year or two for states to ramp up to reporting new measures. Although we do want to point out that there were two first-year measures for the 2023 Child Core Set that met the criteria for public reporting which suggests that the new measures recommended by the Workgroup were both feasible and desirable for states. I will talk about this more on the next slide. Next slide.

The two measures in the Child Core Set and one in the Adult Core Set were publicly reported for the first time, Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Ages 3 Months to 17 Years, or AAB-CH, Lead Screening in Children (LSC-CH), and Colorectal Cancer Screening (COL-AD). As I mentioned on the previous slide, both AAB-CH and LSC-CH were new to the 2023 Child Core Set. Colorectal Cancer Screening was added to the 2022 Adult Core Set, so states needed a little bit more of a ramp-up period for that measure. CMS also publicly reported several composite and ratings performance rates from the Child and Adults CAHPS Health Plan Survey Measures for the first time using state-level results of the AHRQ CAHPS database. The 2023 Core Set data products include state performance on four of the composite measures and four of the ratings in both the Child and Adult CAHPS surveys. Next slide.

This next slide shows the number of states reporting each of the 2023 Child Core Set measures. As you can see, there is a wide range in the number of states reporting each measure. The two measures at the top of the slide, Live Births Weighing Less Than 2,500 Grams and Low-Risk Cesarean Delivery, are calculated by CMS on behalf of states using CDC WONDER data. At the bottom of the slide, the screening for Depression and Follow-Up Plan: Ages 12 to 17 measure had 25 states reporting using Core Set specifications and did not meet CMS data standards for public reporting. All other measures were publicly reported for the 2023 Core Set. Next slide.

This slide shows the number of states voluntarily reporting each of the 2023 Adult Core Set measures. As with the Child Core Set, you can see there is a wide range in the number of states reporting each measure. Notably, the Colorectal Cancer Screening measure was reported by 42 states in the second year it was included on the Adult Core Set and met the threshold for public reporting for the first time. The four measures on the bottom of the slide were not publicly reported. As was the case with the Child Core Set measure, the adult version

of the Screening for Depression and Follow-Up Plan measure did not reach CMS data standards for public reporting. The three measures listed below that did not have enough states reporting for the data to be publicly reported. One is Diabetes Care for People With Serious Mental Illness: HbA1c Poor Control (>9.0%). Note that the measure steward has modified this measure and renamed it as Diabetes Care for People With Serious Mental Illness: Glycemic Status > 9.0% for the 2025 Adult Core Set. The other two measures that were not reported are HIV Viral Load Suppression and Long-Term Services and Supports Comprehensive Care Plan and Update. Note that starting with the 2026 Core Sets, the Long-Term Services and Supports measure is transitioning from the Adult Core Set to the Home and Community-Based Services Quality Measure Set. This slide closes out our high-level overview of the results of 2023 Core Sets reporting. If you are interested in seeing more details, there are a wealth of resources available on Medicaid.gov including a new interactive data dashboard. Next slide.

Let's shift gears now and turn to the 2026 Core Sets. The Workgroup should keep the composition of the 2026 Core Sets in mind when considering what measures to recommend for addition to or removal from the 2027 Core Sets. The 2026 Child Core Set includes 28 measures and the Adult Core Set includes 34 measures. Both Core Sets also include two provisional measures that are voluntary for 2026 reporting. The provisional measures are not considered part of the Core Sets and therefore are not depicted in the figures shown on this slide. Note that when a new measure is added to the Core Sets, CMS makes the determination of whether it will be added as a mandatory or provisional measure on a case-by-case basis. The figure shows the distribution of Core Set measures by domain. As you can see, the Child Core Set is more weighted toward measures of Primary Care Access and Preventive Care, Maternal and Perinatal Health, and Behavioral Health Care, while the Adult Core Set is more heavily weighted towards measures of Care of Acute and Chronic Conditions and Behavioral Health Care. The other Core Set domains are Dental and Oral Health Services and Experience of Care. Please keep in mind that CMCS will assign the domains when updating the Core Sets for 2027, so we will not be focusing on domain assignments during this meeting. We also want to note that some measures cut across the Child and Adult Core Sets, and CMCS decides which Core Set to assign the measures to. And as we have mentioned in the past, CMCS does not have a target number of Core Set measures, either minimum or maximum. Next slide.

I would now like to briefly describe the key changes in the 2026 Child and Adult Core Sets. First, two of the 2025 provisional Child Core Set measures will be added to the 2026 Child Core Set. Oral Evaluation During Pregnancy: Ages 15 to 20 and Prenatal Immunization Status: Under Age 21. Two measures were removed from the Adult Core Set for 2026 reporting. Antidepressant Medication Management, which was retired by the measure steward, and Use of Opioids at High Dosage in Persons Without Cancer. This measure had been recommended for removal by last year's Workgroup. Next, two measures will transition from the Adult Core Set to the Home and Community-Based Services, or HCBS, Quality Measure Set. These are Long-Term Services and Supports Comprehensive Care Plan and Update and the National Core Indicators Survey. Lastly, the Prenatal Depression Screening and Follow-Up Measure was added as a provision measure to both Core Sets. If you would like to see the full list of measures included on the 2026 Child and Adult Core Sets, the measure lists are available in Medicaid.gov. Next slide.

And now I will provide a brief overview of Core Sets mandatory reporting. Beginning with the 2024 Core Sets, reporting of all the Child Core Set measures and the behavioral health measures on the Adult Core Set is required for all states. When reporting mandatory measures, states must adhere to the data reporting guidance in the Core Set resource manuals and TA

briefs issued by CMS. The following populations are exempt from mandatory reporting for 2025 and 2026. Beneficiaries who have other insurance coverage as a primary payor before Medicaid or CHIP including individuals dually eligible for Medicare and Medicaid, and individuals whose Medicaid or CHIP coverage is limited to payment of liable third-party coverage premiums and/or cost sharing. Except for these populations, states are required to report mandatory measures for all Medicaid and CHIP beneficiaries. Feasibility and viability of state and local reporting of current and future measures is a key consideration for mandatory reporting. Next slide. And with that I will pass it over to Alli Steiner to take any questions from the Workgroup.

Alli Steiner:

Thank you, Chrissy. So now we would like to open up for questions or comments from Workgroup members. Please raise your hand if you wish to speak, and I will call on you in turn.

I'm not seeing any hands so far. Just a reminder this is an opportunity for Workgroup members to ask questions. If there are no questions, we can continue on and there will be opportunities through this session. Okay, I see Kai. Derek, can you unmute Kai?

Kai Tao:

Just sort of a logistic question with your last slide there. Are folks who are in waivers or SPAs part of the – if they fall within the qualifications – the denominator? Do you know? If there are covered by waivers or SPAs in the state Medicaid program?

Alli Steiner:

Yes. The answer is that they would be included if their care, their primary care, falls under Medicaid or CHIP.

Kai Tao:

Right.

Alli Steiner:

And if they are eligible for the services that are being assessed in the measure. That's another key component.

Kai Tao:

Gotcha. So, they are in a partial benefit program like a waiver or SPA, they would possibly still be part of it as long as they meet the measure. Okay.

Alli Steiner:

Yes. As long as they meet the measurement criteria. So, for example, if they are not eligible for the services in the measure, they would not be eligible for the measure.

Kai Tao:

Right. Yeah.

Alli Steiner:

Okay.

Kai Tao:

Thank you.

Alli Steiner:

Okay. Are there any other – all right. I am not seeing any other hands at this time. Like I said, we will have opportunities for discussion as we go. So, we are going to start the discussion shortly, but first we will describe the approach to the measure review and do some practice voting. So, I will turn it to Caitlyn Newhard to present next.

Caitlyn Newhard:

Thank you, Alli. Next slide.

We wanted to share some thoughts about the Workgroup's goal in strengthening the 2027 Child and Adults Core Sets. The 2027 Core Sets Annual Review Workgroup is charged with assessing the existing Core Sets and recommending measures for removal or addition to strengthen and improve the Core Sets for Medicaid and CHIP. The Annual Workgroup process is also designed to identify gaps in the existing Core Sets. The Workgroup must first determine whether a measure is feasible for state reporting, and if so, also consider the different facets of desirability and viability of adding the measure to the Core Sets. While there are many good quality measures, we need to keep in mind that to be included in the Core Sets, the measure must be feasible and viable for state-level use in Medicaid and CHIP. Next slide.

Another element to consider is multilevel alignment. This graphic shows how alignment can help drive quality improvement in Medicaid and CHIP. At the bottom, we have measures at the clinician or practice level which feed into measures at the program, health plan, health system, or community level. As an example, the Health Home Core Set measures are at the program level because they are for a distinct subpopulation within a state's Medicaid program. The Child and Adult Core Set measures are state-level measures because they are intended to include all Medicaid and CHIP beneficiaries within the state. State-level measures can then be aggregated to the national level for monitoring the Medicaid and CHIP program as a whole. The alignment of quality measures across programs and levels can help drive quality improvement by addressing each level of care so that improvement at one level may lead to improvement at other levels. Additionally, alignment is intended to streamline data collection and reporting burdens. We ask the Workgroup to consider how the measures under discussion may help facilitate quality improvement both within and across levels. Next slide.

We also wanted to note that measure stewards typically update various aspects of the measure technical specifications each year. Changes can reflect a variety of factors such as new clinical guidance, coding updates, new data sources, and technical corrections identified by users. Many of the measures being reviewed are in the process of being updated or were recently updated. This reflects the evolving nature of quality measurement in healthcare. We have done our best to reflect the most accurate and up-to-date information on each measure. Additionally, the use of alternate data sources to support calculations and public reporting of current Core Set measures continues to be explored. Alternate data sources can reduce state burden and improve the completeness, consistency, and transparency of measures. Core Set measures are currently calculated on behalf of states using data from CDC WONDER, the NCI-IDD surveys, and the AHRQ CAHPS database. T-MSIS is another data source under consideration for the

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

In each meeting, we always come back to our criteria for assessing measures. We know many of you have seen these slides several times before, however, we have some new Workgroup members and public attendees, and the criteria are foundational to the discussions over the next two days. In terms of the measures suggested for addition, the first category is our minimum technical feasibility and appropriateness requirements. All suggested measures must meet these requirements, so the measures we will discuss today and tomorrow have passed through Mathematica's initial screening based on these criteria.

First, a measure must be fully developed and have detailed specifications that enable production of the measure at the state level. It must have been tested in a state Medicaid or CHIP program or currently be in use by one or more Medicaid or CHIP programs according to the measure specifications. There must be an available data source that contains all the elements needed to calculate the measure including an identifier for Medicaid and CHIP beneficiaries. The specifications and data source should allow states to calculate the measure consistently. The measure should also align with current clinical guidelines. And the measure must include technical specifications, including code sets, that are provided free of charge for state use in the Core Sets. These criteria were developed to help ensure that if a measure is placed on the Core Set, states are able to produce consistent state-level results for their Medicaid and CHIP populations. The Mathematica team as assessed the suggested measures for adherence to these minimum criteria. Next slide.

Next, we have the criteria for assessing measures suggested for addition in terms of their actionability. Measures that are recommended for addition to the Core Sets should address pressing healthcare needs of Medicaid and CHIP beneficiaries, can be stratified by the required stratification categories included in the annual Core Set guidance, can be used to assess state progress in improving healthcare delivery and outcomes, and would either fill a gap in the Core Sets or add value to the existing measures on the Core Sets.

Finally, a few other criteria to consider:

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

Next slide.

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

- Are the majority of states unable to access the data needed to calculate the measure?

- Or is the data source leading to inconsistencies across states?
- Does the measure no longer align with current clinical guidance?
- Is measure performance for all populations so high that meaningful distinctions in improvement or performance can no longer be made?
- Is there reason to believe that all states may not be able to produce the measure for all Medicaid and CHIP populations within two years of the measure being added to the Core Sets?

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

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

Are there any questions from Workgroup members about the criteria or voting logistics before the practice vote? We will give Workgroup members a moment here to raise their hand if they have a question. Great. I am not seeing any questions, but I will give it another moment here. All right. Let's move on to the practice vote, but if any questions arise, please contact us. So, next slide.

As a reminder for all attendees, voting will be for Workgroup members only. Workgroup members, please navigate to the Slido voting page. You can follow the QR code, use the link listed in the voting guide, or go to Slido.com and enter 2027ChildAdultCSR, with no spaces, as the event code. You will be prompted to enter your email address and name, after which you will enter the verification code sent to your email. Be sure to use the same email address at which you receive communication from the Mathematica Child and Adult Core Sets Review Team. You can remain on this page for the duration of the meeting, and new voting questions should appear as we make them available. If you don't see the new questions, just refresh your page and it should pop up. We ask that all Workgroup members participate and submit a vote here regardless of if you participated in the practice vote earlier. If you need any help, please refer to the voting guide or send us a chat through the Q&A feature in Slido. The third page of the voting guide has the FAQ section that answers most common problems. During voting on measures, if for any reason you are unable to submit your vote, please send us your vote through Q&A in Slido or to our email address if you are unable to access WebEx. Your votes will only be visible to the Mathematica team. Once you have emailed or sent your votes to our team, please stop trying to submit your vote through Slido. Our team will submit the vote on your behalf to avoid double counting. And please know that Mathematica will do a careful review of all voting results at the end of each day to make sure that each eligible Workgroup member's vote was included and counted only once.

Now let's go through a practice vote. Starting with our first vote: "What is your favorite snow day activity?" The options should appear on your voting page, and they are: "snowball fight," "sledding," "staying inside with a good book," "making hot cocoa," and "I have never

experienced a snow day." If you aren't seeing the questions, try refreshing your browser. Give folks just another moment or two to submit their votes. All right. We see 29 votes. Just waiting on another couple. All right. Thanks for your patience, folks. We are just checking the votes, making sure we got one from all Workgroup members that we expected to receive a vote from.

All right. Voting is closed. And the results are: 45% of Workgroup members who voted prefer sledding. 35% prefer staying inside with a good book. 16% making hot cocoa. And 3% reported a snowball fight. And it doesn't look like anyone has never experienced a snow day. All right. Next slide and let's move on to our next vote.

Remember to refresh the page if you are not seeing this next vote appear on your browser. And the question is: "Do you prefer cats or dogs?" The options are: "cats," "dogs," and, "I am not an animal person". Give folks another moment or two to submit their votes. Thanks for your patience. We are just waiting on a couple more votes here. Oh, I see we had a comment from Kathy in the Q&A. Kathy, we will reach out to you during the break here and make sure we get you squared away.

All right. We will go ahead and close the vote. The results are 70% prefer dogs, 23% cats, and 7% are not animal people.

Thank you all for testing the voting. It should get easier from here. Now we will be taking a break until 12:45 p.m. If you have any questions about voting, feel free to reach out to us through the Q&A or the Core Set Review mailbox during the break. Reminder to please return at 12:45. Thank you all.

BREAK

Caitlyn Newhard:

Welcome back from the break, everyone. As a reminder, we will be reviewing and discussing the two contraceptive care measures together prior to voting separately on each measure. Now I will provide a brief overview of the first measure suggested for removal: Contraceptive Care – Postpartum Women. Next slide.

Contraceptive Care – Postpartum Women was suggested for removal from both the Child Core Set and the Adult Core Set. The Contraceptive Care – Postpartum Women measure is included in the Maternal and Perinatal Health domain.

On the Child Core Set, the measure is defined as: among women ages 15 to 20 who had a live birth, the percentage that were provided a most effective or moderately effective method of contraception within 3 days of delivery and within 90 days of delivery, were provided a long-acting reversible method of contraception, or LARC, within 3 days of delivery and within 90 days of delivery. On the Adult Core Set, the same rates are reported for women ages 21 to 44 who had a live birth. The measure steward is the U.S. Office of Population Affairs, and the data collection method is administrative. The slide also includes the full denominator and numerator definition for reference. Next slide.

The denominator definition continues on this slide. Note that the denominator for both the Child and Adult measures exclude deliveries that meet either of the following criteria: deliveries that did not end in a live birth. For example: miscarriage, ectopic, stillbirth, or pregnancy termination. Live births that occurred in the last 3 months of the measurement year, or after September 30.

The numerator definition is included on this slide. Both the Child and Adult versions of measure include numerators for two rates corresponding to types of contraception. Both rates are also stratified by postpartum window, within 3 days of giving birth and within 90 days of giving birth. The numerator for Rate 1 includes the eligible population that was provided a most or moderately effective method of contraception in the measurement year. Most effective method include female sterilization, intrauterine devices or systems, or contraceptive implants. Moderately effective methods include injectables, oral pills, patch, or ring. The numerator for Rate 2 includes the eligible population that was provided a LARC method in the measurement year. LARC methods include contraceptive implants or IUDs. Next slide.

The measure steward indicated it is feasible to stratify this measure by race, ethnicity, and geography. Note this measure is not subject to mandatory stratified reporting for either 2025 or 2026 Core Sets reporting. 41 states reported the Child Core Set measure and 40 states reported the Adult Core Set measure for 2023 Core Set reporting. Two states reported using other specifications for the Child and Adult Core Sets. The measure is not included on the Medicaid and CHIP scorecard.

The individual who suggested the measure for removal cited that the measure no longer aligns with current clinical guidance and/or positive health outcomes as the reason for removal. They noted that the contraceptive measures included on the Core Sets, the Contraceptive Care – Postpartum measures and Contraceptive Care – All Women measures, only include contraceptives that can be identified in claims, meaning that other effective methods that might be more culturally appropriate for some populations are not counted. According to the individual who suggested the measure for removal, this could result in coercion to use contraceptive methods discordant with one's preferred or cultural preference. In addition, the individual who suggested the measure added that men's role in unintended pregnancies is not addressed by the current contraceptive measures due to data capture limitations, which they argued perpetuate conceptions of women's responsibilities for contraception. They indicated that contraceptive counseling and care should be provided to patients following a needs screening such as the 1E question: "Would you like to become pregnant in the next year?" In their opinion, a person-centered contraceptive counseling measure could help address whether the patient needs contraceptives. However, note that they did not suggest this alternative measure for addition to the Core Sets.

At the 2020 Core Sets Annual Review Meeting, a Workgroup member suggested removal of the Contraceptive Care – Postpartum Women Ages 21 to 44 measure because other – another measure on the Core Sets, the Contraceptive Care – All Women measure, addresses the same measure concept. The Workgroup voted against removing the measure from the Adult Core Set. Workgroup members stated that it was important to retain a measure for postpartum women as effective postpartum contraception can help avoid short interpregnancy intervals which are associated with low birth weight and other poor outcomes. Workgroup members also expressed concern that only the Adult and not the Child version of the measure had been suggested for removal, which could cause misalignment between the Core Sets. A Workgroup member also noted that maintaining the measure on the Adult Core Set could drive states to resolve payment issues around insertion of long-acting reversible methods of contraception. And with that, let's move on to the next measure suggested for removal. Next slide.

Contraceptive Care – All Women was suggested for removal from both the Child Core Set and the Adult Core Set. The Contraceptive Care – All Women measure is included in the Maternal and Perinatal Health domain. On the Child Core Set, the measure is defined as: among women ages 15 to 20 at risk of unintended pregnancy, the percentage that were provided a most

effective or moderately effective method of contraception, were provided a long-acting reversible method of contraception, or LARC. On the Adult Core Set, the measure is defined as: among women ages 21 to 44 at risk of unintended pregnancy, the percentage that were provided a most effective or moderately effective method of contraception of were provided a LARC. The measure steward is the U.S. Office of Population Affairs. And the data collection method is administrative. This slide also includes the full denominator and numerator definition for reference. The denominator for both the Child and Adult measures includes women who were: not pregnant at any point in the measurement year, pregnant during the measurement year but whose pregnancy ended in the first nine months of the measurement year since there was adequate time to provide contraception in the postpartum period, pregnant during the measurement year but whose pregnancy ended in ectopic pregnancy, stillbirth, miscarriage, or induced abortion. Next slide.

The denominator definition continues on this slide. The first step in defining the denominator is to identify all women who meet the age criteria for the measure. These are: ages 15 to 20 for the Child Core Set and ages 21 to 44 for the Adult Core Set. The second step is to exclude women not at risk of unintended pregnancy because they were infecund due to non-contraceptive reasons, had a live birth in the last 3 months of the measurement year, or were still pregnant at the end of the measurement year. Both the Child and Adult versions of the measure include numerators for two rates corresponding to the types of contraception. The numerator for Rate 1 includes the eligible population that was provided a most or moderately effective method of contraception in the measurement year. Most and moderately effective methods of contraception are defined the same way as for the CCP measure. Next slide.

The numerator definitions continue on this slide. The numerator for Rate 2 includes the eligible population that was provided a LARC method in the measurement year. The definition of LARC method is the same as for the CCP measure. The measure steward indicated that stratification by race, ethnicity, and geography is feasible. However, as with the CCP measure, stratification by those factors is not required for the 2025 Core Sets or 2026 Core Sets reporting. 41 states reported the Child Core Set measure and 40 states reported the Adult Core Set measure for the 2023 Core Set reporting. All states reported calculating the measure using Core Set specifications.

The individual who suggested the measure for removal provided the same rationale for removing this measure as they provided for removing Contraceptive Care – Postpartum measure. They cited the measure no longer aligns with current clinical guidance and/or positive health outcomes as the reason for removal since the measure only includes contraceptives that can be identified in claims, meaning other effective methods that might be more culturally appropriate for some populations are not counted. The individual who suggested the measure for removal, again suggested that this could result in coercion to use contraceptive methods discordant with one's preference or culture. In addition, they added that men's role in unintended pregnancies is not addressed by the current contraceptive measures due to data capture limitations. The individual who suggested the measure for removal argued that this perpetuates conceptions of women's responsibility for contraception. They again proposed that contraceptive counseling and care should be provided to patients following a needs screening. Next slide.

We now invite discussion from the Workgroup members about the two measures suggested for removal: Contraceptive Care– Postpartum Women and Contraceptive Care – All Women. Workgroup members, you may raise your hand if you wish to speak. We will call your name and unmute you when it is your turn. Please remember to say your name before making your

comments. Any comments from Workgroup members? All right. I see Stacey Bartell has her hand raised. Stacey?

Stacey Bartell:

Hi. This is Dr. Stacey Bartell on behalf of the American Academy of Family Practice and we are not in favor of removing this measure and several reasons. This measure was put in place to prevent unplanned pregnancies in the postpartum period, which we know reduces the risk of morbidity and mortality, which is a huge problem in the United States today. In addition, I think it was pointed out that this could possibly be a coercive measure, but I think it is important to note that the shared decision making between a physician and a patient is not affected by a planned measure and is not affected by a state reporting measure. So, we do not think that the state nor the plan would be coercive in the – or in the discussion with the patient regarding the need for contraception. In addition, we think that having this measure in place brings both access by the state and by the plan to the patient for both long-acting contraceptives and short-active contraceptives. We feel that the most important thing that the plan and the state is providing here is access and education, and we think the measure helps support that. We are encouraged by the fact that 41 states are reporting the measure today. And although the rates are low, I think it is important to note that no measure has to be 100%, so if they are using some other form of birth control, it is perfectly fine, it does not need to be reported. These methods of birth control, we know especially in the younger population, are very important for preventing unplanned pregnancies. Thank you.

Caitlyn Newhard:

Thank you, Stacey. Next up, let's go with Kai.

Kai Tao:

Hi. This is Kai with American College of Nurse Midwives. I also believe that we should not be removing the CCW or the CCP measures. It is – we know hormonal birth control in the United States, depending on what data set you are looking at, that it ranges from 80 to 90% of sexually active women have used some kind of birth control in their lifetime. We also know that, as the last speaker mentioned, we continue to hear from women after their birth was their pregnancy planned, or was it unplanned or mistimed, and we still see data from about 30 to 40% here in the United States still have unplanned, mistimed pregnancies.

We also know Medicaid continues to cover just shy of 50% - about 40 to 50% of all births in the United States. And with what is happening nationally, including states now having the ability to decide on their own, post Dobbs, around abortion, it is more important than ever that we continue to monitor states' ability to provide access to preventative services such as contraception. This really brings in some visibility. Coercion is definitely something we want to be cognizant of. There is a history of it, and a recent history of it. But without having any data, it concerns me, more for coercion for not being able to see any visibility. I think, you know, as long as states are reporting this, what they do with it, as long as it is not based on a benchmark or the performance of having to use a certain method at a certain percent, it is really critical data. When I talk to Medicaid administrator, state plans, and I asked him, "how are your providers – or how are your members getting access to the birth control of choice?" They often look at me and say, "good question. I don't know. I think I know. Or I think we have OB/GYNs. Or I think I have a women's health provider. But we don't have any data." And I think it is critical that we keep both of these data points.

And the last thing I do want to, you know, bring up that under community health centers, they have UDS data, which maybe you are familiar with, where a bulk of our Medicaid-covered patients are getting their primary healthcare. In 2024, it was just added that we include a screening question to be monitoring something along the line of, do you think you want children or more children at some point, or do you want to be pregnant next 12 years? It was not prescriptive, but it was a reportable measure for all community health centers across the United States, and that just started. And so, having this data interplayed with that would be really important because we are now screening and looking at methods. Because we know also, people still cannot get their method of choice despite here in the United States today reports of from one in three to one in four people are not using their birth control method of choice still. So, I am very much in favor of us keeping this and monitoring this definitely for a few more years. Thank you. As you know, this is for 2027. Thanks.

Caitlyn Newhard:

Thank you, Kai. Let's hear from Ben Anderson.

Benjamin Anderson:

Hi. Good afternoon. Ben Anderson. Families USA. And I agree with both of the comments by the previous Workgroup members. I have been working in maternal health and child and adolescent health for nearly two decades. And I think it has already been mentioned, you know, our nation is still in the midst of a maternal health crisis, a maternal mortality crisis. And we know that Medicaid in particular is an important lever for combatting that crisis as it covers nearly half of all births. And as was noted previously, we know that timely access to contraception reduces maternal mortality by preventing high-risk pregnancies and allowing women time to attain their best possible health before becoming pregnant. While this – while these two measures are not perfect and there – there could be some advantages of having a more person-centered measure, these are, you know, in my view, the best two measures that are widely adopted and used by the states. And given the nature of the current maternal health crisis, I don't think it is appropriate to remove either measure at this point in time. And, again, agree with comments about, you know, there is no baseline, there is no benchmark, and nothing related to the measure prohibits providers from providing culturally competent care which we would, you know, consumers would still expect them to do. That's it. Thank you.

Caitlyn Newhard:

Thank you, Ben. Let's see. I see Jeff has his hand raised.

Jeff Huebner:

Yeah. Thanks, everyone. Jeff Huebner from Wisconsin Medicaid. I appreciate the discussion. This one definitely gave me some pause. I was glad to hear and read about the rationale and also to hear our colleagues' comments in favor of keeping it. And that is my leaning as well but I think it should be acknowledged that the coercion concern is real. I know here in Wisconsin, there has been a workgroup locally based in the Madison region of the health systems as part of their community health improvement work. And that concern has come up, especially in regards to LARC. So, you know, this process makes me wonder and think about I wish we had more data and/or information from the patients, from our Medicaid members who are impacted by this measure. I think all of us are probably in agreement that a measure should first do no harm, similar to our practice in medicine. And I agree that this measure will continue to help, hopefully,

reduce maternal mortality, so I think that is the best thing going for it. But I appreciated learning more about the patient-centered measure that the submitter included information or reference to, and I would encourage everybody to look at that closely if they haven't, and I think it is worth continuing to monitor. The other question I had was, and I don't know if any other states have experience or can comment on this, but what you do with the measure I think is very important. And it would be nice to know if states are not using it or making sure that – or encouraging states not to use this as a pay-for- performance sort of measure given the coercion concerns.

Caitlyn Newhard:

Thanks for those insights from Wisconsin, Jeff. Let's go with Laura Pennington next. Derek, can you unmute Laura, please?

Laura Pennington:

Hi. This is Laura from Washington. Can you hear me okay?

Caitlyn Newhard:

Yes, we can.

Laura Pennington:

Thanks. So, addressing the concern of the last speaker, when we added those two measures to our Washington Common Measures Set, we heard the concerns raised about the coercion. So, we agreed to not use them for – for value-based purchasing for financial incentives, but we do track those measures. And I spoke to our subject matter experts in this area, and they agree with a lot of the justifications for why we should consider removing them, but at the same time they are very concerned that if we do remove them, it will leave a gap. I know we have had conversations in the past about, well, it's the best we have for now, so we keep it. But until there is a better measure out there like, I think, the PCCC measure was mentioned in the materials, and we were one of the states that piloted that measure. Until measures like that are – are ready for implementation, we recommend that we retain the measures. Thank you.

Caitlyn Newhard:

Thank you, Laura. All right. Let's go with Laura Boutwell.

Laura Boutwell:

All right. Thank you very much. I just wanted to take a moment to thank everyone for their comments, and I wanted to echo the sentiments of my colleague from Wisconsin, Jeff. Virginia has struggled with how to use this measure because of the concerns around coercion. And we do not use it for any of our pay-for-performance measurement interactions because of that. And so, I – I know this has been said, but I just want to echo that, especially Laura's comments about how we would really like to explore those additional measures that would be ready at some point. But this is a challenging one to remove, but also for, from a state perspective, for our usage. So, thank you.

Caitlyn Newhard:

Thanks, Laura.

Patricia Rowan:

Caitlyn, I see that Kim has her hand up. Kim, did you have a comment on this measure?

Kim Elliott:

I did. I don't support removing this measure, either. One of the reasons is I think it really does encourage some of the optimal interval spacing between pregnancies. There aren't a lot of things on the Core Measure Set that provide that kind of opportunity or could have that kind of positive effect. But I did have a question, too, and I don't know if anyone is able to answer it. One of the comments in the worksheet was that the individual who suggested the measure for removal stated that the measure no longer aligns with current clinical guidance and/or positive health outcomes. And I would like to understand that a little bit better.

Caitlyn Newhard:

Thanks, Kim. Kai, I see you have your hand raised.

Kai Tao:

I will try, Kim, to kind of address that. Of course, when I heard that, I read that as well, I was like, huh, I mean, there is, you know, obviously there is a move away in the reproductive health arena from talking about tiered effectiveness. That started probably the last four to six years where when IUDs and implants, especially the progesterone IUD, came out, there was a lot of push, everyone should get a LARC. We're LARC happy. There was, you know, a lot of just – the headline was the most effective method, the best birth control method. And that started causing providers to only talk about that, or only refer to that method, and then patients feeling like either they didn't want birth control, or they wanted something that was a different level of effectiveness. It would make them feel shameful, stigma, or they felt pressured to not use their preferred method. So, that, I think has happened in our time, but – so maybe that is what the person is referring to when we talk about most and moderate effectiveness. However, as other speakers have mentioned, there is also a sustained time in the last three to five years, a real push around patient-centeredness and shared decision making for voluntary birth control. But that starts with routine screening for birth control in the primary care setting because that is how we de-silo and destigmatize the use of birth control. And then from there it is asking patients about what is important to them about their birth control method. We also know one of four people may use birth control completely unrelated to pregnancy prevention, but for a first-line treatment of many gynecological symptoms including prevention of ovarian and endometrial cancer, which has been shown in, with good literature, research. So, I do think that maybe the – maybe the person was referring to the tiered effectiveness which is definitely no longer in favor. I cannot comment or agree that there is no good outcome as long as the patient desires birth control.

Kim Elliott:

Thank you. That is very helpful.

Caitlyn Newhard:

Agreed. Thank you for those insights, Kai.

Roshanda.

Roshanda Clemons:

Roshanda Clemons here with Nevada Medicaid. Can everyone hear me?

Caitlyn Newhard:

Yes, we can.

Roshanda Clemons:

Okay. Great. So, I appreciate all the comments and the dialogue that we have been having and happy to hear that we all have a concern about how to provide awareness and accessibility to contraception so that patients can actually have a chance to optimize their chances to have better outcomes for both the mom and the child. And I think that is aligned with ACOG recommendations to improve spacing. So, the question is we know that it is not a perfect measure. If there is no other measure where we can actually track that education is being provided, that accessibility, there is awareness for accessibility, maybe it is not in the interests – the best interests for the patients, and somehow, you know, that is something that we should be considering in the future that we should introduce a measure that would somehow steer against coercion. I know here in Nevada we actually provided a bonus incentive plan for our MCOs for campaigning. And we were very careful to make sure that it was in the language of increasing awareness and accessibility without coercion because we just wanted to capture opportunities for those patients who want to have the opportunity to have family planning to know that they have those choices. So, maybe that is something that the group should consider in the future as we identify that there is a gap in this measure but that the measure should not be removed until we have a better measure in place where we can track this information.

Caitlyn Newhard:

Thanks, Roshanda. Interesting to hear about what you all are doing in Nevada.

Stacey.

Stacey Bartell:

Hi. Dr. Bartell again with the AAFP. I just wanted to circle back to the states' comments a little bit. And from the Academy's standpoint, we just wanted to reinforce that not all measures should be included in pay-for-performance. We would think some of these measures are for plans to look at their patient populations and really assess – you know, we know there are rural health deficits, we know that there are deserts – maternity deserts - out there. And when you look at do you have that in your state or access points for your patients, can you tell from this measure are they getting adequate birth control offered to them and is it available? I know that some healthcare systems, some of the Catholic healthcare systems, may not provide some of this health care, and if that is your only provider in a rural healthcare district, is that why your patients aren't getting that access to care? So, I don't think every measure needs to be pushed to the physician-patient level, which would circle back on this is not probably intended to be a coercive measure. We really need to be thinking in terms of a population health measure from a plan perspective and how are you making sure those patients in rural areas are getting access to health care in all the different ways. And this – agree, this isn't the only way to measure access to birth control, but it certainly is one viable, easy way to measure it.

Caitlyn Newhard:

Thank you, Stacey.

Any additional comments from Workgroup members before we turn to public comment?

Oh, great. David Kelley.

David Kelley:

Good afternoon. I just wanted to weigh in from Pennsylvania's standpoint. We don't support removing these measures, and we do not include them in any of our pay-for-performance programs either at the MCO or provider level. But they are, you know, measures that we monitor internally and – and have discussions. And I think they are helpful especially, again, for the outcomes that have been previously discussed and really helping to reduce – to increase birth spacing and to reduce maternal mortality. So, just wanted to let folks know where we were at and what Pennsylvania Medicaid does as far as not using these measures and incentives and do, you know, feel strongly that I think informed, shared decision making is really vitally important.

Caitlyn Newhard:

Thanks, David. That is helpful information.

Any other comments or thoughts from Workgroup members? All right. We can go ahead and move on to the next slide.

We would now like to provide an opportunity for public comment. If you would like to make a comment about the Contraceptive Care – Postpartum Women or the Contraceptive Care – All Women measure, please raise your hand using the "raise your hand" feature in the bottom right of the participant panel to join the queue, and lower your hand when you are done. We will let you know when you have been unmuted.

I am not seeing any comments from the public, but we will wait another moment or two here. Just a reminder that if you are a member of the public, please raise your hand and I will call on you. Last call before we move on to voting. All right. Well thank you, everyone, for your thoughtful comments. Let's move on to the next slide. Now I will turn it over to Alli and Talia for voting. Alli?

Alli Steiner:

Thank you, Caitlyn. As a reminder, the Contraceptive Care measures are on both the Child and Adult Core Sets, and so this means you will be conducting two votes for each measure, one for the Child Core Set version of the measure and one for the Adult Core Set version of the measure. You will conduct a total of four votes on the two contraceptive care measures. Next slide, please.

Okay, so for our first vote, should the Contraceptive Care – Postpartum Women Ages 15 to 20 measure be removed from the Child Core Set? The options are yes, I recommend removing this measure from the Child Core Set or no, I do not recommend removing this measure from the Child Core Set. Voting is now open. If the question does not appear on your voting page, please refresh your browser.

And while we are waiting for the votes to come in, we wanted to let you know that the voting results you will see onscreen today and tomorrow are preliminary. Mathematica will do a careful review of all voting results at the end of each day to make sure that each eligible Workgroup member's vote was included. And if any of the voting results change after our review, we will let you know during the wrap up for that day.

And we are just waiting for all the votes to come in. Taking a look and we will let you know if any of the Workgroup member votes are missing. Just give us one moment. Thank you.

Thanks for your patience, everyone. I think the first vote always takes a little bit more time, so we are just tracking to see which votes we are missing. Thanks.

We're getting closer, just still waiting on a couple of votes. Thanks, everyone.

Okay, it looks like we may be missing Hannah, Joanne, and Clara. If you could try reaching out through the Q&A and we can make sure we are getting your votes. And that is Hannah Lee-Brown, Joanne Bush, and Clara Filice.

It looks like we are still missing Joanne. If you are on the call, if you could please message us through the Q&A.

Okay, thanks, everyone. Let's close the vote.

Okay. So, for the results, 97% of Workgroup members voted no, I don't recommend removing this measure from the Core Set. So, this does not meet the threshold, and the Contraceptive Care: Postpartum Women Ages 15 to 20 measure is not recommended by the Workgroup for removal from the 2027 Child Core set.

Let's move on to the next vote.

Okay. So, the next vote is, should the Contraceptive Care – Postpartum Women Ages 21 to 24 measure be removed from the Adult Core set? The options are yes, I recommend removing this measure from the Adult Core Set and, no, I do not recommend removing this measure from the Adult Core Set. Voting is now open. If the question does not appear on your voting page, please refresh your browser.

We are just waiting on a couple more votes to come in.

Hannah, if you could try to submit your vote, we are not seeing it yet. We are also missing Clara and Joanna. Hannah, if you could try submitting your vote, please do so. Or otherwise also you could try reaching out to the Q&A and our – our team will assist.

Okay, why don't we go ahead closing the poll.

Okay, so for the results, three percent of Workgroup members voted yes. That does not meet the threshold for recommendation. The Contraceptive Care – Postpartum Women Ages 21 to 24 measure is not recommended by the Workgroup for removal from the 2027 Adult Core Set.

So, let's move on to our next vote.

So, for our third vote, should the Contraceptive Care: All Women Ages 15 to 20 measure be removed from the Child Core Set? The options are yes, I recommend removing this measure from the Child Core Set and, no, I do not recommend removing this measure from the Child

Core Set. Voting is now open. As a reminder, if the question does not appear on your page, please refresh your browser.

Looks like we may be missing Ben Anderson and Hannah Lee-Brown's votes. If you could try submitting your vote or otherwise reach out to the Q&A. Okay, we will close the poll.

Okay. And for the results, three percent of Workgroup members voted yes, so that does not meet the threshold for recommendation. The Contraceptive Care – All Women Ages 15 to 20 measure is not recommended by the Workgroup for removal from the 2027 Child Core Set. Next slide.

And we will move on to our next vote.

So, for our fourth vote, should the Contraceptive Care – All Women Ages 21 to 44 measure be removed from the Adult Core Set? Again, the options are yes, I recommend removing this measure from the Adult Core Set and, no, I do not recommend removing this measure from the Adult Core Set. And voting is open.

We are missing Richard Holaday's vote. Richard, if you could try submitting your vote. We are also missing Chimene's vote. Okay, thank you. Let's close the poll.

Okay. And for this one, zero percent of the Workgroup members voted yes. That does not meet the threshold for recommendation. The Contraceptive Care – All Women Ages 21 to 44 measure is not recommended by the Workgroup for removal from the 2027 Adult Core set. So, thank you to everyone for your participation in the voting process. Next slide, please.

Okay. So now I will pass it over to Deb Haimowitz to describe our first measure suggested for addition to the 2027 Core Sets.

Deb Haimowitz:

Thank you, Alli. We will now discuss the first measure suggested for addition to the 2027 Core Sets: Antibiotic Utilization for Respiratory Conditions. Before we get started on the Antibiotic Utilization for Respiratory Conditions 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. On this slide we have listed the measures on the 2026 Core Sets related to antibiotic stewardship. The Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis measure assesses the percentage of episodes for beneficiaries with a diagnosis of Acute Bronchitis/Bronchiolitis that did not result in an antibiotic dispensing event. This measure is included on the Child Core Set for ages 3 months to 17 years and on the Adult Core Set for ages 18 and older.

Turning now to the measure suggested for addition: Antibiotic Utilization for Respiratory Conditions, this measure is defined as the percentage of episodes for members three months of age and older with a diagnosis of a respiratory condition that resulted in an antibiotic dispensing event. Note that the measure steward does not view higher or lower service counts as indicating better or worse performance. The National Committee for Quality Assurance, or NCQA, is the measure steward, and the measure is specified at the health plan level. The data collection method is administrative. The denominator includes episodes for members three months of age and older as of the episode date who had an outpatient visit, emergency department visit,

telephone visit, e-visit, or virtual check in during the intake period with a diagnosis of a respiratory condition. This slide also shows the conditions for exclusions from the denominator.

This slide shows the numerator. The numerator of this measure is dispensed prescription for an antibiotic medication from the Antibiotic Utilization for Respiratory Conditions Antibiotic Medications list one or three days after the episode date. The measure is currently stratified by age group. The HEDIS measurement year 2025 specifications include the following stratifications by age group for the Medicaid product line (3 months to 17 years, 18 to 64 years, and 65 years and older). NCQA, the measure steward, noted that it is also feasible to stratify the measure by sex and geography. The measure steward confirmed that the measure may be considered for stratification by race and ethnicity in the future. The measure was tested using a database that included claims data from multiple state and Medicaid agencies. Additionally, since 2023, health plans from all states participating in HEDIS reporting have reported the measure as part of their HEDIS submission. For HEDIS reporting year 2023, the measure was reported by all states except those shown in this slide. Finally, the measure is currently in use in Washington State as part of the Washington State Common Measure Set.

This measure was suggested for addition by two individuals. One individual who suggested the measure said that improving antibiotic prescribing is essential to improving Medicaid and CHIP beneficiary health outcomes by reducing the incidence of adverse drug events. According to this individual, antibiotics are among the most common class of drugs that lead to emergency department, or ED, visits with an estimated 200,000 ED visits occurring nationally per year due to antibiotic-associated adverse events. In addition, the individual cited that studies have demonstrated disparities in antibiotic prescribing according to different factors such as geography. The measure can provide essential insights into antibiotic prescribing patterns across states and may aid in reducing prescribing disparities across different populations. The same individual who suggested the measure stated that the current antibiotic-prescribing related measure on the Core Sets, Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis, focuses solely on antibiotic use associated with a specific diagnosis which may provide limited insights into how providers are prescribing for patients with acute respiratory conditions overall. According to this individual, the Antibiotic Utilization for Respiratory Conditions measure will provide a more comprehensive view of overall prescribing practices for a key group of diagnoses that currently contribute to overall prescribing. They asserted that the Antibiotic Utilization for Respiratory Conditions measure will minimize concerns that changes in measure performance are due to diagnosis shifting. Furthermore, we wanted to note that representatives from the CDC expressed support for this measure.

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

Alli Steiner:

Thank you, Deb. So, we will now invite discussion about the Antibiotic Utilization for Respiratory Conditions measure from Workgroup members. First let's hear from Workgroup members who are using the measure in the state. You may raise your hand if you wish to speak, and we will call your name and unmute you when it is your turn. Please remember to say your name before making your comment. And so, again, we would like to hear from any Workgroup members who are currently using this measure in their state. Sarah?

Sarah Tomlinson:

Hi. So, I am Sarah Tomlinson. I am the Senior Dental Consultant for the North Carolina Department of Health and Human Services. And I want to share that North Carolina has concerns about adding this measure to the 2027 Child and Adult Core Sets. Interestingly, the state has used the Antibiotic Utilization for Respiratory Conditions measure for the past two years. It uses the administrative methodology to easily calculate the measure, and it has reported it back to the managed care system beginning in measurement year 2023. And the measure has not been flagged for any data quality issues. However, in the coming years, although the state plans to continue to calculate the measure, they are considering no longer sharing the measure with the plan because it is not a state priority area, and the state is not holding the managed care plans accountable for it. So, as the medication ratio AMR seems to be a comparable measure that North Carolina values as it looks at medication utilization in respiratory conditions. North Carolina Medicaid has focused on asthma medication ratios because research has consistently identified racial and ethnic disparities in asthma mortality and morbidity. Antibiotic Utilization for Respiratory Conditions measure is not a conflicting measure to asthma medication ratio, but North Carolina prioritizes asthma medication ratio which is part of the current Core Set already. And then Avoidance of Antibiotic Treatment for Acute Bronchitis 18 and Older, that measure is also not a conflicting measure, and it is also part of the current Core Set. So, I also want to point out that the measure description notes that it is to be used for internal evaluation only. The measure steward, the National Committee for Quality Assurance, does not view higher or lower service counts as indicating better or worse performance. So, I have got to question the value of requiring states to report nationally a measure that is best used for internal evaluation. So, I do not support adding this measure. Thank you.

Alli Steiner:

Thank you, Sarah, for sharing that perspective from North Carolina. Is there any other representative from a state that would like to provide their perspective? I see David Kelley has his hand raised. David Kelley, would you like to speak?

David Kelley:

Hi. Good afternoon. This is Dave Kelley from Pennsylvania Medicaid. This is a measure that we – we use with our managed care plans. I think it has been available for the – reported for the last two years under NCQA HEDIS measures. We require all of our plans to – to report it. And then we do an average, a weighted average, across all of our plans. We have seen in our, and our data is actually publicly available for this measure, and the other measure that was – that is kind of a sister measure, we publicly report both. And, again, we – we have seen, I'll say, considerable variation within our managed care plans for many of the age bands. So, there is quite a bit of variation by – by health plan. So, we find that to be useful in – in having our health plans look internally at what is going on with them and then, you know, obviously, how do they compare to – to the other plans. It is for internal comparisons only, however, it is helpful, especially if there are major outliers either being, you know, way too high or way too low. I don't know if too low is a thing, but there is always caution there. That is probably why NCQA says what they say about this – this measure.

I know that there, you know, there is a lot of competition and a lot of space, you know, for – for metrics, and we already do have the other antibiotic utilization measure which is more specific, I think, to – to bronchitis and bronchiolitis. And I will say in our pediatrics, when you – they are kind of inverse measures. For our pediatrics, we – we see the measures really synch up. Where they don't synch up is - I think we have a lot of opportunity for, I'll say, we see probably over

utilization of antibiotics in our adult population. So, there is some value of looking at both. I, you know, again, I think part of the – the more heated discussion might be is there a need for real estate where there is already a measure that is, I'll say, similar, you know, on the Core Set? So, I mean, those are some of the challenges. There are other areas where there are huge gaps in the Core Set where there are no measures. So. That's how Pennsylvania uses it. I just wanted to share our thoughts with how we use it with our managed care plans. It is not part of any incentive program. Thanks.

Alli Steiner:

Thank you, David. Very helpful. Next, we will go to Jakenna.

Jakenna Lebsock:

Thank you. Jakenna Lebsock. Arizona Medicaid. I agree with the comments previously made by North Carolina. Because of how NCQA does advise on this measure, we would share concerns about reporting this up as a Core Set measure, although we do generally see value in understanding this from an internal perspective. It is something that our health plans would also be running on a regular basis as part of the NCQA efforts. But agree with previous comments, too, we already have a similar measure on the Core Set, and so to add another so closely aligned when there are so many important areas to focus on, we would not be in support of adding this to the Core Measure Sets.

Alli Steiner:

Thank you, Jakenna. Very helpful. Laura.

Laura Pennington:

Thank you. As noted in the initial description of this measure, Washington State, our Performance Measures Coordinating Committee added this measure to our state Common Measure Set in 2022 while at the same time removing the Avoidance of Antibiotic Treatment for Acute Bronchitis. This doesn't mean we still don't report that, but there were concerns raised by committee members at that time that the Avoidance measure is not an accurate reflection of prescribing practices due to potential gaming of the results. There was probably more discussion at that time, but I apologize I don't recall. But we do support the addition of this measure because we feel that it is a good – it is a good yardstick to see how we are doing in our state. Agree that it is just for reporting at this time with our MCOs, and they have been reporting that to us since 2022. So, we do feel like it is a valuable measure, but I also understand how people feel about having two similar measures. Thank you.

Alli Steiner:

Thank you, Laura. All right. Well, thank you to the states that shared the state perspective. I think at this point we can open it up to other Workgroup members. I see Rich Antonelli has his hand raised. Rich?

Richard Antonelli:

Yes. Can you hear me?

Alli Steiner:

We can. Thank you.

Richard Antonelli:

Thank you. So, I have been listening very carefully, and I really appreciate the – thanks to the chairs and the leadership for allowing the states to go first. And what I heard from states, and whom I have lots of trust in and respect for their work, is that they are using it internally. For me, that doesn't meet the bar of putting it into the national Core Set because of that – how closely aligned with the current measure it is. So, I, you know, think that it is quite good for states to pick and choose, but feel pretty strongly that I haven't heard anything to convince me that we should take up more real estate on the Core Set. Thank you.

Alli Steiner:

Thanks, Rich. We are glad – we are glad that you found that helpful as well. We will hear from Jeff.

Jeff Huebner:

Yeah. Also appreciate hearing from other states. And I do think this is an area that is in need of a better measure. And I do appreciate and heard that the states are using it internally. But I am thinking in my head, and perhaps this is worth us reflecting, or the Workgroup for the future, when a measure is proposed that is so similar to a different measure whether, if we had the opportunity to remove the other measure, if we would be willing to do that and add this one instead. Because I am hearing a potential consensus that this may be a better measure, and from my standpoint, both from the clinical side as well as looking at the population health side, I think there is that potential because it includes more conditions. And definitely I have heard and am aware and have seen how the current measure in the Core Set can be gamed by clinicians or systems. So, I am thinking carefully about this one. And, you know, I would – I would – if I lean toward or I vote for this, I will have to commit myself to making sure that we readdress the other measure next year potentially as one to remove.

Alli Steiner:

Thanks, Jeff. Very helpful. Let's see. I don't see any other hands raised at this time. As a reminder, we're interested in hearing from all Workgroup members at this time. Roshanda.

Roshanda Clemons:

Yes. I would just like to piggyback kind of on what Jeff said because I had a question in terms of with the previous measure, the existing measure already, the question is, is it – how is the effectiveness being measured? Like, are we – are we seeing improved outcomes based off of that measure? Are we seeing more antibiotic stewardship being addressed where we can say that we have a decrease in resistance, we are seeing less ER visits? I mean, if we can't tie that to the outcome existing measure, perhaps we should consider adding this measure and then removing the other measure if it is not showing any outcome. Just a thought. I don't know if we have any information on the existing measure to show whether or not we are seeing some improvement from it.

Alli Steiner:

Yeah, thanks, Roshanda, that is a great question. Is there anybody from the state – a state that is using this measure that can speak to that question, whether they have seen any improvement for the existing measure?

David Kelley:

This is Dave Kelley from Pennsylvania. I'm just looking at our publicly reported results. Over the last three years, we have seen about a four percent improvement in the pediatric rates. This is ages three to 17. Going from 76% to 80%. And with, again, our pediatricians always do a stellar job, I will say, in our adults over the last three years, we actually have seen it go down slightly by about 1-1/2%. But that number is much lower, and there is a bigger opportunity for – for improvement. 49% down to 47%. So, certainly room for improvement. And then we report it by all of our health plans, and I can tell you there is a lot of variation by health plans, probably almost a 20-point difference in percentages from our best performing health plan to our worst performing health plan for the adults. And within pediatrics probably about a 17% variation from the highest performing to the lowest performing. So, hopefully that is helpful.

Alli Steiner:

Thank you, David. And sorry, David. Just to confirm, where those statistics for the existing Core Set measure that focuses on acute bronchitis/bronchiolitis or for the proposed measure? Can we unmute David, please?

David Kelley:

That was for the existing measure. That was the previous three years of reporting. I can also pull up the current measure which we are considering, which has only – I think has only been around for two years. And, again, we have seen, I believe – I believe lower is better, I believe. And actually, in our pediatric group we went from 18.84% up to 28.88%, so we actually slipped there in the pediatric group. And then our adult group, we went from 16% to 21%. Again, those are adults 18 to 64. So, again, certainly room for improvement. And that measure, I think, has only been around for two years. At least we have only reported it for two years. And we actually have seen slippage and not improvement.

Alli Steiner:

Okay. Thank you so much, David. That's – that's what I thought. For that first measure you were referring to the bronchitis/bronchiolitis one, but we just wanted to make sure. So that's a very helpful perspective.

David Kelley:

Yes. That was from the current measure that is on the Core Set.

Alli Steiner:

Great. Very helpful. So, let's go to Angela next.

Angela Parker:

Hello. Okay. Good afternoon. It's Angie from Kentucky Medicaid. In looking at our antibiotic treatment and avoidance and measures for that, we are in the 25th percentile, so it is not good as far as an average through our six MCOs. We do have two MCOs that are a little bit better

than that. I think part of what we are looking at focusing on is through a drug utilization review with our pharmacy benefit manager and how to best address this. But I – I think when you're talking about pediatric patients, a mother with a screaming child goes and expects an antibiotic, and I think that is the challenge that we all have in antibiotic usage. But, in general, overall, our numbers are not the best.

Alli Steiner:

Thanks, Angela. We have – it looks like we have Laura Pennington. Laura, and when you make your comment, can you also just confirm which – if you are going to be speaking about the current Core Set measure that we are trying to ask about or the one proposed for addition.

Laura Pennington:

Thank you. Actually, I was working on the – I was reviewing the results for both, and I will start with the current measure, the existing measure, not the proposed one. Our MCOs, although we saw a slight dip in Measurement Year 2023, all consistently have been performing above the 75th percentile. The proposed measure, on the other hand, there's a lot of room for improvement. They are all below the 50th percentile. So, it could be attributed to the fact that it is a newer measure, and newer measures take time. But definitely an opportunity for improvement in the newer measure. The proposed one. So, if that helps a little bit.

Alli Steiner:

Yes. Thank you, Laura. Stacey?

Stacey Bartell:

Yeah, Stacey Bartell, AAFP. I just wanted to circle back on the comments that were made earlier about the NCQA comments about not considering a higher or level score better or worse in terms of use of antibiotics. I would encourage states to think about other ways of looking at that data, such as, are there types of care or types of providers who may be prescribing their normal ranges for your state. So, in the onset of the digital age, are we seeing more use of antibiotics on telehealth visits? Are we seeing more use of antibiotics in certain types of visits and certain types of nonphysician providers? I think that we all want to think we should never use an antibiotic, but we know that's not true. And I think we just have to be careful as we, you know, listening to Kentucky talk about their – their woes, I don't know that they learned how to game the system it sounds like. As someone noted earlier, we all know that if we don't use the diagnosis of bronchitis, then it doesn't hit the measure set and we look better on paper. And that is what happens sometimes when we hold physicians accountable for a measure that we sometimes don't have any control over. So, we know oftentimes that this measure hits us after the fact, so once it is measured we can't do anything about it. We can't do, you know, other than educating providers not to do it again. And we also note that, you know, from a primary care standpoint, our patients seek care at multiple sites. And when they go to other sites, we find that we have no control over how those antibiotics are dispensed at those sites, whether it is urgent care online telehealth through their insurance company, their payor, or whether it is an emergency room visit. And so, I would encourage the looking at the data from that perspective in the sense that hopefully driving back to your primary care physician reduces the use of unnecessary antibiotics. Thanks.

Alli Steiner:

Thank you, Stacey. Anne Edwards.

Anne Edwards:

First of all, I want to thank Stacey for bringing up that – that last point. We are in support of looking at appropriate use of antibiotics and have been looking for, I guess, the better measure. It is helpful to hear the states talk about how there is opportunity for improvement. Sounds like there may be some variation between state performance. I think the broader measure under the URI overall, we have leaned toward that, to understand that. and yet I agree with earlier comments, do – do we need two measures in this space at this time or can we – or – or is there added focus or an opportunity to look at these both at the same time? But I guess I really want to underscore that understanding the site of that, and I think that is a really important if we look at healthcare delivery, if there is some understanding where people – where the performance might be based on site of practice would support that as well.

Alli Steiner:

Thank you, Anne. Are there any other Workgroup member comments? Give it one more moment. Okay, why don't we move to the next slide?

So now we would like to provide an opportunity for public comment. If you would like to make a comment about the Antibiotic Utilization for Respiratory Conditions measure, please use the "raise hand" feature on the bottom right of the participant panel to join the queue and lower your hand when you are done. And we will let you know when you have been unmuted.

So far not seeing any hands from the public, so just a reminder this is an opportunity for public comment. And you can use the "raise hand" feature in the bottom right of the participant panel.

Okay. Well, not seeing any hands, I think we can move on. Thanks to the Workgroup members for your helpful comments, and we will go to the next slide, please. So, now we will move on to the vote. Next slide.

So, for our next vote, should the Antibiotic Utilization for Respiratory Conditions 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, please refresh your browser. Thanks, everyone. We are just waiting for all the votes to come through. Okay. Let's close the poll.

Okay. So, 31% of the Workgroup members voted yes. That does not meet the threshold for recommendation. The Antibiotic Utilization for Respiratory Conditions measure is not recommended by the Workgroup for addition to the 2027 Core Sets.

At this time, we are going to just pause and have a brief recap, and I just wanted to invite any Workgroup members if they wanted to share any additional insights to their vote before we move on. So, I will just pause, and feel free to raise your hand if any Workgroup members wanted to share additional context about their no vote for that measure.

David Kelley.

David Kelley:

I'm off mute? So, nobody else commented so I – I'll give you insight into my no vote.

Alli Steiner:

Thank you.

David Kelley:

I – I like the measure. I think it is only in its second year. Not sure about that, but I would have liked to – maybe we should have asked NCQA to comment on their – their recommendations on how it could be used. But furthermore, I think that perhaps in a future year we think in terms of adding – adding this and subtracting the other. And – because of the limited real estate and the fact that for right now it is a topic that is covered, this may be a good future addition and thinking in terms of retracting the – the other measure that is a narrower measure. So that is why I voted the way I did. I like the measure. We use it in Pennsylvania. Those were – those were my thoughts.

Alli Steiner:

Thanks, David. We appreciate you sharing that. Chimene.

Chimene Liburd:

I'll try not to be duplicative, but I – I support the previous speaker. I think there should be some consideration to next year removing the existing one and putting this into place or something similar. So that was the reason why I voted no.

Alli Steiner:

Thanks for that insight. That is very helpful. All right, well, not seeing any hands, let's move to the next slide. All right. So now we will be going on a short break, and we will meet back here at 2:45. Thank you.

BREAK

Alli Steiner:

Hi, everyone. Welcome back from the break. Now I would like to turn it over to Talia to present the Evaluation of Hepatitis B and C measure.

Talia Parker:

Thanks, Alli. So, as Alli mentioned, we will now discuss the next measure suggested for addition to the 2027 Core Sets: Evaluation of Hepatitis B and C. Before we jump into the details of this measure, I would like to note that there are no measures on the 2026 Core Sets related to this measure. Next slide, please.

This measure is defined as the number and percentage of adult non-dually eligible Medicaid beneficiaries who are tested for hepatitis B, or HBV, tested for hepatitis C, or HCV, and treated for hepatitis C. Nine rates are reported for this measure.

- Among the overall population, the percentage of adults tested for hepatitis B, tested for hepatitis C, and receiving treatment for hepatitis C.
- Among beneficiaries diagnosed with opioid use disorder, or OUD, the percentage tested for hepatitis B, tested for hepatitis C, and receiving treatment for hepatitis C.

- And among pregnant women, the percentage tested for hepatitis B, tested for hepatitis C, and receiving treatment for hepatitis C.

Next slide.

The measure steward is the Medicaid Outcomes Distributed Research Network, or MODRN, Data Coordinating Center at the University of Pittsburgh. This measure is an intermediate outcome, population health, and process measure. It is not suggested to replace a current measure. This measure uses the administrative data collection method. The measure includes denominators for all nine rates.

In the overall population, the hepatitis B and hepatitis C testing rates, or rates 1 and 2, define the denominator as beneficiaries ages 18 to 64 as of June 30th of the intake period. The intake period spans July 1 of the year prior to the measurement year through June 30th of the measurement year. The hepatitis C treatment rate includes beneficiaries included in the denominator for rates 1 and 2 who had a hepatitis C test during the intake period and a diagnosis of chronic hepatitis C within six months from the index hepatitis C testing date. It excludes beneficiaries who filled any hepatitis C treatment medication within six months before their index hepatitis C testing. The denominators continue on the next slide.

Among beneficiaries diagnosed with OUD, the hepatitis B and hepatitis C testing rates, rates 4 and 5, include beneficiaries ages 18 to 64 as of June 30th of the intake period who had at least one encounter with a diagnosis of opioid abuse, dependence, or remission at any time during the intake period. The hepatitis C treatment rate includes beneficiaries included in the denominator for rates 4 and 5 who had a hepatitis C test during the intake period and a diagnosis of chronic hepatitis C within six months from the index hepatitis C testing date. It excludes beneficiaries who filled any hepatitis C treatment medication within six months before their index hepatitis C testing.

Among pregnant women, the hepatitis B and hepatitis C testing rates, or rates 7 and 8, include beneficiaries ages 18 to 44 as of the date of delivery who had a delivery during the intake period. The hepatitis C treatment rate includes beneficiaries included in the denominator for rates 7 and 8 who had any hepatitis C testing during the pregnancy period and a chronic hepatitis C diagnosis during the pregnancy period. Next slide.

The measure includes numerators for all nine rates. In the overall population, the hepatitis B and hepatitis C testing rates define the numerator as beneficiaries who had at least one hepatitis B or hepatitis C test, respectively, during the intake period. The hepatitis C treatment rate includes beneficiaries who initiate a chronic hepatitis C treatment within six months, or 180 days, of index hepatitis C testing among those with a hepatitis C diagnosis.

Similarly, among beneficiaries diagnosed with OUD, the hepatitis B and hepatitis C testing rates define the numerator as beneficiaries who had at least one hepatitis B or hepatitis C test, respectively, during the intake period. The hepatitis C treatment rate includes beneficiaries who initiated chronic hepatitis C treatment within six months, or 180 days, or index hepatitis C testing among those with a hepatitis C diagnosis. And the numerators continue on the next slide.

Finally, among pregnant women, the hepatitis B and hepatitis C testing rates define the numerator as beneficiaries who had at least one hepatitis B or hepatitis C test, respectively, during the pregnancy period. The hepatitis C treatment rate includes beneficiaries receiving

direct acting antiviral treatment for hepatitis C during the six months postpartum period among those who were tested and diagnosed with hepatitis C during the pregnancy period.

The measure steward indicated that this measure can be stratified by race, ethnicity, sex, and geography. The measure was tested among adults non-dually eligible full benefit Medicaid beneficiaries in Delaware, Maryland, Maine, Michigan, Ohio, Pennsylvania, and Virginia. The measure was also tested in sub populations including pregnant individuals and individuals with opioid use disorder. And demographic subgroups based on race, ethnicity, gender, and geography.

According to the individual who suggested the measure and the measure steward, the measure is not currently in use by any state Medicaid programs. The individual who suggested the measure noted that Medicaid eligibility, category, and benefits could vary for the pregnancy subgroup across states depending on state coverage policy. In particular, not all states provide postpartum coverage up to 180 days as required in the hepatitis C postpartum treatment rate. So, measurement of hepatitis C treatment rates may be affected in those states. Medicaid.gov identifies 48 states, D.C., and the U.S. Virgin Islands that have extended postpartum coverage for 12 months after delivery. As of January 2025, Arkansas, Wisconsin, Puerto Rico, and Guam have not extended postpartum coverage. According to the individual who suggested this measure, since 2020, both the United States Preventive Service Task Force and the Centers for Disease Control and Prevention, or CDC, have recommended universal one-time hepatitis C screening for all adults and periodic testing for those with ongoing risk factors. The individual noted that CDC also recommends hepatitis C screening for all pregnant women during each pregnancy. The American Association for the Study of Liver Disease and the Infectious Diseases Society of America treatment guidelines recommend universal treatment of people diagnosed with hepatitis C except in those with a short life expectancy not remediated by hepatitis C treatment or liver transplantation. The submitter added that hepatitis C diagnosis and treatment has the triple benefit of reducing liver and all-cause mortality, reducing hepatitis C transmission, and reducing healthcare expenditures associated with hepatitis C complications.

The United States Preventive Services Task Force recommended screening for hepatitis B for all pregnant women during each pregnancy and among adolescents and adults at increased risk for infection. In 2023, the CDC recommended universal hepatitis B screening for all adults. The individual who suggested the measure noted that the Office of Infectious Disease and HIV/AIDS Policy, or OIDP, hosted a technical consultation meeting in March 2024 and a public comment period from May to June 2024 that provided an opportunity to build consensus for development of a feasible and meaningful viral hepatitis measure. Through the consensus-building process, the workgroup, consisting of OIDP, CDC, MODRN Data Coordinating Center at the University of Pittsburgh, and six state Medicaid agencies and their university partners focused on a measure that encompasses hepatitis B screening, hepatitis C screening, and hepatitis C treatment initiation. The individual noted that through both of these opportunities input was received from state Medicaid programs, state public health departments, providers, and national or professional organizations representing provider groups, viral hepatitis patients, Medicaid agencies, health plans, and public health departments. We also wanted to note that representatives from the CDC expressed support for this measure. Next slide.

And now I will turn it back over to Alli to lead Workgroup discussion and public comment.

Alli Steiner:

Thank you so much, Talia. So, we will now invite discussion of the Evaluation of Hepatitis B and C measure from Workgroup members. And first let's hear from any Workgroup members who are using the measure in their state. You may raise your hand if you wish to speak, and we will call your name and unmute you when it is your turn. Please remember to say your name before making your comments. David Kelley.

David Kelley:

Good afternoon. And full disclosure, I am the one who actually submitted this, what I am going to call cascade set of measures that really looks at – broadly looks at hepatitis B and hepatitis C. The measures as presented have – were not used in Pennsylvania other than with MODRN actually running the data, but I will say that very similar measures with slight modifications have been used within Pennsylvania to drive quality improvement and hepatitis elimination for probably the last three years. So, based on input from the stakeholder process that we went through, we actually modified, probably significant, some of the things that Pennsylvania was doing. But we used this kind of cascade to really drive quality improvement in bolstering those individuals that got screened especially focusing on individuals living with OUD and pregnant individuals. And we – after a lot of stakeholder discussion, really wanted to at least focus on not just looking at testing, but looking at those who were diagnosed with hepatitis B or hepatitis C, and then also looking at those that get treated, at least initiate treatment, for hepatitis C.

You know, within our state we have our managed care plans that have been very focused on these metrics and have looked at – they have developed their own kind of internal dashboards looking at some of these metrics and are using them for quality improvement efforts to enhance testing or screening. To also then look at individuals newly diagnosed with hepatitis B and C. And then to look at individuals with hepa – newly diagnosed with hepatitis C that have at least initiated treatment. I don't know if any of the statistics were shared, but, again, there is lots of room – opportunity for improvement. I am going to say that those individual – as far as testing, and I won't call it screening, but as far as testing goes, I think for hepatitis B and hepatitis C, again, across our seven states we saw significant variation. I think probably the high – highest percentage was probably around 16, 17% of those that were screened for hepatitis B and C. Screening rates for those living with OUD did go up somewhat. I think somewhere around 30%. And then screening for individuals that were pregnant was higher than that. I am going to say probably north of over 50 – between 50 and 60%. So, there is a lot of opportunity for improvement. Those results, those that were multistate results, we saw very similar results within our state, and we used them to drive quality improvement. With a big emphasis on getting more folks treated with hepatitis C focusing on provider networks who could actually prescribe. We removed prior authorization of these meds, so we really wanted to be able to measure what was happening there as far as getting folks initiated into treatment. And despite our measurements, I am going to say that less than a third of individuals that were newly diagnosed with hepatitis C were actually being treated.

So, again, from a, why should we add this to the – to the Workgroup – or to the Core Set standpoint? It was an identified gap in previous years. There is public support for this. There is also evidence-based guidelines that supports these – these metrics. And there is – the metrics are very feasible. They have been tested within seven states, and so there is good feasibility. And there is actionability. You can actually take the results and do quality improvement around both hepatitis B and hepatitis C. So, I – I will stop there, and I will let others weight in, comment. But if there are questions, I can certainly entertain them or if Dr. Donohue from MODRN University of Pittsburgh is probably on, she may be able to entertain questions as well.

Alli Steiner:

Thanks so much, David. That was a really helpful overview of that measure and how Pennsylvania has been using it. Not seeing any other hands at this time, why don't we open up – open it up to the rest of the Workgroup including federal liaisons. So, if you would like to make a comment or take David up on the offer to answer questions about that measure, please feel free to raise your hand and we will call on it. Stacey.

Stacey Bartell:

Hi. It's Stacey Bartell on behalf of AAFP. I just had a quick question. We had a question about the measure. I do not think that USPSTF has universal screening for hepatitis B. So, I was curious about that being added to the measure. I know there is one for hepatitis C, but I do not think there is one for hepatitis B. And then the future with vaccinations, and hopefully most kids under the age of 30 have been vaccinated. I am just curious about that approach in this population, if that is the right measure for this group.

Alli Steiner:

Thanks, Stacey. Is there anybody available to answer Stacey's question about the recommendations? Do I have Dr. Donohue from MODRN on the phone? If so, please raise your hand. Derek, can you please unmute Julie Donohue?

You should be unmuted.

Julie Donohue:

Yes.

Alli Steiner:

Great. We can hear you. Thank you.

Julie Donohue:

Can you hear? Okay, thanks so much. So, I might ask Stacey to repeat the second part of her question, but as to the first, our understanding was that that was – that USPSTF had recommended universal screening for – for hepatitis C and B. Apologize if that was added in error. Could you repeat the second question that you had?

Stacey Bartell:

It had to do with the land of vaccinations. You know, most kids under the age of 30 have been vaccinated now for hepatitis C, and so I wonder, you know, our hope is if we are vaccinating like we are supposed to, there really – the screening need would be less. You would probably only risk – you would probably only screen high risk individuals, pregnant females, or those with a history of substance abuse or IV drug use. I don't know that you would want – I think universal screening will become less likely. And I think we verified before this meeting that hepatitis B was not a USPSTF recommendation for the general public. But you – someone else can confirm that, but I am pretty sure we looked that up.

Julie Donohue:

Thank you. Yeah, your – I think your comment about the role of screening given vaccination rates is really important. And that that might be a part of state Medicaid agencies' quality improvement activities to measure vaccination rates along with screening in that age group.

Stacey Bartell:

I didn't have any further comments. I was unmuted. Sorry.

Alli Steiner:

Okay, thank you. And our understanding that in 2023, CDC recommended universal hepatitis B screening for all adults. But, again, if anybody on the phone has other information, please do bring that up during this conversation. I see David, you have your hand raised. Did you want to comment?

David Kelley:

Yeah, I just wanted to comment. The CDC did recommend universal screening for – for adults on hepatitis C starting, I think, in 2022 or 2023. So that – the U.S. Preventive Task Force may not have, but the CDC has recommended that. And then, you know, in this – in this testing measure, we don't call it a screening measure, but it is a testing measure where we just look at individuals and maybe not everybody needs to be tested because they have been vaccinated, but I think the most current recommendations are if you are unsure of somebody's vaccination status, and you are testing and they test negative, fine, you just give – either give them the vaccine or you can, again, you can test. So, the measure itself, the testing measure, is not meant to catch everybody. And, again, I think when we ran this across seven states, the testing measure was, you know, somewhere between seven and 12 or 13%. So, we wouldn't expect everyone who – every adult to get tested that year. But, again, the key thing is that there are strategies that can be developed to test more appropriate subsets. But looking overall at the population, looking at those low screening rates, you know, certainly may be of some concern. Now, we actually ran data across multiple years, and one of the things that states can do, and it is not part of this measure, you can continue to look at, across multiple years, how many states have actually – or how many folks have actually been screened across multiple years. Of course, if you have continuous enrollment, that is helpful. So, you know, the vaccination, the hep B vaccination, is certainly important. And, again, when in doubt, you can test, and when in doubt you can re-vaccinate if you can't get those records. So, your point is valid, but I don't think it would really greatly affect the screening measure. Or the testing measure.

Alli Steiner:

Okay, thank you, David. And Julie still has their hand up. Julie, did you have another response to that?

Julie Donohue:

No, I just need to put my hand down. Sorry about that.

Alli Steiner:

Okay. Thank you. No problem. Kim Elliott? Oh, okay. We can hear you.

Kim Elliott:

Okay. One of the reasons is because it is – the priorities, of course, of improving quality of care and improving outcomes for Medicaid beneficiaries. That's, you know, one of the things that we want to do using the Core Measure Set. And this is one of those measures that would demonstrate that priority. The other thing that I like about it is it is really actionable. So, there are multiple different paths you could go whether it is the testing. Whether it is increasing the vaccinations for individuals that are not currently vaccinated. Then, of course, treatment. So, I think this one has a lot of really good value for the measure set.

Alli Steiner:

Thank you, Kim. Did any other Workgroup members have comments, questions? Rachel.

Rachel La Croix:

Yes. Can you hear me?

Alli Steiner:

We can.

Rachel La Croix:

Okay. Yeah. I just wanted to echo Kim's feedback. We have not used this measure in Florida, and I have not been familiar with it before reading all of the information about it as part of this recommendation for addition. I know that we have been asked by some of the stakeholders who are advocates for the HIV/AIDS population here in Florida about potential measures that could be used to look at hepatitis screening and testing, and so I think there – we would definitely have stakeholders that would be interested in our picking up this measure and it being used at the national level for Medicaid. The other thing I really like about it is that it is looking at testing and treatment for hepatitis. But the fact that it has those breakouts for particular populations, for folks diagnosed with OUD and for pregnant women, I feel like it gives additional value to this measure. I know in the past the Workgroup, we have talked about doing stratifications or breaking out some of the existing measures for different populations like pregnant women, or folks with substance use disorders, or things like that. And so, I really felt like that was a value add from this measure as well, the fact that it does look particularly at the testing and treatment for some populations for whom looking at prevalence of hepatitis and treatment could be particularly important. So, those were other things that really made me think this looks like it could be a really good measure for Medicaid.

Alli Steiner:

Great. Thank you so much, Rachel.

Jeff?

Jeff Huebner:

Yeah, thanks, everyone. Regarding the hepatitis B question, I was just looking at the USPSTF file, and it looks like it is still recommended based on high-risk population compared to hep C which is a universal recommendation. And I am very excited about this measure. I was happy to participate in the feedback workgroup that HHS organized and really appreciate the process and the testing that has gone into feasibility around this. I am as well excited about it being an

actionable measure. I think it is a great example of an area for our Medicaid population where there is not focused quality improvement happening. We know there is a public health and population health challenge on this space, in particular for the pregnant and OUD populations. And I think it is a great example of a measure that will have a lot of value in the Core Set to push our states and our collaborative partners in the provider and health care systems as well as managed care forward to work together to address this in a better way. Even though there is universal screening recommendations for hep C, access to treatment, especially for the Medicaid population, is – is very challenged, I think in most states, and this is a measure that will help us improve.

Alli Steiner:

Thank you so much for your comments, Jeff. Laura?

Laura Boutwell:

Hi. This is Laura Boutwell from Virginia Medicaid. Thank you. I just did want to chime in and say that Virginia does track some of these measures for ongoing evaluation for our managed care organizations through our addiction recovery and treatment services program. Specifically, treatment of hepatitis C for our SUD patients as well as cascade of care for hep C. And in particular for treatment of hepatitis C, especially for those with a SUD diagnosis we have seem some modest improvement but that we do have that opportunity. And we echo the comment this is really valuable and actionable from our perspective with the focus that we have had looking at those – those measures for some of these populations.

Alli Steiner:

Thank you so much, Laura. Rich Antonelli.

Richard Antonelli:

Yes, thank you. I am particularly excited about this measure, and I will make two brief comments. The first one is I love the providence of how these measures came about, and so kudos to the MODRN folks for bringing us something in relatively short order, and I am just relishing the impact this could have. The second comment is that, and I am going to reflect back on one of our colleagues that said, gee, what about the people that are getting immunized. I actually think having this in the Core Set could actually allow us to gather really important data going forward. Especially those of us in the pediatric community continue to strongly advocate for immunization of children, and youth, and adolescents, and so this could – the sooner this gets into the Core Set, the sooner we will have data that can show the impact of continuing to promote immunizations for everybody. So, congratulations to the MODRN folks and thank you for bringing this measure forward. I am strongly in favor of it.

Alli Steiner:

Thank you, Rich.

Let's hear from Kai. I thought I saw a hand from Kai, but – oh, yes. Can we unmute Kai, please?

Kai Tao:

Unmuted.

Alli Steiner:

Yes, we can hear you. A little soft, though.

Kai Tao:

Can you hear me?

Alli Steiner:

Yes.

Kai Tao:

All right. So, yeah, definitely just want to put a plug in here for – especially for our pregnant patients. We have seen an increase of hepatitis C I believe, you know, over the – I think whatever data, and I know Lisa is not here from ACOG but obviously, as a nurse-midwife, and we work closely in collaboration with ACOG, we have seen a significant increase over – from 1998 for 2018 I believe, a sixteen-fold increase in hepatitis C in pregnant individuals. And so, it is just key that we make this routine, and I do believe, you know, this will be greatly – we know there is prevention here. We can prevent vertical transmission. And it will be greatly applauded in the maternal health space. So, thank you.

Alli Steiner:

Thank you, Kai. Lisa Patton.

Lisa Patton:

Oh, sorry. I keep muting myself. Yeah, thank you. I just wanted to voice support, as many others have done, for this measure. I think, you know, this group has talked a lot about the need for actionability and also, you know, trying to move toward better stratification. And the populations that this will help us learn more about and support in a variety of ways, you know, are really captured here, so I am just strongly in support of this measure and echo Richard's comments about, you know, thanking the measure developers in moving on this. So, very appreciative of that.

Alli Steiner:

Great. Thank you, Lisa. Angela?

Angela Parker:

Hello. Angie. Kentucky. I am also going to voice my support of this measure. I was on my call yesterday with the Department of Public Health concerning prescription criteria for hepatitis B and mentioned that this was being looked at, and they were like, oh, please, please, please. So, I know that this is something that we definitely need at the state as well. So, I am voicing my support wholeheartedly.

Alli Steiner:

Thank you so much, Angie. Roshanda.

Roshanda Clemons:

I thank everyone for providing the context and the background to this measure that has been introduced. I just have the question in terms of feasibility. For those states that – that don't have expansion. Like the measure said that it is going to require like postpartum, I guess, follow-up for 18 months. And some of us states, we've barely got 12 months postpartum expansion. And then what about for the other states who don't have expansion at all? Like could someone comment as to how that is going to affect the implementation of this measure? If it affects it at all.

Alli Steiner:

Thanks, Roshanda. I see Julie raised her hand. Julie, do you want to respond to that question?

Julie Donohue:

Absolutely. Yeah, so just to clarify, the measure proposes follow up for just six months into the postpartum period. And we recognize in the handful of states that don't have 12 months of coverage postpartum, the denominator will be smaller because there is a requirement for continuous enrollment in the six months postpartum. So, that – that's how we are addressing it. I don't know, Dave, if you have anything to add to that?

Alli Steiner:

I see David's hand is up. Can we unmute David, please?

David Kelley:

Thanks. I think as was mentioned previously there are only a handful of states that do not have the postpartum extension. So – and I don't know that – the data we submitted was, I don't know, back earlier I think in the fall, so there may have been an update from there as well. So, certainly we did call it out and recognized it as a challenge for those few states that don't have the – the extended postpartum period. So, and that is one of the few data challenges that we put forth. But as a workgroup, we had a lot of deliberation about that and we felt that this was really a significant sub-measure to actually look at. And some of the states, this was like one of their big priorities was looking at getting screening rates up even higher and then making sure that individuals that tested positive did get treatment. The thing that complicates it, as you know, is that, at least for right now, treatment is, per guidelines, is not recommended while still breastfeeding. And that's why we wanted to look out, you know, as far as we could in the postpartum period. There are some studies now ongoing that are actually looking at safe treatment of pregnant individuals postpartum that are breastfeeding. So, hopefully that – that will be even less of a barrier to getting this – this population into treatment once – once they have delivered.

Alli Steiner:

Thank you, David, for responding to that. And just to repeat one of the notes from earlier in the presentation, according to Medicaid.gov, as of January 2025, Arkansas, Wisconsin, Puerto Rico, and Guam have not extended postpartum coverage, but 48 states, D.C., and the U.S. Virgin Islands have extended postpartum coverage for 12 months after delivery. So, hopefully that helps provide some additional context. Any other comments from Workgroup members? Okay. Well, why don't we move on to the next slide, please.

So, now we would like to provide an opportunity for public comment. If you would like to make a comment about the Evaluation of Hepatitis B and C 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. And we will let you know when you have been unmuted.

Okay. Derek, can you please unmute Michaela? Please state your name and – thank you.

Michaela Jackson:

Hi. My name is Michaela Jackson, and I am from the Hepatitis B Foundation. The Hepatitis B Foundation is totally nonprofit but is solely focused on eliminating hepatitis B. And so, we were very excited to see this opportunity coming about, and so I just wanted to offer the community perspective of how important it is for this to go ahead and become a reality. So, in the past few years or so, we have seen hepatitis B cases rise by at least 500% in some states, a lot of that due to the opioid epidemic. But it also gave a very, very good insight as to how many people that we are missing because of hepatitis B screenings and how important it is for us to go ahead and make sure that we are doing all that we possibly can to ensure that people are being screened properly. I know there was a couple questions about the USPSTF, and this is something that we have been looking into and working on for a very long time. So, the CDC did recommend universal hepatitis B screening in 2023 officially, and USPSTF is supposed to be taking a look at what they have recommended for hepatitis B very soon at least. They review it every five years, and the last time hepatitis B screening was reviewed was in 2020, so I think we can expect them to take another look and hopefully align with the CDC and what they have to say. But overall, the community is very supportive and believes something like this has been a long time coming. We continue to see people diagnosed with hepatitis B far too late and they develop very serious liver complications that really could have been prevented if we had been testing, and screening, and moving people to care the way that we should have been for a while. So, thank you all to everyone who has voiced their excitement for this measure. The community is incredibly excited as well, and we hope to see it in action. Thank you for your time.

Alli Steiner:

Thank you so much, Michaela. Are there any other public comments? Not seeing any hands, thank you so much to the Workgroup members, to the public for a very robust and helpful conversation on that measure. So, let’s now move on to the vote. We will go to the next slide.

Okay. So, for our next vote, should the Evaluation of Hepatitis B and C measure be added to the Core Sets? The options are, yes, I recommend adding this measure to the Core Sets and, no, I do not recommend adding this measure to the Core Sets. Voting is now open. If you don’t see the question, please refresh your browser.

Emily Brown and Lindsay Cogan, if you could just try submitting your vote, we just want to make sure we are capturing that. Thank you. Just give us one more moment, please. Okay, we can close the vote.

All right. So, for the results, 84% of Workgroup members voted yes. That does meet the threshold for recommendation. The Evaluation of Hepatitis B and C measure is recommended by the Workgroup for addition to the 2027 Core Sets. So, thanks, everyone for your participation in the discussion and voting process. Let’s go to the next slide, please.

I will now pass it back to Tricia for a brief wrap up.

Patricia Rowan:

Great. Thanks, Alli. Thanks, everybody, for sticking with us today and for such a robust discussion. We appreciate all of your contributions. We appreciate your patience while we figured out the voting platform. And your patience with any technical difficulties that folks were experiencing.

So, to recap today's discussion, the Workgroup considered two measures for removal and did not recommend that those measures be removed. Those two measures were the Contraceptive Care – Postpartum Women measure and the Contraceptive Care – All Women measure, which are on the Child and Adult Core Sets. So, neither of those measures met the threshold for recommendation for removal from the Workgroup.

The Workgroup also considered two measures for addition today and recommended one of them be added. So, the two measures that were considered, the first one was the Antibiotic Utilization for Respiratory Conditions measure. That measure was not recommended by the Workgroup for addition. The second one was the Evaluation of Hepatitis B and C measure which was recommended by the Workgroup for addition to the 2027 Core Sets.

Thanks, again, everybody, for your patience and your participation today. I would like to briefly preview the agenda for tomorrow before we wrap up. Can we go to the next slide?

So, tomorrow we will discuss the remaining four measures which were suggested for addition. They are listed on the slide here, but they are the Depression Remission or Response for Adolescents and Adults, Initial Opioid Prescribing for Long Duration, Early Childhood Oral Evaluation by a Dental Provider Following a Medical Preventive Service Visit, and Adults With Diabetes – Oral Evaluation. We will also discuss gap areas which will help inform the Public Call for Measures for the 2028 Child and Adult Core Sets. And I will provide a recap of the meeting and discuss future directions. We will also discuss next steps in the Core Sets Annual Review process and have a final opportunity for public comment. Next slide.

I did promise earlier this morning that I would preview our plan for tomorrow's discussion of gap areas which will help inform the 2028 public Call for Measures. So, tomorrow we will go – go through the roster and ask each Workgroup member to briefly mention one gap area that they think should be a priority for the Core Sets. You can also plus one a gap area mentioned by another Workgroup member meaning that you can add your support or your voice to something that someone else has mentioned. Note that we plan to call on each Workgroup member in the order listed on the roster. So, if you are at the beginning of the alphabet, make sure you are ready tomorrow. And please keep in mind the purpose and the uses of the Core Sets which we discussed earlier today and you can revisit in the slides tonight as you are – as you are preparing. There will also be an opportunity for public comment on those gap areas as well. Next slide.

Before we adjourn, I would like to turn to our Co-Chairs, Kim and Rachel. Do you have any final remarks to close out the meeting today? I think since we started with Kim this morning, we will start with Rachel.

Rachel La Croix:

Yes. Can you hear me?

Patricia Rowan:

We can. Go ahead.

Rachel La Croix:

Okay. Great. Yeah. I would just like to thank everybody for a really robust discussion today regarding the recommendations for possible removals and for additions to the Core Sets. I really appreciated everybody's thoughtful consideration around these measures and really taking into account what else is already in the Core Sets and the context in which we would be adding or removing measures. Particularly around the discussion of potentially adding the Antibiotic Utilization for Respiratory Conditions measure. I really appreciated everybody thinking of that in the context of the existing antibiotic metrics that we have in the Core Sets and how we all might want to think about a strategy next year related to balancing the possible use of one of those measures rather than both and just thinking about all those things for planning ahead for next year. I also appreciated all of the states who have used that measure sharing those experiences and your thoughts around the usefulness of that measure and how you may use it in certain circumstances but not others. That was really helpful to be able to consider as we talked about that measure. I also really appreciated everybody's feedback regarding the Evaluation of Hepatitis B and C metric. It is great to learn about a new measure that many of us aren't as familiar with but that looks like it can really provide valuable information for providing care and improving quality of care for our members. So, that was really helpful as well, and I look forward to our continuing to look at recommended measures tomorrow. So, thank you, everyone, and thank you Mathematica for organizing and keeping all of us on track.

Patricia Rowan:

Thank you, Rachel. Kim?

Kim Elliott:

Thank you. That was a great summary, Rachel, and I agree with everything you said. I really appreciated how prepared everybody was for each of the different measures that were discussed. It was clear that everybody was thinking about the different priority areas, the different things that would really make these measures either successful or not successful as a core measure including the data sources, the populations that would be impacted. Even down to penetration, how many people would be served by including a measure in the measure set. I also think it was really fantastic that we are seeing some perhaps new measure developers also really thinking through what is important to the Medicaid population and what could really improve the quality of care, the outcomes for these measures. But also really important is whether these measures are feasible, and I heard a lot of discussion today on whether these measures would be feasible and be able to be measured by the state, whether it is from data sources or even resource usage, and that the measures that were being discussed, whether they really mattered to the population being served and others within our Medicaid program. So, great job, everybody. Really great day. I am looking forward to tomorrow's discussions on the measures as well. So, with that I will turn it back to you Mathematica, who keeps on track and does a fantastic job every meeting.

Patricia Rowan:

Thank you, Kim. Next slide.

So, thank you, again, for participating in the first day of the 2027 Child and Adult Core Sets Annual Review. We will begin promptly at 11:00 Eastern tomorrow and ask Workgroup members to sign in a few minutes early just to make sure your connection is good.

This concludes the first day of our meeting. Enjoy the rest of your day and we will see you in the morning at 11:00 a.m. Eastern time. And with that I will adjourn our webinar. Thank you.